The Republic of Uganda

MINISTRY OF HEALTH

UGANDA MALARIA ELIMINATION

STRATEGIC PLAN 2026-2030

(UMESP)

"Towards a Malaria-Free Uganda"

National Malaria Elimination Division (NMED)

Foreword

Malaria continues to impose an unacceptable burden on Uganda's health and development. It fills hospital wards, keeps children from school, and causes preventable deaths across the country. Although Uganda has made significant progress in reducing malaria prevalence and mortality over the last two decades, these gains remain fragile. The resurgence observed in recent years highlights the fragility of progress and demonstrates that even short-term reductions in coverage or intensity of interventions can result in renewed transmission.

The Uganda Malaria Elimination Strategic Plan (UMESP) 2026–2030 marks a decisive shift from malaria control to malaria elimination. This Plan articulates a bold vision: **a malaria-free Uganda**, where no child dies from malaria and communities thrive, free from the burden of this preventable disease.

The UMESP adopts a stratified, evidence-based approach tailored to Uganda's heterogeneous transmission landscape. Districts, communities, households, and individuals will be empowered to lead the fight against malaria. Central to this strategy is the Mass Action Against Malaria (MAAM) initiative, championed by His Excellency, the President of the Republic of Uganda, which mobilizes collective action across all levels of society.

The implementation of this Plan will demand not only sustained investment, strong political leadership, and innovation, but above all, a steadfast national will that unites all sectors behind the goal of malaria elimination. The costs of inaction, in human lives and economic losses, far outweigh the investments required. Malaria currently costs Uganda an estimated USD 577 million annually in treatment and lost productivity. Eliminating malaria is therefore not only a public health imperative, but also a critical driver of national development and prosperity.

I call upon all stakeholders, including health workers, local leaders, communities, the private sector, and development partners, to support this Plan with commitment and determination. Together, we will achieve the ambitious goal of zero malaria deaths by 2030 and secure a healthier, more prosperous Uganda.

For God and My Country,

Dr. Jane Ruth Aceng Ocero
Minister of Health, Republic of Uganda

Acknowledgements

The Ministry of Health extends its appreciation to all individuals and institutions that contributed to the development of the UMESP 2026–2030. This Plan reflects a collective vision and commitment to a malaria-free Uganda.

We acknowledge the leadership of His Excellency, the President of Uganda, for his steadfast commitment to malaria elimination, and the Uganda Parliamentary Forum on Malaria (UPFM) for sustained advocacy and policy support.

We recognize the technical leadership of the National Malaria Elimination Division (NMED) led by Dr. Daniel Kyabayinze and formerly, by Dr. Jimmy Opigo. Appreciation is extended to all NMED staff for their dedication and commitment throughout the process. Special recognition goes to Dr. Catherine Maiteki-Sebuguzi for providing overall program management and technical oversight of the exercise and Dr. Bosco Agaba for his exceptional leadership as MPR and UMESP National Coordinator. We thank the heads and members of the Thematic Working Groups on case management, vector control, surveillance, monitoring and evaluation, and advocacy, who provided invaluable technical contributions.

We extend our sincere appreciation to all development partners for their financial and technical support, including the World Health Organization (WHO), Clinton Health Access Initiative (CHAI), RBM Partnership to End Malaria, United States Government (through the President's Malaria Initiative), Bill & Melinda Gates Foundation, Global Fund to Fight AIDS, Tuberculosis and Malaria, Africa Leaders Malaria Alliance (ALMA), Malaria Consortium, and the Ministry of Local Government.

We also appreciate the contributions of district health teams, local governments, civil society organizations, faith-based organizations, academic institutions, research bodies, and the private sector.

Finally, we acknowledge the team of consultants led by Dr. Patrick Okello, Dr. Andrew Balyeku, Dr. Dennis Walusimbi, Sayson Meya, and Julius Mukobe all of whom are subject-matter specialists in malaria and its related disciplines drawing on their combined expertise in programme management, malaria epidemiology, case management, costing, and gender, worked tirelessly to ensure a comprehensive, evidence-based, and high-quality process that guided the completion of this assignment.

Dr. Diana Atwine
Permanent Secretary, Ministry of Health

Acronyms and Abbreviations

ACT	Artemisinin-based Combination Therapy
ACSM	Advocacy, Communication, and Social Mobilization
ALMA	Africa Leaders Malaria Alliance
ANC	Antenatal Care
CHW / VHT	Community Health Worker / Village Health Team
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DMAP	District Malaria Action Plan
eCHIS	Electronic Community Health Information System
eLMIS	Electronic Logistics Management Information System
EPI	Expanded Programme on Immunization
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HMIS	Health Management Information System
HRH	Human Resources for Health
iCCM	Integrated Community Case Management
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITN / LLIN	Insecticide-Treated Net / Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MAAM	Mass Action Against Malaria
MoH	Ministry of Health
NDP IV	National Development Plan IV
NMED	National Malaria Elimination Division
PDM	Parish Development Model
RBM	RBM Partnership to End Malaria
SBCC	Social and Behaviour Change Communication
SMC	Seasonal Malaria Chemoprevention
SOP	Standard Operating Procedure
TWG	Technical Working Group
UBOS	Uganda Bureau of Statistics
UHC	Universal Health Coverage
WHO	World Health Organization

Executive Summary

Malaria remains Uganda's top public health issue, accounting for 30–50% of outpatient visits and causing an annual economic burden of USD 577 million in treatment costs and lost productivity. Uganda is the third-largest contributor to global malaria cases and the tenth-largest contributor to malaria deaths. Although Uganda reduced the prevalence of parasites among children under five from 42% in 2009 to 9% in 2018, the MIS 2024 findings show a reversal, with a rate of 12.5%. The 2022 epidemic resulted in over 3.3 million additional cases, emphasizing the fragility of previous progress and the urgent need to move beyond malaria control toward elimination.

The Strategic Shift

Through this Plan, Uganda commits to transforming its malaria programme into an elimination-focused agenda—safeguarding lives, strengthening the health system, and driving national development. The **UMESP 2026–2030** serves as Uganda's roadmap to elimination, fully aligned with the **WHO Global Technical Strategy for Malaria (2016–2030)**, the **Yaoundé Declaration (2024)**, the **RBM/30 Unity Strategic Framework**, underpinned by **RBM's Big Push Against Malaria**, **Sustainable Development Goal 3.3**, and national frameworks including the **Health Policy**, **Health Sector Development Plan IV**, and **National Development Plan IV**.

Vision: A malaria-free Uganda for socioeconomic growth and national development.

Goal: Achieve zero malaria deaths and cut malaria cases by at least 75% from 2024 levels (from 274 to fewer than 100 cases per 1,000 people) by 2030, reaching pre-elimination status in at least 19 districts.

