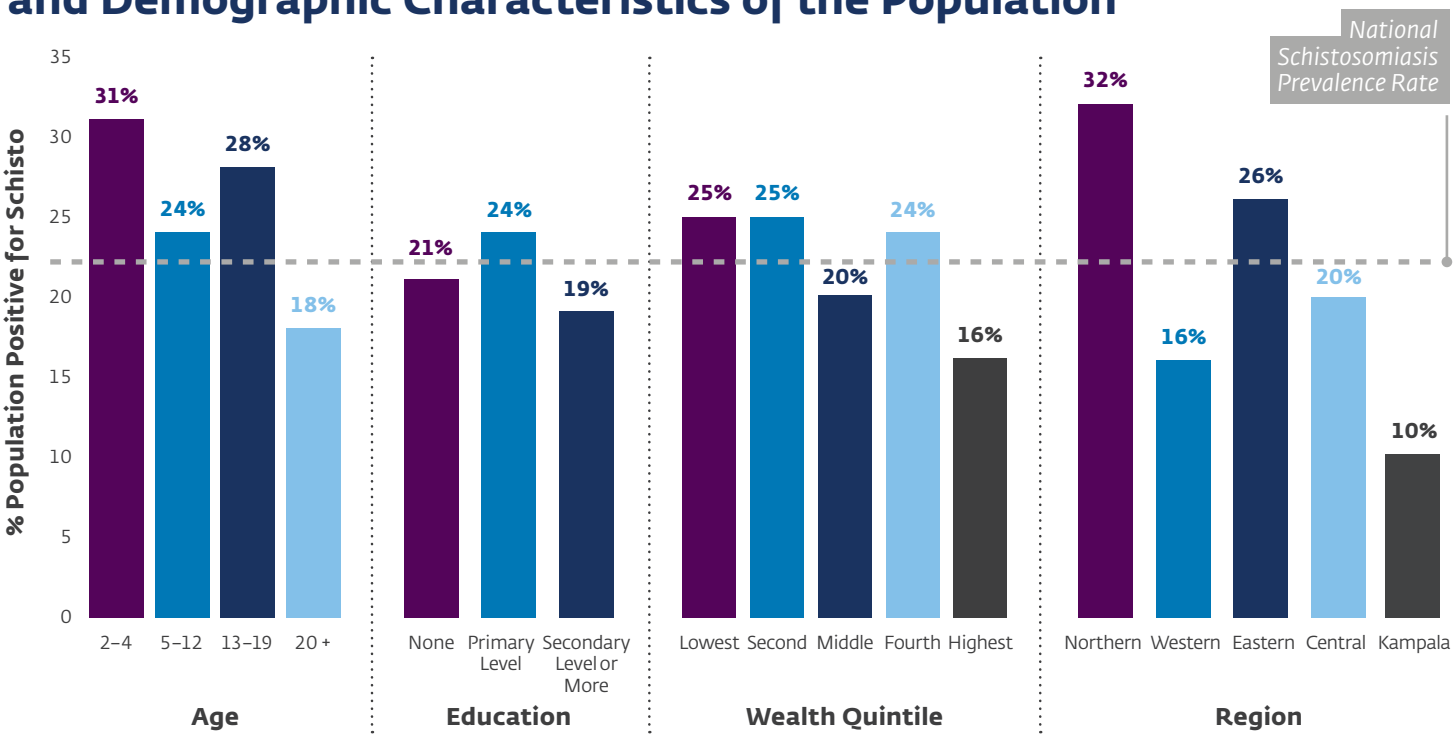
Schistosomiasis ("Bilharzia") Monitoring in Uganda

Round 1
October–December 2016

About Performance Monitoring and Accountability 2020 Schistosomiasis (PMA Schisto)

