UGANDA ROLL BACK MALARIA COUNTRY CONSULTATIVE MISSION: ESSENTIAL ACTIONS TO SUPPORT THE ATTAINMENT OF THE ABUJA TARGETS

18-19 September 2003

James Banda, Albert Kilian, Peter Langi,
Edith Lyimo and Graham Root

1. EXECUTIVE SUMMARY

The Roll Back Malaria Board, representing the global RBM partners, requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries would require to support the attainment of the Abuja Targets. The purpose of the country consultative missions is to re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The Country Consultative Mission for Uganda took place 18-19 September 2003.

As regards progress towards attaining the Abuja targets 2005, the following information was noted.

- It is estimated that by the end of 2005, 45% of under-fives will be sleeping under an ITN
- It is estimated that by the end of 2005, 30% of pregnant women will be receiving 2 doses of IPT (IPT1 and IPT2)
- It is estimated that by the end of 2005, 60% of under-fives with fever will be receiving effective treatment within 24 hours

The following essential actions were identified to ensure that the Abuja targets are met and long-term sustainability of an effective malaria control programme is realised

- Carry out detailed operational planning in preparation for the large-scale implementation of HBM (USD80,000)
- Ensure currently implementing districts do not have Homapak stock-outs prior to the arrival of GFATM funded drugs (earliest August 2004)
- Design and establish national free net re-treatment system (USD2,300,000 (2004-2006)
- Additional investment in National ITN Voucher Scheme if level of subsidy or beneficiaries to be increased
- Consensus meeting on IRS and choice of insecticides
- IRS policy developed and disseminated
- Sustain and expand current malaria emergency response (c. USD900,000)
- Prepare for the next antimalarial drug policy change (2004-2006; c. USD600,000)
- Increased investment in malaria BCC activities prior to arrival of GFATM monies and recruitment of a Communication Adviser (2004; c. USD500,000)
- Sensitise districts on the Global Fund malaria proposal (USD20,000)
- Strengthen zonal co-ordinator system model (inputs: staff, vehicles, equipment, office space, activities; USD500,000 for 3 years)
- Institutional and human resource development at central level through staff recruitment, provision of technical assistance and investment in office space and facilities (USD600,000 for 3 years)

The essential actions listed above were discussed and agreed at a Consensus Meeting held on 19 September 2003 and attended by 12 participants, including two Ministry of Health Commissioners and representatives of national and international partner organisations and agencies

It should be emphasised that the gaps, resource requirements and essential actions identified are additional and complementary to those currently planned and budgeted for within existing resources in the country, including Global Fund monies.

2. TABLE OF CONTENTS

1. EXECUTIVE SUMMARY 2
2. TABLE OF CONTENTS 3
3. ABBREVIATIONS 4
4. INTRODUCTION 5
5. METHODOLOGY 5
6. SUMMARY SITUATION ANALYSIS 5
7. ABUJA TARGETS – WILL THEY BE MET? 6
7.1. ITN coverage among under-fives 6
7.2. IPT coverage among pregnant women 8
7.3. Access to effective treatment for under-fives 9
8. THE ESSENTIAL ACTIONS 10
8.1. Home-based management of fever 10
8.2. ITNs 10
8.3. IRS 11
8.4. Malaria control in IDP and refugee camps 11
8.5. Drug policy 11
8.6. Communication and advocacy 11
8.7. Supporting districts scale up 11
8.8. Institutional and human resource development at central level 12
9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED 13
10. ACTION POINTS TO FOLLOW-UP 14
11. ANNEX 1. LIST OF PERSONS AND ORGANISATIONS CONSULTED 15
12. ANNEX 2. AGENDA – CONSENSUS MEETING 16
13. ANNEX 3. DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION 17

3. ABBREVIATIONS

ADB	African Development Bank
ANC	Antenatal Care
BCC	Behaviour Change Communication
CDD	Community Drug Distributor
CORP	Community's Own Resource Person
CQ	Chloroquine
DHS	Demographic and Health Survey
EARN	Eastern Africa RBM Network
GFATM	Global Fund to fight AIDS, TB and Malaria
HBM(F)	Home Based Management (of Fever)
HIV/AIDS	Human Immunodeficiency Virus/Auto Immune Deficiency Syndrome
HSSP	Health Sector Strategic Plan
ICCM	Integrated Country Co-ordinating Mechanism
IDP	Internally-Displaced Persons
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
LLIN	Long-Lasting Insecticidal Net
MC	Malaria Consortium
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NMCP	National Malaria Control Programme
PLHA	People Living with HIV/AIDS
RBM	Roll Back Malaria
RH	Reproductive Health
SMO	Senior Medical Officer
SP	Sulphadoxine-Pyrimethamine
TA	Technical Assistance
TB	Tuberculosis
USAID	United States Agency for International Development
VHT	Village Health Teams
WG	Working Group
WHO	World Health Organization

