MDA Preparation, Implementation and Evaluation: Lessons learned in Haiti, Benin and Burkina Faso

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Dr. Moudachirou Ibikounle, University of Abomey-Calavi, National NTD Program, Benin

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Getting Started

- Webinar technology orientation
- Access to slides and recording of the webinar
- We want your feedback!
- Previous webinars available at

www.ntdenvision.org/spotlight/ntd_technical_webinar_series
What is ENVISION?

ENVISION is an eight-year, global project (2011-2019) funded by USAID

What is ENVISION?

ENVISION supports national NTD control programs in 19 countries

Website: www.NTD envision.org

Twitter: @RTIfightsNTDs
Dr. Abdel Direny

- NTD Technical Advisor for ENVISION
- Recent fellow at Emory University’s School of Public Health
- Previously worked at IMA World Health as the Country Director for the Haiti NTD Program
Dr. Moudachirou Ibikounle

- PhD in Parasitology and NTD Control
- Previously collaborated with Institute for Research and Development (IRD, France) on STH/SCH epidemiology and vector control
- Lecturer and Head of Parasitology Department at the University of Abomey in Benin
- Assists the MOH in STH/SCH Mapping, coverage surveys and LF transmission assessments

(Presented by Dr. Jean Jacques Tougoue, ENVISION-RTI International)
Mr. Windtare Roland Bougma

- 13 years of experience supporting lymphatic filariasis elimination
- LF focal point for the national NTD program in Burkina Faso
- Provides technical assistance for LF mapping, MDA implementation, transmission assessments and other surveys throughout Africa

(Presented by Daniel Cohn, ENVISION-RTI International)
Haiti: Transmission Assessment Survey results
Dr. Direny

Benin: The effectiveness of health communication tools to educate communities about NTDs
Dr. Ibikounle/Dr. Tougoue

Burkina Faso: Assessing and Improving LF MDA Coverage
Mr. Bougma/Daniel Cohn

Questions and discussion
Transmission Assessment Survey Result from Haiti

Do we always need five rounds of MDA?

Abdel Direny, MD-MPH
NTD Technical Advisor
Haiti NTD program: Partners/Donors

Haiti

Partner Support for the LF Elimination Program in Haiti: 2014

- UND Supported Areas
- USAID/ENVISION Supported Areas
- CDC and UND Supported Areas
- MDA Stopped

Data Source: USAID’s NTD Database

Maps prepared by RTI International with funding from the U.S. Agency for International Development under cooperative agreement no. 693A0047. Disclaimer: Data may not have been approved by at least one level in the USAID NTD data review process.
Mapping methodology:

- **IU**: commune (district)
- **Sites**: 5 primary schools per commune
- **Sampled population**: school children 6-10 years old; 250 per commune
- **Test used**: Immunochromatographic test (ICT)

**Vector**: *Culex quinquefasciatus*

**Parasite**: *Wuchereria bancrofti*
Scaling up MDA

Geographic scale up

Cumulative number of treatments

Year

Cumulative Number of Treatments (in millions)
Mid term evaluation, (2010-2014)

- Sentinel and spot check site conducted after 3\textsuperscript{rd} round of MDA
- 500 persons (5 years old and above) tested in both sites
- ICT test

![ICT results chart](image-url)
Haiti Pre TAS (2014) ICT Results

- Sentinel and spot check sites selected based on their prevalence during mapping
- More or less 500 persons aged 5 years old and above tested in each site with ICT.

