Sustaining

Malaria Investments Gains in Uganda & Prospects of Citizens' Involvement

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Sustaining Malaria Investments Gains in Uganda & Prospects of Citizens' Involvement

A STUDY REPORT

By

Malaria & Childhood Illness NGO Network (MACIS)

Contents

Acronyms

MACIS	Malaria & Childhood Illness NGO Network
UMRSP	Uganda Malaria Reduction Strategic Plan
LLIN	Long Lasting Insecticide Nets
ITN	Insect side Treated Net
MIS	Management Information System
GDP	Gross Domestic Product
HIV	Human Immune Virus
TB	Tuberculosis
HUMCs	Health Unit Management Committees
NGO	Non Governmental Organisation
HCs	Health Centres
FGD	Focus Group Discussion
PWD	People with Disabilities
CBO	Community Based Organisation
FBO	Faith Based Organisations
LC	Local Council
SPSS	Statistical Package for Social Scientists
HMIS	Health Management Information System
NDPII	Second National Development Plan II
IDI	Infectious Disease Diseases
HCT	HIV Counseling and testing
NMS	National medical Stores
DHO	District Health officer
VHTs	Village Health Teams
WHO	World Health organisation
OPD	Out Patient Department
DFID	United Kingdom Department for International Development
IRS	Indoor Residual Spaying
ICCM	Integrated Community Case Management
GoU	Government of Uganda
FY	Financial Year
MoH	Ministry of Health
JMS	Joint Medical Stores
PMI	President's Malaria Initiative
USAID	United States Agency for International Development

Executive Summary

Despite the several malaria investments in Uganda, their magnitudes, gains and commitment of citizens to take over their sustainability are unknown. This makes the country's dream of transitioning of malaria funding from foreign aid to domestic rather uncertain. It is against this backdrop that the Malaria and Childhood Illness NGO Secretariat (MACIS), with financial support from GF-CRG Strategic Initiatives through Technical Assistance Provider KeNAAM, conducted a scoping study; looking at malaria investment processes and their achievements/gains; delineating how citizens were involved. The results of the study were expected to guide malaria investment planning, and direct strategic advocacy to avert crisis when foreign investments are actually withdrawn or substantially reduced.

Findings

Current Investments

Uganda had made commitment to put efforts geared towards strengthening the national health system including governance; disease prevention, mitigation and control; health education, promotion and control. Malaria prevention was being coordinated through targeted behavior change communication, mass distribution of long lasting insecticide-treated nets (LLINs), insecticide residual spraying, larviciding, preventive treatment of pregnant women, scale-up of the integrated community case management of malaria and other childhood illnesses among under fives, as well as facility based malaria case management. Major malaria funding partners in Uganda include The Global Fund, Presidential Malaria Initiative (PMI) and UKaid/DFID The government played a big role in indirect financing of malaria through salaries of service providers, and maintenance of infrastructure. Data on household and private sector contributions were not readily available.

Investment Achievements and Gains

Through different investments, the LLIN coverage and use among the under five children jumped from 16% to 90%, and 10% to 74% respectively. These resulted into reduction of malaria parasitemia and anemia prevalence from 42% to 19% and 10% to 5% respectively in the last 5 years. Majority of communities were knowledgeable about malaria causation, dangers, importance of early treatment and prevention.

Citizens Participation

Community participation in malaria mitigation was more on rapid diagnosis and treatment of children under five by village health team members. Monitoring of health service delivery and demanding of accountability from duty bearers by community members was minimal (29.5%), which means community sense of ownership of health services in the county was still low. However, there was an emerging breed of CSOs that mobilize communities to respond to the malaria programs by demanding for their rights, while at the same time conforming to their roles and responsibilities. Community Score Cards had been introduced in 28 districts on the same.

Sustainability Plans

Apart from a few individuals at national level, majority of Ugandans were oblivious of the looming reduction in foreign malaria financing. Some thought it was a hoax and very unlikely to happen, given that Uganda was not likely to attain the middle income status in 2020, as projected by the World Bank. It was further argued that donors like GFATM had not instituted any sustainability plan then to indicate that they were about to move away. Therefore, there was no discussion of such sustainability plans among stakeholders. However, foresighted managers had come up with some efficiency plans for the program to continue, in case donors actually withdrew. These included minimization of drug wastage through the Test, Treat and Track strategy; reduction of cost expenditures through liberalization of product procurement; encouraging citizens to take charge of their health through LLIN replacement; use of community health extension workers (CHEWs) to case treat, stimulating the private sector, and implementation of the National health insurance policy.

Conclusion

All in all, there are several malaria investments in Uganda, both foreign and local, with significant achievements and health gains; although some of their magnitudes are not known with certainty. However, the sustainability of these investments gains is not guaranteed if the foreign support was to be withdrawn, and majority of citizens are oblivious of any impending reduction in foreign malaria or health financing. Worse still, citizens' participation in the current malaria investments processes in the country is very nascent to be able to take over the gains. Therefore, the sustainability of these investments gains will require stakeholders' strategic thinking, planning, citizens' involvement and guidance.

Recommendations

Given the diverse findings above, we recommend the following strategies:

To Development Partners (DPs)

» DPs should lay down a clear plan and roadmap for gradual pull out, and a favourable strategy for sustainability of their malaria investment gains as not to cause a crisis/epidemics

To Government/Ministry of Health

» MoH should mainstream CHEWs and VHTs in the local council structure, for efficient and sustainable community malaria treatment at low cost

» MoH should implement the Universal Health Insurance Policy, and mobilize private sector to contribute towards Malaria through the Corporate Social Responsibility (CSR)

- » MoH should revitalize Health Unit Management Committees to perform their designate roles such as monitoring of services and mobilization of communities to participate in health facility affairs
- » MoH should invest more in malaria prevention to minimize heavy expenditure on curative services

To National Malaria Control Program (NMCP)

- » NMCP should strengthen the capacity of district local governments to effectively plan, budget and implement their malaria activities; and leave central government to concentrate on commodities
- » NMCP should promote efficiency and minimization of wastage e.g. encourage net repair, better quantification of products etc.
- » NMCP should reduce the cost of doing business e.g. review procurement procedures for health commodities without necessarily going through NMS, which escalates costs

To Local Government (LGs)

- » LGs should empower citizens and instil in them sense of ownership of health programs through the participatory bottom-up planning process
- » LGs should engage communities through conversational dialogues on malaria and health co-financing; LLIN replacement, but put subsidies to protect most at risk persons
- » LGs should design mechanisms for generating local resources for health care and malaria control

16 million

Malaria is one of the leading causes of ill health and deaths in Uganda

1.0 Introduction

This report presents the findings of a study conducted by MACIS, with the aim of appreciating the different malaria investments in Uganda, community participation in malaria response, and prospects of shaping citizens' involvement in malaria investment right from grassroots. The report highlights fundamental findings regarding the foreign and domestic malaria investments, as well as the consumption cycle of malaria investments and initiatives in the country. It is arranged in form of background to the study, objectives of the survey, methodology of the study, key findings and major recommendations on the thematic areas under investigation.

In pursuit of the Uganda Vision 2040, the health sector aims at producing a healthy and productive population that effectively contributes to socio-economic growth by provision of accessible and quality health care to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health care.

Malaria is one of the leading causes of ill health and deaths in the country, with approximately 16 million cases and over 10, 500 deaths reported in 2013. It remains one of the most important diseases in Uganda in terms of morbidity and mortality. Malaria accounts for 30%-50% of outpatient visits and 15%-20% of hospital admissions. It is estimated that 27.2% of inpatient deaths among children under five years of age are due to malaria. A significant percentage of deaths occur at home and are not reported by the facility-based Health Management Information System (HMIS)[1].

The World Malaria Report of 2016 indicates that Uganda has the fourth highest number of annual malaria cases accounting for 4% of the estimated 220,500,000 global cases[2]. Malaria transmission is stable in 95% of the country, and unstable in 5% (UMRSP 2014-20, pg. 22). Whereas the malaria incidence varies from district to district, on average malaria is an acute development challenge for Uganda. This is not only a health challenge but also an economic and development challenge for the country. Major efforts to address this situation have been through the universal distribution of LLINs, and increased access to ACTs currently estimated to be 62%. It is estimated that 69% of the population slept under ITN (MIS 2014).

