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TERMS OF REFERENCE · KT/RES/2026/01

West Nile Leprosy Operational Research and Case-Detection Pilot

Terego, Adjumani and Yumbe districts, Uganda

COMMISSIONED BY Kabukye Trust, Kabukye Village, Kamuli District
FUNDED BY The Leprosy Mission Great Britain
ADVERT PUBLISHED Monday 9 November 2026
PROPOSALS DUE Monday 23 November 2026, 17:00 EAT
CONTRACT Tuesday 1 December 2026 to Friday 30 April 2027
VERSION 2, revised November 2026

00 Summary

Kabukye Trust seeks a Ugandan university or accredited research institution to run a five-month operational research study and leprosy case-detection pilot in Terego, Adjumani and Yumbe districts, West Nile. Government health workers run the skin camps. Village Health Teams and peer researchers screen door to door. Government clinicians confirm and treat every case. The research team designs, observes, measures and reports.

Item	Detail
Reference	KT/RES/2026/01
Commissioned by	Kabukye Trust, Kabukye Village, Kamuli District, Uganda
Funded by	The Leprosy Mission Great Britain (TLMGB)
Primary study area	Terego, Adjumani and Yumbe districts: nine Health Centre IIIs (three per district) and their host and refugee catchments, with Arua Regional Referral Hospital as the referral point
Regional component	Desk review of routine leprosy data (NTLP and DHIS2) for every district in West Nile
Duration	Five months: Tuesday 1 December 2026 to Friday 30 April 2027
Contract ceiling	UGX 202,051,120, inclusive of all fees, costs, overheads and taxes
Advert published	Monday 9 November 2026
Clarification questions close	Monday 16 November 2026, 17:00 East Africa Time (answers published Wednesday 18 November)
Proposals due	Monday 23 November 2026, 17:00 East Africa Time
Contact	research@kabukyetrust.org

In this document, "must" marks a requirement and "may" marks an option.

01 Background and purpose

Leprosy in West Nile is found late. People affected often visit traditional healers first. There is no routine active case finding. Contacts of known cases are rarely examined. Follow-up stops once multidrug therapy starts, and many people leave treatment with avoidable disability. The region also hosts large refugee settlements, where displacement, poverty and stigma compound late diagnosis.

Kabukye Trust runs the Mile One leprosy programme in West Nile with TLMGB funding. Mile One works through the National Tuberculosis and Leprosy Programme (NTLP), the District Health Office and the Ofua Leprosy People's Organisation (OLPO). This study supplies the evidence for Mile One's next phase.

The study has two purposes. First, it finds people with undiagnosed leprosy through the government's own services and links them to treatment. In doing so it tests and strengthens the existing referral pathway from village to diagnosis. Second, it documents the living conditions, livelihoods, rights and access to services of people affected by leprosy in displaced and host communities.

The health system owns the fieldwork. Government health workers run the skin camps. Village Health Teams (VHTs) and peer researchers screen door to door, including the contacts of known cases, and refer

suspects. Cases are confirmed, recorded and treated in government facilities and registers. The contracted institution owns the research outputs and leads publication.

02 Goal, objectives and research questions

Goal. Improve early identification of leprosy in underserved communities of West Nile, and produce the evidence for two future programmes: a government-integrated leprosy service and a community programme for people affected by leprosy and displacement.

Objectives

1. Describe the extent and likely drivers of undetected leprosy through routine data review, government-led screening and community investigation.
2. Find previously undiagnosed cases through government-led skin camps, door-to-door screening by VHTs and peer researchers, and community referral, and link every confirmed case to treatment.
3. Assess the readiness of government health facilities and health workers to detect, confirm, treat, follow up and refer leprosy cases.
4. Document the lived experience, living conditions, livelihoods, rights, stigma, disability, mental wellbeing and access to services of people affected by leprosy, including refugees.
5. Record the basic costs of each detection route, and the costs people bear to reach diagnosis and treatment.
6. Produce two distinct sets of recommendations: one for a health-system programme and one for a community programme (Section 7).

Primary question. What evidence exists of undetected leprosy in Terego, Adjumani and Yumbe, what health-system and community factors delay detection, and how feasible is a government-led approach to active case finding and support for people affected?