<table>
<thead>
<tr>
<th>Site</th>
<th>Baseline</th>
<th>Pre TAS</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plaine du Nord</td>
<td>45</td>
<td>1.2</td>
<td>Eligible</td>
</tr>
<tr>
<td>Saut d'Eau</td>
<td>44</td>
<td>0</td>
<td>Eligible</td>
</tr>
<tr>
<td>Quartier Morin</td>
<td>39</td>
<td>6.5</td>
<td>Non eligible</td>
</tr>
<tr>
<td>Limonade</td>
<td>37</td>
<td>0.98</td>
<td>Eligible</td>
</tr>
<tr>
<td>Port de Paix</td>
<td>34</td>
<td>3</td>
<td>Non eligible</td>
</tr>
<tr>
<td>Plaisance</td>
<td>30</td>
<td>0.4</td>
<td>Eligible</td>
</tr>
<tr>
<td>Milot</td>
<td>30</td>
<td>3.35</td>
<td>Non eligible</td>
</tr>
<tr>
<td>Acul du Nord</td>
<td>28</td>
<td>2.35</td>
<td>Non eligible</td>
</tr>
<tr>
<td>Cap Haitien</td>
<td>28</td>
<td>0.4</td>
<td>Eligible</td>
</tr>
<tr>
<td>Caracol</td>
<td>20</td>
<td>0.8</td>
<td>Eligible</td>
</tr>
<tr>
<td>Limbe</td>
<td>19</td>
<td>0.6</td>
<td>Eligible</td>
</tr>
<tr>
<td>Dondon</td>
<td>14</td>
<td>0</td>
<td>Eligible</td>
</tr>
<tr>
<td>Sainte Suzanne</td>
<td>7</td>
<td>0.2</td>
<td>Eligible</td>
</tr>
<tr>
<td>Chansolme</td>
<td>7</td>
<td>0.2</td>
<td>Eligible</td>
</tr>
<tr>
<td>Trou du Nord</td>
<td>5</td>
<td>0.6</td>
<td>Eligible</td>
</tr>
<tr>
<td>Anse a Veau</td>
<td>4</td>
<td>0.59</td>
<td>Eligible</td>
</tr>
<tr>
<td>L’azile</td>
<td>3</td>
<td>0.2</td>
<td>Eligible</td>
</tr>
<tr>
<td>Anse a Foleur</td>
<td>3</td>
<td>0</td>
<td>Eligible</td>
</tr>
<tr>
<td>Jacmel</td>
<td>2.5</td>
<td>0.4</td>
<td>Eligible</td>
</tr>
<tr>
<td>Anse a Pitres</td>
<td>2.5</td>
<td>0.2</td>
<td>Eligible</td>
</tr>
</tbody>
</table>
Haiti TAS 2014-2015

- **Number of EU**: 14
- **Type of survey**: School based
- **Age**: 6-7 years old
- **Target sample size** and critical cut-off determined by SSB.
- Team composed with departmental lab technicians of MoH trained by CDC, Ste Croix Hospital, and IMA.
- Supervision is done by central level (MoH, IMA, national lab)
## TAS Results 2015

<table>
<thead>
<tr>
<th>Site</th>
<th>Baseline</th>
<th>Pre TAS</th>
<th>Pre- TAS Status</th>
<th>TAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plaine du Nord</td>
<td>45</td>
<td>1.2</td>
<td>Eligible</td>
<td>Fail</td>
</tr>
<tr>
<td>Saut d'Eau</td>
<td>44</td>
<td>0</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
<tr>
<td>Quartier Morin</td>
<td>39</td>
<td>6.5</td>
<td>Non eligible</td>
<td>MDA continues</td>
</tr>
<tr>
<td>Limonade</td>
<td>37</td>
<td>0.98</td>
<td>Eligible</td>
<td>Fail</td>
</tr>
<tr>
<td>Port de Paix</td>
<td>34</td>
<td>3</td>
<td>Non eligible</td>
<td>MDA continues</td>
</tr>
<tr>
<td>Plaisance</td>
<td>30</td>
<td>0.4</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
<tr>
<td>Milot</td>
<td>30</td>
<td>3.35</td>
<td>Non eligible</td>
<td>MDA continues</td>
</tr>
<tr>
<td>Acul du Nord</td>
<td>28</td>
<td>2.35</td>
<td>Non eligible</td>
<td>MDA continues</td>
</tr>
<tr>
<td>Cap Haitien</td>
<td>28</td>
<td>0.4</td>
<td>Eligible</td>
<td>Marginal</td>
</tr>
<tr>
<td>Caracol</td>
<td>20</td>
<td>0.8</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
<tr>
<td>Limbe</td>
<td>19</td>
<td>0.6</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
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</tr>
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<td>0.2</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
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<td>2.5</td>
<td>0.2</td>
<td>Eligible</td>
<td>Pass</td>
</tr>
</tbody>
</table>
Comparing “pass” to “fail” EUs

<table>
<thead>
<tr>
<th>TAS status</th>
<th>ICT Baseline line (Median, range)</th>
<th>Epidemiological treatment coverage (Median, range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass</td>
<td>10.5</td>
<td>85%</td>
</tr>
<tr>
<td>Fail</td>
<td>32</td>
<td>84%</td>
</tr>
</tbody>
</table>
Should it always five rounds?

Sites with low baseline prevalence already reached zero.
These results from Haiti show that:
- In LOWER prevalence areas, mid term results showed zero (2 more rounds of MDA per current guidelines).

