Counting Malaria Out in Partnership with CSOs

A Final Draft Report on the Process & Outcomes of the Fresh Air National Malaria Technical Update and Coordination Workshop at Hotel Africana - Kampala, Uganda held 31st March – 2nd April 2009

MACIS Malaria and Childhood Illness NGO Secretariat

USAID President's Malaria Initiative CDC

THE REPUBLIC OF UGANDA

CORE Group

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Table of Contents

Abbreviations

ACTs	Artemisinin Combination based Therapies
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ANC	Antenatal Care
CCM	Country Coordinating Mechanism for GF
CMD	Community Medicine Distributor
CSF	Civil society Fund
CSOs	Civil Society Organizations
DHO	District Health Officer
EARN	East African Roll Back Malaria Network
GFATM	Global Fund to fight Aids, TB and Malaria
HBMF	Home Based Management of Fever
HC	Health Center
HF	Health Facility
HIV/AIDs	Human Immune Virus/Acquired immune Deficiency Syndrome
IDI	Infectious Disease Institute
IEC	Information, Education and Communication
IRS	Indoor Residual Spraying
JUMP	Joint Uganda Malaria Programme
LCs	Local Councils
LLINs	Long Lasting Insecticide Nets
MACIS	Malaria and Childhood.....
MCP	Malaria Control Program
MMV	Malaria Medicine Venture
MOH	Ministry of Health
NMCP	National Malaria Control Programme
PLWA	People Living with AIDS
PMI	Presidential Malaria Initiative
RTI	Research Training Institute
UNICEF	United Nations for Children's Education Fund
WHO	World Health Organization
WR	WHO Representative

Executive Summary

Malaria & Childhood Illness NGO Secretariat (MACIS) is a coordination centre of over 70 Civil Society Organisations that are involved in malaria control and child health activities in Uganda. It fosters capacity building, collaboration, linkages and networking among member organisations and Ministry of health/partners for concerted efforts.

In line with its mandate, the secretariat, in partnership with the Ministry of Health and Presidential Malaria Initiative/CORE Group, organized and conducted a Fresh Air National Malaria Technical Update and Coordination Workshop at Hotel Africana, Kampala on 31st March – 2nd April 2009.

The theme of the workshop was "Counting malaria out in partnership with CSOs", and the purpose was to strengthen the role of CSOs in controlling and preventing malaria morbidity/mortality in the country by increasing their technical capacity as to contribute to the goal of the NMCP. The objectives of the workshop included provision of technical updates on malaria control in Uganda; allowing CSOs to share experiences on their malaria activities; identification of gaps in coverage of services, proposing pragmatic options to fill these gaps; as well as provision of opportunity for partners to network and collaborate for improved malaria control services.

The workshop employed different methods of work including power point presentations, question/answer panel discussions, as well as group work and plenary discussions. The workshop was colored by official opening by the guest of honour; Honourable Minister of Health, Dr Stephen Mallinga.

WHO and Ministry of Health Uganda recognize the role of civil society organisations in malaria control through their strategic documents, policies and engagements as to promote synergies between actors. Such roles include health care service delivery, advocacy, constructive lobbying on key decisions, innovative and strategic thinking, policy formulation/reviews, as well as strengthening capacities of communities to take charge of their own health.

CSOs' involvement in malaria policy implementation has exhibited best practices and lessons learnt including the successful IDI, UNICEF & Malaria Consortium's support to malaria case management; AFFORD, KIRDP & UMCP's mosquito net distribution; RTI & Pilgrim's support to Indoor Residual Spraying; as well as CDFU's engagement in malaria advocacy. Most CSOs implement their malaria activities through community structures including village health teams (VHTs), community medicines distributors (CMDs) or community health workers (CHWs). These include Healthy Child Uganda, AMREF & PSI.

With increasing coverages of malaria interventions malaria has started showing some down trend as evidenced by studies of UMRC and UMSP. This definitely has implications on malaria policy that the country will move away from malaria presumptive treatment, recommended in high endemic areas, to definitive diagnosis.

However, current coverages of malaria interventions need to be consolidated through increase of access to quality of services if a down trend of malaria is to be maintained. In line with this, the Ministry of Health and some CSOs have come up with new initiatives to increase access to services like malaria case management and LLINs. Notable of these is the Social Health Insurance (SHI) scheme that would increase health sector funding; Affordable Medicines Facility for malaria (AMFm) that increases access to ACTs through the private sector, as well as Hospital access to LLINs and ACTs through PNFP institutional arrangement. Other CSOs are also struggling to secure funds as to maintain or heighten their malaria control activities. Available opportunities for CSO financing include the Global Fund, Stanbic Bank, Standard Chartered Bank, and Stop Malaria Project funds that have been earmarked for the next 5-year malaria control activities.

Although malaria has attracted a number of actors in the country, there is need for harmonised commitment of CSOs if malaria services are to make any significant impact on the disease. Therefore, there is need for CSOs to buy into coordination mechanisms and the national malaria M&E framework for harmonization. As experienced by MACIS and Core Group, CSOs need to build effective partnerships with clear needs, goals, strategies, objectives and priorities if harmonization and collaborations are to be realized. This helps to develop relationships and social capital to effectively share information, build strategies and adapt to changes as to fit within the governmental, cultural and social context, as well as among other partnership member organizations. Furthermore, leadership and management of the partnership and secretariat should be shared among members of the CSO network.

For MACIS members to harmonize their malaria activities in the country, it was agreed that: a joint resource center or an information clearing house be established; joint stakeholders meetings be held regularly; capacity of CSO staff be built; a coordination mechanism be built at all levels; CSOs endeavor to work with existing social structures at community level; MACIS works with NMCP to harmonize malaria guidelines and IEC materials; MACIS coordination mechanisms be established at malaria zonal level based under regional referral hospitals; mapping of CSO activities be carried out periodically; and peer mentorship be promoted at both horizontal & vertical levels.

In order for CSOs to buy into the national malaria M&E plan, it was agreed that: member organisations adopt the plan and consult where necessary; member organisations involve communities as to create community ownership and CSO accountability to beneficiaries; MACIS and NMCP continue to guide CSOs importance and modality of aligning their M&E with the national malaria M&E plan; CSOs do analyze the national policy and ensure that they implement it accordingly; NMCP rigorously monitor CSO activities; CSOs strengthen their internal management and financial systems; CSOs align their objectives with those of national malaria M&E plan, and think through the entire monitoring and evaluation process; CSOs streamline their information system as well as strengthen their record keeping and reporting systems; and all indicators in the national malaria M&E Plan (Pg 29) be sorted to suit different CSOs.

1.0 Introduction

Between the 31st March and 2nd April 2009 MACIS, in collaboration with the Ministry of Health and Core Group, with financial support from PMI/USAID, organized and conducted a Fresh Air National Malaria Technical Update and Coordination Workshop at Hotel Africana, Kampala that brought together 186 participants including policy makers, multilateral and bilateral development partners, district technocrats, research organisations, media fraternity, local and international NGOs, as well as CBOs (Annex 1). The workshop was held at Hotel Africana, Kampala. This report gives an account of the workshop events and outcomes as per notes of the rapporteur and independent observers.

While section one introduces the report by laying out the structure of the document, section two narrates the workshop background information including its purpose. Section 3 then states the workshop objectives and expected outcomes, while section 4 describes the methods of work and workshop progression. As section 5 summarises key presentations and their discussions, section 6 draws conclusion and section 7 puts a way forward.

2.0 Background Information

Malaria is still a big problem in Uganda, as it accounts for 30-50% of all outpatient visits at health facilities, 20% of hospital admissions and 9-14% of inpatient deaths. It is estimated that in areas of medium transmission, 11% of deaths among children under 5 years of age are attributable to malaria, while in areas of high transmission this figure goes up to the tune of 23%. This translates into a malaria specific mortality of 26,800 - 40,700 child deaths annually, a death toll that far exceeds the mortality due to HIV/AIDS.

Children are chronic victims of malaria, suffering an average of six bouts of malaria attacks per year. Fatally affected children often die before being attended to by health workers, given the poor accessibility to health care facilities. In those who survive, malaria drains vital nutrients from children, impairing their physical and intellectual development. Malaria sickness further contributes significantly to poor school attendance, let alone to the irregular reporting at work, thus impacting negatively to the country's economic growth.

The pregnant women are another vulnerable group in whom malaria causes severe anaemia, thus contributing to maternal deaths, as well as low birth weights, premature delivery and abortions. Pregnant mothers who have malaria and are HIV-positive are at even a higher risk of poor pregnancy outcomes and more likely to pass on their HIV status to their unborn children.

Malaria prevention and control in Uganda is between different stakeholders including Government, Multilateral and Bilateral Organisations, as well as Civil Society Organisations (Non-Governmental Organisations (NGOs), Faith Based Organisations (FBOs), Community Based Organisation (CBOs) and communities themselves.

Malaria & Childhood Illness NGO Secretariat (MACIS) is a coordination centre of over 70 Civil Society Organisations that are involved in malaria control and child health activities in Uganda. The Secretariat was founded in 2003 by a partnership of NGOs, WHO, UNICEF and Ministry of Health to foster capacity building, collaboration, linkages and networking among member organisations and Ministry of health/partners for concerted efforts. MACIS also plays an instrumental role in linking these organisations with the Ministry of Health through representation on national and international coordination committees/technical working groups; dissemination of government policies; initiation of plans, organization of technical updates and sharing of best practices. This strengthens the Public-Private Partnership (PPP), a strategy adopted by government to up-scale health activities in the country.

In line with its mandate, the secretariat, in partnership with the Ministry of Health, Presidential Malaria Initiative and CORE Group organized and conducted a Fresh Air National Malaria Technical Update and Coordination Workshop at Hotel Africana, Kampala on 31st March – 2nd April 2009.

The purpose of the workshop was to strengthen the role of CSOs in controlling and preventing malaria morbidity/mortality in the country by increasing their technical capacity as to contribute towards the goal of the NMCP.

3.0 Workshop Objectives

(1) To provide technical updates on malaria control in Uganda
(2) To allow CSOs to share experiences on their malaria activities
(3) To identify gaps in coverage of services and propose pragmatic options to fill these gaps
(4) To provide opportunity for partners to network and collaborate for improved malaria control services

Expected outcomes of the workshop included

- Members being updated on malaria control in Uganda
- Experiences of CSOs on malaria activities shared
- Gaps in service coverage identified, and practical options to fill these gaps proposed
- Networks and collaborations between partners/actors established

4.0 Methods of Work & Workshop Progression

Methods of work in this workshop included power point presentations, question-answer discussions, and group discussions followed by plenary sessions. The workshop progression occurred as per workshop agenda in annex 2.

