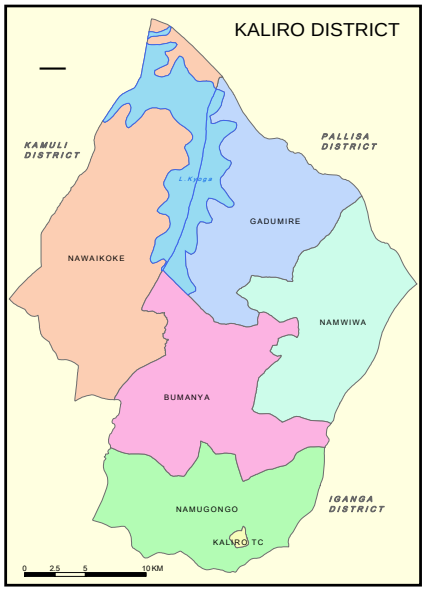
1 Kaliro District

Kaliro District is located was the eastern part of the former Kamuli District till 2005. Named after its 'chief town, it was created out of the eastern part of Kamuli District in 2006, and is now a fully fledged district. With a total surface area of Kaliro District is 904 km^2 of which 710 km^2 is arable land. The total population is 206,900 people as per 2002 population projection Census population density is therefore 188 people per square Kms. It has among the lowest poverty indicators in the country. Administratively, it has one county Bulamogi comprising of one self accounting town council and 5 sub counties with a total of 34 parishes and 294 villages.



The District has a bi-modal pattern of rainfall with the main rains in March/April- June, a short dry season in August - November and a long dry season in December – February. The amount of rainfall is higher in the East, Central and Southern parts of the District and decreases in the northwards. It lies approximately 16 km from Kaliro Town and 5km off Nawaikoke Road.

The district has 17 health facilities: Bumanya Health Centre IV is currently the District highest level facility, 5 health centre III, 9 health centre II. Two new health centre IIs of which Nawampiti is under construction and Kaliro HCII is renting. Each sub county has at least 1 health centre III as per MOH recommendation. However although MOH recommends that every parish should have at least 1 health centre II, 20 parishes do not have health centre IIs. 74% of the population lives within 5km of a health facility while 77.5% is within 1km of a water source. Only 6 of the 10 facilities have laboratory services.

Table 1: Population Distribution, Kaliro District

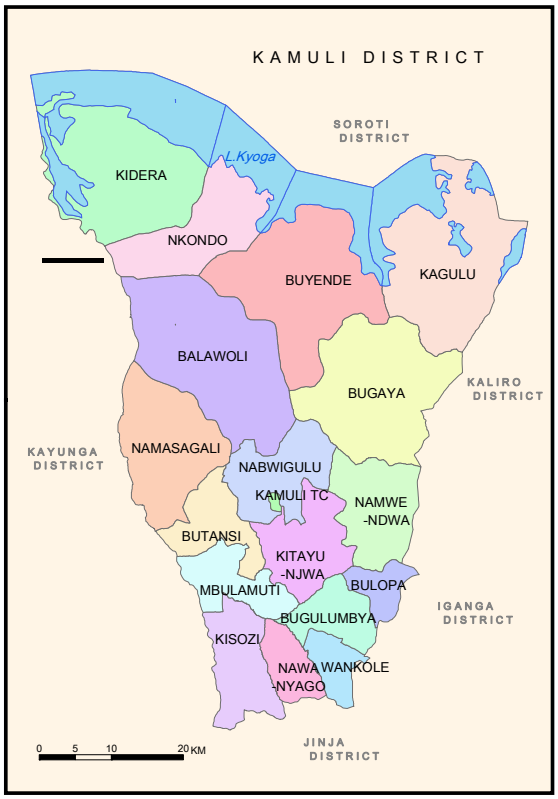
County	Sub county	Parishes	Villages	Households	Population
BULAMOGI	Namwiwa	4	38	3,684	22,105
	Gadumire	5	44	3,343	20,056
	Nawaikoke	8	75	5,895	35,371
	Namugongo	8	59	5,171	31,026
	Bumanya	6	74	5,227	31,360

The national ITN launch was done in Kaliro district and this rapidly raised the household coverage to 71%. However, the drop in malaria cases has not been commensurate with ITN coverage. There is an ongoing study. The district lacks a District Assistant drug Inspector and is currently utilizing Kamuli district DADI.

