IMPLEMENTATION LETTER NO. 5

AN AGREEMENT TO SUPPORT THE GOVERNMENT OF UGANDA'S EFFORTS TOWARDS ENDING THE TB EPIDEMIC

BETWEEN

THE GOVERNMENT OF THE REPUBLIC OF UGANDA

AND

THE GOVERNMENT OF THE UNITED STATES OF AMERICA

USAID
FROM THE AMERICAN PEOPLE

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Office of the Prime Minister

Hon. Matia Kasaija
Minister of Finance, Planning & Economic Development
Kampala, Uganda

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Minister of Health
Kampala, Uganda

Hon. Tom Butime
Minister of Local Government
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Hon. Betty Kamya Turomwe
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SUBJECT: Implementation Letter to Support the Government of Uganda's Efforts to End the Tuberculosis (TB) Epidemic

Dear Honorable Ministers Mary Karooro Okurut, Matia Kasaija, Jane Ruth Aceng, Tom Butime, Betty Kamya Turomwe, and Mr. Moses Kamabare, and Ms. Donna Asiimwe Kusemererwa.

This Implementation Letter (IL) No. 5 is issued in accordance with the terms of the Development Objective Assistance Agreement for Improved Health and Nutrition Status in Focus Areas and Population Groups signed by the Government of the Republic of Uganda (GoU) and the Government of the United States of America (USG), acting through the United States Agency for International Development (USAID) on September 29, 2011, as amended, as well as the Development Objective Grant Agreement between the Government of the United States of America and the Government of the Republic of Uganda to Accelerate Inclusive Education, Health, and Economic Development through Uganda's Systems, signed on June 25, 2018 (the DOAGs). All terms applicable in the DOAGs are applicable to this IL, including provisions which exempt taxation on any goods and services provided herein.

This IL No. 5 follows Implementation Letters Nos. 2-4 (Supply Chain Implementation Letters No. 2 & 3 and Malaria Implementation Letter No. 4). All provisions and requirements specified under ILs 2-4 that may apply to TB control efforts remain in force, unless amended in writing.

I. Background

According to the recently conducted Uganda National Tuberculosis (TB) Prevalence Survey, the overall incidence of TB in Uganda is 234/100,000 – a rate well above previous estimates. Further, an alarmingly high number (87,000) of new cases occur every year, of which only 50 percent are detected. Efforts to end the TB epidemic in the country face increasing levels of Multi-Drug Resistant-TB (MDR-TB), caused in part by sub-optimal treatment success rates (TSR), of 75 percent among new and relapsed patients and 67 percent among previously treated patients. There has been major progress in expanding GeneXpert diagnostic coverage through support from the USG, the Global Fund, and other donors. This has improved the detection of MDR-TB cases, however only about 400 cases of the estimated more than 1,000 MDR-TB cases are detected and treated each year.

Deficiencies in the national TB control program are the result of weaknesses in national systems and structures that address TB, including: policy, leadership and oversight inadequacies; protracted procurement systems that contribute to repeated stock-outs of TB drugs and laboratory supplies; and poor ownership of the national TB program, manifested in part as dependence on donors for TB financing. The current GoU contribution of only 3 percent of TB funding leaves the TB program heavily dependent on international donors, who contribute 26 percent of resources, leaving 71 percent of program costs unfunded (Global TB Report 2017). Moreover, even funded activities are not being carried out as planned due to suboptimal National Tuberculosis and Leprosy Program (NTLP) implementation capacity. Only three of a desired staff number of 28 at the NTLP are GoU-funded. The majority of NTLP staff are seconded by USG-supported implementing partners. Moreover, delays in procurement processes cause stock-outs of TB drugs and lab supplies that lead to service interruptions.

Other factors that contribute to poor performance include feeble community systems to implement the continuum of TB prevention, screening, diagnosis, care and treatment, and critical human resource shortages with inadequate remuneration, both at the peripheral and central levels, hampering the capacity of the TB program to effectively lead, plan, implement, coordinate, monitor, and evaluate efforts to end TB. Additional impediments to effective TB control include: stigma regarding TB; a weak TB laboratory diagnostic network; an inefficient supply chain system for TB commodities; minimal private sector and community structure engagement in TB control; weak operations research; and insufficient monitoring and evaluation systems for TB.

II. Purpose

The purpose of this Implementation Letter (TB IL No.5), is to establish an agreement between the USG, through USAID, and the GOU, through the Ministry of Finance, Planning and Economic Development (MoFPED), with the concurrence of the Ministry of Health (MoH), the Ministry of Local Government (MoLG), Ministry of Kampala Capital City & Metropolitan Affairs, the National Medical Stores (NMS), the National Drug Authority (NDA), the Office of the Prime

Minister (OPM), (each a "Party" and collectively the "Parties"), and in collaboration with the Global Fund, to jointly address the increasing TB burden in Uganda.

This IL describes the respective roles, responsibilities, and undertakings that each Party will assume toward the achievement of this purpose, subject to the availability of funds and the applicable laws and regulations of each Party. In particular, the Parties agree that the high TB burden in Uganda will not be reversed by merely continuing existing approaches and by maintaining the current pace of implementation. In this vein, the Parties will work toward scaling up the implementation of highly effective and strategic interventions, including in the areas of service delivery, policy development and implementation, leadership, supervision, supply chain logistics, operational research, and robust monitoring and evaluation systems that contribute to reducing the TB burden and ending the spread of MDR-TB.