4. INTRODUCTION

The Roll Back Malaria Board representing the global RBM partners requested the RBM Partnership Secretariat to conduct a series of country consultative missions to determine what additional inputs Category 1 countries[1] would require to support the attainment of the Abuja Targets. The RBM Partnership Secretariat requested the Eastern Africa RBM Network – which represents partners in the sub-region – to participate in these country consultative missions.

The purpose of the country consultative missions is to:

- Re-invigorate co-operation between the RBM partnership and countries to support progress towards achieving the Abuja Targets.

The expected outcomes of the missions are:

- Determine the status of RBM implementation in relation to the Abuja plan and targets and the milestones set for the remaining two years of the Abuja plan period
- Identification of the essential actions (beyond those already planned) that need to be implemented during 2004 and 2005 to maximise country action to achieve the Abuja Targets
- A Country Support Package that details the additional investments required to carry out these essential actions

Uganda was the first country to have a Country Consultative Mission, which took place between 18-19 September 2003. The RBM Uganda Scoping Study, which reviewed gaps in the current malaria response, was recently completed (April 2003) and as a result it was decided that only a short country consultative mission of two days duration was required

The mission team comprised: Dr Peter Langi (NMCP Manager), Dr James Banda (Country Partnership Adviser, RBM Partnership Secretariat), Dr Albert Kilian (Malaria Advisor, USAID and East Africa RBM Network), Dr Edith Lyimo (Entomologist, WHO East Africa Inter-country Programme and East Africa RBM Network) and Dr Graham Root (East Africa Regional Director, Malaria Consortium and East Africa RBM Network).

5. METHODOLOGY

The methodology employed included a review and updating of the RBM Uganda Scoping Study, and interviews with key Ministry of Health personnel. On day two a Consensus Meeting was held (see Annexes 1 and 2). Following the Consensus Meeting, the Essential Actions and Country Support Package were revised accordingly and next steps agreed on with the Ministry of Health.

6. SUMMARY SITUATION ANALYSIS

Since 2000, major steps have been made in Uganda towards attaining the Abuja targets. Highlights include:

Policy, strategy and systems

- Political commitment at various levels has been demonstrated

[1] The RBM Partnership Secretariat categorised African countries into 3 groups. Category One countries are those considered most ready to rapidly scale up the coverage of interventions. Uganda is classed as a Category One country.

- Increased awareness by Ministry of Health, districts and external partners of the burden of malaria
- Central level strengthening of the NMCP in terms of number of personnel
- Significant progress in malaria policy and strategy development

Effective treatment and IPT
- Successful implementation of new antimalarial drug policy
- Design and implementation of HBMF strategy
- Supply of antimalarials has improved with overall systems strengthening
- Nationwide implementation of intermittent preventive treatment

ITNs
- Acceptance of ITNs as an effective intervention among policy-makers
- Removal of taxes and tariffs on ITNs
- Development of robust public sector/private sector/civil society partnership for scaling up ITNs through the ITN WG
- Design and piloting of national ITN voucher scheme

We are now at a critical juncture for malaria control in Uganda: significant progress has been made in the development of policies, strategies and partnerships. In order for the current momentum not to be lost, it is imperative that we now act and implement the identified interventions at national scale.

7. ABUJA TARGETS – WILL THEY BE MET?[2]

The Health Sector Strategic Plan (HSSP) and Abuja 2005 targets are:

- 60% (50% - HSSP) of under-fives and pregnant women sleeping under ITNs by 2005.
- 60% of pregnant women receiving IPT1 and IPT2 by 2005.
- 60% of under-fives with fever receiving effective treatment within 24 hours by 2005.

Due to the lack of empirical data and models that would allow us to make firm estimates, the estimates given below should be interpreted as broad indications. Moreover, the estimates share a number of assumptions which are:
- Global Fund monies for malaria will be available by early 2004
- Effective central level management systems and the requisite human resource capacity will be in place to co-ordinate the increased response.
- Gaps identified in the Reaping Table are addressed – either through system strengthening or separately funded initiatives.

