
PRESIDENT'S MALARIA INITIATIVE

UGANDA

**Malaria Country Action Plan
FY 2006**

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EXECUTIVE SUMMARY

On June 30, 2005, the President announced President's Malaria Initiative (PMI), a new five-year, 1.2 billion dollar initiative to rapidly scale-up malaria prevention and treatment interventions in high-burden, sub-Saharan Africa. The goal of the PMI is to reduce malaria mortality by 50% by achieving 85% coverage of at-risk groups with four key interventions: artemisinin-based combination therapy (ACT), intermittent preventive treatment (IPT) for malaria in pregnancy, insecticide-treated mosquito nets (ITNs), and indoor residual spraying with insecticides (IRS). The PMI selected Uganda as one of the first three focus countries for this Initiative.

Uganda's leading cause of morbidity and mortality is malaria, which is endemic in 95% of the country. Estimates show that malaria accounts for about 25-40% of outpatient visits to health facilities and the annual number of deaths attributable to malaria ranges from 70,000 to 100,000. Children under five are most affected by malaria; nearly half of hospital inpatient pediatric deaths are due to malaria.

Uganda has made some progress scaling up prevention and treatment activities. Responding to the reality that for most caretakers, self-medication is the first realistic treatment choice, Uganda has successfully implemented its Home-base Management of Fever (HBMF) program, which has increased the number of children under five receiving malaria treatment within 24 hours of onset of fever by 50%. The Ministry of Health has also recently adopted ACTs as the official treatment policy and it will be introduced in 2006. The Ugandan government has also implemented IPT in some antenatal care clinics (ANC), and household net ownership is now calculated at 25%. The government has also sporadically used IRS in response to malaria outbreaks in the 5% of the country that is epidemic-prone.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) is the predominate source of funding for malaria activities in Uganda. Uganda is the recipient of two malaria grants (Round 2 and Round 4) totaling \$89 million. The round 2 grant contributes to the scaling up of HBMF, IRS, and ITNs and the round 4 grant focuses on the introduction of ACTs nationally.

The PMI will support existing National Malaria Control Program (NMCP) strategies and will coordinate closely with international and national partners to complement their funding and efforts. To achieve the goal and targets of the PMI in Uganda, the following major activities will need to be supported in year 1 of the Initiative:

1. Distribution of ITNs in the conflict districts of the North through large-scale health campaigns, well-child, ANC clinics, and social marketing;
 2. Support the distribution of ITNs procured by the GFATM for children under five and the procurement of additional ITNs for pregnant women;
 3. Conduct IRS with effective insecticides in the epidemic-prone district of Kabale;
 4. Revitalize the national IPT plan by developing ANC curricula and training health workers;
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5. Support the introduction of ACTs nationally by strengthening logistics and distribution systems and by training health workers in the new ACT policy to ensure that ACTs are available and administered correctly in health facilities;
 6. Evaluate the feasibility of including community-based distribution of ACTs in Uganda's HBMF program; and
 7. Involve the private sector in malaria control activities.

The PMI will include a strong monitoring and evaluation component to measure progress against project goals and targets, to identify problems in program implementation, to allow modifications to be made efficiently if and when they are needed, and to confirm that those modifications are having their desired effect. This plan will be coordinated with the NMCP, the GFATM, and other partners to standardize data collection and reporting.

begin an IRS program targeting the highland districts at risk of epidemic malaria using GFATM funds.

Uganda has become a model for HIV/AIDS prevention treatment and care. Through the President's Emergency Plan for AIDS Relief (PEPFAR), the United States Government (USG) has worked with local partners to develop HIV/AIDS care and support resources for people living with HIV/AIDS (PLWHA). These projects provide malaria prevention and treatment through promotion of ITNs and treatment for this particular vulnerable population.

Government

Within the formal government health sector, preventive and curative malaria interventions, as described in the Health Sector Strategic Plan II (HSSP), have been incorporated as part of the Minimum Health Care Package delivered at the primary health care level. Primary health care centers are responsible for the delivery of malaria services through IMCI and mobilization of communities and other partners to address malaria at the household level. At the district level, primary duties include planning, resource allocation and management, as well as oversight of all facilities in the district including those operated by non-governmental organizations (NGOs) (mainly faith-based organizations) and the private sector. Districts are decentralized to a large degree and are responsible for their respective health plans and budgets. The MOH and RBM partners strengthen the existing referral structure to improve access to treatment for severe malaria at higher level facilities. At the central level, the National Malaria Control Programme supports implementation through policy formulation, standards setting and quality assurance, resource mobilization, capacity development and technical support, malaria epidemic control and monitoring and evaluation. Health allocations comprise 9.7% of the GOU's national budget.⁴

NGOs, Private Sector and Institutions

NGOs receive significant funds from the GOU through Primary Health Care Grants to provide outreach and preventive services at hospitals, district and local health care facilities.⁵ NGOs, including FBOs, distribute ITNs at subsidized prices. Some ITNs are distributed free to vulnerable target groups including women and children. Moreover, the GOU has worked extensively with the private sector to produce Homapak for HBMF.