This IL further describes the actions that USAID will take, subject to availability of funds, to provide a) technical and operational assistance to the MoH's National TB Program, b) five or more highly skilled TB technical experts to NTLP, c) procurement of GeneXpert cartridge to reduce the current gap, d) direct support for quality MDR-TB services (technical, operational and Human Resources for Health (HRH) at the National Referral Hospital, in all Regional Referral Hospitals (RRHs), selected district hospitals and e) technical and operational support, primarily through the Defeat TB project, RHITES, and through other national-level systems strengthening and regional-based USAID partners to all districts across the country.

Additionally, the Global Fund will continue to cooperate with the Parties, consistent with its existing agreements, through support to service delivery components, procurement of TB commodities while supporting an integrated forecast and supply plan, and strengthening supply chain systems. The Global Fund additionally agrees to become a member of the Inter-Ministerial Task Force on Ending TB, and to collaborate with the Parties to scale up, align, and coordinate TB control efforts to respond to Uganda's high TB burden. The Parties acknowledge that this IL is not a legally binding commitment on the part of the Global Fund, and that this IL does not create any right vis-a-vis the Global Fund in favor of any party or person.

CDC has agreed to participate, communicate and collaborate with the Parties to ensure that efforts to end TB in Uganda are scaled-up, aligned and adequately coordinated to respond to the high TB burden. CDC further agrees to become a Member of the Inter-Ministerial Task Force on Ending the TB epidemic. CDC agrees to provide technical assistance to the NTLP and NTRL in coordination with USAID. Furthermore, CDC will support TB/HIV service delivery, including among key populations and prisoners in areas covered by CDC implementing partners, enhanced TB case finding strategies (including through improved diagnostics), and TB preventive therapy in alignment with Uganda national guidelines, and public health research and surveillance.

The Parties acknowledge that this IL is not an obligation of funds on the part of any Party or the Global Fund. The Parties further agree that this IL does not amend any existing agreements between the Parties or between any Party and a third party; or between Global Fund and any Party or third party..

III. Objectives

USAID will work with the MoH (AIDS Control Program, NTLP, NTRL, and RRHs), MoLG, MoFPED, NMS, NDA, and in collaboration with GF and CDC to accomplish the following objectives:

1. Increase the case notification rate of incident TB cases from 119/100,000 in 2015/16 to 156/100,000 in 2019/20, and increase the treatment success rate among notified incident cases from 74 percent in 2015/16 to 85 percent by 2019/20.
2. Strengthen TB/HIV integrated care for co-infected patients and increase antiretroviral therapy (ART) coverage among TB/HIV co-infected patients from 88 percent in 2016/17 to 95 percent by 2019/20.
3. Increase the drug-resistant TB case detection rate from 17 percent in 2015/16 to 51 percent in 2019/20, and increase the treatment success rate from 74 percent in 2015/16 to 80 percent by 2019/20.

To achieve these objectives, USAID and GoU, in collaboration with GF and CDC, address the following seven key areas that are critical to ending TB in Uganda:

1. Enhance the leadership and technical capacity of the TB program at national, regional and district levels to effectively coordinate, guide and manage implementation of activities to end TB.
2. Implement innovative, proven and effective strategies and tools for improving TB and TB/HIV case finding and treatment outcomes to meet national strategic plan targets.
3. Improve the programmatic management of the Drug Resistant TB (DR-TB).
4. Ensure uninterrupted availability of effective and quality TB commodities.
5. Improve availability of and access to quality and effective TB laboratory diagnostic services.
6. Strengthen private sector engagement and community systems to end TB.
7. Enhance results monitoring, evaluation and operations research.

To achieve the above objectives, the following roles and responsibilities are defined for different GoU entities and USAID.

IV. Roles and Responsibilities

A. Ministry of Health (MoH)/National TB and Leprosy Program (NTLP):

1. Within three to six months of the signing of this IL, MoH leadership will appoint a substantive NTLP program manager and provide the necessary resources, support, and motivation to effectively address the rising challenge of TB in Uganda.
2. Coordinate and oversee implementing partners and district health teams (DHTs) to ensure that national TB and TB/HIV policies, guidelines and Standard Operating Procedures (SOPs) are developed, implemented on time, at scale and in all districts. Use the TB prevalence survey findings as a tool to advocate with the Ugandan Parliament to declare TB as a public health emergency, and allocate resources commensurate with the TB threat; aim for at least a 50 percent increase from current funding levels over the next five years.