The issues of malaria disease control among women and children, and the concern for citizens' participation in addressing the malaria burden, have been receiving serious attention of the world community. However, due to ignorance

1 The Uganda Malaria Reduction Strategic Plan 2014 - 2020 (UMRSP)
2 World Malaria Report 2016

and contempt for citizens' involvement or participation in guiding development processes in Uganda, the goals and objectives of several initiatives do not sufficiently address the wishes of the people. Consequently, citizens perceive such health initiatives as foreign driven, discriminative, assisting the well-off rather than supporting the marginalized/ disadvantaged/ excluded groups, disempowering rather than empowering citizens, and escalating disparity among the different groups rather than reducing it.

This study therefore sought to establish significant evidence and the empirical data that would guide government, development partners, citizens, civic organizations and private sector associations in identifying social, economic, cultural, environmental and political situations where a significant number of people in the country can be involved in governance and management of their health services.

1.1 The Malaria Management Challenge

In Uganda, the Central Government through the Ministry of Finance, transfers resources to districts and sub-counties for provision of social services to the population every quarter. Besides these transfers, districts and sub-counties also generate resources locally, which are intended to supplement the central government transfers in providing social services. There is no direct malaria financing to CSOs and lower local governments from any development agency. Most investments are material in nature such as drugs, trainings, ITNs and other services. However, the central government coordinates the malaria program within the country.

Currently, approximately 25% of the Uganda national health budget is funded by donors. Abreast by statistics, the GDP of Uganda per capita is now standing at $740, and it is forecasted to jump to 1,000 US$ by 2020, which will shove the country into the middle income bracket. This means Uganda will have to transition away from donor support, to domestic financing of its budget.

Unfortunately, experience from the last 5 consecutive years is that there is no steady or progressive increase in domestic financing, especially in lower local governments to finance key sectors like health, education, infrastructure and agriculture. In addition, the current health service delivery to the people is also not commensurate with the level of resources availed.

Experience from the dialogues, conducted by MACIS in 2016 during the Malaria Constituency engagements to enhance community participation in the national concept note development to the Global Fund, reveals that this situation stems largely from the ignorance of the local population about the several development issues in their communities. This includes plans for their communities, the funds available for malaria interventions, how the funds are used, and other such relevant issues. In addition, there is no mechanism in place for duty bearers to explain to the people how the public funds received by their respective Local Governments are utilized. In the absence of such mechanisms, people would not demand full accountability and better service delivery or performance from the local leadership and public servants; hence they do not participate in efforts to raise local revenue to bridge any possible public health investment gaps.

Such circumstances are overwhelmingly the result of governance deficits at local, regional and national scales. Such governance deficits are typically manifested through such factors as poorly regulated service delivery systems, investment regimes; nonexistent or inchoate citizen participation mechanisms; a growing propensity for corruption; perverse incentives among public officials; inadequate mobilization for community participation in the local budgeting and decision-making processes; and weak law enforcement.

Individually or collectively, these factors contribute to poor service delivery and performance, as well as the unfair, inadequate or/and unequal distribution or/ and allocation of domestic resources raised to key services such as public health services in general, and malaria in particular.

Despite decades of research and development efforts to improve service delivery in the country, these trends continue at an alarming rate in the public health sector. Uganda still faces acute cases for malaria, low citizen's participation and drug stock-

outs, which inhibit the effectiveness of the Malaria, TB and HIV/AIDS efforts supported by the Global Fund and other funders.

Generally, Health Unit Management Committees (HUMCs) are not functional; and where they still function, they are poorly coordinated to undertake their stewardship and watchdog role on public health services. Majority of public health facilities continue to be dilapidated with poor logistical appropriations. Health Centre IIs, which were elevated to Health Centre IIIs, operate without reciprocal structures, facilities and resources following the elevation.

It is against this backdrop that the Malaria and Childhood Illness NGO Secretariat (MACIS), with financial support from GF-CRG Strategic Initiatives through Technical Assistance Provider KeNAAM conducted a scoping study; looking at malaria investment processes and their achievements/gains; delineating how citizens were involved. The results of the study are expected to guide malaria investment planning, and direct strategic advocacy to avert crisis if or when foreign investments are actually withdrawn or substantially reduced. The study areas were at different governance levels, i.e. National, Regional, District and Sub county levels.

1.2 Purpose of the Study

The main objective of the study was to underscore the commitment of Uganda to domestic malaria investment; highlighting prospects of citizens' involvement at different levels of decision-making and care.

1.3 Specific Objectives

a. To ascertain the existing malaria investment efforts, their actors, their achievements/gains, and their sustainability plans
b. To establish the current knowledge, attitudes and practices among Ugandans pertaining to citizens' involvement in malaria investment processes
c. To examine the extent to which the community members are involved in the utilization of malaria prevention and treatment services, as well as in monitoring, planning and decision-making processes on malaria investments.
d. To explore prospects through which citizens can effectively and constructively get/give feedback on quality of health services and be involved in malaria investment processes (financing, planning, budgetary allocations and accountability demand) at different levels
e. To make pragmatic recommendations to guide malaria investment in the country.

1.4 Justification of Study

Although there are several malaria investments gains in Uganda, their magnitudes and commitments of Ugandan citizens to take over their sustainability are unknown. This makes the transition of malaria funding from foreign aid to majorly domestic rather uncertain. The current non-involvement of citizens in the malaria investment processes makes the financing domestication a big hoax. Therefore, the results of this scoping study were expected to guide malaria investment planning in the country, as well as direct strategic advocacy to avert a looming crisis when foreign investments are withdrawn or get substantially reduced.

2.0 Methodology

The study employed multiple approaches agreed upon jointly between the researchers and MACIS. These participatory approaches involved identification of respondents and gathering of data, interlia.

2.1 Overall Study Design, Organization and Approach

A mixed methodology, combining quantitative and qualitative approaches was used to collect data. For the quantitative component, structured interviews, using structured questionnaires, were jointly developed between MACIS and researchers. For the qualitative part, the process was highly participatory, aimed at involving a variety of relevant stakeholders and partners at the community, health facility, district, regional, and national levels. The use of a mixed methods approach intended to generate quantitative and qualitative indicators, on the basis of which future evaluation studies would measure the extent of change towards the desire outcomes. This study was conducted using teamwork oriented processes, involving a great deal of triangulation of methods of data collection in order to get comprehensive, accurate data, and compare results from different primary and secondary sources.

The study sampling frame covered; (a) National stakeholders such as Ministry of Health, Ministry of Finance, Health Development Partners and Non-Government Organizations; (b) Regional Stakeholders such as Regional Malaria Monitors; (c) District stakeholders such as politicians, technocrats, advocates, and service providers in Masindi, Hoima and Kibaale; (d) Sub county stakeholders such as counsellors, villages councils, and community members in the respective districts.

The two principal researchers were responsible for desk review, administering key informant interviews, data entry, data cleaning, data analysis and report writing. In addition, field assistants were recruited, oriented and tasked to administer health facility and household questionnaires, as well as conduct community dialogues.

45

Household respondents interviewed

2.2 Sample Units

At national level, the study captured the opinions of the Health Permanent Secretary, the Director of Health Planning & Policy, the National Malaria Program Manager, the Commissioner Health Planning & Policy, the Program Officer Malaria Environment Control, the WHO National Professional Officer for Disease Prevention and Control, the DFID Malaria Technical Advisor, the Team Leader PMI (Presidential Malaria Initiative), and HEPS

At regional level, the study captured the opinions of the Bunyoro Regional Malaria Monitoring team representative.