The district has 60 Government aided and 30 private primary schools, 4 Complementary Primary Education Centers (COPE), 5 Government and 9 Private Secondary Schools. There are other Institutions: Kaliro National Teachers College, Kaliro Technical Institute and Kaliro Primary Teachers College

2 Kamuli District

Kamuli District is located in the South Eastern Uganda. It is bordered by Lake Kyoga in the North and covers 4,383 km^2, of which 1,016 km^2 (23%) is water. The total population in 2001 was estimated (from projection of the 1991 census) at 645,800 people with a growth rate of 3% (1980-1991), which is above the national average (2.5%). The relatively high population density of 146 km^2 (1.7 times the national average) is found mainly in the south and central parts of the district, which have a more humid climate, better soils and better road links to the larger cities.



Peasantry agriculture is the main economic activity (82%). About 29% of wetland area is cultivated. Key bottlenecks to development identified by the district government are the low tax base, geographical isolation (bounded by water to the north and east), high levels of illiteracy and lack of infrastructure.

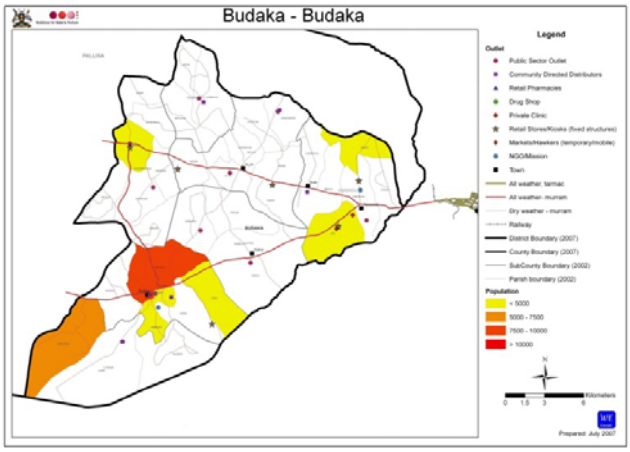
It is estimated that as many as 200,000 people mainly in the northern counties of the district depend on fishing for their livelihoods around Lake Kyoga. Fishing communities are described as highly vulnerable to malaria. Medicine business in Kamuli district is described as very buoyant but personnel are not trained and the outlets ran by nurses. Drug storage is poor.

Table 2: Population Distribution, Kamuli District

County	Sub county	Number of parishes.	Number of villages	Number of Households.	Population
BUDIOPE	1. Bugaya	8	80	6,672	40,032
	2. Buyende	7	74	5,573	33,439
	3. Kagulu	7	83	6,932	41,595
	4. Kidera	6	56	7,001	42,008
	5. Nkondo	3	22	2,832	16,988
BUGABULA	6. Balawoli	8	74	4,551	27,304
	7. Namasagali	4	39	3,525	21,148
	8. Kitayunjula	9	118	7,153	42,922
	9. Butansi	4	48	3,505	42,922
	10. Nabwigulu	7	55	5,376	32,257
	11. Namwendwa	9	49	6,375	38,252
	12. Bulopa	4	36	2,582	16,492
	13. Kamuli T.C	4	21	1,441	8,645
BUZAAYA	14. Bugulumbya	5	66	4,506	27,034
	15. Kisozi	8	57	6,203	37,215
	16. Mbulamuti	4	43	3,823	22,938
	17. Nawanyango	3	37	3,467	20,806
	18. Wankole	3	41	2,466	16,800
TOTAL		**103**	**999**	**107,303**	

3 Budaka District

Budaka district is eastern of Uganda named after the town of Budaka. Formerly part of Pallisa District, it was created out of the former Budaka county and the sub-counties of Kakoro, Kabwangasi, Kirika and Kadama on 1 July 2006. It has a land size of 394 km2 and a total population of 155,891 and population density of 394 people per sq Km.



Budaka is composed of 1 HSD, 8 sub counties, 35 parishes and 182 villages. The district is multi ethnic but dominated by Bagwere, Banyole and Itesots. Malaria is the commonest condition seen in Health facilities. A total of 98,753 cases were seen in FY 2006/7 of which children 0-5 years of age accounted for 43% (42,548) of the malaria caseload. This is up from a total of 87,298 cases seen in 2004/5. The monthly cases (2006/7) show a general bimodal seasonality around December and July.