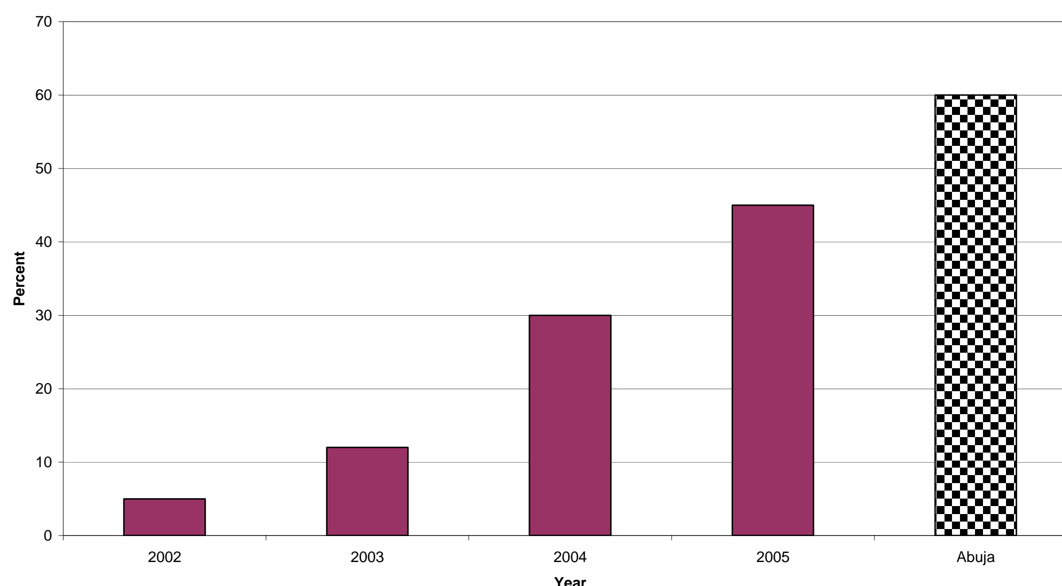
7.1. ITN coverage among under-fives

It is estimated that by the end of 2005, 45% of under-fives will be sleeping under an insecticide-treated mosquito net if the following occurs:

Year	Assumptions and actions
2002	• Coverage was estimated based on Uganda DHS 2000/1 • Coverage is 5%.
2003	• The commercial ITN market continues to expand. Private sector distributors begin to be supported by NetMark+ which strengthens their distribution systems and carries out

[2] This section of the report is an updated version of Section 7.9, Roll Back Malaria Uganda Scoping Study Report, April 2003.

	generic promotion of ITNs. • Health development partners support the free distribution of ITNs to pregnant women and under-fives living in IDP camps in Northern Uganda. • CMS pilots the ITN Voucher Scheme in 4 districts. • Community-based NGO activities continue. • Coverage increases to 12%.
2004	• Preparatory work for the National ITN Voucher Scheme, including establishing the Central Management Unit and tendering for distributors to participate, is completed in 2003. This will enable the National ITN Voucher Scheme to begin early in 2004. • CMS promotes a highly subsidised ITN in northern Uganda which complements the free distribution of ITNs in the IDP camps. • NetMark+ activities are in full swing and the demand for the commercial market supply of ITNs continues to expand. Due to higher volumes and greater competition, the retail price of ITNs falls. • BCC initiatives funded by GFATM monies increase awareness of ITNs. • The national ITN free re-treatment system is implemented early in 2004 following preparatory work in 2003. This enables the majority of the existing crop of (untreated) nets to be treated and dramatically increases ITN coverage. • Community-based NGO activities continue. • Coverage increases to 30%.
2005	• The commercial ITN market continues to grow and prices fall. • BCC initiatives funded by GFATM continue to increase awareness of ITNs • The national ITN free re-treatment system continues to treat the majority of conventional nets. In addition, the majority of new nets sold are long-lasting nets. • The National Voucher Scheme continues and extends to new districts • Community-based NGO activities continue. • The crop of nets that are discarded due to age increases which slows down overall coverage. In addition, there remains a rump of the population that is resistant to using ITNs. • Coverage increases to 45%.