At district level, the study captured the opinions of different decision makers in the three study districts. In Hoima district, the study captured the opinions of District Chairman, Secretary for Health, District Health Officer, District Planner and ACTADE NGO. In Masindi district, the study captured the opinions of the District Chairman, District Health Officer, District Population officer, and Program Officer District NGO Forum. In Kibaale district, the study captured the opinions of the District Chairman, District Health Officer and the District Planner.

At health facility level, the facility in-charges of Kikuube HC IV, Buhimba HC III and Ikoba HC III, Bwijanga HC IV, Kyebando HC III, Kibaale HC IV were the respondents to the health facility questionnaire,

At community level, the study captured the opinions of different citizens through community dialogues of 12-15 persons per district, using a study guide.

At household level, a random sample of at least 7 households from 7 villages that frequented corresponding facilities for malaria treatment, between December 2016 and February 2017, were considered respondents and assessed with a view of contextualizing patterns and perceptions established from the health facilities.

2.3 Data Collection Sites

The data was collected at different sites.

Level	Area	Number of Study Sites
At national level	Kampala,	9
At regional level	Bunyoro (mid-west) region	1
A district level	Kibaale	1. Kibaale HCIV
	Hoima	2. Kyebando HC III
		3. Kibuube HC IV,
		4.Buhimba HCIII and
		5. Ikoba HC II
	Masindi	6. Bwijanga HC IV
A subcounty level	Kibaale	a) Kyebando
		b) Kibaale Town Council
	Hoima	c) Buhimba
		d) Kiziranfumbi
	Masindi	e) Bwijanga

Focus group discussions were also conducted, one in each of the three districts of Masindi, Hoima and Kibaale districts to triangulate the data collected from household surveys.

2.4 Data Collection Methods

Data collection was given utmost importance. The methods of collecting data varied but were both qualitative and quantitative. Data collection tools were jointly and professionally developed by MACIS and the two consultants. Four data collection tools (appended herewith) were used, namely; 1) A Key Informants data collection tool; 2) A Household/Consumer data collection tool; 3) A Community focus group discussion guide; 4) A Health Facility data collection tool

2.4.1 Key Informant Interviews (KIIs)

KIIs were conducted with different stakeholders from government agencies/ departments, development partners/ donors, and as well as non-governmental/ civil society organizations. At National level, a specific tool was designed and administered

to engage the Ministry of Health officials, Development partners engaged in malaria control e.g. WHO, PMI and, DFID; as well as international and national NGOs. At the district level, the study team visited Masindi, Hoima and Kibaale districts; specifically targetting district leaders that were engaged in malaria advocacy, prevention, treatment and management i.e. District Planners, District Chairpersons, District Health Officers and at least one NGO working on malaria or health in each of the districts.

2.4.2 Household Surveys

A quantitative data collection process was conducted in the three districts as a sample on the malaria community funding and response. A total of 45 respondents from the 3 districts were identified and interviewed to inform the study. The respondents were selected randomly, with the help of the research team using a structure of random walk customized as a three (3) by four (4) population skip walk as shared from the tool consultative development process at Hoima Kolping Hotel. Information was collected using semi-structured questionnaires.

Sampling of Villages

Sampling for villages was done at the sub-county level. At least five considerations were made by the study. The outstanding ones were: the need to cover both urban and rural, with emphasis on rural; the need to cover both poor and average villages, with emphasis on poor ones; the need to cover at least three districts of mid-western region where the malaria prevalence is highest in Uganda; the need to use multiple approaches with emphasis on the people who consume malaria services; the need to deeply appreciate the community initiatives and support for the malaria investments; and the need to appreciate the impact of the malaria community investment and sustainability mechanisms among others.

Purposive sampling was used to select the participants of each of the focus group discussion (FGD). For instance, the need for effective representations from women, youth, PWDs, HUMC membership, men, and religious leaders among others, constituted the study FGDs. In each of these, four areas were assessed including knowledge, behavior, practices and attitudes based on tools developed.

Sample Size of Respondents

A total of 45 household respondents were met and interviewed. This provides the basis of the findings to this study. These were identified using the proportion of the sub counties that possessed both health centre IIIs and Health Centre IVs. The study team relied on the saturation theory, which pre-supposes that participants are recruited continuously up to the point where similar information continues to recur. Nevertheless, three FGDs were conducted in the entire region, 45 household heads interviewed, and 6 health facilities/sub counties were visited.

2.4.3 Focus Group Discussions (FGDs)

In a selected community, served by the sampled health facility in each of the 03 districts (Masindi, Hoima and Kibaale), one Focus Group Discussion (FGD) of 12-15 participants was conducted with selected participants including: a member of the HUMC, an LC chairperson, an LC secretary for women and children affairs, an LC secretary for health, opinion leaders, a youth representative, and a representative from a CBO/FBO within the health facility jurisdiction. The Focus Group Discussions covered three themes:

a. Existing malaria investments and their achievements
b. Level of community participation in malaria health related service delivery
c. iMost pressing needs and/or challenges in community participation in malaria health related service delivery and possible solutions to address them
d. Suggestions to improve the sustainability of malaria Investments in the district

2.4.4 Observations

Observation method was employed, especially at response rate by the households' respondents. For instance, the proof of whether suggestion boxes and customer clients' charter existed was observed.

2.4.5 Documentary Review

The other data collection methodologies that were utilized included review of existing information. Specifically, the following documents were reviewed:

» The monitoring standards related to malaria service delivery
» The study document/proposal
» The national malaria programme results framework and Malaria indicator survey
» The profiles of targeted districts in regard to malaria prevalence, treatment and prevention
» Relevant reports on malaria related service delivery, including the National/ District HMIS reports and Scorecards.

The main outcome from this desk review is the sectorial analysis of the malaria health related service delivery and investments at national, regional and local levels.

2.5 Quality Assurance and Control

At each stage of the study, quality was given utmost importance. The following measures were adopted for ensuring quality of data.

Developing and pre-testing data collection instruments:

The data collection instruments (questionnaires) were participatorily developed by MACIS and the two consultants, through a consultative process. The team also customized the tool to meet the local dynamics of the study area and purpose without changing any context. The team also pre tested the tool in Hoima town. This allowed moments

of adjustments and rectification of some identified oversights and errors. It was then used to train research assistants and pre-tested again by the research assistants prior to the data collection exercise. The pre-test exercises focused on ascertaining whether the sequence of questions was logical, the wording of the questions was clear, translations were accurate, or if there was need for additional instructions for interviewers e.g. guidelines for 'probing' certain open questions.

Inter researchers interface meeting.

As a basis of quality, training at each stage of the study was emphasized. The team leaders with guidance from MACIS identified and trained a team of research assistants/ interviewers, with the necessary experience in the data collection methods to be utilized in the study. It was a requirement for the assistants to have experience in working with communities and particularly for such data collection assignments, and fluency in the local language(s) used in the mid western Uganda, particularly Runyoro. These assistants worked under the direct supervision of the team leaders.

a. The research assistants were recruited basing on a set of defined criteria, including experience with large-scale, national-level and population-based surveys. Three teams were formed (1 in each district) to carry out the local government, health facility and individual health consumer studies/ interviews. But questionnaires for key informants at District, Regional and National levels were administered by the two principle researchers.
b. A half-day orientation meeting was held for the research team, and a pre-test of the tools was conducted in one selected HC, following which a meeting was held to finalise and tailor the tools to the findings of the pre-test exercise.

2.6 Data Management and Analysis

As a quality standard, the data team was trained at Hoima Kolping in Hoima in the key variables of data analysis and structuring of the report. An analysis plan was also designed that formed a genesis for this report. Data was managed and analyzed differently using methodologies that allow easy and simple understanding. This provided the basis for this report.

2.6.1 Qualitative Data Analysis

KIIs and FGDs were transcribed verbatim into Microsoft Word. No names were included in the transcription; each speaker was identified only by gender and number. All transcriptions were translated into English. Data was analyzed following the principles of thematic analysis in accordance to the particular interests of the study.

2.6.2 Quantitative Data Analysis

Quantitative data was entered using an excel template and later exported to SPSS for analysis. This supplemented the above qualitative data analysis.