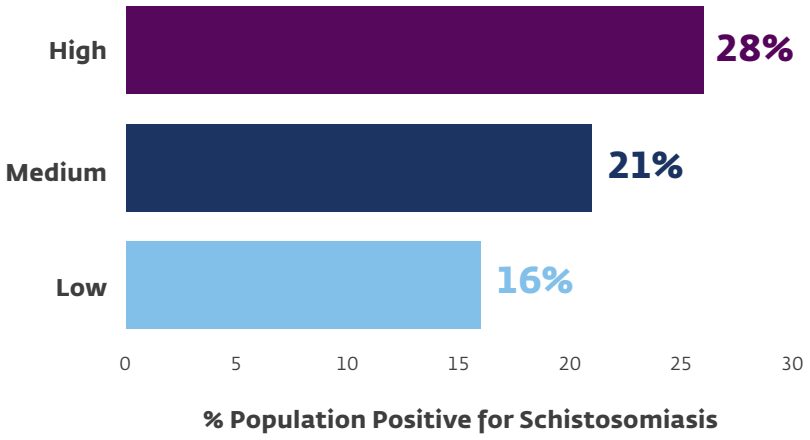
Performance Monitoring and Accountability 2020 Schistosomiasis (PMA Schisto) was a research module created specifically for Uganda, to develop the first nationally representative prevalence rate of Schistosomiasis, a highly endemic and neglected parasitic disease. The first round of PMA Schisto was implemented by Makerere University School of Public Health in Kampala, in partnership with the Uganda Bureau of Statistics (UBOS), the Uganda Ministry of Health's Vector Control Division and the Schistosomiasis Control Initiative. Overall direction and support was provided by the Johns Hopkins University Water Institute and the Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins School of Public Health through a generous gift from Maxmind, Inc.

Schistosomiasis Prevalence by Socio-economic and Demographic Characteristics of the Population



Overall Schistosomiasis prevalence in Uganda is 22% with children ages 2 to 4 as the most at risk age group (31%). These data show a similar prevalence of the disease across education levels and wealth quintiles.

Open Defecation & Urination Risk Index for Schistosomiasis Prevalence



Prevalence of Schistosomiasis is most common when open defecation and urination are practiced in surface water (high), but decreases when this practice is in the bush only (medium). Prevalence decreases further (low) when sanitation facilities are used.

Knowledge and Awareness Related to Schistosomiasis

SELF-REPORTED EVER HAVING SCHISTOSOMIASIS	Sample Size	Percent of Sample
Yes	199	9%
No	2066	91%
UNDERSTANDS THE PURPOSE OF A DOSE POLE *		
Yes	403	11%
No	3209	89%
EVER HEARD OF SCHISTOSOMIASIS		
Yes	1971	54%
No	1694	46%

Those that self-report ever having Schistosomiasis (9%) is lower than the percent that have the disease (22%). There is limited knowledge of the disease throughout the population.

** A dose pole is used to determine the appropriate drug dose on the basis of an infected person's height. Per the current WHO guidelines, individuals under 94cm in height are not eligible to receive treatment with praziquantel.*

Sample Design

The PMA Schisto survey used a three-stage sampling strategy. For the first stage, 170 enumeration areas (EAs) were selected by UBOS based on their distance to water bodies: near (within 5km) and far. Then, households and nearby water bodies were listed and mapped, with 30 households randomly selected per EA. After the household survey was administered, one of the household members older than two years of age was randomly selected for an individual interview and was offered a test for schistosomiasis. Individuals who gave informed consent were asked to urinate in a sterile cup and their urine was tested for the presence of schistosomiasis using a circulating cathodic antigen (CCA) test. Participants were offered treatment for Schistosomiasis with oral doses of praziquantel if they were found to be positive and met the criteria for treatment as advised by the Uganda Ministry of Health. The final sample included a total of 4,731 households and 4,562 individuals. Infection with Schistosomiasis was the main outcome of interest and was found to be positive in 1,097 individuals and negative in 3,418 individuals for a total of 4,515 participants tested and a nearly universal acceptance rate (99.0%) for CCA testing. Data collection took place between October and November 2016.