On Day one, the workshop started with an overview of the MACIS; its mission, composition, objectives, governance, achievements and challenges, as well as the next steps. This was followed by presentations from Core Group and PMI on their experiences in working with CSOs and their networks. The National Malaria Programme Manager painted the picture to participants on where Uganda is as far as malaria control is concerned. This

was followed by a key note address by the WHO Country Representation (annex 3) before the Chief Guest; Honourable Minister of Health Dr Stephen Mallinga made remarks (annex 4) and officially opened the workshop symbolized by a group photo; thereafter a break tea.

Presentations and discussions on malaria case management policy and its implementation were made led by the National Malaria Control Programme, Malaria Consortium and UNICEF *(The full list of presentations made is contained in annex 5).* This was followed by a participants' break out for lunch.

The afternoon sessions started off with presentations and discussions on ITN Policy and its implementation led by Ministry of Health, AFFORD, KIRDP and UMCP. The day ended with a presentation on technical updates on IRS policy by the Ministry of Health, which were not discussed because of time constraint.

Day two was flagged off by recap of the previous day's events, followed by presentations of RTI and Pilgrim's experiences on IRS implementation. Malaria advocacy policy and its implementation were then presented by the NMCP and CDFU respectively, in which best practices and lessons learnt were demonstrated. These presentations were followed by a panel discussion where participants were given chance to ask questions before members broke out for a health break.

A session preceding lunch was characterised by presentations and a panel discussions on the new initiatives in public-private partnerships including: the National Health Insurance Scheme by Ministry of Health, access to affordable antimalarial medicines through the private sector by MMV, as well as prevention and management of malaria through a Private-Not-For- Profit (PNFP) health facility by Kisiizi Hospital.

Following the lunch break was presentations and discussions led by UMSP, UMRC and FIND on trends/pointers to malaria reduction in this era of rolling out malaria interventions in the country; and the need to consolidate efforts as to move from presumptive treatment to definitive diagnosis.

After the health break, presentations were made by 2 district health officers (Gulu and Kiruhura) and a MACIS consultant on how CSOs are currently operating, and the possible harmonisation mechanisms of their activities in the country. The day was crowned by a cock-tail at which participants were treated to drinks, eats and entertainment under the auspice of PMI and Vestaguard.

Day three started off by a recap of the previous day's events, followed by presentations and discussions on experiences working with community structures led by AMREF, PSI and Healthy Child Uganda. This was followed by health break.

Before lunch break, presentations were made on available opportunities to finance CSO malaria activities led by Standard Chartered Bank, Stanbic Bank, PMI and Stop Malaria

Project. This was followed by MOH and UNAIDS consultation with CSOs on the issues of Round 9 Global Fund proposal writing and 2nd Principal Recipient (PR) in the wake of the dual/multiple track financing mechanism prescribed by Global Fund.

Following the lunch break was a presentation and discussion led by Ministry of Health on malaria M&E framework in the country and how CSOs can buy into it. This was followed by a session in which participants broke out into groups to discuss mechanisms by which CSO malaria activities can be harmonised, and how CSOs can buy-in or contribute to the national one M&E framework. A plenary ensued, which culminated into drafting the way forward/next steps.

The workshop was officially closed by Ms Shannon Downey, the Malaria Program Manager CORE Group who hailed MACIS for the great job of coordinating CSOs with all the challenges that secretariats usually face. She thanked participants for their active participation, and she finally handed them certificates of participation.

5.0 Summary of Key Presentations and their Discussions

5.1 Malaria & Its Elimination Strategic Plan

Malaria accounts for 26% of the burden of disease in Uganda (BOD Uganda 1995) and is responsible for 33% of OPD attendance, 25% of hospital admissions, 20% of hospital child deaths, and 320 deaths per day every day. Malaria related anaemia in children and pregnancy increases rates of foetal wastage, abortions, low birth weight, maternal mortality, and infant mortality. Malaria is also responsible for economic losses, lost school days, low economic productivity, and long term disability. The national malaria strategic plan 2005/2006 - 2009/2010 aims at controlling and preventing malaria morbidity and mortality, as well as minimizing the social effects and economic losses attributable to malaria in the country. The strategies to achieve these include scaling up malaria case management at facility and community levels, intermittent preventive treatment of malaria in pregnancy (IPTp) as part of antenatal care services; ITN usage, IRS, BCC/IEC, M&E and Research. Focus is mainly on the most vulnerable groups such as young children and pregnant women in highly endemic areas, disadvantaged or difficult to reach populations, as well as PLWHA. Among the achievements to date include the more than 6 million ITNs that have been distributed targeting pregnant women and children; and the ACTs that have been declassified from prescription only drug to off counter drug. With these interventions in place, reduction in malaria burden at facilities has been registered in the past 2 years. However, to consolidate these gains, scale-up of interventions is needed by different actors including civil society organisations (CSOs) and the private sector. In addition, a coordinating forum should be put in place, and CSOs linked to the ministry of health and to one other as to share information. The internal linkage role especially should be developed further.

5.2 The Role CSOs in Malaria Control

The role of CSOs in the fight against malaria and other childhood illnesses in Uganda cannot be overemphasised given the existing gaps in the country.

5.2.1 The Ministry of Health's Position on CSOs

Of recent, Uganda has come up with an ambitious plan to upscale coverages of malaria preventive and control services such as long lasting insecticide treated nets (LLIN), indoor residual spraying (IRS), and intermittent preventive treatment (IPT) of malaria in pregnancy, as well as prompt case management to the tune of 85% of the entire population. This plan is not only ambitious but equally bold; thus requiring concerted efforts from different actors including civil society organisations. Civil Society Organisations are not only involved in health care service delivery, but equally engaged in advocacy, constructive lobbying on key decisions, as well as on policy formulation and reviews. CSOs are involved in innovation and strategic thinking that guide implementation of evidence based interventions for health, and strengthening capacities of communities with the aim of empowering them to take charge of their own health. A policy on Public–Private Partnership has been drafted to guide the mutual engagements between government and other actors so that all actors are in line with national priorities and actually delivering tangible results.

5.2.2 The WHO Position on CSOs

As part of the civil society, people form the core of health systems as they use the services, contribute to the finances and policy development, thus shaping health systems. Civil society has been understood globally as the social arena that exists between the state and individuals/households. This was concretised by the Mexico Declaration (2000), which called for bridging the equity gap by ensuring active participation of all sectors; active involvement of civil society in planning and implementation of health actions and expansion and strengthening of partnerships for health development. In response to this, a *Civil Society Initiative* was created in 2001 to energize WHO's relations with civil society and NGOs. The latter have engaged with WHO to implement health programmes at country level, making outreaches to remote areas, and worked with WHO to raise funds more effectively. The Roll Back Malaria partnership of 1998 recognized and still recognizes the critical role of CSOs in malaria control and its eventual elimination efforts. Equally, many international and national donors highly recognize the critical role of CSOs in malaria control and elimination. This is more so when there is an urgent call for scaling up for impact of all malaria control interventions so that RBM targets are achieved by 2010 when malaria will cease to be a public health hazard.

5.3 The National Malaria Case Management Policy & Its Implementation

The objective of malaria case management with ACTs is to prevent progression of uncomplicated malaria to severe malaria that result into death and disabilities, to delay development of resistant malaria parasite strains, as well as to reduce malaria transmission through elimination of gametocytes from the body. The first line treatment is Artemether - Lumefantrine; and any other ACTs recommended by WHO & MOH and registered with the NDA is an alternative first line. Quinine is the interim second line treatment drug of choice for treatment of malaria until Dihydroartemisinin & Piperaquine (DP) is available on the WHO treatment guidelines for malaria. Management of severe malaria starts with a pre-referral treatment like rectal Artesunate at periphery, and consolidated with intravenous quinine/injectable Artesunate, blood or relevant IV fluids and ancillary treatments at health

facilities. With the introduction of ACTs there is increasing need to minimise unnecessary treatment while at the same time provide maximum coverage with treatment access. Microscopy is the mainstay of parasitological malaria diagnosis, supported by rapid diagnostic tests (RDT). Malaria in pregnancy is managed by a tripartite of interventions including at least two doses of intermittent preventive treatment (IPTp), use of ITNs among pregnant women, as well as prompt case management.

Malaria case management in Uganda is delivered through health facilities by formal health workers and through the HBMF strategy by Community Medicine Distributors (CMDs). CMDs and community through IEC are trained in basic ways of identifying malaria, given job aides, and support supervised. It is through these CMDs that we have been able to attain high RBM targets of treatment within 24 hrs; reduced death, severe anaemia and other complications; as well as utilisation of public health services. However, CMDs are not supposed to treat severe malaria. The strategy faces several challenges including sustainability of CMD spirit of voluntarism, increasing attrition of CMDs, inadequate supervision, poor data flow and utilization, as well as poor supplies management. All these require innovations, training, equipping, supervision, monitoring and evaluation. For example, in some communities partners are encouraged to bring together the money that would have been given to the individual volunteers as stipend into a pool. The volunteers then make proposals on how they can utilize it more effectively. This has turned out to be more beneficial than the individual hand outs and the volunteers appreciate it better. In another best practice it was found that functional adult literacy programs are critical in dissemination of IEC material like posters, leaflets and fliers. In regards to traditional healers, there is a private-public partnership policy that being drafted, which will help to guide how best traditional healers can be dealt with. CSOs are expected to help monitor activities at the community level, including those of tradition healers.

5.3.1 Experience of Infectious Disease Institute (IDI) in Malaria Case Management

Integrated Management of Malaria (IMM) training with support supervision can improve key indicators of malaria case management and reduced number of unnecessary antimalarial treatments. The program is focused on laboratory diagnosis in health centres where professionals are trained to carry out diagnosis. In HBMF presumptive treatment is still accepted but will later also be phased out as capacity is built. The IMM training is an innovative exercise that brings together clinicians, laboratory staff and record keepers together for integrated training and supervision. Although microscopists are not formerly recognized by ministry of health, they are recommended for a three week training course that has been designed. This innovative training has shown to promote proper history taking, physical examination, diagnosis, prescription, and patient education. It also promotes correct preparation and reading of malaria blood smears, as well as cleanliness and completeness of records. IMM training also helps to promote teamwork in service delivery, as well as utilization of the laboratory results. However, several challenges face the scheme including the inadequate staffing especially in the laboratory; low staff morale; staff transfers that disorganize the built teams; lack of reliable source of power for microscopy; shortage of drugs, medical supplies and equipment; as well as the inadequate funding. Lessons learnt are

that health workers are greatly motivated by money, support supervision as well as provision of basic facilities like equipment and drugs, which they need to execute their duties.

