

POLICY BRIEF

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Ensuring **successful implementation** of malaria policy in **Uganda**



Key messages

1. More capacity building interventions are needed to help communities in preventing the causes of malaria.
2. Government can use subsidies or insurance as a possible mechanism to aid users who are unable to pay for medicines and products from their own pockets.
3. Campaigning and lobbying for more funds from the private sector will be a good way to mobilise resources towards the programme.

Introduction

In Uganda, healthcare services were made available to everyone in 2001, through the abolition of direct user fees for public healthcare services. This eliminated the financial barriers to access to healthcare that had been faced by Ugandan citizens, and was a step towards the control and elimination of the burden of disease.¹ Despite this and the scale-up of other intervention programmes, the prevalence of malaria remains high; it is one of the leading causes of morbidity and mortality in Uganda. In 2019, the number of reported malaria cases was over 1.4 million, primarily in children under the age of five years.² Uganda ranks in the third position in the number of malaria infections in sub-Saharan Africa by country, and it has the highest number of reported malaria transmissions in the world.³ Moreover, reports have indicated that severe anaemia due to malaria remains a public health problem in the country.

Uganda has made progress in improving public health. This is evidenced by a more than 80% coverage of long-lasting insecticidal nets (LLINs) or in-door residual spray for mosquitoes, recorded in 2018.⁴ The number of deaths due to malaria since declined by 39% between 2010 and 2017.⁵ Although there seems to be progress, it has become evident that there is a need to enhance the control of malaria in the country. Government has implemented a malaria control policy programme inclusive of six policy subdomains, namely: policy establishment; implementation; financing; workforce; medicines and products as well as service delivery.⁶

The study on which this brief is based was conducted by the Supporting Policy Engagement for Evidence-based Decisions (SPEED) for Universal Health Coverage in Uganda Project at Makerere University School of Public Health. SPEED applied a monitoring lens, the Policy Implementation Barometer (PIB)[4],⁷ to four of the subdomains of the

1 Basaza RK, Criel B & Van Der Stuyft P (2010) Community health insurance amidst abolition of user fees in Uganda: The view from policy makers and health service managers. *BMC Health Services Research* 10, 33. Accessed 27 May 2021, <http://www.biomedcentral.com/1472-6963/10/33>.
2 USAID (2019) *President's malaria initiative: Uganda Malaria Operational Plan FY 2019*. Accessed 27 May 2021, <https://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy19/fy-2019-uganda-malaria-operational-plan.pdf?sfvrsn=3>.
3 USAID (2019) *President's malaria initiative*.
4 World Health Organization (2019) *World Malaria Report 2019*. Geneva: WHO.
5 World Health Organization (2019) *World Malaria Report 2019*.
6 Hongoro C, Rutebemberwa E, Twalo T, Mwendera C, Douglas M, Mukuru M, Kasasa S and Ssengooba F (2018) Analysis of selected policies towards universal health coverage in Uganda: The policy implementation barometer protocol. *Archives of Public Health [Archives Belges de Santé Publique]* 76, <https://doi.org/10.1186/s13690-018-0258-4>.
7 Hongoro et al. (2018) Analysis of selected policies towards universal health coverage in Uganda.

malaria control programme that had been implemented at the time of the survey, namely financing; workforce; medicines and products, and service delivery. The survey was carried out in two waves, namely PIB1 and PIB2. The second survey, PIB2, was done in order to establish whether there had been significant improvement in the implementation of malaria policy, and to identify gaps where further intervention is needed. This policy brief discusses the results of PIB2 and the implications they have for further revisions of malaria policy and implementation.