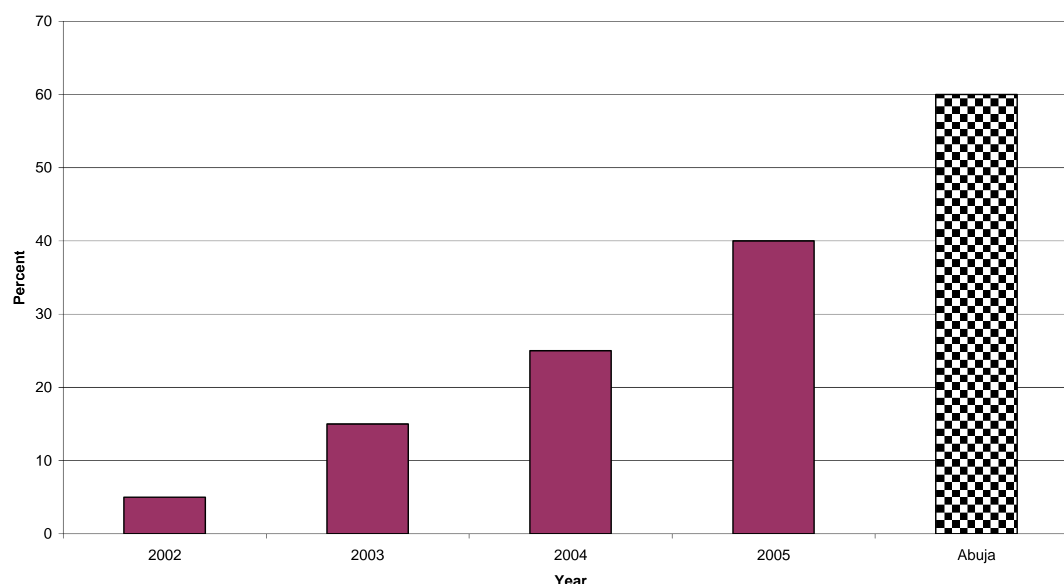


NB. It is estimated that ITN coverage among pregnant women will be at similar level due to the National ITN Voucher Scheme targeting this group for the distribution of the vouchers.

7.2. IPT coverage among pregnant women

It is estimated that by the end of 2005, 30% of pregnant women will be receiving 2 doses of IPT (IPT1 and IPT2) if the following occurs:

Year	Assumptions and actions
2002	• Coverage was estimated based on available data from NMCP • Coverage is 5% (both doses).
2003	• The frequency of SP stock-outs declines due to the new pull drug supply system coupled with SP procured by donors. • As sensitisation of all health workers to the new antimalarial drug policy includes IPT, there is policy reinforcement. • Coverage increases to 15%.
2004	• The scaling up of home-based management of fever includes counselling on IPT to child carers. This is coupled with other BCC activities that aim to increase the timing and frequency of ANC visits by pregnant women. • As the health system strengthens, reproductive health services also improve. The USAID UPHOLD (Services) Programme provides additional support in this area. • However, due to pregnant women continuing to attend ANC late in pregnancy (during third trimester) or only attending once prevents IPT1/IPT2 coverage from increasing at a faster pace. • Coverage increases to 25%.
2005	• Counselling on IPT by CORPs continues as well as related BCC activities. • Reproductive health services continue to improve as the health system strengthens. • However, due to pregnant women continuing to attend ANC late in pregnancy (during third trimester) or only attending once prevents IPT1/IPT2 coverage from increasing at a faster pace. • Coverage increases to 40%.