5.3.2 Experience of UNICEF in Community Malaria Case Management

The experience of UNICEF in community malaria case management became more apparent when Northern Uganda was besieged by rebel activities that lasted for more 22 years; forcing almost 1.8m people in IDP camps and disrupting all the formal health services. The experience started with introduction of HBMF strategy using CQ/SP in 2002, which was later expanded into the Home Based Care (HBC) strategy in 2004 that included malaria, diarrhoea and pneumonia treatment using septrin, ORS and CQ respectively. This was delivered by some members of village health teams (VHT) particularly community medicine distributors (CMDs). The package/kit later on changed content to include ACTs, Cotrimoxazole, ORS, Paracetamol, Tetracycline eye ointment, Benzyl Benzoate lotion, writing materials pens books etc. Recent evaluation shows that CMDs are not only acceptable by their respective communities but majority of them (99.2%) know how malaria is transmitted, 88.3% know three or more ways of preventing malaria, 92.9% know what Coartem dose to give to a 2 year old child, 71.6% know at least three signs of pneumonia, 66% can mention the correct drugs and doses for a 1-year old child with fever and fast breathing. Anecdotally, this has reduced the child deaths in communities. However, the programme faces some challenges including supervision and motivation of CMDs, dual residence and resettlement processes, supplies and drug management chain, as well as rational antibiotic use and record keeping by CMDs.

5.3.3 Experience of Malaria Consortium in the New Home Based Management of Fever

With advent of the new malaria treatment policy with ACTs there was urgency to have information on key issues (feasibility, acceptability, adherence) regarding the use of coartem at community level to ensure the smooth transition from Homapak (CQ/SP) to coartem (AL) use under the HBMF strategy country wide. Towards this, Malaria Consortium (MC), in collaboration with MOH and CDC, launched a pilot study on community delivery of ACTs in Kiboga district. The process involved series of planning and consultative meetings; setting up a district HBMF Advisory Committee; revising and updating training and communication materials; carrying out a situational analysis; developing a communication strategy; quantifying and distributing Coartem; sensitizing district political/civic leaders, members of the press and all NGOs; training of trainers; training of health workers; sensitising stakeholders at sub-county level; orientation of parish mobilizers; sensitisation of communities and selection/replacement of CMDs; training of the CMDs; equipping CMDs with drugs and registers; carrying out regular support supervision; monitoring ACT supply chain, as well as conducting quarterly review meetings. In HBMF monitoring and evaluation, community leaders who supervise the CMDs are given feedback and link up with the communities.

The experience of 2 years so far shows that change to coartem policy has made CMDs work easier because the medicine has no side effects and is easier to dispense; caregivers are more enthusiastic and willing to use the medicine; children get better after treatment and no deaths have been recorded in addition to reduction of fever cases in the community.

However, the strategy faces several challenges that include the often stock outs of coartem; inadequate user tools, gumboots, raincoats, paraffin, candles and torches; delay of parents bringing children for treatment; parents coming to pick medicines without the sick children; parents sending siblings to pick medicines; the restricted age-related dosages of coartem; demanding for other medicines by communities; difficulties in child follow up because of transport constraints; as well as felt inconveniencies to CMDs. There is also a challenge in the distribution mechanism. In places where some partners hold quarterly support supervision meetings CMDs are supplied with fresh supplies of Coartem at the meeting points. In other cases, health extension workers are encouraged to move with coartem as they go for supervision in the communities.

5.4 The National ITN Policy & Its Implementation

According to the national ITN policy, all mosquito nets sold, distributed or manufactured in Uganda should be LLINs with the following specifications: Polyethylene fabric (Olyset, DuraNet, and Netprotect - 200 mesh); Polyester fabric – PermaNet, Interceptor - 100D; and PermaNet 3.0. Uganda pursues the public-private mix distribution approach of LLINs including the stand alone campaigns, integrated campaigns, targeted distributions (antenatal women, people living with HIV/AIDs, children under five and school children), as well as through commercial sales. Through this, ownership and usage of ITN has increased in the country in the recent past. However, the strategy faces several operational challenges including substandard nets on the market; duplication is some areas while deficiencies occur in other areas; resale of nets by communities. Therefore, the need for coordinated activities of actors including procurement, distribution, education, monitoring, reporting, as well as documentation and sharing of experiences/lessons learnt. Experience shows that nets distributed through mothers are usually not resold or abused when you compare to those distributed through fathers. If a CSO is distributing nets, it may be useful to identify a partner whose strength is in IEC and work together so that both can maximize their strengths. UNICEF for instance used Red Cross to carry out IEC in Karamoja region, while UNICEF did the distribution. This kind of approach minimizes abuse of nets, and addresses issues like the reported net inflammability, as well as sneezing/itching secondary to the concentration of the insecticide in the new net.

5.4.1 Experience of AFFORD in Mosquito Net Distribution

AFFORD is a USAID funded project that was formed in 2006, with partnership of 5 NGOs, working with numerous smaller organisations in distribution of nets. Its activities includes procurement of LLINs; campaign distributions targeting children under-five and pregnant women in 26 districts; ante-natal clinic distribution targeting pregnant women in 24 districts in Northern Uganda; and LLIN subsidy programme with commercial partners. This involves behaviour change communication; training of private sector including drug shop operators; door to door enumeration at parish level; distribution of nets and the low literacy malaria IEC materials accompanying each net distributed; as well as monitoring & evaluation. Its areas of focus are guided by MOH/MCP basing on coverage differences. To date, a total of 2,517,766 nets have been distributed. However, challenges exist that include the inaccurate enumeration of target populations, transport of large sums of cash during campaign

distribution, reliance on district storage & accountability systems for delivered nets, non-appreciation of nets by target populations, resale of nets by beneficiaries, nets not being hanged for use, parallel LLINs data collection of at ANC clinics; as well as maintenance of the commercial net distribution channel in wake of the huge free net distribution. AFFORD usually removes net wrappings as to stifle resale of nets, and polyethylene wrappings are usually burnt in open places such as schools and sub-county headquarters compounds. The way to go is also to promote a strategy that includes something for hanging nets e.g. nails and hammer during distribution, depending on the size of the houses, so that nets are not only distributed but actually hanged. Nets ought to be hanged 24 hours before being used. Sensitization is also part and parcel of the AFFORD approach. AFFORD always gives health education to the beneficiaries, even at the ANC level. The midwives talk to the pregnant women individually and advise them on how to hang them. In some districts, distribution of nets through ANC has been problematic where DHOs want dispensing of nets at the 4th visit as a way of encouraging mothers to attend ANC. This approach is counter productive on malaria in pregnancy prevention. Therefore, UNICEF carries out its distribution at the community level as opposed to the ANC approach.

5.4.2 Experience of KIRDP in Mosquito Net Distribution

Kinkiizi Integrated Rural Development Program (KIRDP) is a holistic development programme operating in the Diocese of Kinkiizi, Kanungu district since 2000. In addition to its other development activities, the programme is involved in distribution of free (KIRDP gets support from AFFORD and Africare) and subsidized mosquito nets mainly among the marginalized groups like the Batwa (pygmies). The strategy includes mobilization of communities, conducting workshops, formation of women groups, and community pooling of resources for ITN purchase. Activities include mobilization of communities through church sessions and radios, orientation of KIRDP staff on ITN distribution; registration of beneficiaries at their respective parish centers using immunization and antenatal cards as a proof of eligibility; health education and demonstration on use of ITNs. Through these, 3,319 nets have been distributed so far. Challenges included sell of subsidized nets to communities primed with free nets, working in illiterate communities, maintaining voluntarism among community leaders, excluding non-targeted groups/sub-counties, working with limited budget, as well as preventing double registration of beneficiaries. Since Kanungu district sometimes lacks birth registration cards, the organization intends to use local council registers to overcome double registration.

5.4.3 Experience of UMCP in Mosquito Net Distribution

Uganda Malaria Communities Partnership (UMCP) is a 3 year PMI funded project involving participation of different associates including MIHV, Malaria Consortium, MACIS, 16 local CSOs, Local District Govt's, MOH/NMCP, CDC and USAID. It operates in 7 districts of West Nile Region, targeting pregnant women and under five children with LLINs. Activities include dialogue and building capacity within district health structures, as well as CSOs on LLIN distribution, monitoring and follow up; mobilisation of communities and registration of beneficiaries; allocation of nets and carrying out community education through IEC/BCC (materials, health talks, music and drama, radio spots, role modeling); supporting VHTs/CMDs in a range of activities (delivery of HBMF, promotion of net use, promotion

of ANC attendance and linkage of communities to health facilities); supervise distribution of nets and collecting summary data; as well as sharing lessons learned via newsletters and other fora. Through these, a total of 29,739 nets have so far been distributed. MOH recommends having a few nets distributed in a small area as to create impact. Therefore, UMCP intends to distribute a total of 100,000 nets in a few selected sub-counties of West-Nile. Challenges include costs of getting the nets, distribution and conducting IEC; amount of training given to different structures; as well as maintaining CMD retention and interest.

5.5 The National IRS Policy & Its Implementation

Indoor residual spraying (IRS) involves periodic spraying inside houses with recommended persistent insecticides to reduce the life span and density of mosquitoes for controlling malaria transmission. It is targeted for both endemic and epidemic prone areas using the WHO Pesticide Evaluation Scheme (WHOPES) approved insecticides such as Alpha-cypermethrin, Deltamethrin, Lambdacyhalothrin, and Cyfluthrin. Mosaic and rotational use of insecticides from different Classes (Py, C, OCh, and OPh) are used to manage the development of insecticide resistance. In the last 2 years IRS activities have been conducted in 9 districts namely; Kabale, Kanungu, Kitgum, Pader, Amur, Gulu, Oyam, Apac, and Katakwi. To date a total of 981,730 household have been sprayed and a population of 3,822,767 protected. This has resulted in decline in malaria cases/OPD attendance, parasitaemia and admissions, as well as high compliance and acceptance from community members.

In policy implementation the MOH concentrates on establishing structures and systems for managing IRS activities, advocacy, IEC /community sensitization, coordination of actors, as well as monitoring vector susceptibility, insecticide decay rates, species composition, vector density, vector behavior, sporozoite rates, OPD attendances, IP admissions and deaths, slide positivity rates, and quality of spraying using bio-assay tests. Challenges include suspicion of the community, economic interests and environmental concerns, dependence on donor funds and uncalled for court injunction of DDT use.

The MOH is slowly engaging stakeholders on DDT through dialogue, but can invoke a penal code to CSOs that mislead communities, where one can easily be charged. DDT, when adequately/ properly used for IRS kills mosquitoes, and not humans. MOH has done a comprehensive assessment of the potential side effects of DDT, and DDT was cleared. The National Environment Management Authority (NEMA) also carried out their environment impact assessment and gave MOH a go ahead to use DDT for indoor residual spraying only. WHO also carried out an assessment, and came up with clear guidelines on how IRS should be carried out in-doors. In Lango region, where DDT has been sprayed as IRS, it shows no adverse effects if well handled. The challenge is with the waste disposal, which calls for empties to be taken back to the supplier for destroying. DDT is the preferred choice because of its longevity i.e. lasting 9 months after spraying *versus* 3-6 months of pyrethroids. This means that it can be sprayed at least once a year, unlike other insecticides, making it much cheaper and yet effective.