Strategic Objectives

SO1. Universal Case Management and Chemoprevention: Ensure prompt access to effective diagnosis, treatment, chemoprevention, and vaccines for all.

SO2. Integrated Vector Management: Achieve ≥85% population protection through stratified interventions, including ITNs, IRS, larval source management, and innovative tools.

SO3. Integrated Surveillance and Response: Establish a real-time, integrated surveillance system capable of epidemic prediction, rapid detection, and response.

SO4. Governance, Financing, and Multisectoral Action: Strengthen decentralized programme leadership, secure sustainable financing, and promote accountability.

Implementation Approach

Implementation will be anchored in the MAAM initiative, mobilizing every sector of society. District-led stratified programming and Subnational Tailoring (SNT) will ensure resources are directed to local epidemiological and contextual realities. A comprehensive Monitoring, Evaluation, Learning, and Accountability (MELA) framework will guide performance management. A risk management matrix has been developed to anticipate and mitigate operational challenges.

Expected Impact by 2030

- Zero malaria deaths nationwide
- ≥75% reduction in incidence from 2024 baseline
- Pre-elimination status achieved in at least 19 districts
-

Table of Contents

1. Introduction

1.1. Background

Uganda has achieved substantial progress in reducing the malaria burden over the past two decades. Between 2009 and 2018, the prevalence of parasites among children under five declined from 42% to 9%, and recent MIS 2024 found an increase to 12.5%. Additionally, the WHO estimated that malaria deaths decreased from approximately 23,726 in 2009 to around 14,000 in 2009, and then to approximately 15,495 in 2023. These achievements were driven by improved case management, expanded community-level diagnosis and treatment, and the widespread deployment of long-lasting insecticidal nets (LLINs) and indoor residual spraying (IRS).

However, since 2018, progress has stalled, with parasite prevalence remaining stable, while case numbers have continued to increase. Malaria episodes increased from 5.7 million in 2018 to 18 million in 2022, while epidemics emerged even in previously low-transmission settings. Although malaria-related inpatient deaths declined by 35% between 2019 and 2022, the overall burden remains unacceptably high.

This trend signals an urgent need for a strategic shift from malaria control to malaria elimination. The Uganda Malaria Elimination Strategic Plan (UMESP) 2026–2030 represents the country's response, outlining a decisive pathway to accelerate progress, reclaim lost gains, maintain momentum, and move towards a malaria-free Uganda.

1.2. Policy and Programming Environment

Malaria elimination is a national health priority, explicitly recognized in the National Health Policy, Health Sector Development Plan IV (HSDP IV), and the Ministry of Health's New Strategy 2025. The UMESP is fully aligned with these frameworks as well as with the National Development Plan IV (NDP IV), which emphasizes Universal Health Coverage (UHC) and resilient health systems.

At the global and regional level, the Plan is anchored in the WHO Global Technical Strategy for Malaria 2016–2030 (GTS), Sustainable Development Goal (SDG) 3.3 (ending malaria by 2030), the Abuja Declaration, the African Union Catalytic Framework for Malaria Elimination, the Yaoundé Declaration, the **RBM/30 Unity Strategic Framework**, underpinned by **RBM's Big Push Against Malaria** and the East African Community Health Sector Strategic Plan (2024–2030).

Domestically, the National Will to Eliminate Malaria builds on the strong political commitment outlined in the NRM Manifesto, as well as the Presidential Mass Action Against Malaria (MAAM), which is supported by multisectoral engagement, civil society, private sector partnerships, and parliamentary advocacy led by the Uganda Parliamentary Forum on Malaria (UPFM).

1.3. Malaria Strategic Plan and National Planning Cycle

Uganda's national planning is structured around five-year National Development Plans (NDPs), implemented through the Medium-Term Expenditure Framework (MTEF) and annual budget cycles. Health-sector priorities are cascaded from the Ministry of Health's annual work plans into District Development Plans (DDPs), financed through Primary Health Care (PHC) grants. Other sectors and Ministries, Departments, and Agencies (MDAs) are mandated to integrate malaria into their plans

The UMESP 2026–2030 is fully integrated into this national planning cycle. Its objectives inform both national and district-level budget framework papers and are embedded within District Malaria Action Plans (DMAPs). The integration with the Parish Development Model (PDM) ensures that malaria

elimination receives dedicated resources and benefits from Uganda's decentralization reforms. This alignment guarantees that malaria interventions are not implemented in isolation, but rather as part of Uganda's broader health system strengthening, social protection, and development agenda.

1.4. Development of the Malaria Strategic Plan

The Uganda Malaria Elimination Strategic Plan (UMESP) was developed as a practical, evidence-based tool, firmly aligned with World Health Organization guidance and Uganda's planning and budgeting systems. Its design was informed by the 2025 Malaria Programme Review, which provided a comprehensive assessment of past performance and highlighted the strategic shifts necessary to transition from malaria control to elimination.

The development process brought together thematic working groups on case management, vector control, surveillance and monitoring, epidemic preparedness, advocacy and communication, and programme management. Subnational consultations engaged district health teams, Parish Development Model structures, and community stakeholders, while civil society, academia, and the private sector contributed to ensure broad inclusivity. Development partners were fully aligned under the "Three Ones" principle: one national plan, one coordination mechanism, and one monitoring and evaluation framework.

2. Country Profile and Epidemiology

2.1. Geographic and Ecological Context

Uganda is a landlocked country in East Africa with diverse ecological zones that shape malaria transmission. Extensive wetlands, lakes, and river systems in the lowlands provide perennial breeding grounds for Anopheles mosquitoes, sustaining year-round transmission. In contrast, the southwestern highlands, where cooler temperatures prevail, experience lower transmission levels but remain highly vulnerable to malaria epidemics.

Most of Uganda's territory experiences stable, year-round transmission, with seasonal peaks occurring after the long rains (March–May) and the short rains (September–December). Increasing climate variability (including unpredictable rainfall, floods, and shifting weather patterns) has expanded malaria risk into areas historically characterized by low or unstable transmission, particularly in the highlands. This changing ecological context requires adaptive and climate-resilient malaria programming.

2.2. Sociopolitical and Administrative Environment

Uganda's decentralized governance system provides an enabling environment for malaria elimination. The Ministry of Health sets national policy direction, with the National Malaria Elimination Division (NMED) providing technical leadership and coordination. At the subnational level, district and city health teams play a central role in planning, financing, and supervising malaria control and elimination activities. Implementation at the community level is supported through Parish Development Model (PDM) committees and Village Health Teams (VHTs).