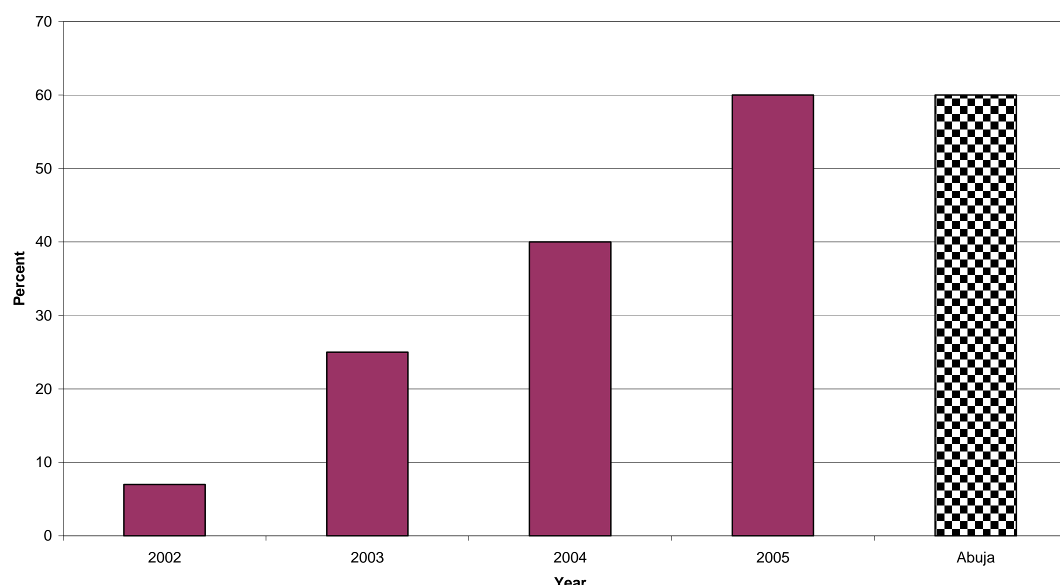


NB. The coverage estimates of IPT1/IPT2 are conservative. However, the majority of the factors influencing IPT coverage are intrinsically linked with broad health system issues and, hence, progress may be slower than other interventions.

7.3. Access to effective treatment for under-fives

It is estimated that by the end of 2005, 60% of under-fives with fever will be receiving effective treatment within 24 hours if the following occurs:

Year	Assumptions and actions
2002	• Coverage was estimated based on available data from NMCP. • Coverage is 7%.
2003	• Antimalarial drug supply to health facilities improves due to donor-procured drugs and the change in the drug supply system • Sensitisation of health workers and drug vendors to the new antimalarial drug improves case management of uncomplicated malaria. • Homapak implementation in the ten WHO districts, eleven ADB districts and IDP camps is consolidated with additional funds. This improves access to effective treatment at the community level. • Coverage increases to 25%.
2004	• Pharmaceutical manufacturers launch commercial versions of Homapak. • GFATM monies are used to continue Homapak implementation in WHO and ADB districts (and IDP camps if still necessary) and also expand to additional districts • Coverage increases to 40%.
2005	• Commercial versions of Homapak widely available in urban and many rural retailers. • Homapak implementation continues using GFATM monies. • Coverage increases to 60%.



NB. An important assumption for this target is that the current first-line combination (CQ and SP) remains effective until 2005. If this is not the case, the coverage estimates would have to be downgraded. In addition, when the new long-term artemisinin-based antimalarial drug policy is introduced (2005/2006?), it is likely to be considerably more expensive (by a factor of at least 10).

Summary

Estimates of where Uganda will be in three years time in terms of the malaria HSSP and Abuja Targets are difficult. Currently, coverage levels for the three key interventions are low. However, if the NMCP and its partners are able to access Global Funds effectively and

efficiently by early 2004, fully utilise the opportunities within the health system, and fill the remaining gaps outlined in the next two chapters, then by the end of 2005 it is envisaged that Uganda will not fall far short of obtaining the targets.

8. THE ESSENTIAL ACTIONS

The essential actions given below are those deemed necessary by the RBM Country partnership, EARN and RBM Secretariat to acceleration implementation and reach the project coverage rates given in the previous section. It should be emphasised that these essential actions only include those that are not currently planned and budgeted for within existing resources in the country, including Global Fund monies. Whilst the Global fund proposal does include support to home management of fever" using pre-packed, unit-dosed malaria treatment for children under five, and increased access of pregnant women and children under five to insecticide treated mosquito nets through targeted subsidies delivered through a national voucher system, the resource requirements identified through the country consultative mission will not duplicate GFATM activities. For example, in the area of home based management of fever, the REAPING mission has identified a resource gap to ensure that there are no Homapak stock outs in implementing districts during the interim period prior to receipt of global fund monies. As regards ITNs, whilst it is noted that the voucher scheme is fully funded under the GFATM proposal, there is a need for a net re-treatment system to ensure that nets remain maximally effective. Scaling up of IPT2 coverage is already included in the GFATM proposal through procurement of SP, BCC activities and in-service training of health workers, and is therefore not included in the gaps identified during the country consultative mission.

8.1. Home-based management of fever

Home-based management of fever is a priority intervention for Uganda. There is broad consensus that the intervention be taken to scale. Global Fund monies will be sufficient to cover implementation and drug costs. However, there is a need for the following:

- Carry out detailed operational planning in preparation for the large-scale implementation of HBM. This should include testing different delivery and monitoring models to address such issues as support/supervision, monitoring, training of new CDDs, integration with VHTs and attrition rates of CDDs (USD80,000).

- Ensure currently implementing districts do not have Homapak stock-outs prior to the arrival of GF funded drugs (earliest August 2004).