5.5.1 Experience of RTI in Indoor Residual Spraying

RTI's large scale IRS implementation commenced in Mar'06 in Kabale and later spread to other 7 districts including Kanungu, Oyam and Apac using lambda-chyhalothrin or DDT. Activities included baseline and post-spray entomological studies; development of information, education & communication materials for awareness and community mobilization; placing radio announcements and radio spots messages; conducting talk shows and district sensitization meetings; hanging banners and posters; training of trainers, spray operators, supervisors, team leaders, wash-persons, store-keepers and mobilizers; conducting M & E; as well as carrying out environmental inspections for compliance. Achievement to date is that more than 95% of targeted homes have been sprayed with a total 4.5 million people protected in past 30 months. Challenges include working in a political environment where IRS is equated to the controversial DDT chemical; unpredictable rains that disrupt programmes; working in resettlement areas with unfinished residential structures that are unsprayable; unanticipated events like outbreak of hepatitis E that diverts focus from the program implementation; ensuring sustainability of trained personnel; operating on impassable roads; the growing chemical resistance; as well as donor dependence of the programme.

5.5.2 Experience of Pilgrim in Indoor Residual Spraying

Pilgrim is implementing the Move on Malaria (MoM) Program, which is joint effort between Pilgrim, MoH, district administration and politicians in 7 districts of Teso region; starting with Katakwi district. The program involves implementation of IRS; malaria case management; IPTp; and ITNs distribution. IRS implementation activities include mobilization of the population through intensive IEC, provision of technical/social facts about malaria through leaflets, pamphlets, radio messages, radio talk shows, newspaper feature articles, sensitization workshops, and conducting film shows; conducting main and follow up spray sessions for mop up; conducting periodic entomological and epidemiological surveys for effectiveness and impact measurement, as well as periodic bioassays to test the quality of IRS. Achievements to date include 55,900 (87%) households sprayed, with a total of 172,260 people protected; 92% reduction in reported cases of malaria at health units; as well as increased confidence of the population for better conditions. Challenges include: working in an environment with impassable roads, increasing cost of materials, chemicals and fuel; delays in securing clearance for imported chemicals; as well as unpredictable population sizes for targeting.

5.6 National Malaria Advocacy Policy & Its Implementation

Advocacy and social mobilization in malaria control aims at winning the support of stakeholders for malaria control and to empower people to manage their own health so as to contribute towards the control and the eventual elimination of malaria in Uganda. Advocacy is targeted at both national and sub-national stakeholders through meetings; social mobilization through electronic and print mass media; while community mobilization is through interpersonal communication using methods such as drama, film shows, talk shows, and focused guided counseling. Other strategies of social mobilisation include capacity building of stakeholders and social operational research. During social mobilization,

politicians are targeted because they influence communities and are representatives of the masses. They are elected, so they have the support of the people. If a pro-people program is to succeed we have to bring politicians on board, make them understand our goals because they are key community gate keepers. At all levels, we need the security, political will and the support of leaders.

5.6.1 Experience of CDFU in Malaria Advocacy

CDFU is a specialised strategic communication service organisation that works through districts and existing CSOs on matters of health and other development programmes in the country. Services provided by the organization include: BCC/IEC training and skills development; development of communication materials; development and broadcast of radio programs/radio spots/radio drama series; as well as communication campaigns through needs assessment, literature review, program and strategy design, management and implementation, as well as evaluation and future planning. CDFU's experience with AFFORD/UHMG in 17 districts, including Kabarole, Kasese, Mbarara, Rukungiri and Kanungu, involves implementing peer educators interventions through ordinary/influential community members that belong to different social networks such as women/men groups, People living with HIV/AIDS among others. The peer educators are known and trusted by the society that elects them. These peer educators utilize informal discussions with community groups/family members on issues like malaria causation, ITN use, IPTp uptake etc. Motivation of these peer educators includes; skills building, regular visits, periodic meetings, transport refund, recognition during community events, as well as provision of identification materials such as certificates, T- shirts, caps, umbrellas and bags. By end of Sept 2008, the peer educators intervention had been implemented in 17 districts, 737 peer educators trained, and 306,080 people reached with Good Life massages including malaria information.

CDFU's experience with Uganda Malaria Partnership Project (a joint venture of MoH, AMREF, Uganda Red Cross, Africare and 4 NGOs) involved implementation of BCC activities in three districts of Kanungu, Kiboga and Kumi. Advocacy interventions included orientation of key district stakeholders, conducting malaria awareness days, documentation of best practices, sharing of experiences, as well as developing periodic newsletters. Social mobilization included refresher training of CDDs, holding malaria awareness competitions, organising community interventions like educational songs/drama/video shows, as well as harnessing the mass media for radio programs/spots/posters. Challenges included the increased demand for ITNs that could not be met by supply, poor return of women for 2nd dose of IPTp, inconsistent use of ITN by target groups, as well as the limited men involvement. Lessons learnt are that the enter-and-educate approach is an important tool for message dissemination; while utilisation of media-mix is important for community reach and message reinforcement. In addition, community based volunteers are good resource persons for transmitting messages and the support of leaders is very crucial. Lastly, integration of malaria control activities into district and sub-county plans is critical for sustainability.

5.7 Experiences of CSOs working with Communities and Private Companies

Most CSOs implement their malaria activities through community structures including village health teams, community medicines distributors/community health workers. Among these include Healthy Child Uganda, AMREF and PSI

5.7.1 Experience of HCU in Working with VHTs/CMDs

Healthy Child Uganda (HCU) operates in 6 parishes of Mbarara and Bushenyi districts, under the umbrella of the faculty of medicine Mbarara University, promoting child health using the integrated management of childhood illnesses (IMCI) strategy in both health facilities and communities. The community strategy through community owned resource persons (CORPs) involves net distribution accompanied by health messages, child weighing and immunizations; promotion of bush clearing and drainage of stagnant waters; promotion of ITN use and closing of doors/widows in evenings; as well as promotion of health care seeking for children with danger signs. The project also promotes model home competitions emphasizing bush clearing and drainage of stagnant water. It also employs malaria focused education using puppets, health talks, school talks, student placements, home visits & health centre activities. CORPs and community leaders also actively participate in planning, and are often excited about receiving bed nets. Through this, incoming reports show a very positive trend on bed net purchase, ownership and usage through community group efforts. However, the project is challenged by other underlying problems such as water scarcity, diarrhoea, malnutrition, food insecurity, newborn health, poverty, and health care inaccessibility. AS part of sustainability plans, Mbarara University is piloting a student training project where students of development studies will work with communities in their 2nd year, for the latter to own the project. Community volunteers have also formed their own network to help them come up with other avenues for sustainability. These community volunteers are elected by the people, so they feel accountable to their communities which they don't want to betray.

5.7.2 Experience of AMREF in working with VHTs/CMDs

AMREF Uganda has worked with communities for the last 25 yrs including: community medicine distributors, TBAs, vaccinators and religious leaders. Through these AMREF ensures community structures are involved in the health improvement processes and respond to the problems and needs of their communities. For example, CMDs in Luweero, Soroti and Nakasongola districts include sensitization of communities on malaria and immunization; strengthening of referral; as well as implementing HBMF strategy and ITN distribution. Motivation include community recognition, refresher training, facilitation like bicycles, drug kits and registers; identifiers like badges &T-shirts; peer supervision; support supervision; preferential treatment at facilities; as well as CMDs involvement in decision making. Operation problems include the irregular and non-harmonized incentives; the inadequate government support in terms of drugs and materials; as well as the absence of harmonized guidelines. AMREF has learnt that success of community involvement depends much on CMD recruitment and selection, continuous training and supervision; logistical support and incentives, as well as political stewardship and adequate resources.

5.7.3 Experience of PSI in working with VHTs/CMDs

PSI's involvement of VHT/CMDs is because the latter are primary partners, opinion leaders, or role models that are established or recognised by government, and are instrumental if the community is to buy-in any programme. PSI always works with district structures, right from program design to implementation, and has used VHTs/CMDs to distribute over 1 million free LLINs in 44 districts nationwide and to increase access to ACTs through the private sector. In the process, VHT/CMDs participate in micro-planning; community sensitisation and door-to-door registration of eligible beneficiaries; mapping out convenient/accessible distribution points and identification of strategic storage centres; distribution of nets and follow up of net hanging up/use; as well as health education and pharmacovigilance in case of ACTs. VHT are given transport refund as a motivation but not a salary. PSI experience so far show that VHTs/CMDs are motivated by self esteem & recognition, learn better through practical and participatory approach, and require continuous support. However, the operational problems working with VHT/CMDs include the high turnover/drop outs of volunteers; and difficulties of standardising/sustaining the incentives/motivations for the volunteers.

5.7.4 Experience of Health Initiatives for the Private Sector (HIPS)

HIPS works with the Uganda business community on cost-effective ways of improving access and utilization of health services (including malaria) by company staff and their families, as well as the surrounding communities. This is based on a public-private partnership model, strengthening the private sector employer organizations. Malaria activities include: workplace policy development; peer education; health fairs; health communication materials; low cost health commodities; access to free IPTp; provision of laboratory equipment & training; as well as clinical & community based trainings. HIPS partners with companies on a cost sharing basis on IEC/BCC including the development and distribution of health information materials and the training of peer educators; on subsidized LLINs including promotion, procurement, distribution and training on their use; on prevention of malaria in pregnancy including promotion, procurement and training of medical staff on service delivery; as well as on monitoring and evaluation and support supervision. Though HIPS works with companies, but identifies relevant CSOs to carry out implementation e.g. training. Through this arrangement 12 companies have adopted the 'Good Life at Work' communications platform to include malaria content; 1500 peer educators have been trained on malaria; 45,500 people reached with malaria prevention messages; 100 healthcare providers trained on IPTp; and over 8500 LLIN have been purchased. Key companies involved in the scheme include: Finlays, Kakira Sugar, Kinyara Sugar, Tullow Oil, Nile Breweries, HIMA cement, Tororo Cement, Wagagai Flowers, Liberty Development Trust, and Rakai Community Health.

5.8 Malaria trends and their implications on Policy

With increasing coverages of malaria interventions, malaria is showing some down trends as evidenced by studies of UMRC and UMSP. This has direct implications on malaria policy that the country is moving away from malaria presumptive treatment to definitive diagnosis.