As of 2025, Uganda comprises 146 districts and cities, 312 counties, 2,191 sub-counties and towns, 10,716 parishes, and 71,208 villages. This decentralized administrative structure enables local ownership of malaria programming but also requires strong coordination and accountability to ensure consistency of interventions.

A broad range of stakeholders contribute to malaria elimination, including development partners, civil society organizations, academia, private sector actors, and religious and cultural leaders. Their engagement is essential in fostering community mobilization, ensuring equity, and sustaining political commitment.

2.3. Demographic Profile and Populations at Risk

Uganda's population is estimated at 47.2 million in 2025, growing at nearly 3% annually. Over half are younger than 15 years old, and three-quarters are under 30 years old. This youthful demographic places a large share of the population at biological risk of malaria. High-risk groups include:

- Children under five, who account for most malaria deaths.
- Pregnant women, especially adolescents and first-time mothers.
- Adolescents and adults, who are increasingly affected in several districts.
- Refugees and displaced populations, where prevalence among children often exceeds 30%.
- Mobile populations such as fisherfolk, farmers, and night-time workers with high exposure.
- Marginalised groups, including indigenous communities with limited access to health services.

2.4. Environmental and Climatic Factors

Uganda's bimodal rainfall pattern drives two main peaks of malaria transmission annually. Increased climate variability is intensifying risks, with floods creating new breeding sites and shifting malaria into previously low-risk areas. Altitude plays a defining role, where lowland areas below 1,200m sustain intense, perennial transmission, while highland areas remain vulnerable to outbreaks.

2.5. Socioeconomic Determinants

Malaria burden overlaps with Uganda's poverty belt, particularly in northern and eastern regions. Poor housing, weak infrastructure, and livelihoods such as irrigated farming and artisanal mining increase exposure. Inadequate road networks disrupt access to care and commodity delivery during rainy seasons.

Households bear more than 70% of the annual malaria cost, estimated at USD 500–577 million (1.5% of GDP), deepening inequities. Cultural and gender norms further delay timely care-seeking, especially for women and children.

2.6. Health System Landscape

Uganda's health system provides a strong platform for malaria elimination. It includes:

- Facilities: a wide network of HC IIs–IVs and hospitals.
- Community structures: more than 60,000 VHTs and CHEWs providing iCCM and health promotion.
- Digital reporting systems: DHIS2, eCHIS, and eLMIS supporting data flow from community to national levels.

Strengths include strong political commitment (through MAAM), widespread facility coverage, and active community engagement. Persistent challenges are human resource shortages, commodity stock-outs, weak quality assurance, and insufficient integration of malaria activities into wider health services.

3. Malaria Situation Analysis

3.1. Historical Trends

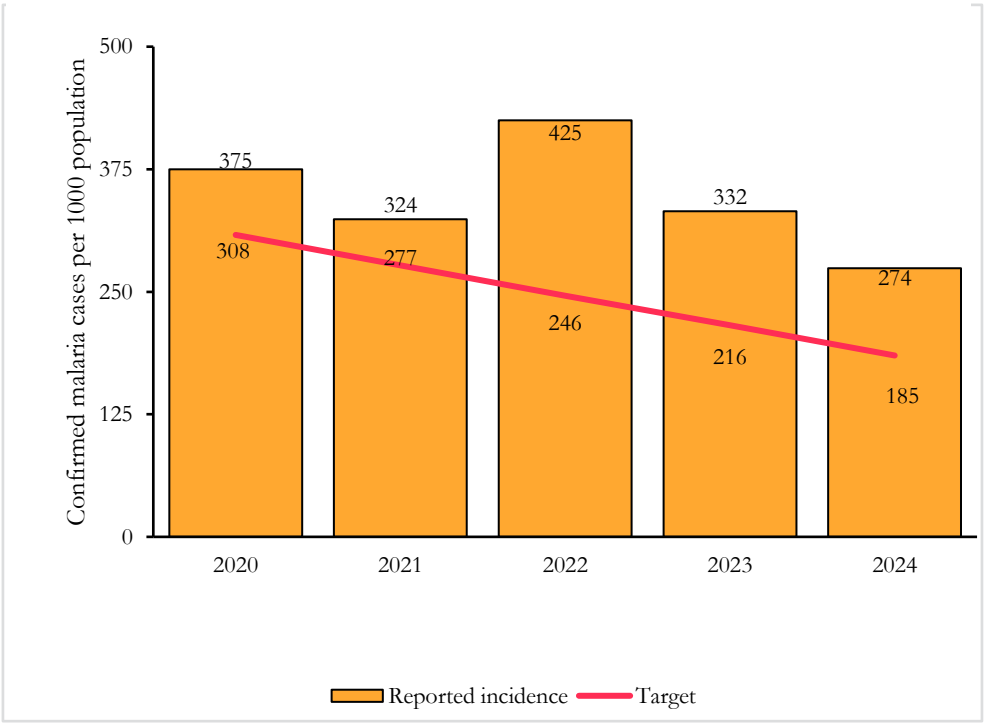
Over the past two decades, Uganda has made important gains in malaria control. The large-scale distribution of long-lasting insecticidal nets (LLINs), Indoor Residual Spraying (IRS), and improved case management contributed to a decline in parasite prevalence among children under five, from 42% in 2009 to 9% in 2018, and the recently released MIS report shows a rise to 12.5%; however, with a substantial reduction in malaria mortality.

However, progress has slowed since 2018. Case numbers rose from 5.7 million in 2018 to 18 million in 2022, because of a major epidemic that year, which reversed several gains. While malaria-related deaths declined from 14,000 in 2014 to 3,000 in 2023/24, the 2020–2025 strategic plan did not achieve its targets for morbidity and mortality reduction.

3.2. Current Burden

Uganda accounts for 5% of global malaria cases and 3% of global malaria deaths. Morbidity has declined only modestly, with the incidence falling from 308 per 1,000 in 2020 to 274 per 1,000 in 2024, which is still well above the target of 185 per 1,000. The burden varies widely across districts, from as low as 13 per 1,000 in Rubanda to as high as 1,661 per 1,000 in Obongi. Mortality has dropped by 39% between 2019 and 2024, yet stark disparities persist, ranging from 1.1 per 100,000 in Masaka to 104 per 100,000 in Soroti City. Malaria continues to strain the health system, accounting for 30-40% of outpatient visits and up to 20% of hospital admissions.