The private sector plays a significant role in expanding access to effective treatment for malaria through direct service provision, pharmacies and drug shops, which provides 60-80% of all malaria treatments. Private sector manufacturers and distributors produce equipment and supplies, and they serve as a source of ITNs for NGOs and the rapidly growing retail market (Total sales of ITNs in 2004 was 565,000, and in the first half of 2005 totaled 371,000).

Research and teaching institutions build pre- and in-service training courses for personnel involved in malaria control interventions. In addition, these institutions promote evidence-based practices through focused operations research.

⁴ Annual Health Sector Performance report, Fiscal Year 2004/2005, October 2005

⁵ Health Facility Survey, 2002

NATIONAL MALARIA CONTROL PLAN

The Ministry of Health established the Malaria Control Programme (NMCP) in 1995. The program developed its first three-year strategic plan in 1997 for 1998/1999 to 2000/2001. This was followed by the second strategic plan which covered four years (2001/2002 to 2004/2005). Development of the third strategic plan to cover five years (2005/2006 to 2009/2010) is one of the pending priority activities.

The NMCP objective is to reduce malaria morbidity and mortality to minimize related social ill effects and economic losses attributable to malaria in the country. It has identified the following core interventions to achieve this goal:

- Improving prompt and effective malaria case management at health facilities, community and household levels;
- Increasing demand for and supply and use of ITNs and net treatment kits;
- Applying selective vector control measures including indoor residual insecticide spraying (IRS) and environmental management;
- Increasing the coverage of IPT in all ANC facilities;
- Strengthening malaria epidemic preparedness and response at all levels (prediction, early detection and control of malaria epidemics); and
- Establishing sound information, education, communications (IEC)/ behavior change communications (BCC) interventions for malaria prevention and control.

Four targets have been set by the Uganda National Malaria Control Program as part of the five-year national malaria control strategy included in the HSSP I:

- Increasing the proportion of the population at risk of malaria who receive appropriate treatment for malaria within 24 hours of recognition of symptoms;
- Increasing the proportion of pregnant women receiving IPT to 60%;
- Increasing the proportion of children aged less than five years regularly sleeping under ITNs to 50%; and
- Reducing the malaria case fatality rate at the hospital level from 4.05% to 3%.

Uganda has several strategy documents that support treatment and prevention of malaria including: Antimalarial drug policy change from CQ/SP to Artemisinin Combination Therapy (2004); Malaria in Pregnancy Control (2000); Home Based Management of Fever (2002); Policy and Strategy for Insecticide Treated Nets (2003); revised draft for The Use of ACTs at the Community Level (2005); and Policy and Strategy for Indoor Residual Spraying (in final stages).

In April 2005 the NMCP prepared a summary table of results to date in terms of the major malaria indicators, which are presented below.

GOAL OF PRESIDENT'S MALARIA INITIATIVE

By 30 September, 2011, reduce malaria-related mortality in Uganda by 50%.

TARGETS OF THE PRESIDENT'S MALARIA INITIATIVE

After three years of full implementation (30 September 2010), the PMI will provide accelerated resources to assist the country to achieve the following targets among at-risk populations for malaria:

1. 85% of children under five will have slept under an insecticide-treated bed net (ITN) the previous night;
2. 85% of pregnant women will have slept under an insecticide-treated bed net (ITN) the previous night;
3. 85% of children under five with suspected malaria have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms;
4. 85% of houses targeted for indoor residual spraying will have been sprayed; and
5. 85% of children under five with suspected malaria have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms.

MONITORING AND EVALUATION

Current status

Monitoring and evaluation to measure progress against project goals and targets, to identify problems in program implementation and allow modifications to be made, and to confirm that those modifications are having their desired effect will be a critical component of the PMI. In Uganda, rapid scale-up of malaria prevention and control interventions and achieving high coverage rates with ACTs, ITNs, IPT, and IRS are priorities not only for the PMI, but also for the NMCP, the GFATM, and other national and international partners working on malaria. For this reason, an effort will be made to coordinate all monitoring and evaluation activities funded by the PMI with those of the NMCP and other partners into a single integrated system to avoid duplication, conserve resources, and ensure as much uniformity as possible in the indicators chosen to measure progress, in approaches to collecting and analyzing data, and in reporting.

Baseline data (as of 2004) for the key indicators for the PMI were identified for Uganda's Health Sector Strategic Plan II (HSSP) 2005-2010. A Demographic and Health Survey (DHS) will take place in early 2006 (field work to be done in January/February 2006) which will provide final baseline data. A malaria module will be included in the DHS, and specific questions have been added to meet the needs of the PMI. Baseline data from the HSSP have been included in table below, to be confirmed or adjusted depending on DHS results.

Evaluation of Progress toward the President's Malaria Initiative Goal and Targets:
