**Goal 2 : Meet global and regional elimination targets**

**a. Achieve maternal and neonatal tetanus elimination**

Uganda received validation for having eliminated MNT in 2012. The main strategies the country is employing to sustain elimination consist of:

* TT immunization of high school girls (15-17 year olds) through annual school-based vaccination campaigns;
* A strong culture of vaccinating all women who come for antenatal care services (the rates of which have been increasing) with at least two doses of TT.
* Mandating of TT vaccination for all women 18-49 years of age, as well as for all 15-17 year old girls through the new Immunization Act. Parents and schools are held responsible for ensuring vaccination of girls and can receive fines or imprisonment if they are not (the same holds true for 18-49 year old women).

The current TT coverage rate (for two doses??) is 58% among women of child-bearing age, while the protection at birth (PAB) rate among infants is 85%.

There remains some (albeit a low?) risk of not sustaining the elimination in some areas of the country, however, (confirm with Messeret or Annet) due to weak surveillance, reported cases are not always investigated and at least one district in the 2011 risk assessment report had a rate above 1/1,000 live births (ref). There remain pockets of low TT coverage. In addition, the stated policy of ring vaccination around a confirmed case is probably not taking place, according to two informants. A further constraint to high TT coverage rates is that target-age girls not enrolled in school are missed through the school-based program. In addition, health personnel have difficulty calculating PAB rates and require training in this.

The following steps can help ensure sustainability of MNT elimination:

* Improve NMT surveillance, including investigating and testing all suspected cases;
* Strengthening and sustaining the school-based TT vaccination program for girls, and extend it to 15-17 year old girls not in school;
* Provide additional booster doses (of TT or Td) during childhood and include boys, since there have been cases in boys following circumcision (at what age?). This proposal is currently under discussion within the government.

1. **Achieve measles elimination and rubella & CRS elimination**

**Measles**

An estimated 46% of districts achieved coverage with a single dose of measles vaccine of ≥95% in 2015, against the GVAP target of \_\_% of districts, according to the Joint Reporting Form. National measles vaccination coverage is estimated by WHO and UNICEF at 82% in 2015. The country has experienced measles outbreaks each year of different magnitude, in areas with low vaccination coverage, including a large outbreak in 2015 with more than 60,000 reported cases (see Annex). The country is therefore not currently on track to eliminate the disease by 2020 (can we say this?).

A key factor in the continuing outbreaks is that, due in part to a global shortage of measles vaccine, actual measles vaccination coverage in 2012 was only around 30%, according to the cmyp (in contrast to the considerably higher WUENIC estimate) (cymp, p. 33). Because of this as well as continued low coverage in some areas of the country, there were an estimated 1.56 million children not immunized against measles by 2013 (EPI review). This has created a large susceptible population of unimmunized older children and a consequent shift in the age of cases to older children and adults, who have the potential of causing outbreaks.

Key challenges and issues affecting Uganda’s ability to meet the measles elimination target include:

* The fact that case-based measles surveillance is still weak and only an estimated 35% of cases are investigated, according to one informant. There are continues to be some “silent districts” and delays in reporting cases to higher levels of the system. The reasons are many of the same mentioned above, including a shortage of health workers, means of transport and fuel to investigate cases in the field and to collect and transport specimens to the reference lab. Polio funds are often used for case investigation, specimen transport and testing.
* While national measles SIAs are conducting every three years, along with localized campaigns in outbreak areas, actual coverage rates of these campaigns is unknown, due to data quality issues (reported coverage rates are often 100% or higher). The frequency of the SIAs is, however, considered adequate.
* The introduction of the second measles vaccine dose, originally planned for 2015, has been postponed to at least 2017, due to the issues with co-financing and the sustainability of the government’s contribution to immunization mentioned above. The year of introduction will depend on the results of the cost assessment and financial sustainability plan currently in progress and subsequent decisions about other new vaccine introductions.
* Rapidly reducing the population of susceptibles missed due to prior poor vaccination coverage would require conducting SIAs with a wide-age cohort, such as 9 month to 15 year olds. However, the Government lacks the funding to conduct these and GAVI only supports SIAs for children under five. However, UNEPI plans to conduct SIAs with measles-rubella vaccine in 2018, with GAVI support, which will target children up to 14 years of age.

**Rubella**

According to informants, rubella outbreaks have been occurring, and many suspected cases of measles that are not lab-confirmed are believed to be rubella. However, MR has not yet been introduced into the infant immunization schedule, as discussed above, though MR campaigns are planned for 2018.