Figure 1: Trend in malaria incidence, 2020-2024 (MOH, 2025)



3.3. Parasite and Vector Dynamics

Uganda's malaria landscape is shaped by both parasite and vector pressures:

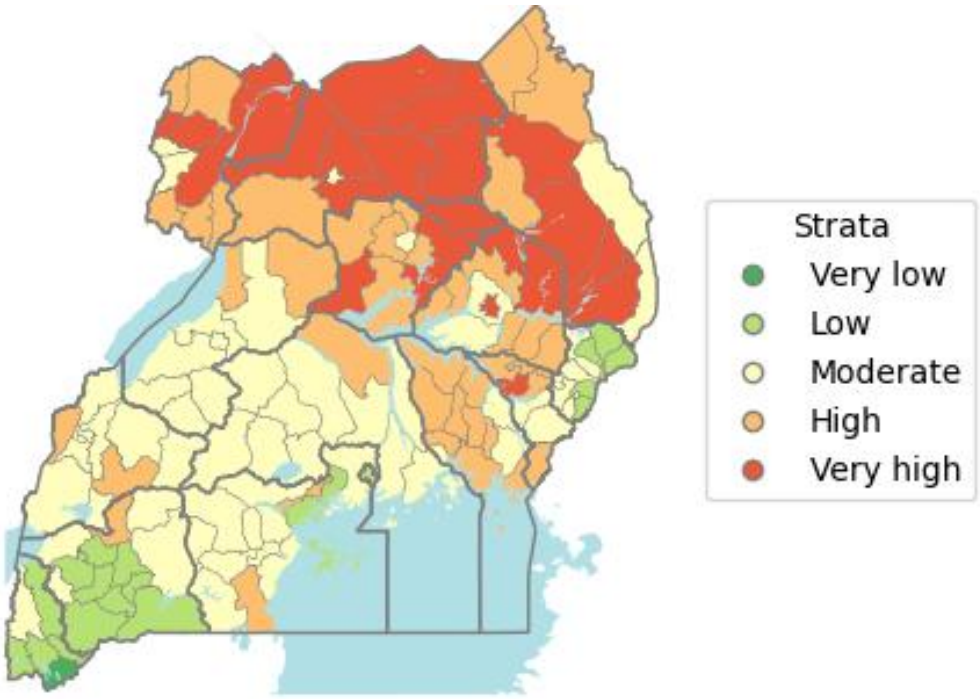
Parasites: *Plasmodium falciparum* causes 98% of cases. Other species include *P. malariae*, *P. ovale*, and *P. vivax*. High rates of asymptomatic infection sustain the disease's transmission. Artemisinin resistance has been confirmed, posing a threat to treatment efficacy.

Vectors: Malaria transmission dynamics in Uganda have evolved, with a shift from dominance by *Anopheles gambiae sensu stricto* to an increasing contribution from *Anopheles funestus*, a species that exhibits more outdoor and early evening biting behavior, reducing the effectiveness of current vector control tools. The potential spread of *Anopheles stephensi,* already detected in neighboring countries, poses an emerging threat to malaria elimination efforts.

3.4. Transmission Stratification

Malaria in Uganda is highly heterogeneous. Approximately 95% of the population resides in areas with stable, year-round transmission, while low-burden zones, such as parts of Kampala and the southwestern highlands, remain susceptible to epidemics. To address this variation, districts are stratified into five burden categories: very high, high, moderate, low, and very low. This allows interventions to be tailored to local contexts.

Figure 2: Malaria Epidemiological Stratification Map



3.5. Lessons from the Previous Strategic Plan (UMRESP 2021–2025)

a. **Programme Capacity:** Of the 199 activities planned under the previous strategy, 84% were implemented, with 49% completed in full and 35% only partially. Persistent weaknesses included limited rollout of social and behaviour change communication, inadequate programme management, and low readiness for elimination. Implementation of mid-term review recommendations was minimal, with only 13% achieved in full.

b. **Financing**: The programme required USD 1.01 billion but mobilised only USD 741 million, leaving a funding gap of 27%. Donor contributions accounted for 62% of total resources, while domestic allocations remained relatively stable at approximately USD 19 million annually. Households shouldered a heavy burden through out-of-pocket spending. The suspension of U.S. government

funding in 2025 exposed the risks of donor dependence and the fragility of financing for malaria control.

c. **Key Lessons:** The experience underscored that sustained financing is essential, and reliance on donors is unsustainable. Stratification has proven effective, as uniform approaches fail to capture Uganda's diverse epidemiological contexts. Withdrawal of interventions can rapidly trigger resurgence, exemplified by epidemics following the suspension of indoor residual spraying. Weak epidemic preparedness, delayed outbreak response, and limited district ownership constrained subnational implementation. In contrast, strong community engagement has reinforced the uptake of prevention and treatment practices. The private sector, though a first point of care for many Ugandans, remains underutilised in malaria programming.

3.6. Implications for the New Plan

Malaria continues to undermine health, economic growth, and social development in Uganda. Annual treatment and productivity losses exceed USD 600 million, equivalent to 1.4% of GDP. The disease reduces school attendance, diminishes workforce productivity, and perpetuates poverty. New biological threats, climate variability, and volatile financing amplify the urgency of accelerating elimination efforts. Malaria elimination is therefore both a public health necessity and a national development priority, directly advancing Uganda's Vision 2040 and the Sustainable Development Goals.

Moving towards elimination will require sustaining high coverage of proven interventions such as ITNs, IRS, IPTp, ACTs, and vaccines, while tailoring intervention packages to local epidemiology through routine stratification. Uganda must establish early warning and rapid response systems for epidemics, expand entomological and molecular surveillance, and diversify domestic financing, including through the operationalization of the Malaria Fund. Equity, gender, and inclusion must be mainstreamed across all programmes, and accountability mechanisms strengthened at both national and subnational levels.

4. Strategic Framework (2026–2030)

4.1. Vision and Goals

Vision: A malaria-free Uganda that advances socioeconomic growth and national development

Mission: To ensure universal access to equitable, high-quality, and affordable malaria prevention, diagnosis, and treatment through evidence-based, people-centred, and inclusive strategies.

Goals:

1) Achieve zero malaria deaths by 2030
2) Reduce national malaria incidence by ≥75% from 2024 levels (from 274 to <100 cases per 1,000 population).
3) Attain pre-elimination status in at least 19 of the districts.

Strategic Objectives

1. Ensure universal access to prompt, effective malaria case management and chemoprevention for all people in Uganda.
2. Prevent and reduce malaria transmission by achieving and sustaining universal access and use of effective vector control interventions by 2030.
3. Strengthen Malaria Surveillance, Monitoring & Evaluation, and Operational Research to Drive Evidence-Based Decision-Making
4. Strengthen Program Governance, Management, Sustainable Financing, and Multisectoral Collaboration for Malaria Elimination

4.2. Guiding Principles and Values

The UMESP 2026–2030 and its implementation are anchored in principles that ensure interventions are evidence-driven, equitable, and sustainable.