And
- In most HIGH prevalence areas, more than five rounds will be required

Considerations include:
- Concern about recrudescence
- Status of surrounding areas of the IU (are they all high/low prevalence?)
- WASH access and vector control status
- Cross border surveillance
- Efficient use of available resources
Thank you!
Acknowledgements

- Ministry of Health of Haiti
- USAID
- IMA World Health
- RTI/ ENVISION
- Centers for Disease Control (CDC)
- University of Notre Dame
- PAHO
- GSK
Lessons Learned from Benin Coverage Surveys

Effectiveness of health communication tools for the Benin NTD Program

April 5th, 2016
Moudachirou Ibikounlé, PhD
University of Abomey-Calavi, BENIN

(presented by Dr. Jean Jacques Tougoue
ENVISION-RTI International)
INTRODUCTION

• Total Population: 10,694,986 (2015)
• 117734km²
• 12 Departments
• 77 Communes
• 545 Districts
• 3755 Villages
• School Enrollment rate: 75% (20%-85%)
• NTDs are known as public health problem
• Since 2013, The ENVISION Project funded by USAID supports the NTD program _five NTDs (LF, Oncho, SCH, Trachoma, STH)
## Population targeted for MDA

<table>
<thead>
<tr>
<th>NTD</th>
<th>Endemic communes</th>
<th>WHO recommendation</th>
<th>Targeted population for MDA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphatic Filariasis</td>
<td>50</td>
<td>≥5 year olds</td>
<td>2,889,265</td>
</tr>
<tr>
<td>Onchocerciasis</td>
<td>51</td>
<td>≥5 year olds</td>
<td>6,417,654</td>
</tr>
<tr>
<td>STH</td>
<td>77</td>
<td>5-14 years and High-risk adults</td>
<td>2,371,384</td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>74</td>
<td></td>
<td>2,367,740</td>
</tr>
</tbody>
</table>

*Excluded from each MDA: pregnant women, nursing women under one week and bedridden patients
The aims of this study were to:

- Evaluate the knowledge of population (households) of NTDs
- Evaluate the effectiveness of health strategies and tools used by the national NTD control program

**Sampling**

- Among the communes targeted by MDA, **10 were purposely selected**
- Targeted population: population concerned for each MDA
  - IEC survey: only the heads of household were included and selected randomly:
  - **Total sample size: 605 for 2014 And 1038 for 2015**
Method

Questionnaire:
- The questionnaire on the IEC survey includes the following components:
  - The channel through which information on the MDA reached household members
  - Understanding images and messages displayed on posters and flyers
  - Knowledge about NTDs and clinical manifestations
  - Knowledge of mode of transmission of targeted NTDs
  - Knowledge of preventive measures including MDA
  - Suggestions to improve posters and flyers, information channels, health education and communication tools
## RESULTS (1/6)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>LF and Oncho</th>
<th>Sch and STH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of survey</td>
<td>2014</td>
<td>2015</td>
</tr>
<tr>
<td>Households</td>
<td>605</td>
<td>1038</td>
</tr>
<tr>
<td>Communes</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Villages</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>54.70%</td>
<td>51.54%</td>
</tr>
<tr>
<td>Female</td>
<td>45.30%</td>
<td>48.46%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schooled</td>
<td>40.05%</td>
<td>34.68%</td>
</tr>
<tr>
<td>Unschooled</td>
<td>59.95%</td>
<td>65.32%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 years</td>
<td>3.31%</td>
<td>1.20%</td>
</tr>
<tr>
<td>18y and over</td>
<td>96.69%</td>
<td>98.80%</td>
</tr>
<tr>
<td>Therapeutic coverage observed</td>
<td>62.75%</td>
<td>71.30%</td>
</tr>
</tbody>
</table>
Knowledge of clinical signs of each NTD by the population

**Onchocerciasis**
- Blindness: 69%
- Appearance of worms under skin: 6%
- Not applicable responses: 25%

**LF**
- Elephantiasis (big foot): 80.7%
- Hydrocele: 6.8%
- Not applicable responses: 16.6%

**Soil Transmitted Helminths**
- Digestive disorders: 12%
- Not applicable responses: 88%

**Schistosomiasis**
- Presence of blood in urine: 55%
- Presence of blood in the stool: 16%
- Not applicable responses: 29%

**RESULTS (2/6)**
Knowledge of transmission mode of each NTD by targeted population

**Onchocerciasis**
- backwaters and rivers attend, 32%
- being bitten by insects (Simulium); 20%
- Not applicable Answers; 48%

**Lymphatic Filariosis**
- being bitten by mosquitoes, 30%
- Not applicable Answers; 70%

**STH**
- non-compliance with food hygiene rules, 14%
- walking barefoot, 6%
- drink dirty water, 0%
- Not applicable Answers, 80%