Recent assessment by Uganda Malaria Surveillance Programme (UMSP) 2007 in low endemic areas of Uganda (Kanungu district) shows a reduction in the number of patient load at OPD and those suspected to have malaria after IRS. However, no significant change was noticed in highly endemic areas such as Apac district after IRS was implemented. Therefore, antimalarial savings are truly possible if IRS is implemented coupled with accurate diagnosis in areas of low to moderate transmission, but yet to be proved in highly endemic areas. Another study was carried out by Uganda Malaria Research Centre (UMRC), which involved 4 districts, 195 facilities, 233 health workers and 1,763 outpatient consultations (33.3% of which were children below 5 years). The results showed that while the prevalence of fever among outpatient groups is high (79.2%), that of parasiteamia is lower than previously expected (27.8%), which leads to malaria over-diagnosis in Uganda. For facilities with functional laboratories, microscopy use is very rare, of poor quality and negative results are often ignored in management of patients.

5.8.1 From Presumptive treatment to Definitive Diagnosis

Given the up-scaling of malaria interventions and notable decreasing of malaria prevalence in the country, Uganda is moving away from presumptive treatment of malaria to definitive diagnosis. Theoretically, this would reduce on the frivolous use of ACTs which exaggerate drug budgets and contributes to parasite resistance. It also reduces the delays in instituting appropriate treatments of diseases like urinary tract infections that often present with fever that are clinically diagnosed as malaria. Microscopy, if performed by well-trained and motivated laboratory personnel using good-quality equipment, gives accurate diagnosis at low cost. However, this is not always available to all patients with suspected malaria. That is why Rapid diagnostic tests (RDTs) have been brought on board and they are simple to use, requiring no special equipment/laboratory personnel. However, there are still challenges in parasitological diagnosis, such as quality assurance and control, availability and motivation of staff, availability of RDT kits, other supplies, as well as ensuring health workers' and clients' acceptance/use of results.

5.9 Uganda Public-Private Partnership & New Initiatives

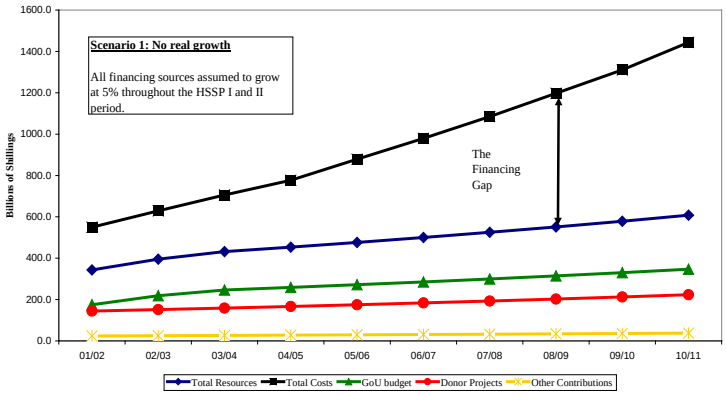
Current coverages of malaria interventions need to be consolidated through increase of access to quality of services if a down trend of malaria is to be maintained. In line with this, the Ministry of Health and some CSOs have come up with new initiatives to increase access to services like malaria case management and LLINs. Notable of these is the Social Health Insurance (SHI) scheme that would increase health sector funding; Affordable Medicines Facility for malaria (AMFm) that increases access to ACTs through the private sector, as well as Hospital access to LLINs and ACTs through PNFP institutions.

5.9.1 Social Health Insurance Policy & Scheme

Social Health Insurance (SHI) is a financial risk protection scheme, which is a response to the ever increasing health funding gap (Fig. 1) accruing from the high population growth, changing disease patterns/epidemics, economic inflation, and external economic pressures that lead to high commodity prices. The purpose of the scheme is to provide complementary health care financing, as well as supporting quality improvement, increased accessibility and

affordable healthcare. The *modus operandi* of the scheme is such that the rich people would subsidise the poor, while singles subsidise families, the healthy subsidise the unhealthy, and the young subsidise the old. The scheme is in line with constitutional mandate of the Government of Uganda and the National Health Policy. Operation of the scheme will include recruitment of membership; management of scheme funds; licensing and monitoring of other health insurance schemes; accrediting its health care providers; protecting the rights of its clients; as well as promoting private sector growth in terms of scope, volume & quality of health care provided. Membership will start with public servants, then formal and informal private sector that will be required to pay member contributions and employers' contributions. In return members will benefit from prescribed outpatient inpatient, preventive and referral services, as well as pharmaceutical products. Patients will also always vote on the best facilities and have an opportunity to log in their complaints. CSOs will greatly help to ensure transparency and monitoring the system. The existing schemes will not be phased out but will work hand in hand with the new policy. If one is already enlisted with a private scheme, he/she can stay there but pay the premium which will be forwarded to his/her service provider. Though the scheme is voluntary, the premium of social health scheme is mandatory. The church leaders can work with the Ministry and help to work out a strategy for targeting the clergy who do not get a formal salary. In case somebody loses a job, the scheme will cater for him for that year, ending December. However after that, since the scheme needs to be renewed annually, they will not be able to renew unless they have another job. However, there is need for enough sensitization on all these issues, and MOH is currently mobilizing resources to reach out to the people through the media, meetings, etc.

Graph 1. The Financing Gap
for the Ugandan Health Sector Strategic Plans I and II



5.9.2 Experience of MMV in increasing Access to affordable ACTs

Medicines for Malaria Venture (MMV), is a consortium of 6 partners (NDA/MOH, PSI, Surgipharm, Malaria Consortium, IDA Solutions and MSH) designed to increase access to ACTs through a private sector subsidy as to decrease mortality and minimise monotherapies. Over 60% of patients in Uganda access malaria treatment from the private sector where

ACTs are either unavailable or unaffordable. Currently, ACTs cost between 6 and 10 US$ in private sector outlets. In relation to this, a project was designed and piloted in 4 districts (Kamuli, Soroti, Budaka and Pallisa) to test the capacity of the AMFm (Affordable Medicines Facility for malaria) in the private sector to improve quality malaria case management through increased supply and demand of ACTs. The initiative is involved in aligning the policy for wider distribution of ACTs as an OTC drug. Therefore, it is involved in repackaging of medicines, setting/labelling of medicine packages of maximum recommended retail prices, generating service demand, improving supply chain management, garnering political support and community participation, as well as training of licensed providers on correct ACT dispensing, use and pharmaco-vigilance, plus referral. After a period of 3 months the initiative had observed an increase in number of registered clinics to benefit from the scheme, increased ACT uptake among malaria patients, as well as ACTs displacing CQ and other anti-malarials. Challenges on the ground include the limited availability of licensed outlets in underserved areas, absence of wholesalers or Stockiest (Pharmacist) in some districts, limited qualified staff for eligibility, currency fluctuations for drug purchase, as well as maintaining incentives so that traders adhere to the fixed recommended retail prices. Enabling factors include political commitment, stakeholder partnerships, multi-level ownership, community empowerment, parasitological diagnosis, and involvement of local manufacturers.

5.9.3 Experience of Kisiizi Hospital (PNFP) on Malaria Prevention and Control

Malaria management is according to the recommended government policy, and patients are usually triaged on arrival according to severity. Treatment is instituted after the definitive diagnosis and classification are made. Coartem is used in the uncomplicated malaria, while quinine is used in severe/complicated types with other supportive investigations/treatments like blood transfusion, intravenous fluids, blood glucose etc. The hospital also carries out an outpatient/community outreach malaria prevention programme twice a week, offering health education, mosquito net distribution, as well as intermittent presumptive treatment among pregnant women. Malaria prevention services are also extended to hospital wards involving patient education, indoor residual spraying, as well as ITN provision to patients and staff. This has led to disappearance of mosquitoes from the wards, and reduction of malaria complaints among the staff and their dependents. Challenges include blood deficits, high cost of care, drug stock outs, heavy workloads, low staff salaries, and patients' refusal to use nets at wards. Motivation of staff includes scholarships, as well as free access to power, water and food items. On non use of nets by patients, IRS would be a better alternative in crowded settings like hospitals.

5.10 Available Opportunities for CSO Funding & their Management

CSOs are currently struggling to secure funds as to maintain or heighten their malaria control activities in the country. Available opportunities for CSO financing/funding include banks and other funding agencies that have earmarked resources for malaria control activities in the next 5 years.

Stanbic Bank is one of the initial beneficiaries of the huge donation to International Standard Bank by Global Fund to fight HIV/AIDS, Malaria and Tuberculosis. Stanbic Bank's role as a partner will focus on its areas of expertise and competencies such as provision of financial training; provision of management expertise; provision of advice and practical support services to grant-receiving projects to ensure that funds reach the recipients in a timely manner; as well as assisting with ongoing administration and reporting requirements. Therefore, the bank is now seeking to network with any CSOs and development partners that are involved in the fight against malaria as to benefit from this fund since the pro bono initiative/services will be demand-driven and unconditionally provided.

On another hand, Standard Chartered Bank Uganda is one of the 8 African country banks benefiting from the 'Nets for Life' partnership project launched in 2006 to distribute 1 million LLINs to the most vulnerable people in Africa; primarily children under 5, pregnant women, the chronically ill persons and the elderly. As the bank aims at building a sustainable business, community programmes are part of its social contribution. The aim is to strengthen the relationships between the bank's businesses, customers, local communities and governments while providing opportunities to involve their employees; developing their skills. Since inception of the project in 2006, the bank has given out 166,000 LLINs to the Ugandan community through Church of Uganda structures in areas where there are no donors already operating, with high malaria endemicity or with no routine net distribution. The team has a good relationship with DHOs who also provide guidance. Standard Chartered Bank in partnerships with Coca Cola have each committed $5million over the next 5 years, and continue to look for funding partners who can bring on their core competencies which will fit into the current partnership e.g. governance, financial expertise etc. The bank operates robust measures to ensure donor money is spent most effectively through its close partnerships with international NGOs, its own evaluation and monitoring processes, as well as through its local expertise and experience.

The President Malaria Initiative (PMI) is a five-year funding project worth $1.2 billion to rapidly scale-up malaria control interventions (IRS, ITN, Case management and IPTp) in high malaria burden countries in Africa, led by USAID with HHS/CDC as a key partner. It works closely with host governments, as well as international and in-country partners/CSOs to ensure that efforts that are complementary. So far, 35 CSOs have benefited from the PMI project in Uganda, and these include AFFORD/UHMG, UMCP and UHC in Bushenyi that have distributed LLINs to target groups.

Stop Malaria Partnership (SMP) is another 5-year project with funding from USAID, targeting 45 districts in Uganda with malaria prevention and control support. The support is geared towards strengthening the national malaria control unit, IPTp delivery, LLIN promotion, strengthening of diagnosis & treatment at health facility, as well as consolidating the HBMF strategy. SMP intends to work through DHT and CSOs. The pre-qualification of CSOs will be done in collaboration with the corresponding DHOs/DHTs. The selection criteria is that the CSO bidding must be working within the prescribed SMP area of

operation; currently working in the health sector and through district structures; having sound financial and management capabilities; being interested in or actively involved in working with VHTs; as well as being fully registered with relevant authorities.