- **Subnational Stratification.** Resources and interventions are tailored to Uganda's three-tier district classification (high, moderate, and low burden), reflecting local endemicity and ecological context.
- **Decentralized Implementation.** Planning, execution, and oversight are led by districts and parishes under the Parish Development Model, shifting authority from central to local levels.
- **Equity, Human Rights, Gender Equality, and Inclusion.** Malaria programming integrates safeguards to prevent discrimination, ensure equitable access, and address structural barriers through links with health, social protection, and legal systems. Special focus is placed on underserved groups such as refugees, mobile populations, persons with disabilities, and informal urban residents.
- **Results-Based Management.** Routine data, real-time dashboards, and impact indicators drive planning, resource allocation, accountability, and course corrections.

- **Innovation and Sustainability.** The strategy incorporates new tools, including vaccines, AI surveillance, and digital health, while strengthening existing systems and mobilizing domestic and diversified funding to enhance resilience.
- **Whole-of-Government and Whole-of-Society.** Elimination requires multisectoral collaboration, engaging health, local government, private sector, CSOs, and communities alongside sectors such as housing, WASH, education, agriculture, environment, and disaster preparedness.

The Uganda Malaria Programme is guided by the values of **HEARTS**: **H**onesty, **E**quity, **A**ccountability, **R**espect, **T**ransparency, and **S**elf-Leadership. These values shape every decision, partnership, and action, thus ensuring integrity, fairness, responsibility, dignity, openness, and personal accountability. Together, they reflect a values-driven commitment to a malaria-free Uganda.

4.3. High-Level Strategies

The UMESP is organized around four core strategic objectives that span prevention, case management, integrated surveillance, and programme governance and financing. The cross-cutting interventions, including advocacy, communication, and social mobilization, as well as the private sector, have been integrated into the core intervention areas.

1. SO1: Ensure universal access to prompt, effective malaria case management and chemoprevention for all people in Uganda.

Uganda aims to achieve 100% access to quality-assured malaria diagnosis and treatment services by 2030 in line with the WHO malaria elimination framework. This will require strengthening quality diagnostic capacity, ensuring uninterrupted availability of effective Artemisinin-based Combination Therapies (ACTs) and other antimalarial medicines, promoting early care seeking and initiating treatment of uncomplicated malaria within 24 hours and severe malaria cases within 2 hours, enhancing health worker skills, and integrating malaria case management into community and facility-level service delivery platforms.

- **Strategy 1.1: Strengthen prompt malaria parasite-based diagnosis at all levels of care**
  Uganda aims to ensure uninterrupted access to quality-assured malaria diagnostics, guaranteeing that RDTs and microscopy commodities are available across public, community, Private not-for-profit (PNFP), and private facilities. Health worker capacity will be strengthened through decentralized refresher training, with at least 90% of laboratory staff assessed every two years to maintain competency in the use of RDTs and microscopy. Strict adherence to the national "*test, treat, and track*" policy will be promoted across all service levels through advocacy, communication, and social mobilization. By 2027, external quality assurance systems for diagnostics will be established in every district, supported by an integrated national malaria reference laboratory with the capacity to monitor antimalarial drug resistance and the genomics of parasites and vectors. Targeted SBCC campaigns will further drive early care-seeking within 24 hours of fever onset, improve recognition of severe malaria signs, and deepen community engagement and policy support for timely treatment.
- **Strategy 1.2: Improve prompt access to quality-assured malaria treatment**
  Uganda will ensure the uninterrupted availability of quality-assured commodities for the treatment of both uncomplicated and severe malaria at all levels of service. Adherence to national treatment guidelines will be reinforced through capacity building, supervision, mentorship, and accountability,

with a target of reaching at least 80% of facilities annually. The 24/2-hour protocol will be institutionalized at both the facility and community levels to ensure timely care, referral, and treatment of severe cases, complemented by community follow-up of patients after discharge to ensure adherence to treatment.

Strategy 1.3: Expand and sustain high-quality malaria case management through integrated community and private sector engagement

Uganda will expand integrated community case management (iCCM) through VHTs in high-burden rural areas, strengthen functionality with CHEWs, and pilot directly observed treatment in very low transmission settings. Community Case Management of malaria will be extended to all age groups in prioritized areas. A value chain analysis of malaria commodities in the private sector will inform supply and access strategies. Private providers will be systematically mapped, accredited, trained, and integrated into national frameworks, with digital reporting to DHIS2/eCHIS. Co-payment mechanisms will be implemented where feasible. Engagement of diverse stakeholders will reinforce the uptake of diagnostic and treatment services, complemented by strengthened advocacy, communication, and social mobilization at both facility and community levels, to promote timely care-seeking, provider compliance, and patient adherence for rational drug use.

- **Strategy 1.4: Mitigate the spread of antimalarial resistance through the implementation of an antimalarial management strategy**

  Uganda will strengthen the capacity of health workers across public, private, and community levels to implement the antimalarial resistance strategy, focusing on identifying drivers, enhancing surveillance, and promoting adherence to updated treatment guidelines. Rational use of ACTs will be promoted through targeted provider support, supervision, and community-level risk communication, while robust quality assurance systems will be reinforced to monitor the safety and effectiveness of antimalarial medicines. The quality and efficacy of antimalarial drugs will be regularly monitored through therapeutic efficacy studies, ex vivo parasite assays, and molecular markers of antimalarial drug resistance (K13 mutations), coordinated by the national malaria reference laboratory.

- **Strategy 1.5 Protect high-risk populations in targeted areas with chemopreventive therapies and vaccines**

  Uganda will strengthen intermittent preventive treatment in pregnancy to ensure that at least 90% of pregnant women receive three or more doses of SP. Seasonal malaria chemoprevention will be expanded to eligible high-transmission districts and high-risk age groups during peak rainy seasons, targeting at least 80% coverage. By 2028, pilots of intermittent preventive treatment for schoolchildren and infants will be introduced in selected districts. In parallel, malaria vaccination will be scaled up to all targeted districts, with the goal of achieving 80% uptake of the recommended doses.

2. SO2: Prevent and reduce malaria transmission by achieving and sustaining universal access and use of effective vector control interventions by 2030.

Malaria prevention in Uganda faces complex and interlinked threats that weaken the impact of current interventions. Insecticide resistance and shifting mosquito behaviour, such as biting in the early evening and outdoors, have reduced the effectiveness of net-based indoor strategies. Meanwhile, inequities in ITN use, net damage, and financial and operational barriers to IRS, exacerbated by community refusals, further limit the effectiveness of these core vector control tools. Climate variability compounds these challenges by altering mosquito ecology, extending transmission seasons, expanding breeding sites, and changing vector species composition.