3. Create staff positions and secure approvals with the Ministry of Public Service, to match NTLP's staffing needs; advocate for increased GoU-funded staff at MoH/NTLP (to at least 50 percent of the need over the next five years).
4. Determine skill gaps and capacity building needs of NTLP staff
5. Use an appropriate Human Resource Information System to monitor NTLP staff development and management.
6. End chronic stock outs of TB reagents and supplies by creating a dedicated MoH budget line for TB lab reagents and supplies.
7. Ensure Global Fund-funded activities and procurements are approved in a timely manner to avoid delays in implementation as these greatly impact TB grant absorption. Specifically, price quotes received from the Global Drug Facility (GDF) should be signed by MoH within five working days of receipt to prevent quote expiry.
    a. MoH will review the approval process to address approval delays for other activities beyond procurement.
8. Many TB drugs, especially drugs for MDR and X-DR TB that are needed in smaller quantities, do not have registered suppliers in Uganda as there is inadequate market incentive to establish such agreements to do so. These drugs are critical for treating and saving the lives of Ugandans suffering from MDR/X-DR and would have significant public health impact in mitigating the spread of MDR/X-DR TB. However, it is becoming increasingly difficult to import these drugs due to a protracted National Drug Authority (NDA) clearance process. This leads to shortages or stock outs resulting in delayed initiation of treatment for new cases and treatment interruptions for those already on treatment. With the recommendation of the Inter-Ministerial Task Force, MoH and NDA will set up an expedited process for clearance of TB drugs.
9. Create an environment of zero tolerance towards stock-outs of TB drugs and reagents through the following:
    a. Procure lab commodities and equipment for DR toxicity monitoring for DR-TB treatment sites.
    b. Continue to coordinate with the Pharmacy Division to fully integrate TB commodities supply and management needs into Quantification and Procurement Planning Unit (QPPU) activities.
        i. Initiate procurement planning process 12 months in advance.
        ii. Ensure adequate buffer of 3 months for TB lab reagents-6 months for TB drugs.
    c. Coordinate NMS, Global Fund, GDF, and other entities to ensure that TB medicines are procured, cleared at port and delivered to NMS in a timely manner.
    d. Ensure that the TB medicines web-based ordering and reporting system (TWOS) is fully implemented and integrated with the web-based ARV ordering system (WAOS).
    e. Coordinate with NMS, Global Fund, and GDF to ensure consistent availability of First Line and Second Line Drugs (SLDs), standard laboratory supplies (ZN and FM reagents, sputum containers, LPA kits, GeneXpert cartridges) and X-ray supplies.
    f. Work with the MoH Department of Planning to monitor TB budgeting, planning and execution to maximize use of resources for TB commodities and reduce underspending.
10. Build the technical capacity of district health teams and regional teams on TB.

11. Improve diagnostic capacity (access to GeneXpert and X-ray penetration), through procurement and maintenance of X-ray machines and GeneXpert machines and cartridges with Global Fund resources and generate demand for services, enhance health care provider capacity to utilize these diagnostics.
12. Given the strategic role of chest X-rays in the diagnosis of TB, engage the Atomic Energy Council of Uganda to ensure that X-ray units meet safety requirements to avoid their closure.
13. Allocate funding for optimal utilization of available digital and manual X-rays.
14. Develop training materials on X-ray diagnosis, and coordinate rollout of training.
    a. Train and conduct supportive supervision and mentoring for healthcare workers and hold them accountable for utilizing Health Management Information System (HMIS) tools at the site level for reporting into DHIS2 and the Uganda Electronic Medical Records (EMR). Develop a roadmap towards the adoption of a unique TB patient identifier system to improve TB case finding and treatment outcomes. Initiate the long-term process of implementing the electronic patient management and monitoring systems in order to facilitate the process of transition from the mixed paper/electronic service reporting system to a purely electronic case-based surveillance system as a necessity for the end TB strategy.
    b. Establish a fully empowered (Supervision), M&E, Surveillance and Research TWG. The TWG shall be responsible for directing the process of enhancing M&E systems, including by strengthening partnerships to improve the quality of data, and improving data demand and use in decision making. This includes supporting activities to roll out the revised HMIS tools and ensure its expedited use; monitoring implementation and data entry DAPs, facilitating Regional and National Quarterly Performance Review meetings; as well as organizing Biannual planning and National Stakeholder Performance Review Meetings.
15. Coordinate periodic Data Quality Assessments (DQA) to evaluate the quality of data collected and reported by districts into DHIS2.
16. Expand the role of the private sector in ending the TB epidemic through:
    a. Coordinating, mapping, selecting, training and providing accreditation to private providers for TB services.
    b. Maintaining oversight, stewardship, coordination, and strategic leadership of private partners involved in TB control to ensure their accountability through the Public Private Partnership (PPP) working group.
    c. Training private providers, when and where needed, to ensure compliance with national quality of care standards and adherence to reporting requirements.
    d. Expanding monitoring and supportive supervision activities to include private sites.
    e. Creating formal linkages/roles and responsibilities between the public and private health sectors for essential TB services. Functionalizing referrals for TB diagnosis and treatment.
    f. Procuring and distributing TB medicines, lab supplies and data tools to private facilities that are accredited, compliant with MoH technical and accountability standards and
    g. Strengthen district capacity to supervise the Private for Profit entities' role in TB services.
17. Build capacity for community structures in TB control activities (support case finding, linkage, and DOT implementation).