Table: Monthly Malaria Cases

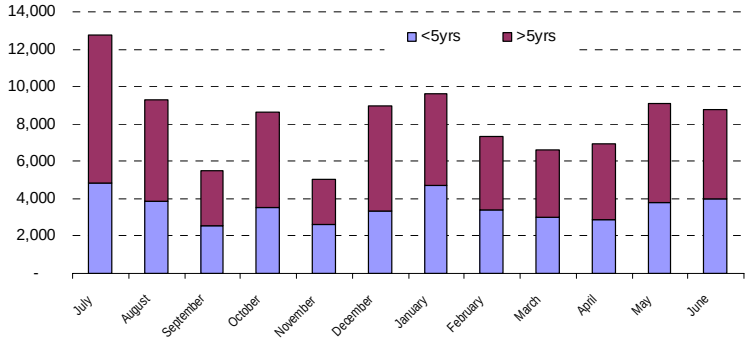


Table 3: Population and facility Distribution, Budaka District

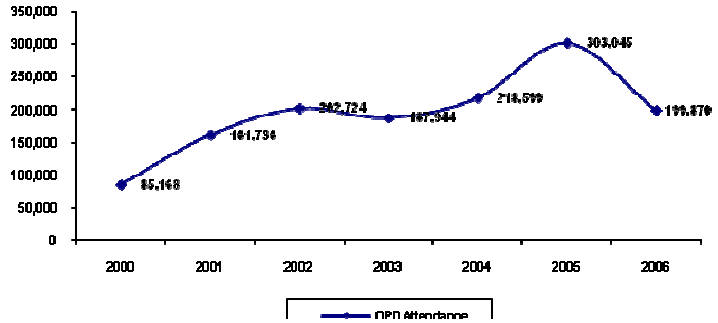
HSD	SUB COUNTY	POPULATION	HC IV	HC III	HC II
Budaka	1. Budaka Rural	13,160	-	-	-
	2. Lyama	19,831		1	1
	3. Budaka TC	17,749	1	1	
	4. Kaderma	23,617		1	
	5. Kamonkoli	27,204		3	
	6. Lyoma	19,831			
	7. Naboa	19,133		1	
	8. Kemeruka	11,204		1	
	9. Ikiki	27,383		3	

All facility workers are trained on ACT policy with support provided by UPHOLD and malaria Consortium. The district has only 4 facilities with laboratory services and rapid diagnostic tests have not reached any of the facilities

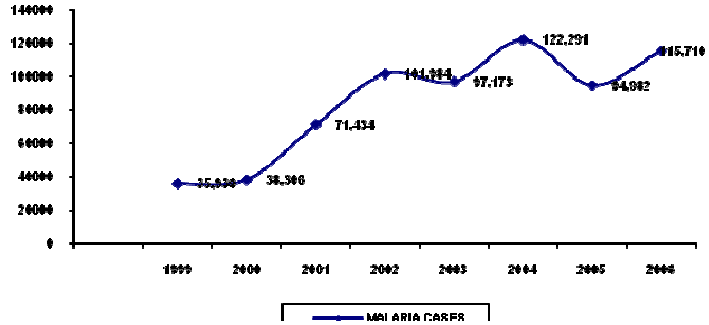
4 Kamwenge District

Kamwenge District is located in western Uganda. It borders with Kabarole, Kyenjojo in the North, Ibanda, Kiruhura in the East, Bushenyi in the South and Kasese on Western side. The district covers a total area of 2,458km^2 and a total population of 308,715 people projected from 2002 population census. Annual population growth rate is estimated at 3.2%. There are two counties Kibaale and Kitagwenda; eight rural sub counties and 1 Town Council and 48 parishes and three wards in the Town Council. In each sub county there is a health center III.

NAME OF HSD	NO. OF S/C's	POPULATION	Hospital	HC IV	HC III	HC II
RUKUNYU	4	182,533	0	01	6	8
NTARA	4	126,182	0	01	3	8
TOTAL	**8**	**308,715**	**0**	**2**	**9**	**16**