Domain	Research questions
Undetected leprosy	What patterns of notification, disability grade and screening yield suggest missed or late diagnosis?
Case detection	Which route — skin camps, door-to-door screening or community referral — finds suspected and confirmed cases, at what cost per case?
Referral pathway	Where do suspects fall out between referral, confirmation, treatment start and follow-up?
Health-system readiness	What gaps exist in recognition, confirmation, drug supply, disability care, recording and follow-up?
Living conditions and rights	How do displacement, poverty, stigma, disability, gender and insecure livelihoods shape care-seeking, wellbeing and access to rights and services?
Government integration	What would the districts and NTLP need, and commit, to run active case finding as routine?

The design is exploratory and mixed-methods. Findings describe the three study districts. Where a finding may apply elsewhere in West Nile, the report must say why and label it "potentially relevant elsewhere". The household and qualitative samples are purposive. They show experiences, pathways and priorities, not population estimates.

03 Scope, study area and minimum targets

All primary fieldwork takes place in Terego, Adjumani and Yumbe districts. Each district contributes three Health Centre IIIs and their catchments. Arua Regional Referral Hospital confirms cases the health centres cannot, and manages reactions and disability (see the safeguards in Section 4). All three districts combine host and refugee populations. Terego hosts an OLPO and is where Mile One already works. The regional picture comes from NTLP and DHIS2 data for every West Nile district, reviewed at the desk.

The table sets minimum targets. A bid may propose more and must say what it buys. A bid that proposes less must justify it. Targets are confirmed at inception against clinical capacity and site selection. After that, no target falls without written approval from Kabukye Trust and TLMGB.

Government commitment. Before the contract is signed, Kabukye Trust obtains letters of commitment from the NTLP and from each of the three District Health Offices, confirming the screening targets and the nine skin camps. The letters are addressed by office, not by name, so they stand if staff change.

Component	Minimum target	Work stage
People screened for leprosy and other skin conditions, each counted once	12,000 across the three districts (4,000 per district): about 8,640 door to door (24 screeners × 9 days × 40 people a day) and about 3,600 at skin camps (9 camps × 400 people)	3
Government skin camps observed and recorded	9, one at each study Health Centre III	3
Door-to-door screening by VHTs and peer researchers	About 960 people in each of the nine Health Centre III catchments, in villages agreed at inception, including every traceable household contact of index cases notified in the three districts since January 2021, subject to register quality	3
Government health facilities assessed	10: the nine study Health Centre IIIs and Arua Regional Referral Hospital	2
Households affected by leprosy surveyed	70, at least 40% refugee	4
Client-cost interviews	Every newly confirmed case, plus up to 20 people diagnosed in the last 24 months	3
In-depth interviews	39: 24 key informants and 15 people affected by leprosy (five per district, at least 40% refugee)	3 and 4
Focus group discussions	5: four with people affected by leprosy and one with VHTs	4
Peer researchers affected by leprosy, paid at parity	15, five per district	4
Validation workshop	One day, in West Nile	6

What the screening can support. Expected yield is about 1 to 2.5 new cases per 1,000 people screened. At 12,000 people and a yield of 2 per 1,000, the study would find about 24 cases. The 95% confidence interval on that yield would run from about 1.3 to 3.0 per 1,000. That is enough to show whether active finding uncovers hidden cases, and to compare districts roughly. It is not enough to prove that one route beats another. The report must compare routes descriptively, using the larger denominators: suspects referred, suspects confirmed, treatment started and follow-up kept.

Out of scope. Clinical delivery, drugs and diagnostics (government); screening and safeguarding training for VHTs and peer researchers, and safeguarding training for the research team (Kabukye Trust, Section 4); a comparison group of unaffected households; and economic evaluation beyond the basic costing in Section 6.

04 Who does what

The government delivers the service. Kabukye Trust opens doors and coordinates. The contractor runs the research. These roles are agreed in writing at inception and signed by the District Health Officer of each district, the Director of Arua Regional Referral Hospital, the NTLP Regional Coordinator, Kabukye Trust and the contractor.