**Schistosomiasis**
- Bathing in fresh water, 1.60%
- Not applicable Answers; 98.40%
Knowledge of NTD treatment/prevention

**Onchocerciasis**
- Non applicable, 8%
- Participate to MDA, 28%
- Protect themselves against the bites of blackflies, 14%
- Go to a health center if sick, 50%

**Lymphatic Filariasis**
- Participate to MDA, 35%
- Protect themselves against mosquito bites, 32%
- Sleep under mosquito net, 5%
- Go to a health center if sick, 5%
- No applicable answers, 8%

**STH**
- Participate to MDA, 4%
- Observed the food hygiene rules, 16%
- Go to a health center if sick, 5%
- Wear the shoes regularly, 2%
- No applicable answers, 73%

**Schistosomiasis**
- Participate to MDA, 4%
- Avoid swimming in waterbodies, 16%
- Be checked by a nurse, 5%
- No applicable answers, 75%
Effectiveness of MDA information channels

**Effectiveness (%)**

- Poster
- Flyers
- Local Radio
- TV
- Public criers
- School
- CDD
- Health center
- Church/Mosque
- Others

**MDA information channels**

- LF
- Oncho
- Sch and STH
Ways to Improve IEC strategies and tools

- Review poster images: 28.30%
- Review flyer messages: 13%
- Broadcast messages by churches, mosques and other places of worship: 80.40%
- More involvement of local authorities: 47%
- Several passages of town criers: 28.50%
- Organized focus groups in villages: 62.10%
- Increased messages in local radios: 68%
- No comment: 12%
Conclusions

- Town criers and local radios are the most effective health education channels for the NTD program in Benin

- More efforts should be made to effectively use religious leaders (churches and mosques) in social mobilization during MDA and for NTD prevention

Next steps:
- Need to undertake a follow up study about disputed communes, migrants and cross borders issues in areas bordering Nigeria and Burkina
ACKNOWLEDGEMENTS

• Ministry of Health, National Program for Communicable Diseases

• ENVISION Project, RTI International

• USAID
Experience Implementing MDA for Lymphatic Filariasis in Burkina Faso

W. Roland BOUGMA

LF Focal Point, National NTD Programme, Burkina Faso

(presented by Daniel Cohn, ENVISION – RTI International)
Located in West Africa
Area: 274,000 km²
Total Population (2015): 18,450,494
Divided into: 13 regions, 70 health districts (since 2007)

- **PCT NTDs targeted:**
  - Lymphatic Filariasis
  - Onchocerciasis
  - Schistosomiasis
  - Trachoma
  - Soil-transmitted Helminthiasis
Introduction

- Adopted resolution WHA 5029, for elimination of LF by 2020
- 2000: LF mapping in Burkina
- **Results**: the entire country is classified as a transmission zone for LF
- **High baseline prevalence**: ICT= 2-74%, mf= 24%
- Start of MDA in 2001, with full scale-up in 2005
Before the MDA

• Mobilization of supplies
• Development of guidance for implementers
• Cascade-training of implementers: integrated training sessions for regional and district levels; community distributors trained before each MDA
Distribution Strategies

Door to door & Field to field

Specific groups

Door to door

Fixed point: Health centers

Health workers as distributors in urban areas

Specific groups at places of employment
During the MDA campaign

• Carrying-out of operating procedures by implementers
• Cascade supervision of all the implementers
• Daily monitoring of treatment results in the health facilities
• Mop-up treatment in the villages that did not reach expected minimum coverage
• Supervised drug-taking in the CDs’ presence (partially applied)
• Locate and treat the positive cases from the sentinel and spot-check sites
Advocacy and Social Mobilization

- Advocacy meeting in all regions and districts before distribution
- MDA campaign launch ceremony
- Broadcast messages via radio (spots) and TV (spots, films) before and during MDA at all levels
- Using criers in villages and towns
- Film screening in villages with low epidemiological coverage
- Production and distribution of posters and fliers
After the MDA: Results/Flow of data

- Use of data from the national census (RGPH2006)
- Epidemiological coverage determined by village
- Monitoring of those who decline treatment
- Confirmation of reported coverage through coverage surveys
- Monitoring and case management of serious adverse events
Epidemiological and geographical coverage at national level, 2001-2015