a. Coordinating, mapping, and training of CHEWS, CBOs and other community structures for TB detection, treatment and prevention.
b. Integrate activities to end the TB epidemic into community health extension workers (CHEW) strategy.
c. Maintaining oversight, stewardship, coordination, and strategic leadership of CSOs and CBOs in TB control.
d. Develop and disseminate standard operating procedures and Guidelines guiding the implementation of community-facility linkage, client and sample referral as well as other activities that enhance TB case finding and treatment outcomes.
e. Expanding monitoring and supportive supervision activities to include community structures involved in TB control.
f. Spearhead evaluation of CB DOTS making it relevant to the needs of DR and DS TB patients in both rural and urban settings. Identify, train, and support former TB patients as champions and advocates for TB control activities. Incorporate into TB services existing multi-sectoral efforts that address the interrelationship between health, nutrition and food security.
g. Ensure that all individuals with active TB receive an assessment of their nutritional status and appropriate counselling based on nutritional status at diagnosis and throughout treatment.
h. Ensure that all school-age children, adolescents (5 to 19 years), and adults, including pregnant women with active TB and malnutrition are evaluated and managed in accordance with the WHO recommendations for the management of malnutrition
i. Coordinate and monitor an effective and transparent system for providing Global Fund supported enablers (funded food packages and transport refunds) to DR-TB patients.

18. Develop and disseminate guidelines, through existing district structures, and tools for tracing and screening of all DR-TB household contacts in communities.
19. Support and monitor the implementation of infection prevention and control practices in facilities managing TB cases. This includes procurement of personal protective equipment and the provision of appropriate transport system for transferring MDR/XDR-TB patients between facilities.
20. Ensure that quarterly TB cohort reviews and quarterly supportive supervision visits by MoH/NTLP to DR-TB treatment sites take place and key outcomes are shared with the Inter-Ministerial Task Force and used for improving quality of services.
21. Provide technical and programmatic oversight to increase Drug Resistant TB (DR-TB) patient diagnosis, enrollment, DR-TB patient management, and quality DR-TB treatment.
22. Ensure all NRH and RRHs have DR-TB treatment units and serve as a hub for quality DR-TB services in their region.

B. MoH/AIDS Control Program (ACP):

1. Work with NTLP, NMS and other stakeholders to further enhance the 3Is (Isoniazid Preventive Therapy-IPT, Infection prevention and control, and Intensified case-finding) and ART for TB/HIV co-infected clients.
2. Increase TB case detection among People Living with HIV (PLHIV) by improving TB screening and access to X-ray and GeneXpert in HIV care setting.
3. Implement innovative approaches for increasing GeneXpert utilization.

4. Increase IPT coverage among PLHIV from 20 percent to 90 percent in the next five years through:
    a. Mobilizing and committing more resources for procurement of IPT commodities for all PLHIV.
    b. Developing an implementation road map with relevant stakeholders.
    c. Coordinating with NTLP to jointly monitor districts and implementing partners.
    d. Planning and committing resources annually for the procurement and availability of adequate Isoniazid (INH) and Pyridoxine at all TB/HIV integrated care sites.
    e. Working collaboratively with the NTLP to provide supportive supervision, mentoring and training to support IPT uptake.
5. Establish a robust monitoring and evaluation (M&E) system for PLHIV on IPT.
6. Put in place measures for enhanced TB infection control in HIV settings.

MoH/Regional Referral Hospitals (RRHs):

1. Implement intensified TB case finding at all entry points within the hospital.
2. Take the lead in addressing the challenge of DR-TB and serve as technical hubs in managing complex DR-TB cases.
3. Quantification, ordering of TB medicines and lab supplies to ensure zero stock out and mitigate expiries.
4. Implement TB and infection control guidelines and Standards of Practice (SOPs) issued by the MoH/NTLP.
5. Ensure that adequate and qualified GoU appointed health care workers are assigned to TB units.
6. Train, supervise, mentor and provide continuous medical education (CME) to health workers at hospitals and lower facilities in the region. This will be done in coordination with DHOs and TLS.
7. Support TB and DR-TB diagnosis and surveillance and link all newly diagnosed DR-TB patients from peripheral facilities to TB care. Psychosocial support for DR-TB cases through community health department.
8. Build on the technical capacity of RRH-based DR technical panels to establish a hub and spoke model (with RRHs at the center) to oversee clinical management and quality of care of DR-TB cases.
9. Provide the locus for regional capacity building, coordination, ensuring reliable medicines and supplies, quality assurance, performance improvement and reporting to district and sub-district levels within the region.
10. Support and participate in TB/DR-TB cohort and performance review meetings in the districts and regions.
11. Serve as regional centers for TB sputum microscopy external quality assessment (EQA).
12. Design, test and implement innovative strategies for facility and community based active TB case finding.
13. Support maintenance of laboratory and radiology equipment in their catchment area.