Party	Responsible for	Not responsible for
Government (NTLP, District Health Offices, Arua Regional Referral Hospital, health facilities, VHTs)	Running skin camps with government health workers; VHT door-to-door screening and referral; Arua Regional Referral Hospital as the referral point, with a named focal clinician; confirming diagnosis; disability grading; treatment; single-dose rifampicin post-exposure prophylaxis for eligible contacts, in line with national guidelines; recording cases in government registers and DHIS2	Research design, data analysis, reporting
Kabukye Trust	Field Coordinator (Kabukye Trust staff); community entry; links to OLPO, VHTs and district leprosy networks; letters of commitment from the NTLP and District Health Offices; chairing and paying for the steering group; transport and follow-up support for confirmed cases for 12 months; three-day screening and safeguarding training for VHTs and peer researchers; safeguarding training for the whole research team; stock of basic treatment for common non-leprosy skin conditions found at the camps, prescribed by government clinicians	Data collection, analysis
Contractor	Protocol; obtaining and paying for all research ethics committee, UNCST, district and OPM approvals; drafting data collection tools; recruiting, training, paying and supervising peer researchers; transport and meal reimbursement for health workers and VHTs on screening days; observing and recording screening; facility assessment; household survey; qualitative work; client-cost interviews; analysis; reports and publications (Section 10); mentoring Kabukye Trust staff	Clinical work of any kind; paying for treatment

Arua Regional Referral Hospital. The study depends on Arua confirming the cases the health centres cannot. Four safeguards apply:

- The hospital director signs the roles agreement and names a focal clinician for the study.
- The NTLP leads a readiness visit to Arua in January 2027, before the skin camps. This is routine supervision, not research, so it may take place before ethics approval.
- Stock of leprosy drugs and reaction treatment is confirmed before the camps start.
- The NTLP Regional Coordinator reviews the referral log every month.

If Arua cannot confirm a case, the Regional Coordinator reviews photographs of the case and refers the person to a named back-up referral point agreed at inception.

Screening training. The VHTs and peer researchers in the three districts have no previous leprosy or safeguarding training. Before fieldwork, Kabukye Trust runs a three-day screening and safeguarding course in each district, taught by the District TB and Leprosy Supervisor, a Kabukye Trust medical officer and the Kabukye Trust Safeguarding Lead. Kabukye Trust's Medical Officer and Leprosy Adviser reviews the training materials in advance. The course covers leprosy signs, door-to-door screening, referral, safeguarding and supervised practice. The contractor then gives the same VHTs a half-day briefing on the screening record,

consent and confidentiality, and gives peer researchers their five-day research training. Bidders must not price the screening course.

Safeguarding training for the research team. During inception week, Kabukye Trust's Safeguarding Lead trains the whole research team: the Principal Investigator, Data Manager, research assistants, transcribers and interpreters. Nobody starts fieldwork without completing it. Kabukye Trust pays for this training, and bidders must not price it.

Transport and meals for government staff and VHTs. Screening is part of the work of health workers and VHTs, so there is no screening fee. For screening days outside their routine duties, they receive transport and meal reimbursement at one flat rate, agreed at inception in line with government-approved rates. This reimbursement sits in the contractor's budget as a separate, ring-fenced line, with no overhead charged on it. It covers VHTs on the door-to-door screening days in each catchment, government health workers on skin-camp preparation and screening days, and District TB and Leprosy Supervisors on supervision days. Paying it does not make the contractor the service provider. The study records the actual time VHTs give, so government can see what routine delivery would need.

Who pays for each screening line.

Screening cost	Paid by
Transport and meal reimbursement for VHTs, health workers and District TB and Leprosy Supervisors on screening days	Contractor (ring-fenced line, no overhead)
Skin-camp mobilisation and logistics (venue, tents, community announcements, consumables)	contractor
Screening record, observation and data collection at camps and door to door	Contractor
Screening and safeguarding training for VHTs and peer researchers	Kabukye Trust
Basic treatment for non-leprosy skin conditions found at the camps	Kabukye Trust
Transport and follow-up support for confirmed cases, for 12 months	Kabukye Trust
Diagnosis, leprosy drugs, post-exposure prophylaxis and disability care	Government

05 Work stages

One team delivers all six stages under one Principal Investigator.

Stage 1. Inception, government engagement and approvals (1–18 December 2026). Hold the inception meeting with the NTLP, the three District Health Offices, the District TB and Leprosy Supervisors, Arua Regional Referral Hospital, facility in-charges, settlement health partners, OLPO and Kabukye Trust. The whole research team completes Kabukye Trust's safeguarding training in inception week (1–4 December). Sign the roles agreement. Check what routine data exist and how complete they are, and report this data-availability check in the inception report. Finalise one protocol: screening record, facility tool, household survey (target length 45 minutes, maximum 60, tested at pilot; participants may pause or stop at any time), client-cost module, interview guides, sampling and analysis plan.

