Malaria Free Campaign (MFC) in Uganda

According to WHO in 2016, approximately half of the world's population is at risk of acquiring malaria (WHO, 2016). Figures on a global scale show that there have been 429,000 malaria related deaths and 212 million cases of malaria. Among the countries with highest prevalence of malaria in Africa, Uganda has been ranked sixth with statistic evidently show an approximately of 16 million cases and over 10,500 deaths annually (WHO, 2016). Over 34 out of 112 districts in Uganda are suffering lack of access to the malaria preventative measures because of their location in rural or remote areas with districts named Kabale, Kanungu and Kisoro have the highest cases of malaria (Kiwanuka, 2010). If the current situation of high rates malaria cases in these districts continue increasing and spreading across to the other district, Uganda is likely to miss out from achieving Target 6C for MDG 6 that addresses the halting and reversal of the incidence of malaria by 2015 (Max, 2016). The national malaria survey in Uganda (2011) evidently showed that 34.5% of Kabale and Kisoro districts parts live in wetlands which can closely be identified as stagnate waters that supports breeding site for mosquito while on the other side 66.5% live on land that is not close to the stagnate waters (Aceng, 2018). Also, lack of treated nets and insecticides as the survey reports a distribution of 16,708 mosquito nets in a population of 30,000 people in one district with insecticides covering 1/4 of each district because of their location (remote areas) (Yeka et al., 2012). This has aided in the spread of malaria in those districts.

The prominent reason for the spread of malaria is lack of access long lasting insecticide treated mosquito nets and the poor drainage of water especially stagnate water. For example, the distribution of treated mosquito nets was reported to cover 42.7% of the country and the because of the larger population being left out, malaria cases are mainly found in the children under age of 10 years because their parents do not apply the mosquito net prevention method (Wetaya, 2016). Moreover, the districts being in a remote and rural area have problematic issue of accessing health mosquito related information e.g. treatment, control and prevention. The report provided evidence for the household in terms of TV, radio ownership, there are 11.6%, literacy rate was 25.3%, 10% of accessing mosquito nets and level of income is [5,000/= - 20,000/=] which makes it had to afford most of the mosquito insecticides (Agaba & Mutabazi, 2017). Moreover, these districts suffer from poor water drainage system and this is because the receive frequent rainfalls which are reported to be 1500 mm that can last for 24 hours which contribute to large stagnate waters that favors breeding sites for mosquitoes (AMF, 2017).

This shows that without or lack access to malaria prevention measures in Kabale, Kisoro and Kanungu districts in western Uganda, the sustainable development is unachievable. Due to these reasons, a Malaria Free campaign was implemented in these districts with the aim to

provide access to mosquito insecticides treated nets and other control measures. This is intended to reduce by half the malaria cases and death as a MDG 6 target 6C because it is important to the human to be healthy among individuals. This campaign provided informative materials, education, donations and the communication strategies that will reduce the burden of the malaria cases in those areas in order for them to meet the MDG6 goals target 6C.

Analysis of article by Ssempiira et al., 2017

The Malaria Free Campaign (MFC) was conducted after from national survey on malaria that identified the main districts that contribute largely on the burden of malaria in Uganda: Kabale, Kisoro and Kanungu. The beneficiary of the campaign was the department of health as it was conducted in response to the high cases of malaria in this districts (Ssempiira et al., 2017). The vector department provided insecticides and observed what is the best medicine for implementing for the whole country. Moreover, the campaign mainly focused on the community, children and pregnant mothers with an objective of reducing malaria. The project used a cluster sampling in locating places and with a case-study design as means of identifying people to study on with in the districts (Ssempiira et al., 2017). The cases were the people located in more swamp areas that have the drainage area that are already infected and the control people who shared the same county but are not yet developed any malaria illness (Ssempiira et al., 2017). This cluster sampling design was appropriate because it helped the researcher and health activist to cover large areas in a district through dividing them in to parishes thus reaching out to those who cannot make it out to the community gathering (Ssempiira et al., 2017). Also, the use of a case control study design in their research provided benefits to both the districts and the researcher. The benefits were: spotting those who need the malaria treated net, repellent and drugs to prevent transmission and the clearing of the drainage of stagnate waters that are close to place to their homes to prevent the breeding sites. This design actually prevented bias sampling frame as all households of the 3 districts were tallied before survey (Ssempiira et al., 2017). Moreover, the control was supplied by mosquito nets and provided educative information on how to prevent malaria. The study design provided enough evidence in backing up the program goals and objectives.