2.7 Deliverables

This process comprises of two key deliverables mainly the draft report, dissemination and the final report upon submission of the stakeholder inputs.This study report presents the findings of the study on malaria investment trends in Uganda, as well as projected citizens' involvement in malaria investment processes.

2.8 Ethical Considerations

Participants in the interviews were consented prior to the interview. The informed consent process was in a language which the respondents understood. Specifically, these were either in English or in the local language.

3.0 Findings

The findings of the study were clustered based on the study objectives, tools used, assessed thematic areas, and emerging issues. This was done cognizant of the need to establish the citizens' knowledge level, attitudes, and behaviors or practices regarding the malaria management and financing, as well as community linkages for initiatives at the client and health facility levels. This backdrop was informed by the study purpose, underscoring the commitment of Uganda to domestic malaria investment; highlighting prospects of citizens' involvement at different levels of decision-making and care.

3.1 Demographics of Respondents

3.1.1 Respondents by Age Groups

Majority of respondents (52%) were young adults (18 - 30 Years), while very few were elderly above 60 years (2%).

Table 1: Showing the Respondents by age groups

Age group	Percentage
18 - 30 Years	52%
31 - 45 Years	31%
46 - 60 Years	15%
Above 60 Years	2%
Total	**100%**

3.1.2 Respondents by Sex

Majority of people interviewed were male (51%), while 49% were female. This was done randomly from the random sampled households

3.1.3 Respondents by Marital Status

The study interviewed 22.2% respondents who were single, 66.7% married, 6.7% divorced or separated, while 4.4% were widowed. It was further showed that respondents who were single expressed limited awareness on malaria and other health initiatives at community level in their areas than the married ones.

3.1.4 Respondents by Religion

Of the people interviewed, 24.4% were Anglicans, 53.3% Catholics, 8.9% Muslims, 2.2% Seventh Day Adventists, 4.4% Pentecostals, and over 6.7% other religions.

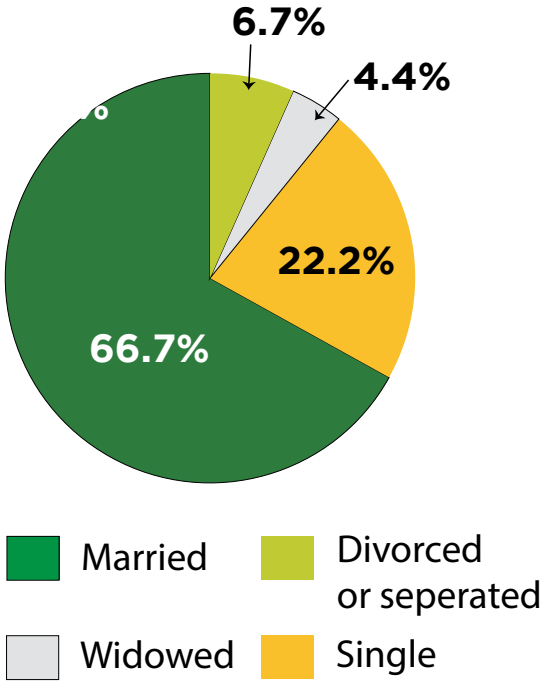

Figure 1: Respondents' Marital Status

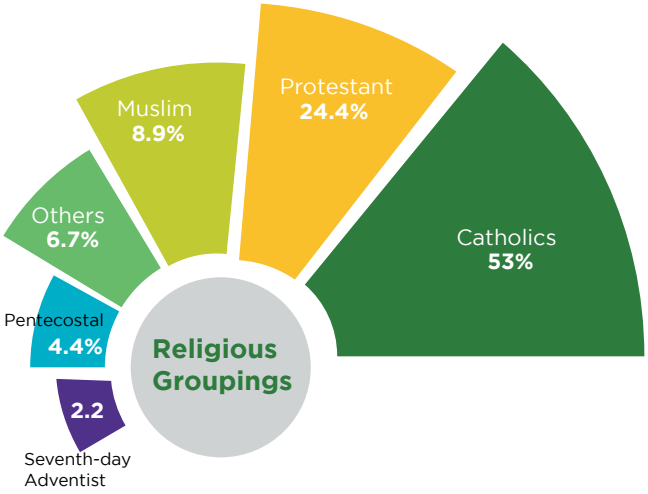

Figure 2: Religious Groupings

3.1.5 Respondents' Highest Level of Formal Education

Majority of respondents' highest level of education was ordinary level, constituting 28.9%; and approximately 18% were totally illiterate. However, majority of communities who believed in the faith of unity (Obumu Bwa Bisaka) religion had not attained any education at all, and these were in Kibaale district. The study indicated that 40% of the respondents had not attained even primary education.

Table 2: Showing the Respondents' Education Levels

Respondents' Highest Education Level	Percent
No Formal Education	17.8%
Not Completed Primary Education	22.2%
Completed Primary	17.8%
O' Level	28.9%
A' Level	6.7%
Post Secondary Education	6.7%
Total	**100%**

There was a relationship between education levels and the response to malaria treatment/mitigation. For instance, the use of mosquito nets was tagged with a lot of social expressions, especially in Kibaale district where illiteracy was most prevalent. In there, some LLIN holders were reported to be using the nets as curtains for doors, fencing poultry yards and harnessing white ants. A few people considered the LLINs to be negatively impacting to their life, and the thicker nets were alleged to be causing a lot of heat, and some people preferred the lighter nets.

3.2 Malaria Services' Access and Utilization

Access to quality health facilities was not just considered a right in Uganda, but the country had committed itself that by 2017, it will have achieved and sustained protection of at least 85% of the population at risk through recommended Malaria Prevention Measures .

The consumption of malaria based treatment and utilization of lower health centres was largely based on the proximity of health facilities to particular respondents. The study revealed that over 40% of the respondents consumed services based on their closeness to facilities, while 15.6% consumed services because they were cost free. The study was however informed that 26.7% of the community members visited health facilities because of the availability of drugs, though the frequency of drug distribution was

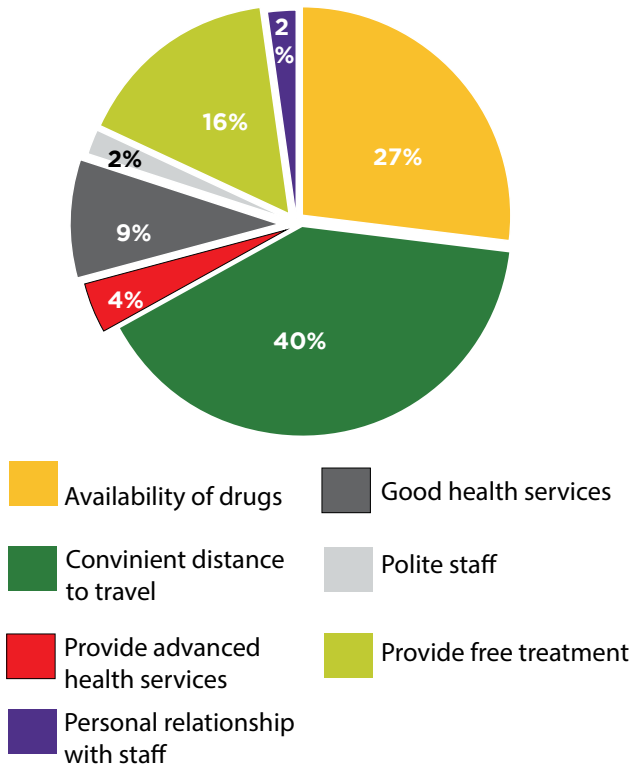

Figure 3: health Utilization in Uganda

not known by the communities. The study revealed that the use of district hospitals by communities was largely on a referral basis by nearby health centers.

3.3 Community Feedback onto their Health Services

The study showed community understanding of the role of health facilities and services provided. However, this knowledge was in general perspectives not on disease specifics. The study showed that only 27.3% knew whether their health facilities had a duty roster displayed publicly in the health facility. The knowledge of existing staff on duty was vital on communities' engagement on the services consumed from a public health facility.