Data collection tools. The contractor drafts the tools. Kabukye Trust's Leprosy Advisers and the NTLP review the clinical content. OLPO reviews language and stigma. The steering group approves the tools by Monday 14 December 2026, so that later changes do not need ethics amendments. Use validated stigma and participation scales where they exist. Submit to a research ethics committee, the Uganda National

Council for Science and Technology (UNCST), the three districts and the Office of the Prime Minister (OPM) for settlement access by 18 December, before the Christmas closure.

Stage 2. Routine data and health-system readiness (December 2026–February 2027). Review five years of notification data for every West Nile district from NTLP records and DHIS2, and from facility registers in the three study districts only: age, sex, multibacillary share, child cases, grade 2 disability at diagnosis, geography and reporting gaps. Treat routine figures as a minimum, not the true burden, and measure the gaps as a finding. Report completeness by district and by variable. Aggregate data may be analysed before approval. Published tables and maps show "<5" instead of an exact figure of 1 to 4, so that nobody can be identified. This does not apply to clinical records or data shared securely with the NTLP. Where numbers are small, report at district level or above. After approval, assess 10 facilities, the nine study Health Centre IIIs and Arua Regional Referral Hospital: recognition of leprosy by vignette and photographs, drug stock, referral routes, disability care, recording and follow-up. Use the results to plan the skin camps and to list index cases for contact screening in each catchment.

Stage 3. Government-led case finding (February–March 2027). Each district runs three skin camps, one at each study Health Centre III, presented as general skin clinics with private examination. Each camp follows a day of mobilisation and has a preparation day and a screening day. Before each camp, VHTs and peer researchers screen about 960 people door to door in its catchment, including household and neighbour contacts of index cases, and refer suspects to the camp. Arua Regional Referral Hospital receives cases the health centres cannot confirm, with the back-up route in Section 4. Communities refer through VHTs, leaders, refugee representatives and OLPO. Suspects are confirmed by government clinicians recognised by the NTLP. The Regional NTLP Coordinator reviews photographs of every confirmed case. The contractor records, for each route: people screened, suspects, suspects reaching confirmation, cases confirmed, treatment started immediately and contacts examined. It documents where cases had sought care before without diagnosis, and runs client-cost and journey-to-diagnosis interviews.

Stage 4. Living conditions and community research (February–March 2027, alongside Stage 3). Survey 70 households affected by leprosy, purposively selected to include refugees, host households, women, children's carers, people with disabilities and people diagnosed late. Cover care-seeking, treatment interruption, disability, stigma, housing, water, food security, land, livelihoods, documentation, rights, access to services and benefits, and social participation. Include a brief mental wellbeing block, the WHO-5 Well-Being Index preferred, with no item on suicide or self-harm. Run 39 in-depth interviews and 5 focus groups with the participants in the table below. Map existing government, humanitarian, rehabilitation, disability and social support services as a list Kabukye Trust can maintain. Fifteen trained peer researchers affected by leprosy, five per district, screen door to door, collect survey data and support community consultation. Peer researchers do not ask about income, debt, violence or household conflict.

Recruiting people affected by leprosy. In Terego, recruit through OLPO. Adjumani and Yumbe have no OLPO, so recruit there through the District TB and Leprosy Supervisors. Interview the same five profiles in each district, with at least 40% refugees overall. If a profile cannot be found in a district, such as a pregnant woman, the steering group agrees a substitute.

Method	Participants	Number
In-depth interview: key informants	Facility TB and Leprosy Focal Person, one per district	3
In-depth interview: key informants	District TB and Leprosy Supervisor, one per district	3
In-depth interview: key informants	Regional TB and Leprosy Supervisor	1
In-depth interview: key informants	Laboratory technician, one per district	3
In-depth interview: key informants	Traditional healer, one per district	3
In-depth interview: key informants	Executive Consultant, Arua Regional Referral Hospital	1