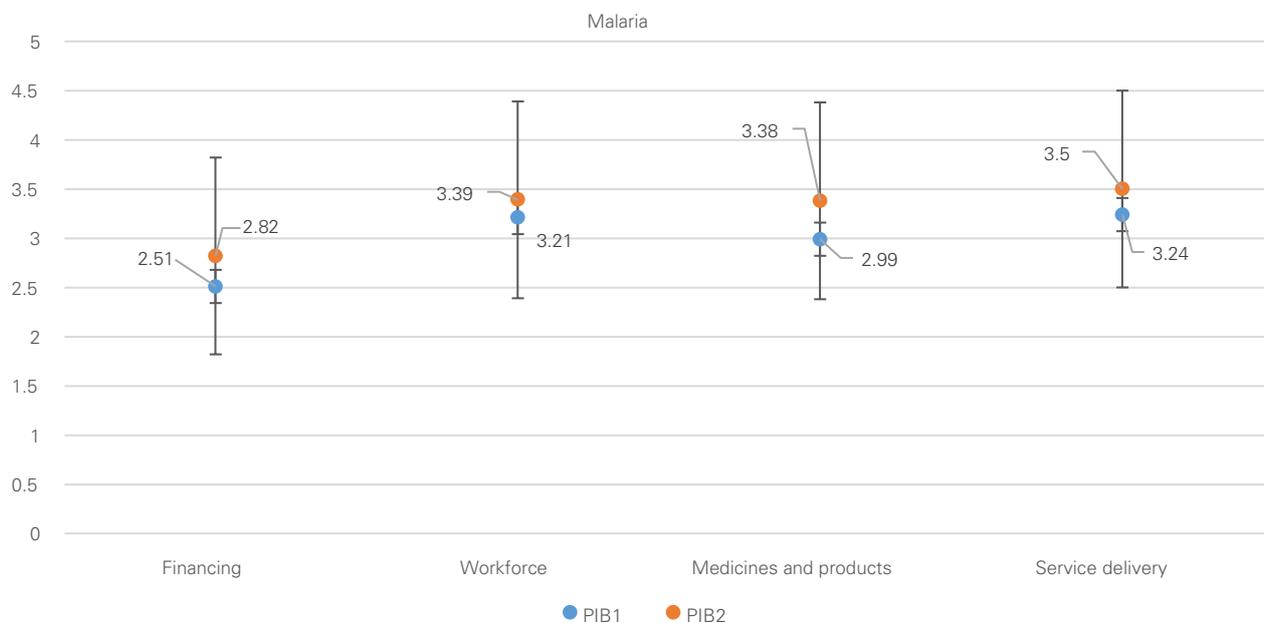
Survey methods

The Policy Implementation Barometer focused on three levels of policy implementation, namely national (macro), district (meso) and facility (micro) levels. The SPEED project conducted a survey among central government officials, district officers, and health facility workers (health centres and hospitals), assessing the effectiveness of implementation within the four subdomains of the malaria policy. A six-level Likert scale was used to assess respondents' perceptions and opinions at these three levels of implementation. Average scores were generated from responses in the four subdomains of implementation, and an overall average was indicated for each subdomain.

Overall results

In total, the number of participants that responded in the survey was 289. Figure 1 presents the average scores within the four subdomains: financing, workforce, medicines and products, and service delivery. As Figure 1 indicates, in PIB2, the average scores had an overall increase (although not statistically significant) compared with PIB1.

Figure 1: Overall average score for each malaria policy subdomain, 95% confidence interval for the mean



Source: Hongoro et al. 2018

Financing

Respondents generally agreed that financing for malaria programmes was adequate, predictable and sustainable with 36%, 42% and 30% respectively stating their agreement. Also, 62% of respondents agreed that the malaria programme was providing optimal value and benefits from the funds made available for the programme. This is an increase compared to the 56% that was observed in the baseline (PIB1). Additionally, 54% of the respondents agreed that government is the main source of financing for malaria programmes.