8.2. ITNs

Establishing a nationwide free net re-treatment system will dramatically increase ITN coverage in Uganda. Moreover, it will be a finite intervention due to the advent of LLINs – likely to be the dominant ITN product by 2006. The re-treatment system will be based on two free re-treatments per year (e.g. April, October) using a mass campaign approach. This system may be complemented with continuous social marketing activities for re-treatment kits.

- Design and establish a nationwide free net re-treatment system (Shortfall: USD2,300,000 (2004-2006)

The National ITN Voucher System will deliver a subsidy to pregnant women attending ANC. The system is fully funded through GFATM monies. However, if the level of subsidy is to be increased or the beneficiaries expanded (e.g. under-fives, PLHA, orphans), additional investment in the system will be needed.

- Additional investment in National ITN Voucher Scheme if level of subsidy or beneficiaries to be increased

8.3. IRS

The use of indoor residual spraying as a malaria control intervention in Uganda remains unresolved. It is important for consensus to be reached on when and where IRS is appropriate as well as the type of insecticides used. Following this, a policy should be put in place clearly stating under what circumstances should IRS be employed and what insecticides are to be used.

- Consensus meeting on IRS and choice of insecticides

- IRS policy developed and disseminated

8.4. Malaria control in IDP and refugee camps

A sustained malaria control response in IDP and refugee camps in northern, eastern and western areas is a priority. This response should include access to effective treatment in camps (using HBM), distribution of free ITNs to displaced populations, strengthening of IPT through fixed and outreach facilities, and integrated health promotion activities.

- Sustain and expand current malaria emergency response (c. USD900,000)

8.5. Drug policy

To maintain improvements in access to effective treatment with the declining efficacy of the first-line antimalarials, there is a need to begin planning for the next drug policy change.

Key steps that will need to be taken to ensure a smooth, appropriate and on-time policy change include reaching consensus on the new policy; calculation of drug demand, logistics and associated costs; advocacy and resource mobilisation for the new combination; regulatory issues (including addressing pre-packaging); phasing out of old drugs and introduction of new drugs into public and private systems; communication and advocacy strategy for introduction of new drug policy; and implementation of training of all levels of health care providers

- Prepare for the next antimalarial drug policy change (2004-2006; c. USD600,000)

8.6. Communication and advocacy

There is a need for intensified efforts at the community level in terms of social mobilisation and BCC activities, particularly involving inter-personal communication methods prior to the arrival of GFATM monies. Also central level advocacy is needed for malaria to remain high on the political agenda. Moreover, there is a need for a good communicator to effectively articulate the concerns and needs of the NMCP, especially on contentious and difficult policy issues.

- Increased investment in malaria BCC activities prior to arrival of GFATM monies and recruitment of a Communication Adviser (2004; c. USD500,000)

8.7. Supporting districts scale up

In order for districts to plan appropriately and scale up malaria control interventions, increased levels of support and supervision are needed. There is a need to reorient district health

personnel on the scaled up malaria response and ensure that planned interventions are appropriate.

It is proposed this can be done through a strengthening and development of the zonal co-ordinator team system that would initially cover malaria, IMCI and reproductive health (RH), with a view to expanding to include other programmes. Each zone would have dedicated staff providing support to districts and would work closely with the health planning department and relevant technical departments. In addition, the zonal co-ordinator would draw on existing specialised staff within the zone to provide support on specific activities (e.g. management of severe malaria). This model, once developed, will be expanded.

A more immediate need is to sensitise districts on the Global Fund malaria proposal.

- Sensitise districts on the Global Fund malaria proposal (USD20,000)

- Strengthen zonal co-ordinator system model (inputs: staff, vehicles, equipment, office space, activities; USD500,000 for 3 years)

8.8. Institutional and human resource development at central level

Adequate management capacity is necessary given the increased workload of the NMCP and massively increased investment in malaria control in Uganda. Moreover, the RBM partnership mechanism in Uganda needs to be consolidated. Likewise, it is important there is a conducive working environment for the NMCP. Hence, it is proposed capacity is strengthened in the following ways:

- Recruitment of a senior administrator
- Recruitment of a management advisor supported through periodic technical assistance
- Creation of a conducive working environment through investment in additional office space to house expanded team, provide a meeting room and an office for the programme manager
- Total cost for above three items: USD600,000 for 3 years

In addition, there is an urgent need for the replacement of MOs who have been promoted and recruitment for the two vacant Senior Medical Officer (SMO) posts