Method	Participants	Number
In-depth interview: key informants	Representative, German Leprosy and Tuberculosis Relief Association (GLRA)	1
In-depth interview: key informants	Commissioner, National TB and Leprosy Programme	1
In-depth interview: key informants	United Nations High Commissioner for Refugees (UNHCR), Arua	1
In-depth interview: key informants	Office of the Prime Minister (OPM), refugee department	1
In-depth interview: key informants	Settlement health partner, one per district	3
In-depth interview: key informants	Refugee Welfare Council leader, one per district	3
Subtotal: key informants		**24**
In-depth interview: people affected by leprosy	In each district: a man; a pregnant woman; a boy or young man; a girl or young woman; a woman. At least 40% refugees overall	15
Total in-depth interviews		**39**
Focus group: people affected by leprosy	Men; women; girls; boys (one group each)	4
Focus group: VHTs	VHTs from the study catchments	1
Total focus groups		**5**

Interviews and groups with anyone under 18 follow the consent rules in Section 10. A woman interviews women and girls. Age bands for the girls' and boys' groups are set at inception.

Stage 5. Analysis and recommendations (March–April 2027). Integrate the screening, facility, household, cost and qualitative evidence. Produce the two recommendation sets in Section 7 and a priority matrix for each. Assess what the districts and NTLP would need to sustain active case finding, and what they have committed.

Stage 6. Validation and handover (April 2027). Hold a one-day validation workshop in West Nile with the districts, NTLP, health workers, OLPO, peer researchers and Kabukye Trust. Peer researchers present their own findings. Record disagreements in the final report. Hand over datasets, data collection tools and training materials under Section 10.

06 Basic costing

The costing compares detection routes and informs future budgets. It has three parts.

Part	What is recorded	Source	Output
Route costs	Cash spent on each skin camp and on door-to-door screening: transport and meal reimbursement, other transport, mobilisation, consumables, supervision	Expenditure records held by the contractor, Kabukye Trust and the districts	Cost per camp; cost per person screened door to door

Part	What is recorded	Source	Output
Cases by route	People screened, suspects, cases confirmed and treatment started, for each route	Screening record	Cost per person screened and per case found, by route
Client costs	What people paid to reach diagnosis and treatment: transport, fees, medicines, food, time lost from work, and who they saw first	Short interview with each newly confirmed case and up to 20 recently diagnosed people	Median cost and range to diagnosis; share facing a cost above one month's household income

Research costs are excluded from the route costs. Costs are reported in Uganda shillings. Small numbers mean every figure is reported with its range.

07 Two sets of recommendations and the deliverables

The study is one, but its recommendations are two. Each set must stand alone, so it can be shared with a different audience.

	Set A: health-system programme	Set B: community programme
Covers	Case detection, contact tracing, follow-up and integration with government services	Living conditions, livelihoods, human rights and access to services for people affected by leprosy in displaced and host communities
Main audience	Ministry of Health, NTLP, District Health Offices	Funders, humanitarian and development partners
Must state	Which detection routes to keep, drop or change, with cost per case; what the districts and NTLP have committed in writing and what remains a condition; what a five-year programme would need from government and from partners	Who is affected and how many; the main needs, with evidence; three to five candidate interventions; partners already working in the area; indicative annual cost ranges
Format	Chapter of the final report and a four-page brief	Chapter of the final report and a four-page brief written as the evidence base for a funding proposal

Deliverables

1. Inception report (including the data-availability check), final protocol, data collection tools approved by the steering group, signed roles agreement, field calendar, data management plan, mentoring plan and authorship plan.
2. Evidence of all approval submissions; West Nile routine-data profile, with completeness by district and variable; skin-camp and door-to-door screening site plan.
3. Fieldwork complete; cleaned datasets, transcripts, analysis code and case-handover records.
4. Draft integrated report with both recommendation sets, route costs and client costs.
5. Validation workshop; final report; Brief A; Brief B; slide set; peer-researcher certificates; signed mentoring record.