Table 1: Financing for malaria control programmes

Item	PIB1			PIB2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Funding adequacy	48 (48%)	26 (26%)	18 (18%)	75 (30%)	74 (26%)	105 (36%)
Timely availability	40 (40%)	18 (18%)	28 (28%)	81 (28%)	76 (26%)	100 (35%)
Favourable allocations	40 (40%)	21 (21%)	24 (24%)	66 (26%)	82 (28%)	106 (37%)
Government source	31 (31%)	3 (3%)	57 (57%)	89 (31%)	29 (10%)	157 (54%)
Predictable funding	30 (30%)	16 (16%)	33 (33%)	76 (26%)	53 (18%)	120 (42%)
Sustainable funding	36 (36%)	22 (22%)	18 (18%)	84 (29%)	58 (21%)	86 (30%)
Users' ability to pay	48 (48%)	19 (19%)	18 (18%)	147 (51%)	53 (18%)	73 (25%)
Optimal value	13 (13%)	20 (20%)	56 (56%)	33 (11%)	59 (20%)	178 (62%)

Source: Hongoro et al. 2018

Workforce

In terms of workforce of the malaria control programme, 77.5% of respondents agreed that the workforce had in place the essential guidelines and directives necessary for performing programme activities, while 70.9% of the respondents agreed that government was the main employer for the workforce supporting the malaria programme. Of the respondents, 28.7% thought that the salaries paid to malaria workforce were reasonable; 46.7% indicated that there was adequate deployment of malaria health workers to the programme; and only 37.7% of respondents felt that the workforce for the malaria programme was adequate, a slight increase from the 32% at baseline (PIB1).

Table 2: Workforce for malaria control programmes

Item	PIB1			PIB2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate workforce	50 (50%)	16 (16%)	32 (32%)	95 (32.8%)	80 (27.7%)	109 (37.7%)
Adequate time devotion	24 (24%)	23 (23%)	51 (51%)	52 (18.0%)	75 (26.0%)	158 (54.7%)
Adequate training and skills	13 (13%)	28 (28%)	57 (58%)	30 (10.4%)	70 (24.2%)	185 (64.0%)
Adequate deployment	37 (37%)	20 (20%)	37 (37%)	67 (23.2%)	80 (27.7%)	135 (46.7%)
Guidelines availability	7 (7%)	10 (10%)	78 (79%)	15 (5.2%)	43 (14.9%)	224 (77.5%)
Government workforce source	21 (21%)	3 (3%)	74 (74%)	62 (21.5%)	21 (7.3%)	205 (70.9%)
Reasonable salaries	46 (46%)	17 (17%)	31 (31%)	96 (33.2%)	95 (32.9%)	83 (28.7%)
Sufficient tools	32 (32%)	30 (30%)	35 (35%)	52 (18.0%)	85 (29.4%)	148 (51.2%)
Optimal supervision	19 (19%)	26 (26%)	53 (53%)	33 (11.5%)	87 (30.1%)	167 (57.8%)
Community-level workers' contribution				16 (5.5%)	70 (24.2%)	197 (68.2%)

Source: Hongoro et al. 2018

Medicines and key products

Timely availability of medicines in quantities that match the demands for the malaria programme is essential for successful implementation. Most of the respondents (74.8%) agreed that the government was the main source of medicine for malaria, which is an increase when compared to the 52% indicated in the baseline. Additionally, only 27.6% of the respondents agreed that users are able to pay for medicines and products themselves. As seen in Table 3 below, 79.6% of the respondents expressed that the quality of medicines and products was optimal. Perceptions about medicine and products have improved from the baseline to the follow-up: this is indicated in a number of issues such as adequate stock, the timely availability of medicines and products and the sustainability of the supply chain.