To confront these challenges, Uganda will adopt an Integrated Vector and Parasite Management (IVPM) framework as the backbone of its malaria prevention strategy. This adaptive, evidence-driven system combines next-generation LLINs, targeted IRS, larval source management, environmental and biological controls, parasite management, and complementary interventions tailored to local epidemiology, resistance profiles, and operational contexts. The IVPM emphasizes the need to reduce both the parasite reservoir and vectorial capacity to sustain achieved reductions in endemicity without any lag.

The IVPM approach rests on five pillars: stratified decision-making informed by entomological, genomic, and resistance surveillance; integrated indoor and outdoor interventions, and parasite management adapted to transmission intensity; multisectoral collaboration across sectors such as agriculture and housing; strong community mobilization and advocacy to build acceptance and ownership; and reinforced technical capacity and regulatory systems at national and subnational levels.

- **Strategy 2.1: Achieve universal coverage and use of ITNs in prioritized areas**
  Uganda will sustain universal ITN coverage by combining mass distribution in moderate to high burden areas with targeted catch-up campaigns in districts with low coverage, ensuring one net for every two persons. Continuous distribution through ANC, EPI, schools, and community channels will be scaled up to maintain high coverage, while advocacy, communication, social mobilization, and behavioural insights will drive correct and consistent use. Private sector engagement will be strengthened and regulated to expand equitable access to ITNs.

- **Strategy 2.2: Implement IRS in prioritized districts, rotating insecticides to mitigate resistance.**
  Indoor residual spraying will be implemented in high-burden districts based on stratification data and resistance profiles, with insecticides rotated in line with WHO and national guidance to manage resistance. In moderate- and low-burden areas, as well as in priority institutions such as schools, military barracks, and plantations, IRS will be applied in a targeted manner. Local capacity for planning, budgeting, implementation, and monitoring will be strengthened, with IRS training institutionalized at the district level to ensure technical sustainability and ownership. Advocacy and social mobilization will engage government, civil society, and community leaders to secure IRS prioritization in plans and budgets and to build community acceptance for high coverage. Transition plans in targeted districts will integrate parasite and vector management with community surveillance, while encouraging private sector and CSO-led fumigation in urban settings and hospitality facilities.

- **Strategy 2.3: Apply larval source management and other new tools in specific settings**
  Uganda will target breeding sites in urban and peri-urban areas through larviciding and environmental management, working with local governments to lead community-driven campaigns. Additionally,

novel WHO-recommended outdoor tools, such as spatial emanators, will be piloted and adopted where effective and feasible.

- **Strategy 2.4: Integrate vector control and prevention efforts across sectors, engaging the private sector, CSOs, and other stakeholders.**
  Uganda will intensify advocacy and inclusive stakeholder engagement to secure malaria prevention as a national priority. Collaboration with water, sanitation, agriculture, education, housing, and environmental sectors will be strengthened to address breeding sites and promote vector-proof housing through integrated policies, joint planning, budgeting, and accountability mechanisms. Public–private partnerships and civil society engagement will be expanded to support the implementation of integrated vector management interventions.

3. SO3: Strengthen Malaria Surveillance, M&E, and Operational Research to Drive Evidence-Based Decision-Making

In 2025, the NMED conducted a surveillance assessment to measure system performance, identify gaps, and develop tailored recommendations to ensure Uganda has an integrated, flexible, and representative surveillance system that allows the NMED to meet the demands of changing malaria transmission in the country. An elimination-ready surveillance system requires an integrated system with high-quality data and strong governance, underscored by a culture of data use that empowers staff at all levels with the resources to measure and respond to granular patterns and drivers of malaria transmission. By 2030, Uganda will have a surveillance system capable of detecting, reporting, and responding to all malaria cases and outbreaks in real-time, enabling targeted interventions in line with the country's malaria elimination goals.

- **Strategy 3.1 Develop an Integrated Surveillance, Monitoring, and Evaluation (SME) Framework.**
  Uganda will establish and regularly update integrated malaria surveillance guidelines, SOPs, tools, and templates for both routine and non-routine surveillance, including case-based systems in elimination settings, with clearly defined roles and responsibilities across the decentralized response system. Capacity will be strengthened through continuous training, supportive supervision, and performance monitoring of health workers, district health teams, and VHTs. Infrastructure, including computers, mobile devices, and reliable internet, will be provided to support effective reporting. Policy reforms will enforce mandatory private sector reporting, case registration, and notification, ensuring comprehensive surveillance, particularly in low-transmission settings.

- **Strategy 3.2: Strengthen malaria surveillance systems to enable elimination**
  Uganda will establish case-based surveillance in low-transmission areas by 2027, covering case detection, notification, investigation, and response in line with national guidelines. Integrated sentinel sites will be established across ecological zones to collect entomological, epidemiological, molecular, and meteorological data on a routine basis. These sites will also support routine therapeutic efficacy studies, genomic surveillance, and annual monitoring of insecticide resistance. Entomological surveillance will track key indicators, including sporozoite rates, species composition, density, temporal abundance, and the presence of invasive species. In parallel, routine systems will be developed to capture community-level indicators, including malaria deaths, reducing reliance on large-scale surveys.

- **Strategy 3.3: Improve data systems to enable elimination**
  Uganda will strengthen digital health systems by upgrading eCHIS, HMIS, and EMRs to capture detailed case and foci data (including travel history, symptom onset, treatment, parasite species, and origin), enabling patient and village-level line listing in low-transmission areas. Malaria data systems across all sectors will be integrated into the national HMIS, while eCHIS will be expanded nationwide to incorporate VHTs and CHEWs into real-time reporting platforms. A National Malaria Data Repository will be operationalized to triangulate multi-source data and generate automated dashboards and alerts for timely decision-making.

- **Strategy 3.4: Strengthen Data Quality and Reporting across all sectors, including the private sector**
  Uganda will implement a National Data Quality Assurance (DQA) workplan with automated validation checks, dashboard reviews, district-led audits, updated HMIS tools, and systematic tracking of follow-up actions. Reporting compliance will be enforced by linking private sector accreditation to DHIS2 reporting and customizing digital tools for drug shops and small clinics. Quarterly DQAs will be conducted in all districts, while private sector malaria case reporting will be expanded and strengthened to ensure comprehensive data capture.

- **Strategy 3.5: Foster Data Use and Evidence-Based Decision-Making at the levels**
  Uganda will develop and disseminate a malaria data use strategy with SOPs tailored to all cadres and levels. Regular malaria surveillance review meetings will be institutionalized at district and national levels, with standardized action plans to address gaps, supported by two-way feedback between national and subnational levels. Cross-thematic dashboards will be deployed, tailored to each user's decisions across all levels of care and transmission settings, including stock monitoring. Data use will be strengthened through routine disaggregated analysis by age, species, and location, alongside advanced analytics such as mathematical modelling for subnational stratification. District and facility staff will receive training in data analysis and its application to enhance evidence-based decision-making.