MoH/National TB Reference Laboratory (NTRL)/Supranational Reference Laboratory (N/SRL):

1. Ensure availability of specialized TB testing at the national level (culture and drug susceptibility).

2. Prioritize commitment of resources for regular maintenance of TB equipment (GeneXpert machines, microscopes etc.) through the district local government budget and regional maintenance workshops, placements, and bundle pricing.
3. Under the UNHLS, the NTRL should be obligated to address the NTLP objectives.
4. Ensure implementation of a comprehensive TB LMIS linking patient care and diagnosis.
5. Advise MoH on budget required for TB lab reagents/commodities.
6. Prioritize and advocate for improved utilization of laboratory investments (GeneXpert, microscopy, LAM for increased TB case finding and better treatment outcomes).
7. Support TB laboratory services at the intermediate and lower levels by providing standard operating procedures and oversight for the handling, reconstitution, and utilization of reagents and supplies for TB diagnosis.
8. Ensure a functional laboratory network for TB diagnosis in all the diagnostic and treatment units in the country:
    a. Improve TB sample referral and the transportation system through the hub network to ensure timely sample transportation and result return.
    b. Provide coordination, review, monitoring and technical guidance to implementing partners on operationalization of effective TB sample transportation.
9. Conduct in-service training and supervision of TB laboratory services for both sputum microscopy and GeneXpert tests.
10. Establish and ensure a functional external quality assurance (EQA) scheme for all the TB diagnostic techniques in the country and decentralize sputum microscopy EQA to the RRHs.
11. Work with NTLP to implement a phased expansion of GeneXpert services to all the Health Center IVs, hospitals and other lower level health facilities to ensure universal access to Drug Susceptibility Testing.
12. Technically advise MoH in setting up sustainable equipment maintenance agreement with suppliers.
13. Need to improve technical quality and strength of lab personnel. Should revise public service structure to include higher qualified lab staff. Improve working environment and avail supplies for highly qualified lab personnel to expand profile of lab tests to accommodate capacity of highly qualified lab staff, for better job satisfaction.
    a. Review the Ministry of Public Service cadre definition and appointment of degree holders in laboratory management services to manage TB at health center IVs and above.
14. Ensure timely management and communication to MoH/NTLP of patient care related data both for DS TB and DR TB for decision making.

Ministry of Finance, Planning and Economic Development (MoFPED):

1. Designate a MoFPED representative to participate in the Inter-Ministerial Task Force on TB Control.
2. Work with MoH to advocate with the Parliament of Uganda to declare TB as public health emergency and allocate increased resources towards it.
3. Monitor that GoU and donor funds allocated for TB are used for the intended purposes, for impactful activities and in a timely manner.
4. Support the implementation of approved policies and guidelines.

5. Ensure timely approval and procurement of Global Fund-financed TB commodities and other related activities to avoid interruption of patient treatment which impacts TB treatment outcomes.
6. Given that the current resources allocated to TB don't match the high TB burden, MoFPED and members of the inter-ministerial task force will advocate with Global Fund and other donors for increased TB funding for finding missed cases and TB commodity gaps. Coordinate with MoH and NMS to adequately budget and ring-fence funding for the procurement of drugs, supplies and equipment necessary for the prevention, diagnosis and treatment of TB.
7. End chronic stock outs of TB reagents and supplies by creating a dedicated MoH budget line for TB lab reagents and supplies.
8. Provide NMS **with timely access** to funding needed to procure, warehouse and distribute TB commodities; monitor NMS procurement to ensure that it follows the QPPU supply plan.
9. Annually notify task force members of the amount of funding allocated.

C. Ministry of Local Government (MoLG)/District Health Offices (DHOs):

1. Designate a MoLG and DHO representatives to participate in the Inter-Ministerial Task Force on TB Control
2. MoLG Permanent Secretary will include TB case notification, prevention and cure rate targets for district Chief Administrative Officers.
3. Improve performance around key TB indicators (including case notification and treatment outcomes) and work with MoH/NTLP to create TB awareness among district, political and community leaders so that the threat of TB among their populations is adequately understood and addressed.
    a. Dedicated local resources/revenue for TB planning, implementation, and monitoring.
    b. Districts allocate and effectively utilize primary health care funds for TB.
    c. Mobilize local leaders (political, cultural, and religious) to raise community awareness on TB.
4. Develop TB action plans and targets that adequately respond to the accurate TB burden in all districts and city councils, including Kampala.
5. Advise all chief executive officers working with DHOs to assign a full-time TB-leprosy focal person (TLFP), under DHO supervision, for managing TB and leprosy control and surveillance activities in respective districts.
6. Ensure universal access to DST (GeneXpert test) for all confirmed TB cases and link patients with DR-TB to treatment initiation centers.
7. Maintain a directory of DR-TB patients within the districts DHOs office.
8. Implement Directly Observed Treatment (DOT), patient centered care, tracking of patients lost-to-follow-up for improved TB treatment adherence, cure rates, treatment successes, and reduction in loss to follow up. Piggy back on the already established HIV/AIDS/ACP established structures including the DSDM.
9. Conduct quarterly data validation meetings to prepare data for the Regional Quarterly performance meetings for further validation and entry into the DHIS2.
10. Integrate TB services into existing facility and community based health services (immunization, MNCH, EID, HIV, nutrition).