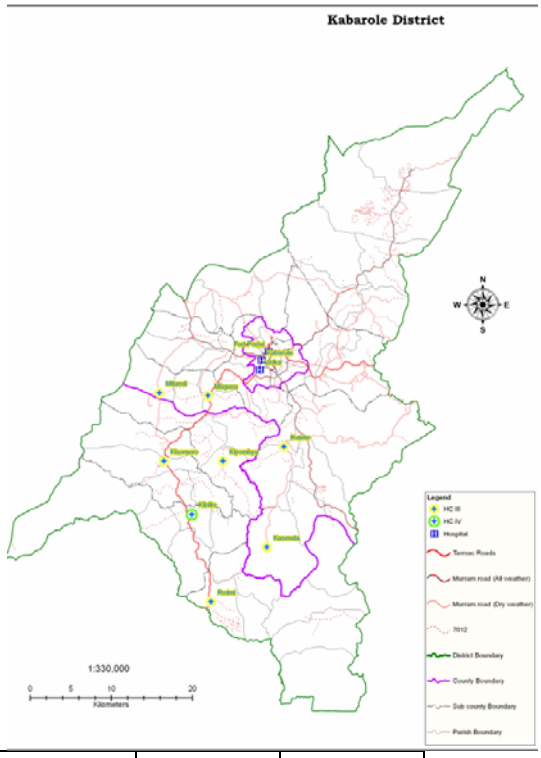
The increase in OPD from 2004 to 2005 could be attributed to full functioning of health centre IV's, the fall in the number OPD cases in 2006 due to HMBF, indoor residual spraying and provision of mosquito nets by UNICEF, GTZ and malaria consortium. However data from community volunteers is rarely incorporated in the monthly report.



All health workers were trained in the new malaria treatment with Coartem as First Line Treatment for uncomplicated malaria. There has been a steady supply of Coartem® to Government facilities. Private not for profit facilities access their supplies from joint medical stores. Drug shop owners, private practitioners and newly recruited health workers were trained on how to use this new drug.

5 Kabarole District

Kabarole district is located in western Uganda approximately 320 km from Kampala via Mubende. Kabarole District was originally much larger and was made up of present-day Kamwenge, Kyenjojo and Kabarole. It borders Kasese, Kyenjojo, Kibaale, Kamwenge and Bundibugyo districts.



It is administratively composed of 3 HSD of Kibiito, Bukuku and Fortportal. There are 13 subcounties, 3 divisions and 384 villages. The surface area is 1,814 km^2 with a population of 427,428. The residents of Fort Portal are mainly of the Batooro ethnicity, but the district has diverse cultures and people, such as the Bakiga.

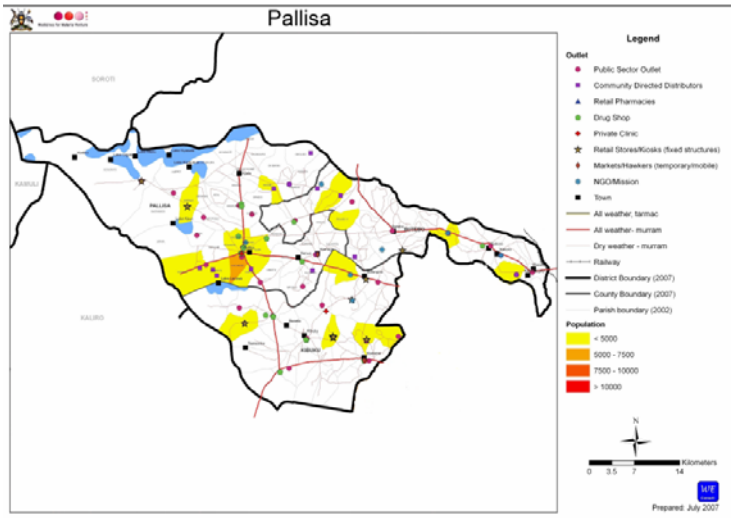
Key malaria control constraint includes lack of health inspectors and Laboratory assistants and only two parishes have trained VHTs.

There are 3 hospitals all in the Municipality.

HSD	S/County	Population	Hosp	HC IV	HC III	HC II
Kabiito	Rwimi	29,938			1	2
	Kabiito	46,485		1	1	2
	Kisomoro	36,702			1	1
	Buheesi	39,040			1	1
	Katebwa	?			1	2
Bukuku	Bukuku	25,791		1		1
	Kicwamba	31,829				2
	Rutete	49,768				5
	Busoro	27,258			3	2
	Mugusu	23,726			1	1
	Hakibale	44,129			2	2
	Karambi	23,667			1	2
Fort Portal	West	16,490			1	1
	East	16,384			1	1
	South	16,217	3			3

6 Pallisa District

The district boarders the districts of Mbale in the east, Kumi in the north, Kamuli in the west, Tororo and Iganga in the south and Soroti in the north-west. The district has 3 counties, 21 sub-counties, 101 parishes, 506 villages and the predominant ethnic groups are Bagwere and Iteso.