- **Strategy 3.6: Enhance malaria epidemic preparedness and response**
  Uganda will develop epidemic preparedness and response guidelines and SOPs, ensuring all districts maintain updated plans, with priority given to epidemic-prone areas in collaboration with PHEOC, OPM, and other stakeholders. Early warning systems will be implemented using meteorological, epidemiological, and entomological indicators, supported by automated outbreak detection and notification at subnational levels. Preparedness will be reinforced through prediction, pre-positioning of commodities at regional hospitals. Response to epidemics will follow the Incident Management System approach, depending on the extent of the outbreak, including district-led support by the regional teams or national response teams. Post-epidemic evaluations will be conducted, and lessons will be disseminated to strengthen future responses.

- **Strategy 3.7: Strengthen evidence, innovation, and learning systems to accelerate malaria elimination**
  Uganda will establish a national malaria research agenda aligned with elimination priorities and support studies on new vaccines, therapeutics, diagnostics, innovative vector control tools, and effectiveness and cost-effectiveness of interventions. Pilots of novel chemoprevention, case management, and vector control approaches will be undertaken, with successful innovations scaled up for implementation. Elimination demonstration zones will be established to test approaches, evaluate outcomes, and assess the scalability of accelerated elimination. Annual surveillance

assessments will track system effectiveness, while regular routine programme reviews (including annual reviews, a mid-term review in 2028, and an end-term evaluation in 2030) will guide adaptive implementation.

4. SO4: Strengthen Program Governance, Management, Sustainable Financing, and Multisectoral Collaboration for Malaria Elimination

By 2030, the country aims to strengthen and sustain a coordinated, multisectoral, decentralized, and integrated malaria program that ensures effective resource mobilization, commodity availability, strong accountability, and oversight of policy and strategy implementation. Program governance, management, and sustainable financing mechanisms to ensure efficient and effective delivery of malaria interventions at all levels through a multisectoral arrangement with a goal of achieving full domestic and partner funding of the national malaria programme.

- **Strategy 4.1: Strengthen national and subnational programme management capacity**
  Uganda will strengthen national and subnational capacity to lead, coordinate, and monitor implementation of the UMESP 2026–2030. Functionality of malaria structures—including focal points, VHTs, and CHEWs - will be reinforced through decentralized systems, while advocacy will focus on addressing critical human resource gaps for malaria control and elimination at all levels.

- **Strategy 4.2: Improve multisectoral coordination mechanisms and partnerships across all levels**
  Uganda will strengthen governance for malaria elimination by establishing and maintaining functional technical working groups and inter-sectoral committees at national and subnational levels. SMART malaria elimination accreditation will be introduced for private sector companies, while collaboration with civil society, the private sector, parliament, and partners will be deepened through joint planning and reviews to align activities with national priorities. The capacity of CSOs and private sector coordination structures will be enhanced at all levels to foster community leadership and engagement. VHTs and CHEWs will be fully integrated into community interventions, including vector control, chemoprevention, vaccination, and SBCC. Suggested interventions will be periodically reviewed to identify opportunities for integration.

- **Strategy 4.3: Mobilize and sustain financing for malaria elimination.**
  Uganda will increase domestic government allocations for malaria to at least 50% of total programme funding by 2030, while leveraging innovative mechanisms such as health bonds, levies, philanthropy, and private sector contributions to ensure sustainable financing. Strong accountability systems will be established at the national, subnational, and partner levels to ensure timely implementation, complementarity of resources, and cost-effective use of funds.

- **Strategy 4.4: Ensure malaria commodity security at all levels.**
  Uganda will strengthen supply chain management to guarantee uninterrupted availability and accountability of quality-assured malaria commodities, blood, and equipment. Collaboration with the National Drug Authority and other stakeholders will be reinforced to ensure the quality of commodities through strict policy enforcement and effective post-market surveillance.

- **Strategy 4.5: Enhance monitoring, supervision, and accountability**
  Uganda will use reported data to guide annual and quarterly supply planning for all malaria commodities. National-level review meetings (quarterly and annually) with NMED, NMS, and partners will monitor progress, while quarterly supportive supervision visits to districts and high-volume facilities will strengthen stock management, pharmacovigilance, and reporting capacity. District malaria programs will undergo annual performance reviews against agreed-upon targets, and national performance reports will be published annually to promote transparency and advocacy.

- **Strategy 4.6: Integrate Advocacy, Communication, Social Mobilisation, and marketing across all interventions**
  Uganda will conduct a policy and regulatory landscape analysis to prioritize and advocate for key reforms such as mandatory notification of severe malaria and private sector reporting into DHIS 2, amongst others. Mass media, social media, and innovative platforms will be leveraged to raise awareness, generate demand, and drive engagement in the elimination of malaria. National, subnational, and community leaders will be empowered to champion advocacy, behaviour change, and ownership of interventions, while grassroots mobilization will be strengthened to sustain community participation. Effective communication strategies will promote risk perception and inform effective responses to epidemics and emergencies. Key malaria events, including World Malaria Day, will be commemorated to sustain visibility and commitment.

5. Implementation Framework

Uganda's transition from malaria control to malaria elimination requires a robust, decentralized, and adaptive implementation system. The UMESP 2026–2030 will be executed through a district-led, community-owned model, anchored in strong national stewardship and guided by stratification, subnational tailoring, partnerships, sustainable financing, and risk management.

5.1. Intervention Stratification and Subnational Tailoring

Malaria transmission in Uganda is highly heterogeneous, requiring interventions tailored to local epidemiology. Stratification enables efficient resource use, equitable coverage, and maximum impact. All 146 districts have been classified into three epidemiological zones based on malaria incidence and parasite prevalence, which guides planning and implementation (see Annex 6).

- **Zone 1: High burden (Northern Uganda and above Lake Kyoga).** Prioritized interventions include IRS with insecticide rotation, seasonal malaria chemoprevention (SMC), expanded iCCM/CCM, strengthened referral systems, and enhanced surveillance.
- **Zone 2: Moderate burden (Central belt).** Strategies focus on achieving universal ITN coverage, strengthening case management, and implementing targeted focal IRS or larval source management (LSM) where entomological and epidemiological evidence supports their use, alongside hotspot mapping and targeted seasonal malaria chemoprevention (SMC).
- **Zone 3: Low burden (Southwestern and Kampala).** Approaches emphasize surveillance-driven interventions such as case-based surveillance, reactive case detection (RACD), focal IRS, targeted LSM, and elimination demonstration pilots.