11. Ensure contact tracing activities are implemented in all facilities and communities in the districts.
12. In coordination with the MoH, conduct regular inspections to ensure that division authorities supervise and monitor appropriate use of Health commodities in public and private facilities.
13. Monitor the availability of TB medicines and supplies in private and public facilities and report back to the Inter-Ministerial task force.
14. Work with districts/divisions to ensure that medicine and health supply needs are correctly estimated, appropriately ordered and well managed at the district and facility levels.
    a. Ensure health care workers are trained and mentored to accurately forecast, quantify and order TB commodities from NMS.
    b. Deploy medicine management supervisors (MMS) for timely reporting of the TB commodity situation in the districts to avoid stock outs.
    c. Implement national TB supply chain initiatives (e.g., Web-based ordering system).
    d. Provide USAID, the Global Fund representatives, CDC, and/or their representative's access to the inventory records of districts and health facilities to track ordering, receipt, storage and distribution of TB commodities.
15. Improve TB sample referral and the transportation system through the hub network to ensure timely sample transportation and result return.
16. Sensitize health care workers and community member on TB contact tracing, DR-TB, and stigma reduction.
17. Strengthen TB health facility-community linkages (for drug sensitive and DR TB) through CHEWs to increase demand for and uptake of TB health services, enhance patient retention and reduce loss-to-follow-up. Train and motivate CHEWs to ensure competency in community level screening, referral and follow up of TB cases.
18. Mentor health care staff in all TB facilities to implement continuous quality improvement towards improved TB and TB/HIV indicator performance.

D. Kampala Capital City Authority (KCCA):

1. Ministry of Kampala Capital City and Metropolitan Affairs representative will participate in the Inter-Ministerial Task Force on TB Control.
2. Improve performance of key TB indicators (including case notification and treatment outcomes) and work with MoH/NTLP to create TB awareness among division, political and community leaders so that the threat of TB among their populations is adequately understood and addressed.
    a. Dedicate local resources/revenue for of TB planning, implementation, and monitoring.
    b. Divisions allocate and effectively utilize primary health care funds for TB.
    c. Mobilize leaders (political, cultural, and religious) to raise community awareness on TB.
    d. Director of Public Health and Environment will ensure that all division TB action plans and targets will adequately respond to the accurate TB burden.

3. Ensure universal access to DST (GeneXpert test) for all confirmed TB cases and link patients with DR-TB to treatment initiation centers.
4. Maintain a directory of DR-TB patients within the divisions Directorate of public health office.
5. Implement Directly Observed Treatment (DOT), patient centered care, tracking of patient's lost-to-follow-up for improved TB treatment adherence, cure rates, treatment successes, and reduction in loss to follow up.
6. Integrate TB services into existing facility and community based health services (immunization, MNCH, EID, HIV, nutrition).
7. Ensure contact tracing activities are implemented in all facilities and communities in the all divisions.
8. Monitor the availability of TB medicines and supplies in private and public facilities and report back to the Inter-Ministerial Task Force.
    a. Work with divisions to ensure that medicine and health supply needs are correctly estimated, appropriately ordered and well managed at the division and facility levels.
    b. Ensure health care workers are trained and mentored to accurately forecast, quantify and order TB commodities from NMS.
    c. Deploy medicine management supervisors (MMS) for timely reporting of the TB commodity situation in the divisions to avoid stock outs.
    d. Implement national TB supply chain initiatives (e.g., Web-based ordering system).
    e. Provide USAID, the Global Fund representatives, CDC, and/or their representative's access to the inventory records of divisions and health facilities to track ordering, receipt, storage and distribution of TB commodities.
9. Improve TB sample referral and the transportation system through the hub network to ensure timely sample transportation and result return.
10. Conduct quarterly data validation meetings to prepare data for the regional quarterly performance meetings for further validation and entry into the DHIS2.
11. Sensitize health care workers and community member on TB contact tracing, DR-TB, and stigma reduction.
12. Strengthen TB health facility-community linkages (for drug sensitive and DR TB) through CHEWs to increase demand for and uptake of TB health services, enhance patient retention and reduce loss-to-follow-up. Train, motivate and oversee CHEW training curriculum to ensure competency in community level screening, referral and follow up of TB cases.
13. Mentor health care staff in all TB facilities to implement continuous quality improvement towards improved TB and TB/HIV indicator performance.

E. National Medical Stores (NMS):

1. Ensure that broad supply chain capacity building activities covered under the Supply Chain IL No. 3, including forecasting, supply planning, inventory control, storage and distribution, as well as logistics information systems, and data analysis and use for better management and decision-making, also address TB-specific commodity issues (Refer to IL No.3).
2. Designate an NMS representative to the Inter-Ministerial Task Force TB-IL.

3. Participate in joint annual forecasting and supply planning for TB commodities that should be completed and signed at least three months prior to the new GoU fiscal year.
4. Procure commodities in line with the supply plan developed jointly with MoH (NTLP, ACP, NTRL, NMS, USAID, CDC and other stakeholders)—refer to IL-3 for appropriate language
5. Collaborate with MoH in the development of policies, guidelines and tools for TB supply chain management.
6. Receive TB drug and lab orders through web-based ordering systems.
7. Report, on quarterly basis on disbursements, quantities ordered and received as it applies to TB drugs and TB lab supplies.
8. Share with MoH /NTLP information on supplies made to TB DTUs and quantities.

F. National Drug Authority (NDA):

1. Designate an NDA representative to participate in the Inter-Ministerial Task Force on TB Control.
2. Ensure timely provision of waivers for TB medications (less than 10 working days) whose suppliers are not registered in-country due to low country consumption rates, especially MDR-TB medicines. This will avoid interruption of patient treatment which impacts TB treatment outcomes and reduces the emergence of XDR-TB.
3. Implement active drugs safety monitoring for TB drugs.