However, the study showed that 52.3% of facilities lacked functional suggestion box mechanisms, and only 47.7% had suggestion boxes. Presence and use of suggestion boxes is essential in communication to and from communities, for they facilitate meaningful feedback about malaria and other services provided by the health facilities.

The study showed that the extent of utilization of the information and suggestions made by communities as recommendations and proposals was low. Only 31.8% of the communities believed that the health facilities utilized the information that they made in form of proposals and recommendations. Over 61.4% expressed skepticism about the use of the suggestion boxes and its contents at facility level. This implied that citizens' input into their health services at community level was minimal.

Table 3: Showing Utilization of Suggestion Box Information from the Communities

Response	Frequency	Percent
Yes	14	31.8%
No	27	61.4%
Don't Know	4	6.8%
Total	**45**	**100%**

The study revealed that 4 out of the 6 health facilities visited in Bunyoro had labels on the health facility rooms. These provided meaningful guidance and direction to health facility clients. It was observed that all facilities had major units labeled. These included the theatre, the in-charge room, the maternity, the children ward, interlia. The labels were improvised using printouts and masking tape, especially in Kibaale Health Centre IV and Kyebando Health Centre III.

3.4 Malaria Investments Efforts and Actors in Uganda

Over time, the government of Uganda had made utmost commitment to improving the health services of its citizens. This was done both as a commitment in the development processes and as a constitutional obligation. Specifically, the government committed itself to accelerate wealth creation and employment. While enhancing competitiveness, the country prioritized investment in developing a strong human capital, the components of which are health, nutrition education and skills development.

To realize these investments, the key development strategies included harnessing of the demographic dividend . In addition, the government made a health sector commitment to put efforts geared towards strengthening of the national health system, including governance; disease prevention, mitigation and control; health education, promotion and control, contributing to early childhood development, curative services, rehabilitation services, palliative services, and health infrastructure development . The development focus of Uganda focused on investment in malaria prevention through coordinated and targeted behavior change communication, mass treatment, mass distribution of long lasting insecticide-treated nets (LLINs), insecticide residual spraying in high transmission districts, larviciding (killing of mosquito larvae), preventive treatment among pregnant women, scale-up of the integrated community case management of malaria and other childhood illnesses, as well as improvement of facility based malaria case management .

In this vein, Uganda, in conjunction with her partners, had made significant investments in its malaria program in the recent years. Major malaria funding partners in Uganda included The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), Presidential Malaria Initiative (PMI) and

UKaid/DFID, contributing over 90% of the malaria budget, while the GoU contributed only 8.5% (Table 3), though played a big role in indirect financing through salaries of service providers, and maintenance of infrastructure. Data on contributions of households and the private sector were not readily available.

3.5 Malaria Investments Achievements and Gains

The huge foreign and domestic malaria investments had correspondingly resulted in impressive malaria program achievements. For example, in the last 10 years LLIN coverage had jumped from 16% to 90%, and LLIN use among under the five children had jumped from 10% to 74% (Table 4).

Correspondingly, those malaria program achievements had resulted into remarkable malaria impact health indicators. For example, the prevalence of malaria parasitemia among the under five children had reduced from 42% to 19% in the last 5 years, while prevalence of anemia among the same age group had reduced from 10% to 5% (Table 5).

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Table 4: External and domestic malaria financing efforts in the last 4 years (NMCP 2017)

Input Indicator	2014	2015	2016	2017	Total	%
External funding (USD)	110,000,000	110,000,000	110,000,000	120,000,000	450,000,000	91.5
GoU Funding (USD)	11,500,000	11,500,000	7,000,000	11,500,000	41,500,000	8.5
Private Sector (USD)	-	-	-	-		
Household (USD)	-	-	-	-		

Data not available by the time this study was being concluded for these periods

Table 5: Uganda malaria program achievements over years (MIS 2014-2015)

Outcome Indicator	2006 (UDHS)	2009 (UMIS)	2011 (UDHS)	2014-15 (UMIS)
LLIN coverage (1 net per household)	16%	47%	60%	90%
Under 5' that sleep under ITN	10%	33%	43%	74%
Pregnant women that sleep under ITN	10%	44%	47%	75%
Pregnant women that take IPTp 2	16%	32%	25%	45%

Table 6: Uganda malaria health impact indicators over years

Impact Indicator	2006 (UDHS)	2009 (UMIS)	2011 (UDHS)	2014-15 (UMIS)
Prevalence of malaria parasitemia among under 5's children	N/A	42%	N/A	19%
Prevalence of anaemia in under 5's children	N/A	10%	5%	5%

3.6 Community Malaria Knowledge, Attitude and Practices

The provision and consumption of information on malaria prevention, mitigation and treatment to the communities is essential in controlling its spread and treating it. This is based on the notion of prevention and sustainable management of malaria. As such, efforts to make communities informed of the key interventions like the under-five treatment of malaria at the village level, the sustainable and continuous use of insecticide treated mosquito nets, early treatment of case, among others, is presumed to address the malaria challenges in the community.

The study showed that only 18% of the communities had heard of the updated malaria information. However, that information was only provided at facility levels. The in-charge Kyebando Health Centre III expressed that health education was an integral part of the facility especially when clients went for treatment. She said that all clients were given basic information at group and individual levels, as a measure of mitigating and supporting suitable use of drugs provided. The in-charge Bwijanga HC IV informed the study that they provided a comprehensive health program including malaria and HCT to communities, supported by NGOs such as TASO and IDI.

At the facility level, the study showed that facilities displayed most information regarding malaria services provision, prevention and drugs received on the walls. On the other note, a Clients' Service Charter was displayed at every facility visited during the study.

Table 7: Provision of Updated Malaria Information at Health Facility

Response	Respondents' Number	Percent
Yes	8	18.2%
No	16	36.4%
Doesn't Know	20	45.5%
Total	**44**	**100%**

Findings also reveal that the communities were accessing information about malaria investments through talk shows, spot messages and dialogues on health service delivery.

3.7 Community Knowledge on Anti-malarial Drug Availability

The NMS distributed drugs on a quarterly routine basis. The drugs were requisitioned by the health facilities according to the DHO Masindi district. The study however revealed that there were supplementary drug distribution schemes, particularly for paracetamol/anti-malarial drugs by the Malaria Consortium to the health units and Village Health Teams (VHTs).

Majority of the community members expressed ignorance about the pattern of drug distribution in their facilities. For instance, when asked whether they knew when their health facilities receive drugs, 64.4% expressed not knowing, and only 35.6% knew. The level of awareness of anti-malarial drugs availability at health units by clients was critical in shaping their pattern of consumption of the drugs and curbing the malaria trends among communities.

Generally, communities showed limited appreciation of their need to monitor drug distribution. They however noted that malaria drugs like all other drugs were available in some months of the year, and unavailable in other months. The study was informed that malaria drug distribution to facilities by the National Medical Store took a quarterly routine basis. As part of the technical assistance provided by WHO, efforts to advocate for increased drug funding and effective distribution were under way according to Dr. Nanyunja, the National Professional Officer for Disease Prevention and Control, WHO Uganda.