Global Fund is another funding option from which CSOs can raise money for their malaria activities. The Government of Uganda has expressed interest in applying for Round 9, building onto the Round 8 proposal that was never submitted. The proposal shall focus on IRS, RDTs and health systems strengthening. So far, needs assessment has been finalized with input from various development partners, and this is being used to develop the proposal with support of a consultant from Columbia University, USA. Very soon an advert will be posted in newspapers calling for successful proposals from CSOs, which will be incorporated into the national proposal. CSOs can develop an activity depending on their area of expertise or combine capacities with different expertise.

Though Uganda will submit one proposal, it will follow the Dual Track Financing (DTF) mechanism prescribed by GFATM, where the grant will be handled by more than one Principal Recipient (PR) as to improve efficiency. The two PRs will be drawn from the public sector on one hand and from the civial society/private sector on the other. Currently, Ministry of Finance, Planning and Economic Development (MoFPED) is the sole PR of Uganda GF grants, serving both the civil society and public sector. In round 9, the country will be required to have more than one PR nominated by the CCM, and assessed by the local funding agency (LFA). These PRs will be responsible for grant accountability, focusing on financial management; programme leadership and management; procurement and supply chain management; sub-recipient engagement; supervision and mentorship; as well as activity monitoring, evaluation and reporting. The CCM is now making consultations on second PR from the civil society/private sectors, which must be a legal entity in Uganda, satisfying the standard criteria provided by GFATM and competitive in selection. In all these consultations CSOs are fully embodied in the 40% representation on CCM/HIPAC.

5.11 CSOs' buy-into the National Malaria M&E framework

Although malaria has attracted a number of actors in the country, there is need for harmonised commitment of CSOs and uniform monitoring if malaria services are to make any significant impact on the disease. Therefore, there is need for CSOs to buy into existing coordination mechanisms and the national malaria M&E framework for harmonization.

The need for streamlining the country malaria M&E system has become intense because of the increased emphasis on coverage and quality of services; multiplying number of indicators required by different stakeholders; increased demand for the one monitoring plan; linkage of financial tracking to programme monitoring; standardization of performance measurement for in or cross country comparisons; need for monitoring absorptive capacities of countries/institutions; as well as the need for monitoring epidemics and their responses. Therefore, the national malaria M&E framework guides collection, processing, analysis and use of malaria data; guides periodic documentation of planned activities, outputs, expected outcomes and impact; provides a comprehensive list of indicators to guide implementers;

and outlines key actions to implement or better malaria programs. Data sources include Health Management Information System (HMIS), Home Based Management of Malaria (HBMF), Integrated Disease Surveillance and Response (IDSR), Sentinel Site Surveillance (SSS), Demographic and Health Survey (DHS) and Malaria Indicator Survey (MIS). Current operation difficulties include poor floor of data and transparency; inadequate capacity and tools; poor consultation, collaboration and coordination between actors; lack of shared vision, mission, teamwork, leadership, management and respect; lack of effective supervision; problems in power relations and tendency of actors to bypass local authorities; as well as poor quality of services.

In order for CSOs to buy into the national malaria M&E framework, they should align their project objectives and activities with the national malaria strategic plan with corresponding or appropriate indicators; equip, facilitate and establish their monitoring sections; streamline their data flow systems with districts and NMCP; establish monthly activity logo with planned activity, achievements, challenges, innovations to overcome, lessons learnt; quarterly reports, annual reports with success stories and photographs; train and supervise staff on data management for quality assurance and management; carrying out regular surveys to capture community based information; dis-aggregation of data by age and sex; routine monitoring for continuous quality improvement; periodic evaluations, lesson learning and decision-making; capacity building in terms of abilities, relationships, values, processes, systems and rules that shape collective and individuals' ability to play new roles or adapt to new demands/situations; as well as building consensus, shared visions, missions & clear roles.

5.12 Coordination and Harmonisation of CSOs

5.12.1 Experiences of Gulu & Kiruhura districts in working with CSOs

In the last 2 decades, Gulu district underwent a period of instability, coupled with infrastructural and social breakdown that necessitated support from CSOs. This attracted numerous partners including UNICEF, WHO, Malaria Consortium, NUMAT, ICRC, ACORD and RTI in support of the health sector. Support is on activities like social mobilization, training of facility and community health workers, provision of treatment kits, coartem and ITNs, as well as community malaria surveillance, VHT meetings/logistics and mobile drama/plays/radio spots/talk shows. This has resulted into a district wide net coverage of 42%, IRS coverage of over 90%, and the 50% increase in child access to malaria treatment. In turn, there is a notable 16% reduction of malaria OPD attendance among the under 5 children. However this is not without problems. There are difficulties of coordinating partners in the district; duplication of services; lack of transparency among some CSOs, absence of memorandum of understandings and accountabilities; absence of CSO mapping and district data base; un-harmonized VHT training and incentives; as well as district monitoring and supervising different activities. Gulu holds monthly meetings, and gives them VHTs transport refunds, as an incentive which motivates them. It is a duty for CSOs to hold government accountable to ensure that VHTs are well motivated; otherwise partners shall continue training and losing them thus having a high turn over.

On the other hand, Kiruhura district suffers from a high malaria disease burden with limited support from the government for essential medicines, health education, LLINs distribution, and IPTp delivery among pregnant women. There is no support from CSOs, as previous NGOs wound up their activities in 2006, yet the district is faced with difficulties like low staffing levels compared to the disease burden, inadequate staff training, inaccurate diagnosis at both clinical and laboratory levels, absence of drugs at both facility and community levels, inadequate human resource attraction and retention, as well as delivering services to a sparsely populated district.

5.12.2 Coordination and Harmonisation of CSOs

From the above experiences, the importance of CSOs in Uganda cannot be overemphasized. CSOs are critical in bringing social equity by delivering health services to the underserved, marginalized, vulnerable, and the disadvantage communities. Their position is also critical in innovation and strategic thinking, community capacity building and empowerment, advocacy for accountability and health rights/resource allocation, as well as lobbying for appropriate policies, laws and practices on health. However, CSOs' are bogged down by lack of coordination, legal mandate, technical capacity, relevant information, and meaningful representation at strategic position to carry out their moral obligations. There is need therefore to develop a harmonization/coordination mechanism that will facilitate CSOs to carry out their social duty. The mechanism chosen should have a vision, a mission, objectives and expected benefits; as well as legitimacy, moral values, competence/technical capacity and programme of action to facilitate streamlining of member activities.

Among its objectives the mechanism would be to harmonize and coordinate CSO malaria activities; build capacity of member CSOs in critical areas; facilitate sharing of skills/expertise; dissemination of information and best practices; building alliances with other networks; mobilizing resources for its activities; monitoring CSO activities; as well as arbitrating between CSOs and other partners. Among its qualities the mechanism should be supported by key civil society groups in the malaria control arena; having no conflict of interest in its operation; being neutral in dealing with CSOs that align according to their areas of comparative advantages; being complementary to existing coordination mechanisms in the health sector; being accountable for coordinating CSO in malaria and health; strengthening the spirit of multi-sectoral approach to health; representing CSOs at national and international levels, as well as bringing representatives of other non-malaria on board.

5.13 Experiences in Working with Civil Society Organisations

NGO collaboration is becoming increasingly important with global policies shifting toward rapid scale-up of disease prevention and control, as well as health systems strengthening. NGOs must build advocacy capacity and work together to influence policy and develop strategies at the national, regional and global levels.

5.13.1 Core Group's Experience working with CSOs

Core Group, a network of 51 international non-governmental organisations, creates a platform for NGO actors to be actively involved at national, regional and global levels of policy making and strategic development. The network secretariat is situated in Washington

DC, and helps to bridge the gap between NGOs, CBOs, FBOs, Private Sector and governments to more effectively solve problems. It also empowers NGOs to mobilize communities toward a common goal, as well as facilitating the harmonization of NGO programs with government approaches, thus creating more integrated health systems. Generally, NGO partnerships and secretariats facilitate information sharing, problem solving, exchange of ideas on programmatic approaches/impact, as well as resource leveraging. They also create a unified voice and message for advocacy; participate in dialogue on malaria and health development; document and disseminate best practices; as well as coordinating scale-up of health services. In its experience of 11 years, the Core Group Secretariat has learnt that effective partnership development requires clearly identified needs, goals, strategies, objectives and priorities. The investment in workshops and meetings to develop relationships and social capital is important throughout the process to effectively share information, build strategy and adapt to changes. Partnership goals and strategies must fit within the governmental, cultural and social context and among partnership member organizations. Furthermore, leadership and management of the partnership and secretariat should be shared among members of the CSO network.

5.13.2 MACIS' Experience working with CSOs

The MACIS' six year experience shows that CSO network secretariats are good linkages of CSOs with Ministry of Health and international bodies like GFATM Board and RBM through representation on strategic committees. Secretariats are also good platforms for disseminating policies/technical updates, sharing of information and good practices/lessons learnt; as well as linking strategic CBOs with other organisations for meaningful collaboratives/partnerships. However, these tasks have operational problems such as difficulties in obtaining necessary funding, non-payment of membership fees by constituent CSOs, limited capacity to meet the needs of diverse groups; competition among member CSOs, as well as CSOs' laxity to collaborate. MACIS is now in the process of building internal capacity through fundraising and joint proposals; strengthening coordination with Ministry of Health, creating MACIS 'nodes' at district level; as well as streamlining coordination among member CSOs. This is intended to be achieved through creation of an effective decentralized nationwide network of CSOs engaged in malaria and IMCI interventions at community level; strengthening the internal capacity of the secretariat; improving the effectiveness of members' activities through capacity building, coordination and information sharing; as well as building of platform for advocacy at all levels.

6.0 Conclusion

The workshop was successful given that partners were provided technical updates on malaria by NMCP; 28/28 of planned CSOs managed to share their experiences on malaria activities; gaps in service coverages were identified, and practical options to fill these gaps proposed. In addition, networks and collaborations between partners/actors were fostered by the 3 day workshop. All these were in line with the workshop objectives.