G. USAID (through the Defeat TB Project and Other National-level Systems Strengthening and Regional-based Partners):

1. Recruit and second a highly qualified TB Technical Adviser to NTLP. The Adviser will assist the NTLP manager to effectively respond to the challenges of the TB program and expeditiously implement recommendations of the Inter-Ministerial task force.
2. To ensure efficient and effective functioning of the NTLP, provide technical support to the MoH/NTLP through the secondment of five technical staff (through the Defeat TB project) in various technical areas as identified by needs assessment conducted in collaboration with the NTLP. This will be conducted consistent with agreed upon staff transition plans developed in collaboration with the MoH.
3. Support MoH to track TB resources.
4. Support NTLP in coordinating and monitoring implementations of the District Action Plan (DAP) making use of dashboards to enable MoH to track district performance on TB case finding and other aspects of ending TB.
5. Support NTLP and districts to ensure rapid uptake and quality of DHIS2 rollout and use.
6. Assist in building NTLP leadership and technical capacity for effective TB control.
7. In collaboration with NTLP/MoH and other donors, including the Global Fund, provide support for the development, dissemination, and printing of revised TB-related policies, guidelines, manuals and tools for implementing effective and high impact interventions that address the high TB burden.
8. Provide assistance to MoH/NTLP and districts for implementation and monitoring of evidence-based and effective interventions at facility and community levels.
9. Procure additional GeneXpert cartridges to reduce the projected gap in supplies.
10. Support NTLP/NTRL to decentralize EQA for TB.

11. Support innovative e-learning platforms to enhance knowledge and skills transfer between different levels.
12. Support implementation and scale up of an effective urban DOT models for improved TB case detection and treatment success in Kampala, Wakiso, and Mukono and other regional towns by regional IPs.
13. Work with the Quality Assurance Department, the Planning Unit and NTLP to support institutionalization of quality improvement across all levels. Support each district to develop a quality improvement plan, emphasizing community engagement and facility-based improvements for high impact interventions and more effective health management systems.
14. Support DHTs to improve coordination and integrated programming among service providers and strengthen local government capacity to manage and coordinate the district health system at district, health sub-district (HSD) and facility levels.
15. Facilitate DHOs/division medical officers and District TB leprosy supervisors (DTLSs), DLFPS to conduct routine supportive supervision visits to health units to ensure quality services and to maintain up to date and quality district records for TB.
16. Strengthen DR-TB surveillance by supporting internet connectivity at sites with GeneXpert machines to enable timely reporting into GXAlert Laboratory Information management systems, transitioning this role to MoH over a period of 2-3 years.
17. Provide technical assistance for effective transition from 20-24 months MDR-TB treatment to the 9-11 month and other DR-TB treatment regimens through training healthcare workers on these shorter course regimens.
18. Provide technical assistance (as needed) at the national, regional and district levels to implement different pharmaceutical management and supply chain interventions to address long standing TB commodities issues.
    a. Improve district level system and activities for planning, managing and monitoring the availability and utilization of TB commodities.
    b. In collaboration with the MoH Global Fund provide technical assistance to improve ordering, tracking, warehousing and distribution and provide physical structures to ensure the security of commodities through the system as indicated in IL #3.
    c. Support training healthcare workers in facilities accredited for providing TB diagnosis and treatment services on the use of web-based ordering for TB commodities at the district level.
    d. Strengthen systems for redistribution of TB commodities in the region/district to avert stock-outs and expiry.
    e. Support the proper use of the Logistics Management Information System including stock cards and stock books, issue requisition vouchers and dispensing logs.
    f. Support pharmacovigilance reporting systems for TB drugs with emphasis on DR-TB medicines.
19. Support continuous laboratory quality improvement towards accreditation and laboratory biosafety to ensure safe handling TB sample during sample collection, processing and transportation.
20. Support the rollout of the electronic Laboratory Information Management System (LIMS) at the laboratory hubs with provision of hardware, software and training.
21. Support operationalization of the Uganda TB PPP National Action plan, by facilitating discussion and coordination between MoH/NTLP and the private sector, to ensure that

private facilities comply with TB service quality standards and are able to effectively manage and account for TB drugs and commodities supplied by public sector.
22. Support TB services quality assessment (SQA) for the overall TB program in Uganda. The TB SQA will inform the MoH TB quality improvement framework and the tools will be adopted as a standard for TB quality improvement assessment by the MoH/NTLP.
23. Support NTLP to develop a database, (similar to SIMS database), where supervision teams can submit facility SQA results and data are automatically analyzed and shared in a simplified dashboard that will be accessible by USAID, partners, MoH, and DHOs.
24. Jointly with MoH, review the TB dashboard on a quarterly basis to measure progress towards improvement and address quality and program issues in a timely manner. Make the dashboard accessible to other key stakeholders like the Global Fund.
25. Improve functionality and utility of the national Management Information Systems (MIS) by equipping health facilities and labs with hardware and software for data management. MoH in turn will ensure security and maintenance of equipment maintenance.
26. Conduct Data Quality Assessment (DQAs) to regularly evaluate the quality of data collected and reported.
27. Jointly with the DHTs, conduct quarterly site mentorship visits to support site-level performance improvement, documentation and records and data management.
28. Support the development of IEC materials for increasing community awareness through the USAID supported communication mechanism.
29. Support NTLP to build capacity for clinical diagnosis and X-ray reading abilities by clinicians.
30. Train technicians in preventive maintenance of GeneXpert machine.