The study further revealed increased drug stock-outs, especially for malaria drugs at most health facilities. For example, on the date of study visit at Kibaale Health Centre IV, anti-malarial drugs were out of stock. The health facilities however noted that the malaria clients were seasonal, based on rain and dry spells; and communities needed anti malaria drugs largely during the wet seasons. The study revealed that information about malaria treatment services was largely shared among patients who visited the various health facilities. Over 40% of the respondents received information from their fellow facility clients. The presence of drugs

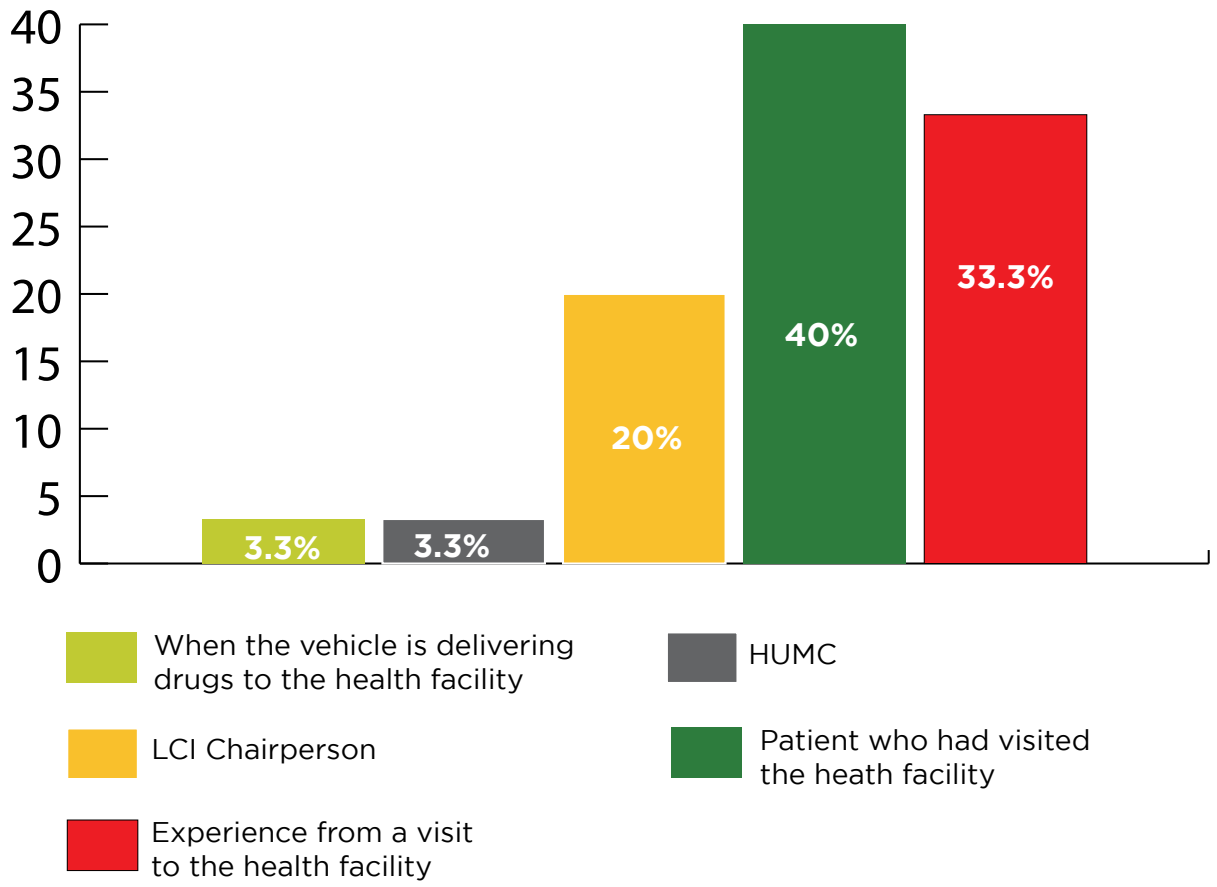

Figure 4: *Sources of Community Knowledge of Anti-malarial drug availability*

implied that NMS had supplied and absence implied that they had not supplied.

33.3% of respondents obtained the information about drug availability at their health facilities from their experience of visiting the health facility, while 20% from the LC I chairpersons. The study showed that majority of the female respondents had knowledge on the availability of drugs but not on delivery mechanisms. Men were less engaged in the community malaria initiatives.

The study revealed that communities were appreciative of the need and importance of visiting health facilities for malaria treatment. Majority knew the dangers of not treating malaria sufficiently. The study found out that despite incidences of misuse of the mosquito nets, communities expressed knowledge of the importance of sleeping under insecticide treated mosquito nets.

When asked whether they received information about the importance of visiting health facilities for malaria treatment and its dangers, over 43.2% of the respondents admitted, while 55.6% did not. However, even those who did indicate not having received such information, could ably communicate the malaria dangers including death. An old woman with no formal education in Kisomabutuzi village, Bwijanga sub-county, Masindi district noted that without treatment for malaria, she could die. This fear was also associated with basic malaria mitigation practices like use of mosquito nets, avoidance of water logged places that breed mosquitoes, and early treatment of malaria among others.

3.8 Health Facility–Community Linkages

By the time of the study, Uganda had increasingly implemented community

outreach initiatives coordinated by the health teams from the facility and district Local Government levels. As such, efforts to communicate to communities suitably were viewed to be a sustainable mechanism for reducing and mitigating malaria spread at community level.

When asked whether the staff from their corresponding health facilities had visited their localities in the last six months, over 54.5% of community members had experienced these health visits, while 40.9% had not witnessed them, and 4.5% did not know. The study was informed that there were no typical malaria outreaches then; instead there were HIV/AIDS outreach services that incorporated malaria treatment and prevention services.

Table 8: Showing Visitation of communities by the Staff from Health Facility

Response	Frequency	Percent
Yes	24	54.5%
No	18	40.9%
Don't Know	2	4.5%
Total	**44**	**100%**

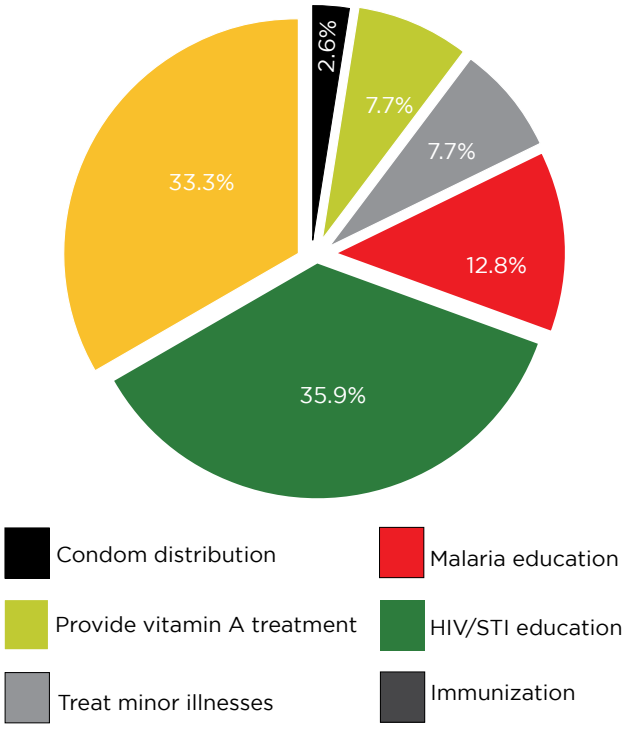

Figure 5: *Level of Health Staff Visit to Villages/Communities*

The services provided during the community health programs largely included immunization (33.3%), Malaria Education (12.8%), HIV/STI education (35.9%), Treatment of Minor Illnesses (7.7%), vitamin A treatment to children (7.7%) and Condom Distribution (2.6%). This further implied that while malaria information was disseminated in communities, it was not core as it was supposed to be. The study further revealed that in an effort to facilitate facility-community linkage, facilities were found to possess duty roster displayed publically at the facility levels.

3.9 Health Unit Monitoring

Health service delivery monitoring is essential for compliance and maintenance of standard service delivery. The study revealed that only 29.5% of the health facilities were monitored by the Local Council leaders. 25% of the communities indicated that there was no monitoring of facilities by Local Council leaders, while 45% did not know whether monitoring was done or not. The study showed that 4.5% of the communities knew whether there was a specific staff trained on malaria care at their facilities. This further implies that the efficiency of the health services was likely to be compromised due to limited monitoring by the local leadership.

The Ministry of Health, under the department of quality assurance had issued the Health Unit Management Committee (HUMC) guidelines for health centre IIs, IIIs and IVs in 2013; expressing critical roles of the community, such as monitoring of facility administration, supporting the management of finances of the facility, providing advice and oversight to procurements, and facilitating communication between the facility and community members. The six member committee was critical in creating community reach, and efficacy of health service provision chain.