However, the study excluded most districts as the concentrated mainly on the 3 districts and you cannot use only these districts to generalize or apply the interventions findings to the rest of 112 districts in Uganda and hoping for the program to be effective enough for the whole country in meeting the MDG6 target 6C. In terms of the study participants, in every district it used a maximum of 4/10 county and collected, supplied information and nets to roughly 150 people out of 500 people in each parish thus leaving the rest of population not even attended to or provided with malaria prevention knowledge (Ssempiira et al., 2017). The intervention in this districts mainly focused on: treated mosquito net coverage and keeping dumping site clean e.g. clearing stagnate waters but information or data collected was not conclusive enough to be generalized

to other district as it need to put into consideration of the other interventions that can be applicable to their study area for strong data collection (Ssempiira et al., 2017).

The Malaria Free Campaign: Strength and limitation

The campaign introduced and increased the coverage of treated mosquito nets in support with all the health departments. There was increase in the mosquito coverage the rose significantly by 8.37% from the base line 33.35% to 41.75% after the introduction of the Malaria Free Campaign (Ssempiira et al., 2017). However, reflecting on the objective 2 of the project, the campaign did not achieve the 75% coverage of treated mosquito nets across all households (reference). Moreover, the analysis showed significant results to objective 1 of the project because that there was an increase 0f children >5 years and pregnant mothers by 23.5% - 66.23% in the use of mosquito bed nets (Ssempiira et al., 2017).

Moreover, the campaign aimed at providing 65% of malaria related information to the local people and both health settings. Even though there was increase of the dissemination of 10% -22.2% media e.g. one on one health talks, radio, television coverage, still the percentage are too low to achieve the goal of the of the project thus not helping in achieving the half of malaria cases by 2015 MDG 6 (Ssempiira et al., 2017). Such problem can be prevented through increasing the number of trained volunteers and communication with district heads and the local leaders of each county.

A successful intervention that was recorded from the campaign was the building of capacity for managing the larva sources. The campaign administrator worked in hand with the Vector Control Division and National Chemotherapeutic Research which helped in the conducting baseline and follow ups the vector coverage. the importance of the intervention was to provide or train health workers, mapping potential larva source and larviciding the breeding areas. They managed to discover 57 breeding areas that they treated in each county as their objective 3 was to discover 65 breeding sites from every county in a district (Ssempiira et al., 2017). Moreover, proper drainage system was implemented that was also significant in stopping breeding. Each district had 2 main drainages and 15 dumping area (Oguttu et al.., 2017).

Additionally, these district were using DDT and lambda cyhalothrin as an indoor residual spraying for the past years but with the increase of malaria outbreak, the campaign introduced other insecticides that were approved by the ministry of health. These are: carbamates and pyrethroids which were introduced in most of the shops of these districts so that people can buy them for indoor prevention. Follows ups show that there has been an increase in the buying of this insecticides from the shop thus it has showed positive effect in the reducing of malaria among children and mothers (JHCCP, 2017). However, small percentage 15%-25% was reported not to be using these insecticides as it was expensive in terms of their family income

and these percentages can prevent the district from eradication of malaria cases (Ssempiira et al., 2017) and the campaign did not follow up. Solution can be through using the local means in eradicating the mosquitoes e.g. mosquito traps, smoking the surroundings and cutting down the fully grown grass.

Moreover, the clinical case management of malaria in pregnancy with a strategic objective which suggest that by 2014, 65% of pregnant women must receive 2 dose of Sulpadoxine-Pyrimethamine (SP) in their 2nd and 3rd trimester. However, by end of 2013 the SP dose reduced from 30% coverage to 22.3% because the medicine was stocked out thus only 16% of women got the 2 treatments with SP during the pregnancy checkups (Ssempiira et al., 2017).