7.0 Way Forward

7.1 Harmonization

For MACIS members to harmonize their malaria activities in the country, it was agreed that

- a joint resource center or an information clearing house be established
- joint stakeholders meetings be held regularly
- capacity of CSO staff be built
- a coordination mechanism be built at all levels
- CSOs work with existing social structures at community level
- MACIS works with NMCP to harmonize malaria guidelines and IEC materials
- MACIS coordination mechanisms be established at malaria zonal level, originally based under regional referral hospitals
- mapping of CSO activities be carried out periodically
- peer mentorship be promoted at both horizontal & vertical levels

7.2 CSOs buy-into the National Malaria M&E Plan

In order for CSOs to buy into the national malaria M&E plan, it was agreed that

- member organisations adopt the plan and consult where necessary
- member organisations involve communities as to create community ownership, and CSO accountability to beneficiaries
- MACIS and NMCP continue to guide CSOs importance and modality of aligning their M&E with the national malaria M&E plan
- CSOs do analyze the national policy and ensure that they implement accordingly
- NMCP rigorously monitor CSO activities
- CSOs strengthen their internal management and financial system
- CSOs align their objectives with those of national malaria M&E plan, and think through the entire monitoring and evaluation process
- CSOs streamline their information system, as well as strengthen their record keeping and reporting systems
- all indicators in the national malaria M&E Plan (Pg 29) be sorted to suit different CSOs

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Annex 2: Workshop agenda

AGENDA FOR A FRESH AIR MALARIA WORKSHOP SCHEDULED TO TAKE PLACE MARCH 31ST – APRIL 2ND 2009, AT HOTEL AFRICANA, KAMPALA			
Theme : Counting Malaria Out – in Partnership with CSOs			
Day One (31st March 2009)			
Time	**Topic**	**Presenter**	**Facilitator**
8:30 – 9:00am	Arrival & Registration	**Secretariat**	**MACIS**
9:00- 9:15 am	• Welcome & Recognition of dignitaries • Background of MACIS & its purpose • Purpose & Objectives of this workshop • Announcement of logistics & materials	**MACIS National Coordinator**	**MACIS**
9:15 – 9.35 am	Core Group's experience in working with Networks of CSOs	**CORE Group Representative**	**Director General, MOH**
9:35 – 9.55 am	PMI's Support to the CSOs' Malaria Agenda	**PMI Representative**	
9:55 – 10:15 am	Malaria and its control in Uganda: Where we are as a country	**Programme Manager, NMCP**	
10:15 – 10.30am	Key Note Address: Historical synopsis of malaria and the role of CSOs	**WHO Country Representative**	
10:30 – 10.50am	Remarks & Official opening	**Hon. Minister of Health**	
	Group Photo	**MACIS**	**MACIS**
10:50 – 11:20am	**TEA / COFFEE BREAK**		
11:20 – 11.40pm	Uganda Malaria Case Management Policy (including IPTp): Technical Updates	**Malaria Case Management Focal point, MOH**	**Director Health Services(C&C)**
11.40 – 12.00pm	IDI's experience on health facility malaria case management	**Malaria Focal Point, IDI/JUMP**	
12.00 – 12.20pm	MC's experience on community malaria case management (VHT & CMDs)	**Malaria Focal Point; Malaria Consortium Uganda**	
12.20 – 12.40pm	UNICEF's experience on community malaria case management through basic package in Northern Uganda	**Child health Focal point, UNICEF**	
12.40 – 1.00 pm	Question & Answer session (Panel discussion)	**All case management presenters**	
1:00 – 2:00pm	**LUNCH BREAK**		
2:00 – 2:20 pm	Uganda ITN Policy: Technical Updates	**ITN Focal point, MOH**	**RBM Regional Coordinator**
2:20 – 2:40 pm	AFFORD's experience on ITNs distribution in Uganda – NGO approach	**ITN Focal point, AFFORD**	
2:40 – 3:00pm	KIRDP's experience on ITNs distribution in communities – a CBO Approach	**ITN Focal point, KIRDP**	
3:00 – 3.20pm	UMCP's experience on ITN distribution: a CSOs' collaboration approach	**UMCP Lead collaborator, Minnesota International**	
3:20 – 3:40pm	Question & Answer session (Panel discussion)	**All ITN presenters**	

3:40 – 4:00pm	**TEA / COFFEE BREAK**		
4:00 – 4:20pm	Uganda IRS Policy: Technical Updates	**IRS Focal point, MOH**	**Plan International/ Uganda Red Cross**
4:20 – 4:40pm	RTI experience on IRS implementation in Uganda	**IRS focal point, PMI/RTI**	
4:40 – 5:00pm	Pilgrim's experience on IRS implementation in Uganda	**IRS focal point, Pilgrim**	
5.00 – 5:20pm	Question & Answer session (Panel discussion)	**All IRS presenters**	

Day Two (1st April 2009)

Time	**Topic**	**Presenter**	**Facilitator**
8:30 – 9:00 am	Registration	**MACIS**	**MACIS**
9:00 – 9:20 am	Recap 1 – Key issues from the previous day's discussions	**Rapporteur**	**Assistant Commissioner, HP&E**
9:20 – 9:40 am	Uganda Policy on Malaria Advocacy & Social Mobilization: The Role of CSOs	**HP&E Focal Point, MOH**	
9:40: 10:00 am	CDFU's experience in Malaria Advocacy & Social mobilization in Uganda	**Malaria Focal Point, CDFU**	
10:00 –10:30 am	Question & Answer session (Panel discussion)	**All Advocacy & Social Mobilization Presenters**	
10:30 –11:00 am	**TEA / COFFEE BREAK**		
11:00 – 11:20am	Uganda Public-Private Partnership and the Social Health Insurance Scheme: Policy Updates	**PPH/SHI Focal point, MOH**	**UNHCO**
11:20 – 11:40am	Access to effective malaria medicines through the private sector: Experience of Malaria Medicine Venture (MMV)	**Malaria Focal point, MMV**	
11:40 – 12:00pm	Experience of the Core Private Sector in Malaria control	**Quality Chemicals (U) Ltd**	
12:00 – 12:20pm	Malaria management and prevention – Perspective from a PNFP health facility	**Medical Superintendent, Kisiizi Hospital**	
12:20 – 1:00pm	Question & Answer session (Panel discussion)	**All Public-Private Partnership Presenters**	
1:00 – 2:00pm	**LUNCH BREAK**		
2:00 – 2:20pm	Trends of malaria morbidity & mortality in the era of ACT role out - a Uganda Malaria Surveillance report	**Uganda Malaria Surveillance Project**	**WHO**
2:20 – 2:40 pm	Key research findings on OPD malaria case management under the ACT policy	**Uganda Malaria Research Centre**	
2:40 – 3:00 pm	Diagnosis of Malaria: From presumptive to definitive	**Malaria Focal Point, FIND**	
3:00 – 3:20pm	Question & Answer session (Panel discussion)	**All Research presenters**	
3:20 – 3:40pm	**TEA / COFFEE BREAK**		

3:40 – 4:00 pm	Working with CSOs in Malaria Control – An Experience of a District Health Officer	**DHO, Gulu**	**Programme Manager, Malaria Control**
4:00 – 4:20 pm	Working on Malaria without CSOs – experience from a District Health Officer	**DHO, Kiruhura**	
4:20 – 4:40 pm	CSO harmonization mechanisms in implementation of health activities including malaria	**MACIS' Consultant**	
4:40 – 5:00 pm	• Group Work: CSO harmonization and collaboration mechanisms on malaria	**Group leaders**	
6:00 – 7:30pm	**RECEPTION**		**MACIS**

Day Three (2nd April 2009)

Time	**Topic**	**Presenter**	**Facilitator**
8:30 – 9:00am	Registration	**MACIS Secretariat**	
9:00 – 9:20am	Recap 2 – Key issues from the previous day's discussions	**Rapporteur**	**Africare**
9:20 – 9:40am	AMREF's experience in working with VHTs/CMDs on malaria: an NGO approach	**Malaria Focal point, AMREF**	
9:40 – 10:00am	PSI's experience in working with VHTs/CMDs on malaria: an NGO approach	**Malaria Focal Point, PSI**	
10.00 10:20 am	CHU's experience in working with VHTs/CMDs on malaria: a CBO approach	**Malaria Focal Point, Health Child Uganda**	
10:20 –10:40 am	Question & Answer session (Panel discussion)	**All Presenters working with VHTs and CMDs**	
10:40 –11:00 am	**TEA / COFFEE BREAK**		
11:00 – 12:15am	Resource mobilization for CSOs for malaria activities: Available opportunities	• **PMI** • **UNICEF** • **GFATM** • **Barclays Bank** • **Standard Chattered Bank** • **Stanbic Bank** • **UTL** • **The Stop Malaria Project**	**CORE Group**
12:15-12.30 pm	Global Fund Round 9 Consultations	**NMCP**	
12:30 – 1:00 pm	Question & Answer session (Panel discussion)	**Presenters resource mobilization**	
1:00 – 2:00pm	**LUNCH BREAK**		

2:00 – 2:20 pm	Uganda Malaria M& E Plan: Policy updates	**Malaria M&E Focal point, MOH**	**UNICEF**
2:20 – 3:20	Group work • M & E of CSO malaria activities	**Group Leaders**	
3.20 - 4:00pm	Plenary presentations and discussion on •CSO harmonization and collaboration mechanisms on malaria •M & E of CSO malaria activities	**Group Leaders**	
4:00– 4:30pm	**TEA / COFFEE BREAK**		
4:30 – 5:00pm	Way Forward	**MACIS**	
5:00 pm	Workshop closure	**MACIS/MOH**	

Annex 3: Key Note Address

Delivered by Dr Charles Katureebe on behalf of Dr Joaquim Saweka, The World Health Representative, Uganda

- Hon Minster of Health
- Bilateral and Multilateral partners present
- Officials from the CORE group
- Malaria Programme manager
- National Coordinator, MACIS secretariat
- All invited guests, ladies and gentlemen

I would like to thank the MACIS Secretariat for having invited me to this workshop aimed at sharing, reviewing and re-strategizing ourselves in the areas of malaria prevention and control efforts in this country.

This meeting is indeed timely because of the urgent call for scaling up for impact of all malaria control interventions so that RBM targets are achieved by 2010 and malaria seizes to be a public health hazard. And I hope you agree with me that this scale up will have to involve efforts of everybody including the critical role of CSOs.

In order to share with you the history and importance of CSOs in Health, allow me to note that malaria has been a world-wide problem for centuries. Civil society and non-state organizations have been contributing to public health for centuries too. People, as part of the civil society form the core of health systems since these people use health services, contribute finances, are care givers and have a role in developing policies plus shaping health systems.

Civil society has been understood globally as the social arena that exists between the state and individuals or households. For instance, the following declarations or charters have recognized the role of the individual, community, households or civil society associations in public Health:

1. The Alma Ata Declaration in 1978 in Russia; Community involvement and participation was recognized as important ingredient for primary Health care
2. The Ottawa Charter (1986); People's empowerment for environments supportive of health and increased social support for health action
3. Adelaide Declaration (1988) called for strong public health alliances especially at community level
4. Jakarta Declaration (1997), Private sector involvement and partnerships in health development, and iincreased community capacity and empowerment of individuals.
5. Mexico Deceleration (2000), called for bridging the equity gap by ensuring active participation of all sectors; active involvement of civil society in planning and implementation of health actions and expansion and strengthening of partnerships for health development
6. Civil society initiative was created in 2001 to energize WHO's relations with civil society and NGOs. NGOs and CSOs have engaged with WHO to implement health programmes at country level, made outreaches to remote areas, advocated for public

Health issues to a broader audience and worked with WHO to raise funds more effectively.