The study asked communities and users of the health services in Bunyoro as to whether they knew anyone who was a member of the HUMC of their facility. Only 39.5% knew someone, while the 60.5% did not know any. This implied that even though HUMCs were available at facility level, they were less popular among the communities. This

was perhaps due to the limited role the HUMCs played between health facilities and communities. However, in some communities like in Masindi district there was maximum recognition of the role of the HUMCs in the management and monitoring of the health facilities. The in charge Bujenje Health Centre III at Ikoba informed the study that the HUMC link the community and the health units. For example, the availability of drugs at the respective health facilities were made known to the communities through the HUMCs.

The study also revealed that the HUMCs discussed critical issues surrounding the management of the health facilities. For instance, at Kyebando HCIII, the HUMC had discussed the renovation of the water tank and the toilets drainage for health staff quarters, prompting the sub county leadership to renovate them. At Buhimba Health Centre III, the HUMC meetings had discussed staff absenteeism and time management. The in-charge indicated that some improvements were experienced in both attendance and time by staff after HUMC interventions.

3.10 Community Health Initiatives

The Government of the Republic of Uganda committed to implement the post-2015 development agenda which prioritizes universal health coverage (including mass treatment of malaria in all its forms; reducing maternal mortality, ending preventable newborn, infant and under-five deaths, ending malaria and neglected tropical diseases . In this agenda, people involvement and community response to malaria is key. The government of the Republic of Uganda had been implementing a community development strategy where communities who are the primary users of the services are pivotal to the service delivery chain. As such, the study assessed the community engagement in malaria initiatives in Bunyoro.

It was found out that the Village Health Team (VHT) malaria program was the most adored and popular anti malaria community initiative in Uganda. This however, was focusing on children under five years. The VHTs were well coordinated and had a facility link and community based outlook according to the study. The VHTs were however less motivated, and distribution of basic anti malaria drugs turned out to be costly for them in terms of collection from health facilities and distribution to their villages.

The LCV chairperson Masindi Mr. Byaruhanga Cosmas informed the study that community participation in public initiatives was highly politicized to the extent that communities were demanding to be paid for their participation, even on public health interventions like malaria. In his view, this compromised citizen participation; and the sustainability of malaria investments processes.

By the time of the study, the Ministry of Health had designed a Health Insurance Scheme that was yet to be implemented by the government across the population. However, according to Connie Balayo, a Senior Health Environmentalist at the Ministry of Health, this required government, CSOs and the private sector to interest the citizens through deliberate efforts and enhanced popularisation

These community initiatives facilitated specific malaria case management, and prevention through mosquito nets distribution. However, some of the initiatives like the mosquito nets were perceived to be unfriendly with specific type of ITNs described to be thick, thus used for covering chicken, while others were just kept safe by the communities.

The study however was informed that most citizens do not know their roles in the malaria management chain, thus finding it difficult to demand and monitor what takes place at facility level. According to Robert Rukahemura, a CSO activist from Hoima, the citizens' competence was still low to engage in health based decision making processes of meaningful impact. He however asserted that the efforts to empower communities to demand and influence service delivery was on the rise especially by non state actors like NGOs. This was envisaged to shape demand for effective sustainable malaria initiatives, influencing decision making among others.

3.11 Current Community Involvement in Malaria Investment Processes

To attain objective 3 of the Uganda Malaria Reduction Strategic Plan 2014 - 2020 (UMRSP) that at least 85% of the population should practice correct malaria prevention and management measures by 2017, community participation in malaria initiatives was key. The epicenter of any community participation is information, and the involvement or co funding of any initiative by the user of the services provided is critical to the sustainability of any health program. The continuum of care and health service provision chain also requires much appreciation by the communities of the value of the process and development of a sense of ownership of the services provided or the facilities themselves.

At the time of the study, the public health facilities were purely reliant on government financing and foreign donations for their sustained health and malaria programs. Households only paid for their care in the private sector, and there was low participation of the community in the public health financing, monitoring and accountability processes. When the study asked communities as to whether they had contributed anything towards making services better at the facilities where they consumed the malaria and other treatments, the findings revealed that 84.6% had not contributed anything. Only 2.6% had ever contributed money to any services improvement, while 12.8% had offered their labor during the infrastructure development at the facility level.

In an FGD conducted in Kyebando, Kibaale district, community members expressed their participation in form of advocacy for drugs at facility level, and mobilization of household response to malaria interventions such as mosquito net use. According to Dr. Nanyunja of the WHO Uganda office, citizens were not well involved in malaria or health investment processes, apart from the out of pocket expenses to travel to facilities and buying missing medicines at facilities.

The study revealed that significant community participation was largely hampered by the general public ignorance and belief that communities were supposed

Figure 6: *Community Contribution towards Health Improvements*

to be mere consumers of services and not participants in the health service delivery chain. There was a general lack of enforcement of bylaws that specify community roles and responsibilities in health prevention and promotion, as well as the poor response from health workers in case of community agitation for better quality services.

3.12 Best Practices in Community Malaria/ Health Investment

A good or promising practice on community health health financing was noted at Bujalya Health Centre III, located in Hoima district. This Health Centre is located in a rural poor community, serving up to 15,000 people but inadequately funded by GoU and GAVI, with about 1.6m UGX (approx. $500) per quarter. The centre had no connection to any power grid and as a result OPD remained closed at night for the environment was not safe for health workers. Child deliveries were done

on torches or hand lanterns; and health workers' attitudes were sickening. Because of this, a platform for information sharing was instituted by ACTADE between community members, technical members and the political leadership to increase citizen's confidence and competence to engage in development processes. In the process, the community prioritized education, health and water & sanitation challenges as their community felt needs. In health, lighting of Bujalya HC III was prioritized. All stakeholders agreed to the urgency of lighting at least the faccility ward. Instead of waiting for the uncertain budget cycle, fundraising was prioritized which yielded 1.500.000/= the equivalent of slightly under $500. The Area MP complemented the efforts with 2 physical solar panels. These efforts lit up the maternity ward and the staff quarters. Correspodingly, this resulted in increased immunization numbers, especially for BCG because of boosted refrigeration of vaccines; increased hours of work for staff; reduced risks for deliveries at night; better motivation of the health workers; and enhanced relationships amongst stakeholders. The great lesson learnt out of this was that community contributions are not only necessary, but they are possible in both cash and in-kind. However, awareness rising is critical before this exercise can be embarked on. Community members need to be educated about how health services are financed in the country. Existing financing gaps need to be explained. Local politicians need to understand their roles in influencing budget allocations and proper utilization. It is also important to build a stakeholders' trust before you collect people's money. Platforms for information sharing between leaders and community members reduce suspicion and finger pointing, instead contribute to problem solving. Transparency and accountability are important values in such initiatives. Lastly, community involvement is a process; it takes time, and CSOs can play a major role in galvanizing these local financing initiatives at community level.

3.13 Sustainability of Malaria Investments Gains

Apart from a few individuals at the national level, Ugandans were oblivious of the looming reduction or scrape of foreign malaria or health investments. Majority thought this was a hoax and unlikely to happen then, given that Uganda was very unlikely to attain the middle income status by 2020, as had been projected by the World Bank. Secondly, some respondents indicated that major malaria investors had not instituted any sustainability plan so far to indicate that they were moving away any time. Therefore, there was no such discussion among stakeholders. As a matter of fact, the study was informed that the development partners' funding had of recent shifted paradigm focusing on malaria.

According to the DFID's Technical Advisor, Ms Robinah Lukwago, the DFID funding that formerly concentrated on budget sector support, had in 2012 shifted to supporting thematic areas such as IRS, LLINs, and ICCM, increasing every year i.e. £5,000,000 (2013); £7,364,466 (2014); £13,004,176 (2015); and £22,343,330 (2016); though that paradigm shift and progressive increases in foreign malaria investments had not attracted direct increases in domestic financing for the different malaria interventions in the country.