(Add more limitation)

Intervention in other setting

The Malaria Free campaign which was implemented throughout this essay in Kisoro, Kabale, Kanungu districts of Western Uganda can also be implemented in Apac district in northern Uganda. The Malaria Free Campaign will be appropriate to be applied in this setting because it is one of the other district with the highest malaria cases that was reported in the National survey on malaria. Apac district is believed to have a reported proximity of 350,000 cases of malaria in both children and pregnant mothers (Eunice, Wanjoya, & Luboobi, 2017). With the mosquito net coverage to be roughly 15% -28.5% in the district and the district is reported to have no main hospital and 3 main clinics that does not match the standard clinical setting (Gissel, 2014). The media coverage on malaria related information is still low because 65% of people a below the poverty line and cannot afford to buy media means and live in rural areas (PMI, 2012). The district is believed to have a literacy rate of 25% thus making it hard for people to read and understand this malaria related information (AINEBYOONA, 2015). The Malaria Free Campaign was mainly targeting the local people but did not involve most of the people who are influential in this local areas e.g. the musicians' local leaders etc., inadequate workshops that could train the residents of those area in equipping them with educative skills and knowledge.

Recommendations

Malaria eradication in an area is recognized as one of the biggest challenges in the health departments and there have been slow progress in the intervention effects due to a problem of sustaining them when implemented. Although malaria programs are known for its partnership with most of the largest companies and donor across the world, there have been a disappointment to the international health organizations. Reasons that linked with this disappointment are said to be political issues (corruption of most of the governments), in

cooperation with the local communities, conflicts thus implementation goes wrong and inadequate health resources. This barrier must be solved when advocating for a decrease in malaria cases. Another recommended skill to the campaign is to adopt the evidence-based approach that will enlighten them for the successful approach of the communities thus producing better results. Besides that, Community mobilization will provide the members with powers to own and trust the implementation if there involved in participating the program. This can be done through working with the local people especially the most influential people e.g. musician that will help to advertise the campaign through music thus attracting a larger group. Moreover, the campaign should partner with the local radio that are being listened to the majority of the local people and also include schools in the campaign in order to advocate in young adults. The campaign should work in hand with the government in providing cheap insecticides that are affordable to the local people and also make sure that each child has mosquito net. This can be improved through monitoring and evaluating the program at the end of every year.

Appendix

Program overview

The Malaria Free Campaign program was conducted in the provision assured services for Malaria prevention and the treating of the people in Western Uganda. The campaign was targeting Kabale, Kisosro and Kanugu districts in western Uganda. It is reported to be running from 2010 to 2014. According to the Uganda Malaria Reduction strategic plan, the Malaria Free Campaign helped in providing a framework that will benefit all the districts in speeding up a large coverage of the evidence-led malaria reduction interventions by the government, development partners and stakeholders. It specifies the priority interventions and strategies that are required to achieve the goals and targets.

Main goal

It is to reduce malaria mortality and morbidity by 75% by end of 2014, there by setting the ground for pre-elimination subsequently. This is in track with region strategic elimination of malaria by the Uganda movement

Vision

To increase the acceleration of malaria elimination in region areas.

Goals

• By 2014, reduce annual Malaria deaths to nearly zero deaths (1 death per 1000 people) in each of the district

• By 2014, Reduce malaria morbidity to 15 cases per 100 people in each district

• By 2014, reduce malaria parasite prevalence to less than 8% in each district

Strategic objectives

The following objectives were believed to lead the successful of the above goals

• By 2011, the treated mosquito nets coverage to be 75% coverage in each of the district

• By 2013, 65% of malaria related information to be disseminated in every part of the districts.

• By 2012, Discover and treat over 65 breeding areas every after 3 months

• By 2011, the ratio of pregnant mothers who get treated with two doses of Sulpadoxine-Pyrimethamine to be 60% in every district.