7. Bangkok Declaration (2005) emphasised the critical role of people, groups and institutions
8. International Health partnership: CSOs are part of this Global partnership for Health
9. The Public Private partnership for Health is a well established arrangement in Uganda.

I would also like to highlight that; the Roll Back Malaria partnership of 1998 recognized and still recognizes the critical role of CSOs in malaria control and its eventual elimination efforts. Many international and national donors highly recognize the critical role of CSOs in malaria control and elimination

Governments through the public–private partnership recognize the critical role of CSOs in malaria control and elimination. I could go on and on!

Hon Minister, ladies and gentlemen, we all recognize and appreciate that health work or health activities are no longer the domain of medical specialists alone but should involve politicians, economists, layers, communicators, social scientists and ordinary people everywhere.

Malaria Control has undergone a lot of transformation and improvements based on research and evidence since the eradication efforts of the 50s. Because of resistance partners to antimalarial drugs, effect of malaria on pregnancy, evidence on the critical role of ITNs and IRS, countries have been urged to adopt new and effective antimalarial medicines like the ACTs, ensure use of LLINs, implement IRS in both endemic and epidemic prone areas, use IPTp in pregnant women, and above all, ensure universal coverage with all these interventions. Hon Minister, ladies and gentlemen, the role of CSOs is very clear in malaria control efforts especially after knowing what interventions are approved by the country and programme. I am happy that all these updates have been included in the programme to be covered in your 3 days stay here.

I would like to end by encouraging all you to work together with the malaria programme in a coordinated manner under one leadership and coordination of the programme manager. We should have one strategic plan; follow one coordination mechanism and one monitoring and evaluation plan. Always make sure that all your progress reports are submitted to NMCP in order for you to remain relevant in the struggle to control and eliminate malaria.

There is great potential for improving public Health and above all, of improving malaria control through systematic collaboration between the government (Ministry of Health and malaria control programme) and civil society.

There is great potential to move forward towards malaria elimination especially today when there are a lot of commitments from the international community, donors and governments. We need to work together, civil society, private sector, international community and Governments alike, in reversing the current trend of Morbidity and mortality due to malaria, the current school absenteeism and absenteeism from wok due to malaria. We need a malaria free world and together we can achieve it as "we count malaria out" of Uganda.

Annex 4: Opening Remarks

Delivered by Hon Minister of Health, Dr Stephen Mallinga at the Fresh Air National Malaria Technical Update and Coordination Workshop at Hotel Africana, Kampala on Monday 31st March 2009

- The WHO Country Representative
- Director General of Health Services,
- Representative from CORE Group Washington
- Representative from Presidential Malaria Initiative
- Health Development Partners,
- Other technical staffs from ministries
- District Health Officers
- Members of the Civil Society
- Member of the Press
- Ladies and Gentlemen

It gives me much pleasure to see all of you congregating here to discuss how to address one of the most dreadful problems of our communities today - in the name of malaria

The burden, malaria exerts on the health system of Uganda and socio-economic status, cannot be overstated.

Malaria contributes 25-40% of all the out patient attendances at facilities, 20-25% of all facility admissions, and 17-20% of all hospital deaths.

In response to this, Uganda has come up with an ambitious plan to upscale coverages of preventive services like long lasting insecticide treated nets (LLIN), indoor residual spraying (IRS), and intermittent preventive treatment (IPT) of malaria in pregnancy to 85% of the entire population.

Furthermore, effective malaria case management using artemisinin-based combination therapy (ACT) drugs has been expanded in the whole country through health facilities, and we have started to roll ACTs down to communities through the Home Based Management of Fever (HBMF) strategy. Through these the country is targeting 85% of all malaria cases to be effectively treated within 24 hours of fever onset.

However, this plan is not only ambitious but equally bold; thus requiring concerted efforts from different actors and partners for its realization. Therefore, the need for complementary health services delivery from Civil Society Organisations cannot be overemphasized.

Involvement of Civil Society Organisations in health care services delivery is not a new phenomenon in Uganda. It dates back in 1897 when Dr. Sir Albert Cook led a team of young missionary doctors of the Christian Missionary Society (CMS) from the United

Kingdom to come and provide health services to the people of Uganda. This team started their work from a humble environment where they used to reach out to some of the most disadvantaged people in the society. This gave chance to many individuals to be treated of the then "impossible diseases" like syphilis and trypanosomiasis, which were a menace to Ugandans. This marked the beginning of complementary health service delivery in Uganda.

Overtime, various groups have rallied behind the Government to provide complementary health services to our people, especially to the disadvantaged groups of the society. At this juncture, I would like to salute all facility based and non- facility based CSOs, Faith Based Organisations and all other players who have given us a helping hand for quite a long period of time.

I would also like to congratulate other players who later joined the fray, having realized that the undertaking wasn't any small task. This contribution became more visible when the country went through troublous times characterized by regional instabilities, relentless wars, economic breakdown, chronic internal conflicts that instigated internally displaced persons (IDPs), and natural disasters like HIV/AIDs pandemic.

I am happy to note that Civil Society Organisations are not only involved in health care service delivery, but equally engaged in advocacy, constructive lobbying on key decisions, as well as policy formulation and reviews. It is also gratifying to note that CSOs are involved in innovation and strategic thinking that guide implementation of evidence based interventions for health, and strengthening capacities of communities with the aim of empowering them to take charge of their own health.

I am also happy to note that through the Malaria and Childhood Illnesses NGO Secretariat (MACIS), more and more Civil Society Organizations are coming together, in partnership with the Uganda government, to improve their coordination and collaboration on malaria and child health activities in the country. This does not only minimize duplication of efforts, but reduces operation costs, improves aid effectiveness in the country, and fosters knowledge sharing among actors/development partners. This spirit becomes more important in a time like this when the global financial crunch is affecting all nations; the developing and developed ones alike.

I have been reliably informed that during your stay here of 3 days, you will have an opportunity to discuss some of the modalities and mechanisms by which CSOs can harmonize, collaborate and network for maximum benefit. However, implementation of all these modalities takes selflessness and commitment among members to materialize.

I want to thank development partners like Core Group Washington and PMI for supporting these CSO coordination, harmonization and collaboration activities, which are precursors of cost-effective service delivery.

As you will later hear from my staff, the Ministry of Health in consultation with partners has already drafted a Public – Private Partnership Policy for Health (PPPPH), which will guide the mutual engagements between government and private actors. I believe you, as CSOs will continue to make useful input in this policy so that it can be acceptable and useful to all.

In this Policy we want to see that every actor is in alignment with national priorities and actually delivering tangible results. Gone are the days when the NGO's prowess would be gauged by a fleet of strong vehicles it imports in the country. Now communities want to see what actors actually deliver on ground. Therefore, let us learn from the example of those young doctors of the Christian Missionary Society (CMS) who humbled themselves to serve our people in difficult situations and limited resources.

I want to thank members who have realized this call and are already responding to it by using the limited resources available and sometimes working in very difficult situations to deliver services to our people. I want to encourage those CSOs that have not yet joined the collaboration, to do so as to promote the principles of equity.

Finally, ladies and gentlemen let me take this opportunity to thank MACIS and her partners for organizing such an important workshop; fruits of which will certainly help improvement of health services delivery in this country

I wish you fruitful deliberations during your stay here in the next 3 days, and I now declare this Fresh Air Malaria Workshop 2009 open.

Annex 5: List of Presentations

1. AFFORD's Malaria Programme - *Ann Kusiima*
2. AMREF's Experience Working with VHT and CMDs - *Dan Muyanja*
3. CDFU's Advocacy and Social Mobilization for Malaria - *Bazel Tushabe*
4. Consultation On Dual Track Financing Under GFATM - *Byenkya Julius Atwooki*
5. Ensuring access to ACTs: Update from the MOH-MMV - *Andrew Balyeku*
6. Exploring the possibility of harmonizing and strengthening participation of Civil Society in implementation of Health Sector Strategic Plan - *Romano Larry Adupa*
7. Health Initiatives for the Private Sector (HIPS): Engaging the private sector for improved access and utilization of health services - *Barbara*
8. Healthy Child Uganda (HCU): Partnering in Malaria Control - *Teddy Kyomuhangi*
9. IDI'S Experience on health facility malaria case management – *Umaru Ssekabira*
10. IRS policy in Uganda and technical updates - *Michael Okia,*
11. MACIS' experience in coordination of CSOs - *Enid Wamani*
12. Malaria and its control in Uganda: where were as a country - *Richard Ndyomugyenyi*
13. Malaria case management and Diagnostics under artemether-lumefantrine treatment policy in Uganda - *Joaniter Nankabirwa*
14. Malaria case management: from presumptive to definitive diagnosis - *Heidi Hopkins*
15. Malaria management & prevention: perspective of PNFP facility - *Tonny Tumwesigye*
16. Standard Charted Bank: A potential source of CSO malaria funding -*Herbert Zake*
17. National malaria control policy on advocacy and social mobilization - *Mary Byangire*
18. National malaria prevention & control M&E plan 2008-2010 - *Ebony Quinto*
19. NGO Collaboration: CORE Group's experience - *Shannon Downey*
20. Pilgrim's experience in implementing IRS in Katakwi district - *Anthony Esenu*
21. KIRDP`s experience on ITNs distribution - *Kenneth Kanyankole*
22. President Malaria Initiative (PMI) support to CSOs malaria agenda - Gune
23. PSI's experience in working with VHTs/CMDs on malaria - *Dennis Kakooza*
24. Charted Bank: A potential source of CSO malaria funding - *Jane Kabbale*
25. Stop Malaria Project: A potential source of CSO malaria funding - *Ellen Bajenja*
26. The experience of Malaria Consortium of HBMF in the era of ACTs – *Grace Nakanwagi*
27. The national Health Insurance scheme - *Francis Runumi*
28. The National ITN Policy – *Connie Balayo*
29. Trends of malaria morbidity following IRS: Indicators from a sentinel site surveillance system in two epidemiologic settings - *Hasifa Bukirwa*
30. RTI's experience in IRS – *Doreen Kabasindi*
31. CSO collaboration in ITN distribution: a UMCP experience – *Jonathan Debuni*
32. Uganda malaria policy guide – *George Mukone*
33. UNICEF's experience in Community Case Management – *Flavia Mpanga*
34. Working without CSOs on malaria – experience of Kiruhura DHO – *Franco Zirabamuzaale*
35. Working with CSOs on malaria: Experience of the Gulu DHO – *Paul Onek*