However, the National Malaria Program Manager did not take the threat of foreign donor cuts lightly, and was already instituting measures to mitigate shocks that may result from the looming donor cuts. He appreciated the fact that there was no way the country could match or take over the current foreign malaria funding. Therefore, the mitigation measures included: promotion of efficiency and effectiveness of the program, minimization of malaria medicine wastage and cost expenditures through the T3's approach (test, treat and track), decentralization of the malaria program to enhance district responsible-ness, empowerment of districts' accountability for their malaria outcomes; increased social mobilization and behavioral change communication to enhance prevention, as well as advocacy for mainstreaming malaria, positioning malaria and training a positive risk perception, stimulating a multi-sectoral action on malaria, thus making malaria a cross cutting issue.

According to Dr Henry Mwebesa, the Director Planning & Policy of the MoH,

Uganda was on the right path to sustainable malaria management. He informed the study that Uganda was manufacturing ACTs in the country. This had contributed towards the provision of adequate ACTs to the different communities and health facilities in the country. Whereas ACTs were still expensive, he commended the efforts by GF to introduce subsidized ACTs through the private sector.

Dr. Byakika Sarah, the Commissioner Planning at the MoH informed the study that he country had invested in universal distribution of mosquito nets, diagnosis and treatment, advocacy and social mobilization, malaria research, indoor residual spraying in a few districts, monitoring and surveillance, and program management. She further asserted that over 80% of the population was being treated after parasitological diagnosis with either microscopy or RDT. This reduced pressure on the drug bill, a move towards sustainable malaria management. The study was further informed that government had also established a malaria research centre, supporting efforts for every district to have a sound surveillance system, responsive to any epidemic, though there were still some gaps existing. Other efforts reported were those geared towards case treatment, coordination, and research . Dr. Byakika further asserted that the Ministry of Health was encouraging citizens to take charge of their health through ITN replacement and implementing health insurance policy. With this in place, Government would concentrate on other prevention strategies like IRS, and according to Dr. Nanyunja of WHO, technical support was expected to continue beyond 2020;

3.14 Citizens' Readiness to take over their Malaria Services

Although the above scenarios painted a gloomy picture for sustainability of public health services, the study was informed that some Private-Not-For-Profit health facilities were emerging. These had deeper community contribution and participation frameworks, and were predominantly situated in Kibaale district. As an effort to enhance civic responsiveness towards malaria investments, civil society organizations were engaging communities to appreciate their roles and duties. This was anticipated to translate into deeper campaign for communities to take responsibility of their own health concerns, while engaging the government to enhance value for money for the services provided in public institutions. The Ministry of Education had also engaged all schools to advance an awareness campaign including the health education "Talking Compounds".

The study was further informed that more efforts to involve communities in health service delivery were under way, such as training of Community Health Extension Workers (CHEWs), Village Health Teams (VHTs), and revitalization of the Health Unit Management Committees (HUMCs), among others. However, all these efforts lacked sufficient follow up, hence ended with limited appreciation of their impacts.

The study showed that there was an emerging breed of CSOs that mobilized communities to respond to the malaria programs by demanding for their rights, while at the same time conforming to their roles and responsibilities. Mr. Rukahemura Robert, the Program Assistant for African Centre for Trade and Development (ACTEDE) informed the study that different CSOs in Bunyoro regions were engaged in mobilizing communities to participate in development processes including health through their citizen participation.

In addition, the study was also informed by the District Chairperson for Masindi, Mr Byaruhanga Cosmas that, for effective community contribution to be enhanced, the political leadership needs to match their capacity with the needs of the health service improvements. He said, Masindi District was already working on a policy framework for Community Health Insurance that would be implemented under a Private–Public Partnership Arrangement. Ms Connie Balayo, a Senior Health Environmentalist at the Ministry of Health, also called for Local Governments' and individual households' to contribute towards malaria management. She commended the growing effort of the CSOs to increase monitoring and accountability demand, and he proposed health insurance uptake by citizens.

According to Dr Kassahun Belay; the Team Lead-PMI and GHSA under the USAID/

Uganda, formal, educated, productive and wealthy societies were ready to involve themselves in health related matters. He however recommends the use of civil societies to represent citizens in malaria investment processes until a critical mass is ready to takeover at community level.

Dr. Byakika the Commissioner, Planning and Policy at the Ministry of Health informed the study that Community Score Cards had been introduced in some communities (28 districts); aimed at mobilizing communities to take charge of their health situation, building responsibility among citizens and enhancing value for money at the health service delivery chain. The Ministry was also embracing citizen efforts, such as citizen organizations and Constituency Health Task Forces to hold health assemblies to get feedback on different health issues including malaria.

3.15 Conclusion

All in all, there are several malaria investments in Uganda, both foreign and local, with significant achievements and health gains; although some of their magnitudes are not known with certainty. However, the sustainability of these investments gains is not guaranteed if the foreign support was to be withdrawn, and majority of citizens are oblivious of any impending reduction in foreign malaria or health financing. Worse still, citizens' participation in the current malaria investments processes in the country is very nascent to be able to take over the gains. Therefore, the sustainability of these investments gains will require stakeholders' strategic thinking, planning, citizens' involvement and guidance.

3.16 Key Recommendations

Given the diverse findings above, we recommend the following strategies:

To Development Partners (DPs)

- DPs should lay down a clear plan and roadmap for gradual pull out, and a favourable strategy for sustainability of their malaria investment gains as not to cause a crisis/epidemics

To Government/Ministry of Health

- MoH should mainstream CHEWs and VHTs in the local council structure, for efficient and sustainable community malaria treatment at low cost
- MoH should implement the Universal Health Insurance Policy, and mobilize private sector to contribute towards Malaria through the Corporate Social Responsibility (CSR)
- MoH should revitalize Health Unit Management Committees to perform their designate roles such as monitoring of services and mobilization of communities to participate in health facility affairs
- MoH should invest more in malaria prevention to minimize heavy expenditure on curative services

To National Malaria Control Program (NMCP)

- NMCP should strengthen the capacity of district local governments to effectively plan, budget and implement their malaria activities; and leave central government to concentrate on commodities
- NMCP should promote efficiency and minimization of wastage e.g. encourage net repair, better quantification of products etc.
- NMCP should reduce the cost of doing business e.g. review procurement procedures for health commodities without necessarily going through NMS, which escalates costs

To Local Government (LGs)

- LGs should empower citizens and instil in them sense of ownership of health programs through the participatory bottom-up planning process
- LGs should engage communities through conversational dialogues on malaria and health co-financing; LLIN replacement, but put subsidies to protect most at risk persons
- LGs should design mechanisms for generating local resources for health care and malaria control

3.17 Key Concerns

1. **Limited Awareness on the Country's 2020 Agenda:** There is very low / no awareness of the country's 2020 agenda to transition from foreign health funding to domestic financing. The central government should deliberately sensitize the public and local governments of this intended shift.
2. **The dwindling local revenue base:** None of the districts surveyed had a strategy in place for local malaria financing. In addition, Local Governments had very low self-financing mechanisms. The dwindling local revenue leaves the districts incapacitated to provide and sustaining health and malaria initiatives in case of no or limited foreign/external financing. Currently, districts were rising only 3 -7% of their local budgets.
3. **Supply chain challenges in the public sector:** The health commodities at NMS were expensive; and their supply was irregular at facility level. This is in line with the President's Malaria Initiative Uganda Malaria Operational Plan FY 2016 that asserts that, "commodity supply to public sector health facilities remains a major challenge. The Mission had serious issues with the National Medical Stores' (NMS) capacity, accountability, and transparency to supply malaria and non-malaria USG-procured commodities. For USG-procured commodities to go through the NMS, a major transformation process within the NMS and the MoH is needed. These exercises need high level advocacy, budgetary, and system support from the GoU". Until the issue is resolved with the NMS, PMI advocates for commodities to reach the public sector through the Joint Medical Stores (JMS) in hard-to-reach areas and in times of outbreaks.

Kenya NGO Alliance Against Malaria (KeNAAM)
P.O Box: 788-00100,
Nairobi, Kenya
Tel: +254202023442
Email: info@kenaam.org
www.kenaam.org