Table 3: Medicines and products for malaria control programmes

Item	PIB1			PIB2		
	Disagree	Neutral	Agree	Disagree	Neutral	Agree
Adequate stock	40 (40%)	17 (17%)	36 (36%)	47 (16.2%)	60 (20.8%)	176 (60.8%)
Timely availability	23 (23%)	31 (31%)	39 (39%)	45 (15.6%)	54 (18.7%)	187 (64.7%)
Government main source	17 (17%)	9 (9%)	52 (52%)	43 (14.9%)	23 (8.0%)	216 (74.8%)
Reasonable cost	29 (29%)	22 (22%)	37 (38%)	53 (18.4%)	62 (21.4%)	129 (44.6%)
Acceptable quality/safety	9 (9%)	22 (22%)	53 (53%)	18 (6.2%)	46 (15.9%)	190 (65.7%)
Predictable flow	18 (18%)	20 (20%)	55 (55%)	33 (11.4%)	47 (16.3%)	200 (69.2%)
Sustainable supply chain	21 (21%)	25 (25%)	44 (44%)	34 (11.8%)	59 (20.4%)	184 (63.7%)
Users' ability to pay	51 (51%)	25 (25%)	15 (15%)	136 (47.1%)	59 (20.4%)	80 (27.6%)
Optimal quality medicines and products				8 (2.7%)	46 (15.9%)	230 (79.6%)

Source: Hongoro et al. 2018

Service delivery

The survey indicates that malaria service delivery improved significantly between the two PIBs as evidenced by positive scores across its dimensions. Agreement on service outputs was at 74% and access to services at 65.7% in PIB2. More important to malaria control are the prevention services, which were considered adequate by 64.1% of the respondents. However, only 37.4% of the respondents agree that the community is doing enough in terms of preventing the causes of malaria.

Table 4: Service delivery of malaria control programmes

Item	PIB1			PIB2		
	Disagree	Neutral	Agree	Strongly Disagree	Neutral	Agree
Adequate service outputs	11 (11%)	23 (23%)	63 (63%)	8 (2.7%)	61 (21.1%)	214 (74.0%)
Identified priority groups	14 (14%)	12 (12%)	66 (67%)	23 (8.0%)	58 (20.1%)	202 (69.9%)
Satisfactory access	23 (23%)	26 (26%)	48 (49%)	27 (9.3%)	67 (23.2%)	190 (65.7%)
Favourable attitudes	19 (19%)	19 (19%)	57 (58%)	17 (5.8%)	81 (28.0%)	185 (64.0%)
Wide reception of Information, Education and Communication programme	19 (19%)	33 (33%)	44 (44%)	58 (20.0%)	81 (28.0%)	141 (48.8%)
Adequate prevention service	26 (26%)	26 (26%)	45 (45%)	29 (10.0%)	71 (24.6%)	185 (64.1%)
Continuous preventive services	44 (44%)	22 (22%)	30 (30%)	71 (24.5%)	97 (33.6%)	117 (40.5%)
Adequate clinical services distribution	19 (19%)	23 (23%)	51 (51%)	29 (10.0%)	67 (23.2%)	187 (64.7%)
Community prevention responsibility	11 (11%)	20 (20%)	66 (67%)	13 (4.5%)	54 (18.7%)	217 (75%)
Communities are doing enough to prevent the causes				50 (17.3%)	116 (40.1%)	108 (37.4%)

Source: Hongoro et al. 2018

Recommendations

The survey indicates that significant improvements can be seen in the overall implementation of the malaria programme. However, there are still some challenges that are evident within the four policy subdomains. For finance, the score indicates that respondents still believe it is inadequate, and for medicines and products, there are low scores for costs involved and users' ability to share the costs (e.g. for the rapid diagnostic tests programme). In terms of service delivery, there is much indecisiveness on whether communities are doing enough to prevent the causes of malaria, or not.

Most of these gaps can be filled through the following:

1. Inter-sectoral collaboration between government and other sectors, including civil society, should be fostered.
2. The issue of users not being able to pay for medicines and products can be eased by the use of subsidies from the government, insurance, and creating more policies aimed at ensuring universal health care coverage.
3. Campaigning and lobbying for more funds from the private sector will be a good way to mobilise resources towards the programme.
4. More capacity-building interventions are needed to help communities in preventing the causes of malaria.

References

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ENQUIRIES

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