Therapeutic coverage
- 2001: 77%
- 2002: 69%
- 2003: 72%
- 2004: 74%
- 2005: 77%
- 2006: 80%
- 2007: 81%
- 2008: 82%
- 2009: 80%
- 2010-2011: 81%
- 2012: 81.26%
- 2013: 80.32%
- 2014: 80.96%
- 2015: 80.34%

Geographical coverage
- 2001: 100%
- 2002: 100%
- 2003: 100%
- 2004: 100%
- 2005: 100%
- 2006: 100%
- 2007: 100%
- 2008: 100%
- 2009: 91.43%
- 2010-2011: 77.14%
- 2012: 44.29%
- 2013: 44.29%
Proportion of persons treated in 2015, by sex

52% Femmes
48% Hommes
Validation of reported coverage through surveys

Methods

- Sentinel sites: (WHO_CDS_CPE_CEE_2000)
- Cluster sampling: EPI  
  (WHO/CDS/CPE/CEE/2005.50)
- Comparative survey 2015: EPI/PPS/LQAS with NTD Support Center in Atlanta, GA
- KAP survey
- Assessment of frequency of adverse events
Reported vs Surveyed Coverage in Sites/Villages 2005-2013
Reported vs Surveyed Coverage in Districts (cluster sampling) 2003-2015

Expanded Program on Immunization (EPI) survey
Lot Quality Assurance Sampling (LQAS)
Probability Sampling with Segmentation (PSS)
KAP survey results

Urban (2003)
Rural (2015)

MDA Communication Channels

Mode of LF Transmission

- Close relative/friend: 17.8% (2003) vs 17.8% (2015)
- Places of worship: 2% (2003) vs 0.4% (2015)
- TV: 8.9% (2003) vs 1% (2015)

- Poor hygiene: 11.9% (2003) vs 10% (2015)
- Contact with blood: 9.3% (2003) vs 4% (2015)
- Flies: 1.9% (2003) vs 7% (2015)

2003 N= 1445  2015 N = 1044
2003 N= 1350  2015 N= 713
Eligible persons: Reasons for not taking the drugs (2015)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>21</td>
<td>25.61</td>
</tr>
<tr>
<td>Out of drugs</td>
<td>15</td>
<td>18.29</td>
</tr>
<tr>
<td>Not offered the drugs</td>
<td>2</td>
<td>2.44</td>
</tr>
<tr>
<td>Not informed of the campaign</td>
<td>25</td>
<td>30.49</td>
</tr>
<tr>
<td>Refusal</td>
<td>12</td>
<td>14.63</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>8.54</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>82</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

N=82/3096
Frequency of adverse events
2001 vs 2015

2001 N= 1110/2990
37.10%

2015 N= 42/1110
2.30%
Status of LF Elimination

- **MDA stopped**: 39 districts
- **Total population**: 11,736,789
- **Ongoing MDA**: 31 districts
- **Total population**: 6,713,705
Challenges/Constraints

• Mf prevalence of $\geq 1\%$ after more than 6 rounds of MDA in certain health districts

• Probable causes/hypotheses:
  • high baseline prevalence
  • environmental factors
  • entomology
  • social/cultural factors (KAP)
  • non-compliance
  • important migration flows in certain areas
  • supervised ingestion of MDA drugs insufficiently applied
  • insufficient IEC

• Treatment fatigue in some areas due to multiple MDAs
Looking forward

• Continue to organize annual MDA in districts needing treatment
• Strengthen IEC
• Develop complementary MDA strategies (LF strategy review)
• MDA data validation meetings after the campaign
• Conduct stop-MDA and surveillance surveys in eligible districts
• Continue implementation of passive surveillance activities
Conclusions

• Specifics include: projections of films in villages with low coverage, daily monitoring of data at health facility level, validation of reported data through surveys, identification and treatment of positive cases from sentinel and spot-check sites
• MDA has stopped in 39/70 districts
• In the majority of cases, reported epidemiological coverage was validated in post-MDA coverage surveys
• Coverage surveys gave us the opportunity to: adjust strategies, change sensitization messages, adapt IEC materials, and strengthen supervision
• Partner support is needed to implement additional strategies, strengthen IEC supervision, and work with us to slowly but surely interrupt transmission of LF in Burkina Faso for good.
Acknowledgements
Thank you!

- **Slides** and an archived **recording** of the webinar will be made available on the ENVISION website at [www.NTDenvision.org](http://www.NTDenvision.org).

- Previous webinar recordings can also be found on our website.

- We want your feedback! Please click on this link (also in the chat box) to complete a very brief survey:

  **SURVEY**: [https://www.surveymonkey.com/r/GTXR2XK](https://www.surveymonkey.com/r/GTXR2XK)

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