08 Timeline

Milestone	Date
Advert published	Mon 9 Nov 2026
Clarification questions close	Mon 16 Nov 2026, 17:00 EAT (answers published Wed 18 Nov 2026)
Proposals due	Mon 23 Nov 2026, 17:00 EAT
Shortlist notified	Wed 25 Nov 2026
Interviews (PI and Data Manager attend)	Thu 26 – Fri 27 Nov 2026
Award	Mon 30 Nov 2026
Letters of commitment from the NTLP and three District Health Offices (Kabukye Trust)	Before contract signature
Contract start and inception meeting	Tue 1 Dec 2026
Safeguarding training for the research team (Kabukye Trust)	Tue 1 – Fri 4 Dec 2026 (inception week)
Data collection tools approved by the steering group	Mon 14 Dec 2026
Inception report; all approval submissions made	Fri 18 Dec 2026
Christmas closure	Sat 19 Dec 2026 – Sun 3 Jan 2027
West Nile routine-data profile; site plan	Mon 11 Jan 2027
NTLP-led readiness visit to Arua Regional Referral Hospital	January 2027, before the skin camps
Screening and safeguarding training for VHTs and peer researchers (Kabukye Trust)	Mon 18 – Fri 29 Jan 2027
Approvals expected	By Fri 5 Feb 2027
Health-worker orientation; supervised pilot; facility assessments begin	From Mon 8 Feb 2027
Fieldwork: skin camps, door-to-door screening, survey, interviews	Mon 15 Feb – Thu 25 Mar 2027
Fieldwork complete; data handover	Wed 31 Mar 2027
Draft integrated report	Fri 16 Apr 2027
Validation workshop	Wed 21 Apr 2027
Final report and both briefs	Fri 30 Apr 2027

09 Team, budget and payment

Team. The contractor fields a lean team. Government provides every clinical function. Kabukye Trust provides the Field Coordinator.

Role	Provided by	Core requirements
Principal Investigator and Qualitative Researcher	Contractor	PhD or equivalent record in public health or social science research; led mixed-methods studies in Uganda; qualitative research on stigma or disability; government engagement; can mentor junior researchers. Named duty-of-care lead for the study.
Data Manager and basic costing	Contractor	Designs and runs KoboToolbox or ODK data collection tools; manages secure data; analyses small samples in R or Stata; builds the basic costing.
Peer researchers (15, five per district)	Recruited by the contractor with OLPO (Terego), the District TB and Leprosy Supervisors (Adjumani and Yumbe) and Kabukye Trust; paid by the contractor	People affected by leprosy; trained for five days with a supervised pilot; paid the same daily rate as any other data collector.
Field Coordinator	Kabukye Trust	Based in West Nile; field logistics, community entry, day-to-day link with VHTs and facilities.

The contractor may add research assistants or transcribers within the ceiling. It must not price further specialist posts. The team, or budgeted interpreters, must cover Lugbara (Terego), Aringa (Yumbe) and Madi (Adjumani). Settlement work needs the main refugee languages.

Budget. The contract ceiling is UGX 202,051,120. Bids above it will not be considered. Itemise by work stage and line, in Uganda shillings. These lines must be shown separately:

- Peer-researcher pay, at the same daily rate as other data collectors. A bid that pays them less will be rejected.
- Transport and meal reimbursement for government health workers and VHTs on screening days, at one flat rate (Section 4). This line is ring-fenced and carries no overhead.
- Client-cost interview costs and participant compensation.
- Mentoring of Kabukye Trust staff.
- Institutional overhead, capped at 10% of direct costs, excluding the transport and meal reimbursement line.

Bidders must not price community entry, introductions to OLPO and district networks, screening and safeguarding training for VHTs and peer researchers, safeguarding training for the research team, costs for the Kabukye Trust Field Coordinator, steering group costs, communication and branding. Kabukye Trust provides these outside the contract.

Payment. No payment is made before the inception report is accepted.

#	Deliverable (Section 7)	Due	Share
1	Inception report and approval submissions	Fri 18 Dec 2026	20%
2	Routine-data profile and site plan; approvals granted	Fri 5 Feb 2027	15%
3	Fieldwork complete; data handover	Wed 31 Mar 2027	30%
4	Draft integrated report	Fri 16 Apr 2027	25%
5	Final report, both briefs, validation, handover	Fri 30 Apr 2027	10%

#	Deliverable (Section 7)	Due	Share
	Total		**100%**

Mentoring Kabukye Trust staff. Three named staff — the Monitoring and Research Officer, the Medical Officer and Leprosy Adviser, and the Head Leprosy Programme — join the study team. Each co-works on at least one stage. The contractor runs two one-day sessions, on protocol design and on analysis, and agrees an authorship plan under ICMJE criteria, which becomes an annex to the contract. The Chair of the Kabukye Trust Board signs off this deliverable.