V. The Inter-Ministerial Task Force on Ending the TB Epidemic

Pursuant to this IL No. 5, MoFPED will create an Inter-Ministerial Task Force on the TB epidemic. The Task Force, which will include the signatory and collaborating parties, will have an agreed Terms of Reference. The Parties further agree to the following:

1. The MoFPED shall preside over the Task Force as the chair and MoH will serve as the Secretariat for the Task Force's operations.
2. The Task Force will invite the Global Fund, CDC, other donors and representatives from civil society organizations to join the Task Force, in addition to the original members.
3. The Parties agree to use this Forum to discuss and resolve issues between members.
4. Policy issues that the Task Force is unable to resolve shall be referred to the Office of the Prime Minister by the MoFPED.
5. Members will accept and apply the terms of reference of the Task Force.
6. The Parties agree to ensure that each is represented by officials with the full knowledge and authority to speak for their respective Ministry, NMS or NDA.
7. OPM will chair every third monthly meeting of the Task Force to review progress and address all policy related issues that the Task Force, under chair of MoFPED, was unable to resolve.

VI. Work Plan

Within sixty (60) days after this IL is signed, MoH, in collaboration with all Parties and collaborators of this IL, will complete and submit a joint work plan setting forth the actions necessary to comply with the terms, conditions and objectives of this IL, which shall include the

participation of the Parties in an Inter-Ministerial Task Force on Ending TB, which shall serve as the highest coordination and accountability forum for TB.

VII. Monitoring and Evaluating Implementation of this IL

The activities outlined in this IL will be monitored on a quarterly basis at the Inter-Ministerial Task Force meeting. Within sixty (60) days after this IL is signed, all relevant Parties, in collaboration with USAID, will complete an M&E plan which will describe the approaches for ensuring effective implementation and achievement of results. The M&E plan will identify appropriate indicators for each level of the results framework; show data sources and describe how the data will be collected, and collated to regularly inform performance. The proposed plan will provide preliminary five-year performance indicator targets which will be reviewed and possibly revised during implementation discussions. The IL M&E plan is not a standalone plan. It will be building on existing MoH M&E plan and routine reporting systems.

VIII. Records and Audits

The Parties shall furnish USAID with performance data, technical reports and accounting records for activities that involve USAID commodities or technical assistance related to IL No. 5, whenever USAID reasonably makes this request.

IX. Project Management

For technical and administrative management of the implementation of this IL, USAID shall be represented by the individual and/or his/her alternate designated in a separate letter to the Parties and the Parties shall be represented by the individual and/or his/her alternate designated in a separate letter to USAID. The USAID representative shall be the primary liaison with the Parties and their implementing agents in the day-to-day implementation of the IL, and the Parties' representatives shall be the primary liaison with USAID in the day-to-day implementation of the IL.

X. Suspension and Termination

Either Party may terminate this Implementation Letter in whole or in part, or suspend this Implementation Letter in whole or in part, upon written notice to the other Party, if an event occurs that the terminating Party determines makes it improbable that the objectives of this Implementation Letter will be attained, or the terminating Party determines that continuation of the assistance described in this IL is no longer necessary or desirable.

Suspension or termination will suspend, for the period of the suspension, or terminate, as applicable, any obligation of the Parties to provide financial or other resources under the IL. Any portion of this IL which is not suspended or terminated shall remain in full force and effect. In addition, upon such full or partial suspension or termination, USAID may, at USAID's expense, direct that title to goods financed under the IL, or under the applicable portion of the IL, be transferred to USAID if the goods are in a deliverable state.

XI. Completion Date

This IL No. 5 will remain in force until December 31, 2021, unless terminated, suspended or otherwise amended by written agreement between the Parties.

XII. Amendments

This Implementation Letter may be amended or modified only by written agreement of the USAID/Uganda and the Ministry of Finance, Planning and Economic Development, with the concurrence of the responsible ministries, as applicable.

Sincerely,

Joakim Parker
Mission Director, USAID/Uganda

Witnessed:

Deborah R. Malac
U.S. Ambassador to Uganda

Acknowledged and Accepted By:

Hon. Matia Kasaija, Minister
Ministry of Finance, Planning and Economic Development:

Concurrence:

Hon. Busingye M. Karooro Okurut, Minister in Charge of General Duties
Office of the Prime Minister

17/07/18

Hon. Dr. Jane Ruth Aceng, Minister
Ministry of Health

24.08.18.

Hon. Tom Butime, Minister
Ministry of Local Government

Hon. Betty Kamya Turomwe
Minister for Kampala Capital City & Metropolitan Affairs

Mr. Moses Kamabare, Managing Director
National Medical Stores

Ms. Donna Asiimwe Kusemererwa
Executive Director, National Drug Authority

In Collaboration:

Mark Eldon- Edington
Head Grant Management Division
The Global Fund for AIDS, Tuberculosis and Malaria