9. PROPOSED COUNTRY SUPPORT PACKAGE: ESSENTIAL ACTIONS AND INVESTMENTS REQUIRED

#	Essential actions (in addition to ongoing activities)	Products	Investments needed							Meeting the Gap
			Human resources	Commodities	Equipment	Cost 2003	Cost 2004	Cost 2005	Cost 2006	
1.	Operational planning for nationwide implementation of HBM	Sound HBM delivery and monitoring system in place for all districts	TA	Materials	N/A	30,000	50,000			MC (partial)
2	Ensure Homapak stock-outs do not occur in HBM implementing districts	HBM implementation maintained in 30 districts	N/A	Homapak	N/A	350,000				
3	Design and establish a nationwide free net retreatment system	All nets treated until 2006	TA	Treatment kits; materials	Various	500,000	300,000	800,000	700,000	
4	Reach consensus on IRS and choice of insecticides and develop IRS policy	MoH and partners adhering to IRS policy	TA	Materials	N/A	2,000				
5	Sustain and expand current malaria emergency response	IDPs and refugees protected against malaria	TA	ITNs, Homapak, SP	N/A	450,000	450,000			MC (partial)
6	Prepare for the next antimalarial drug policy change (2004-2006)	Smooth, on-time and appropriate drug policy change	TA	Materials	Various	-	50,000	150,000	400,000	
7	Increase investment in malaria BCC activities; recruit Communication Adviser	Intensified communication activities at community level	Staff	Materials	Various	-	500,000			
8	Sensitise districts to GFATM proposal	Districts ready to implement GFATM activities	Staff time	Materials	Various	20,000				
9	Strengthen zonal co-ordinator system	Districts planning appropriately and receiving timely support and supervision to scale up interventions	Staff	N/A	Vehicles, equipment, office space, activity budget	-	250,000	125,000	125,000	MC (design) GF (capital costs?)
10	Institutional and human resource development at central level	Conducive working environment; management capacity strengthened	Administrator/ management adviser; TA; vacant posts filled	N/A	Space for expanding NMCP	-	200,000	200,000	200,000	RBM Sec (HR)

10. ACTION POINTS TO FOLLOW-UP

- Distribution of Country Support Package table at Health Development Partners Meeting
- Communication from Health Development Partners and RBM Secretariat to Chair of ICC M on elements of the Country Support Package that can be supported
- Meeting of ICC M in October to review progress in filling gaps identified
- Representative from ICC M to attend East Africa RBM Review and Planning Meeting (Jinja – 10-14 November 2003) to discuss with RBM Board (14 November) on how remaining gaps in Country Support Package can be met

11. ANNEX 1. LIST OF PERSONS AND ORGANISATIONS CONSULTED

Commissioner Lwamafa, MOH
Commissioner Okware, MOH
Peter Langi, NMCP Manager
Graham Root, East Africa Regional Director, Malaria Consortium
Edith Lyimo, WHO EAGL ICP
Charles Paluku, WHO EAGL ICP
Albert Kilian, USAID/CDC Malaria Adviser
Andrew Collins, Health Systems Adviser, Malaria Consortium East Africa

List of participants at RBM Country Consultative Consensus Meeting (to be finished)
Ambrose Talisuna
Geoffrey Ochaye
Jessica Nsungwa
James Banda
Edith Lyimo
Albert Kilian
Commissioner Zaramba
Commissioner Okware
Ros Cooper
Susan Fraser
Suzanne McQueen
Andrew Collins

12. ANNEX 2. AGENDA – CONSENSUS MEETING

COUNTRY CONSULTATIVE RBM MISSION: ATTAINING THE ABUJA TARGETS

19 September 2003

1. OPENING REMARKS – Chair – Dr Zaramba
2. ROLL BACK MALARIA – James Banda
3. WILL WE MEET THE ABUJA TARGETS? – Graham Root
4. GAPS TO BE FILLED – Peter Langi
5. DISCUSSION AND CONSENSUS ON COUNTRY SUPPORT PACKAGE
6. CLOSING STATEMENT BY MINISTER

13. ANNEX 3. DOCUMENTS REVIEWED DURING COUNTRY CONSULTATIVE MISSION

Achieving Impact: Roll Back Malaria in the Next Phase. Report of the External Evaluation of Malaria, April 2002

The African Summit on Roll Back Malaria. WHO, CDS, RBM, Abuja, 2000

Budget Framework Paper for the Health Sector 2002-03 to 2004-05. Ministry of Health

Management of Uncomplicated Malaria: A Practical Guide for Health Workers. 2nd Edition. Ministry of Health, 2002