10 Ethics, duty of care, data ownership and governance

- **No research before approval.** No participant is recruited and no research data collected until ethics, UNCST, district and (for settlements) OPM approvals are in place. Protocol drafting, aggregate data review, translation, classroom training and the NTLP readiness visit to Arua may proceed earlier. Government skin camps are routine services and may run regardless; the study records them only once approved.
- **Every case reaches care.** Each confirmed case is notified through the District TB and Leprosy Supervisor and handed in writing to a named treatment point. Failure to start treatment within the agreed period is reported to Kabukye Trust within 48 hours. The study logs every break in the referral pathway it observes and reports it to the districts each month.
- **Referral routes.** Before fieldwork, agree written referral routes for skin conditions, disability, protection, legal aid and psychosocial support, each with a named contact and working number. The psychosocial route must be a real service confirmed in writing. A low wellbeing score is not a diagnosis. Any distress or disclosure in the field is passed to the PI the same day, who arranges referral.
- **Safeguarding and consent.** Every team member completes Kabukye Trust's safeguarding training before fieldwork and follows Kabukye Trust's safeguarding policy. Disclosures are reported within 24 hours. Written informed consent, with parental consent and assent for anyone under 18. No household is identified to neighbours as affected by leprosy.
- **Data protection.** Comply with the Data Protection and Privacy Act 2019. Identifiable data stays in Uganda on encrypted devices. Breaches are reported within 24 hours. TLMGB receives no personal data. Published tables and maps show "<5" for any figure of 1 to 4 (Stage 2).
- **Who owns what.** Clinical records belong to the government health system and live in its registers. The contracting institution owns the research data and outputs and leads publication. Kabukye Trust receives anonymised datasets, code and data collection tools before final payment, with a free, permanent licence to use them for programme design and fundraising.

Reports and publications

The contractor is responsible for all study reports and for publications. These terms continue after the contract ends on 30 April 2027 and are set out in the contract's authorship annex:

- The contractor leads publication.
- ICMJE criteria decide authorship. Eligible Kabukye Trust staff and peer researchers are offered authorship.
- The NTLP, TLMGB and Kabukye Trust have 20 working days to check any draft for facts and confidentiality. They have no veto.
- Nothing is published before the final report is accepted.
- Every output credits TLMGB as funder, and the NTLP and the three District Health Offices.
- Who pays any open-access fees: [TO BE AGREED].

Steering group

The steering group meets at inception, at the end of fieldwork and at the draft report. It approves the data collection tools, reviews fieldwork findings and comments on the draft report. Between meetings it may decide by email, with members replying within five working days. The contractor sends a one-page progress note every fortnight. Any change to sample, method, timeline or budget needs written approval from Kabukye Trust and TLMGB first. Members are named by office, not by individual.

Member	Role
Kabukye Trust	Chair; convenes meetings; pays steering group costs
TLMGB	Funder oversight; approves changes to scope or budget
NTLP Regional Coordinator	Technical approval; clinical standards
Three District Health Offices	Service delivery; district commitments
Arua Regional Referral Hospital	Referral and clinical capacity
OLPO and a refugee representative	Community voice; checks on stigma and language
Principal Investigator	Secretary; reports progress; no vote on the contractor's own deliverables

11 Eligibility, how to apply and evaluation

Eligibility. Bidders must be a Ugandan university or research institution with access to an accredited research ethics committee, registered with the Personal Data Protection Office, bidding under a named Principal Investigator. Consortia may bid under one lead institution.

Proposal contents. Technical proposal of no more than 12 pages; draft protocol; CVs of the PI and Data Manager (three pages each); itemised budget; the ethics committee's December 2026 and January 2027 meeting dates; two references for similar work.

Clarification questions. Send questions to research@kabukyetrust.org by Monday 16 November 2026, 17:00 EAT. Answers are shared with all bidders on Wednesday 18 November 2026.

Criterion	Weight
Method: screening design, sampling, analysis plan and limits stated honestly	30%
Government integration: how the study runs inside district and NTLP systems and strengthens the referral pathway	20%
Team: PI and Data Manager record; language cover; peer-researcher plan	20%
Value for money: what the budget buys, peer-researcher parity, realism	20%
Ethics, safeguarding, data governance and mentoring plan	10%

The UGX 202,051,120 ceiling is a maximum, not a target. Bidding the full ceiling earns no credit. Value for money is scored on what the budget buys.

Proposals scoring below 60% on the technical criteria are not shortlisted. Send proposals to research@kabukyetrust.org, subject line "KT/RES/2026/01 – [Institution]", by Monday 23 November 2026, 17:00 EAT. Late proposals will not be considered.