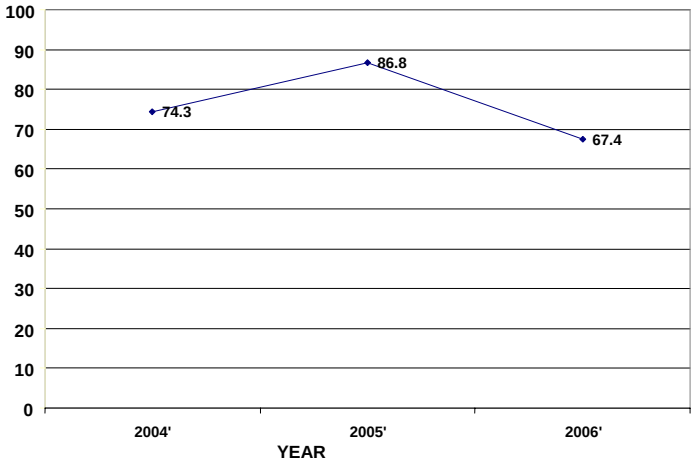


Pallisa District is malaria mesondemic with a constant transmission throughout the year. There is high density of mosquitoes especially near the water bodies.

The population is mainly partial Immunes with vulnerable groups being the < 5s and the pregnant women. Malaria cases constitute about 35-45% of annual OPD cases (HMIS reports). Mortality is mainly in <5s due to complicated Malaria, severe Anaemia.

The district has 2 Hospitals (Gov't & NGO), 2 H/C IVs, 25 H/C IIIs (5 NGO), 13 H/C IIs (2 NGO) and 3 HSDs. 2 CMDs per village have been trained though these are still providing HOMAPAK. ITN coverage. Only 10 out of the 42 Health facilities have functional Laboratories that can perform malaria diagnosis. Current ITN coverage estimate is 80%. IPT coverage is 48% and IRS has been done only in institutions like schools.

PREVALENCE OF FEVERS IN CHILDREN BELOW 5 YEARS OF AGE (%)



There are 59 registered private drug-shop outlets and 13 registered private clinics. The district lacks a pharmacy and thus relies on bigger towns in neighbouring districts of Mbale, Iganga and Kumi.

Formal referral is still poor. The commonest of self referral and referral by CMDs to higher level health facility. Lack of blood transfusion facilities at HC IVs especially in the new districts without hospitals is a key problem especially for management of severe malaria.

At community level, CMDs record Malaria cases in their registers, and submit monthly returns to the Health facilities that also have a register for HBMF. At facility level, all Malaria cases are recorded in OPD registers, ANC registers, inpatient registers and laboratory registers. Weekly reporting is done by each Health facility to the HSD, District & then to the MOH. Monthly reporting is made by each Health facility to the HSD, District & MOH. Quarterly and Annual reporting are held with the DHTs and DHMTs.

Gaps discussed by districts Officers most districts

Key gaps during discussions included

- Dual (Homapak and ACTs) drugs promoted in the health system.
- ACTs have not yet been rolled out at community level and HBMF is still using CQ/SP.
- Irregular supply of ACT is in the public health facilities leading to frequent stock outs of all ACT varieties. So there is need to include buffer ACT stocks in quantification
- In the private sector, ACTs are not the first line of malaria treatment. The change in policy was poorly communicated in the private sector and the district have no IEC materials to reach especially the numerous informal sector
- It was observed that some districts like Kabarole and Pallisa do not have any source of Coartem for the private sector.
- Pilfering coartem to the private sector is. It was also believed that ACTs are too expensive to be stocked by the private clinics

Key Opportunities during discussions included

- Private medicine outlets are well distributed in rural communities where access to public health facilities is low
- A large proportion of them are owned by trained health workers though not attended by them
- There is a good regulatory system operating through the NDA and DHO especially in form of licensing.
- A number of private medicine outlets are not licensed though they have been under operation for a number of years.
- There is a supply and procurement system that has evolved in the private sector over time in all districts.
- It was felt that compliance to full medicine doses increases as the value attached to medicine increases. Already, health workers attach great value to ACTs.
- Though the private sector is motivated by profit, they tend to have a better customer care approach than public facilities.
- As the MoH is rolling out ACTs at community level, there is need to be examine factors that caused low Homapak uptake.
- It was found that women are more reliable as CMDs

ACT stocks

- Include