The Case for a Bigger Budget for the Health Sector. Ministry of Health, September 2002

Delivery of and Support to the Ugandan HSSP in the Context of a Constrained Resource Envelope: Selected Issues Arising During the Health Sector Joint Review of 14th – 18th October 2002. Sally Lake, Ireland Aid, December 2002

Budget Call Circular: Estimates for Recurrent and Development Revenues and Expenditures for FY 2003-04. MoFPED, October 2002

Investing in Health for Economic Growth and Poverty Reduction: New Perspectives and Opportunities. Short Report on Wilton Park Conference, in Association with DFID, NORAD and Institute for Global Health, University of California, May 2002

Draft Working Paper on Malaria and Poverty: Opportunities to Address Debt Relief and Poverty Reduction Strategies. April 2002

Fiscal Decentralisation in Uganda: The Way Forward. GoU-Donor Sub-Group on Decentralisation, January 2001

Public Expenditure Review 2002. K. Muhakanizi, Director Economic Affairs, MoFPED, May 2002

Malaria Control Strategic Plan 2001-02 to 2004-05. NMCP, Ministry of Health

Anti-Malarial Drug Policy. Ministry of Health, June 2002

Annual Health Sector Performance Report, F/Y 2000-01. Ministry of Health, September 2001

Health Sector Strategic Plan 2000-01 to 2004-05. Ministry of Health, August 2000

Uganda – Five Year Malaria Strategy, as part of the Integrated Strategic Plan 2002-07. USAID, September 2002

Guidelines for Annual Work Plans for Health Sub-Districts and DDHS Office. Ministry of Health, January 2001

National Health Policy. Ministry of Health, 1999

Guidelines for Community Health Departments. Ministry of Health, 1998

Providing Support to District Health Services Under Decentralisation and Sector Wide Approaches: Workshop Proceedings at Hotel Triangle, Jinja. Owarwo et al, December 2002

District Guidelines on the Utilisation and Management of Grants for Delivery of Health Services. Ministry of Health, December 1999

Studies of Human Resources for Health in Uganda. Group 5 Consulting Engineers, March 1999

National In-Service Training Strategy. Ministry of Health, October 2001

Buying and Selling of Malaria Treatment in Private Sector Drug Outlets in Uganda. CMS, Meinert L. and Nsabagasani X., 2002

The Burden of Malaria in Pregnancy and the Prospects of Integrating its Control Activities into Reproductive Health Services in Uganda. A National Baseline Survey, MoH/WHO/UNICEF/DFID. Mufubenga P. et al, 2001

Insecticide Treated Net Strategy. Ministry of Health, July 2002

Malaria in Pregnancy Control Strategic Plan. NMCP and Reproductive Health, Ministry of Health, 2000

Uganda Demographic and Health Survey. Uganda Bureau of Statistics, 2001-02.

Training of Drug Shop Attendants in the Treatment of Simple Malaria: A Trainers Guide. NMCP, Ministry of Health, Dec 2001

Inventory of NGOs working in the Health Sector in Uganda. Okiria, E. M., 1998

Design of a National Insecticide Treated Mosquito Voucher Scheme for Nets in Uganda. Prepared for Vector Control / ITN Sub-Committee of the ICCM by Mennonite Economic Development Associates, February 2003

Home Care and Management for Malaria: A Policy to Strategy and Implementation Brief. Marsh V. and Kachur P., October 2002

Public Expenditure Review: The MTEF and Budget Framework for FY 2002-03 to 2004-05. Muduuli M. C., Deputy Secretary to the Treasury, MoFPED, May 2002

‘Budget Speech’, delivered at the Meeting of the 2nd Session of the 7th Parliament of Uganda by Hon. Gerald M. Ssendaula, Minister of Finance Planning and Economic Development, June 2002

Strategic Issues in the Government-Donor Partnership. Kassami C. M., Permanent Secretary to the Treasury, MoFPED, (undated internal document)

Health Financing Strategy for Uganda. Ministry of Health, March 2002

Review of Staffing Levels and Restructuring of Local Governments. Ministry of Public service, July 2002

Manual for Planning and Management of Health Services in the Health Sub-Districts. Ministry of Health, Mbarara University for Science and Technology, WHO, September 2002

Malaria and Poverty: Opportunities to Address Malaria through Debt Relief and Poverty Reduction Strategies. A Background Paper for the Fourth RBM Global Partners’ Meeting, 18th -19th April 2001, Washington DC. Malaria Consortium, April 2001