Stratification will be updated every two years to capture evolving transmission patterns and enable adaptive programming. Universal interventions will remain in place nationwide, including diagnostics, ACTs, severe malaria treatment, IPTp, ITNs, and vaccines, while zone-specific strategies will layer targeted measures to accelerate progress toward elimination line with WHO elimination guidance.

Because malaria transmission is often highly focal, even within a single district, the UMESP will progressively introduce micro-stratification at sub-county, parish, and eventually village levels. This finer granularity will enable DHTs to detect and respond to emerging hotspots in moderate- and low-burden areas, deploy reactive case detection, focal IRS, and larval source management with precision, and continuously adapt interventions in real time. Over time, parishes and villages will become the primary planning units for evidence-based, elimination-focused action.

Table 1: Districts per transmission strata, 2025

Risk Score	Number of districts and district names	
High	66	Adjumani, Agago, Apac, Dokolo, Gulu, Kapelebyong, Katakwi, Kibuku, Lamwo, Madi-Okollo, Maracha, Moyo, Nabilatuk, Napak, Obongi, Omoro, Otuke, Soroti, Terego, Alebtong, Amuru, Kitgum, Kotido, Nakapiripirit, Pader

		Amolatar, Amuria, Budaka, Bugweri, Bukedea, Buliisa, Busia, Butambala, Butebo, Buyende, Ibanda, Iganga, Jinja, Kaabong, Kaberamaido, Kalaki, Kaliro, Kamuli, Kamwenge, Karenga, Kiryandongo, Koboko, Kole, Kumi, Kwania, Kyotera, Luuka, Mayuge, Nakasongola, Namayingo, Nebbi, Ngora, Oyam, Pakwach, Pallisa, Yumbe, Zombo, Abim, Bundibugyo, Nwoya, Lira
Moderate	59	Arua City, Arua, Bugiri, Buikwe, Bukedea, Bukomansimbi, Buliisa, Bundibugyo, Busia, Butaleja, Butambala, Gomba, Gulu, Ibanda, Jinja, Kaliro, Kalungu, Kayunga, Kazo, Kiboga, Kikuube, Kiruhura, Kiryandongo, Kole, Kwania, Kyegegwa, Kyotera, Lira City, Lira, Luwero, Lwengo, Lyantonde, Manafwa, Mayuge, Mbale City, Mityana, Moroto, Nakasongola, Namutumba, Ngora, Nwoya, Pallisa, Rakai, Serere, Soroti City, Tororo, Zombo
Low	20	Bududa, Buhweju, Bukwo, Bushenyi, Isingiro, Kalangala, Kampala, Kapchorwa, Kisoro, Kween, Mbarara, Mpigi, Namisindwa, Ntungamo, Rubanda, Rukiga, Rukungiri, Rwampara, Sheema, Kibale

Figure 3: Three-Tier Stratification Map

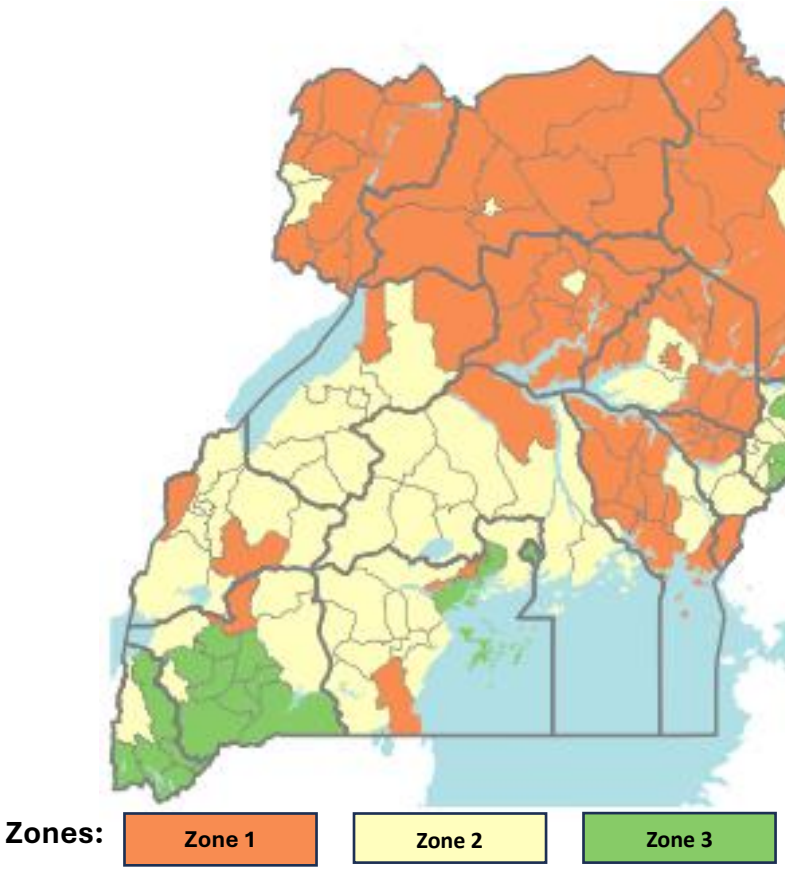


Table 2: Intervention packages by stratum

Package of interventions **							
		Strengthening effective coverage (SEC)	**H and VH**	**M**	**L**	**VL**	**Remarks**
Diagnosis	**SEC**	Universal access to quality-assured, diagnostic testing (RDTs/microscopy)	ALL	ALL	ALL	ALL	Establish a quality-assured laboratory system in all malaria laboratory services. Priority should be given to Referral hospitals, General hospitals, HCIV, and III
	SPS	Quality-assured diagnostic services for the detection of malaria species for suspected severe malaria cases at HCIII, HCIV, hospitals	ALL	ALL	ALL	ALL	
Case management	**SEC**	Universal access to quality-assured ACTs for confirmed cases; rectal and injectable artesunate as pre-referral treatment	ALL	ALL	ALL	ALL	Injectable Artesunate for pre-referral treatment is recommended for health facilities where severe malaria case management services are not available
	SPS	24,2 Hours initiative	ALL	ALL	ALL	ALL	Initiating treatment of uncomplicated malaria within 24 hours and severe malaria cases within 2 hours
		Community-based free-of-charge malaria case management services (CMCM) for all age groups in rural and sub-urban areas	RU, SU	RU, SU	RU, SU	RU, SU	To reduce malaria deaths and severe malaria cases, priority should be given to scaling up CMCM in VH, H, M, and sub-counties classified as moderate or higher in districts categorized as L and VL. In L and VL, VHT can contribute to active case findings and reactive case findings.

Vector Control	**SEC**	Universal LLIN coverage	ALL	ALL	RU, SU		The co-deployment of LLINs and IRS is not recommended by the WHO. Based on local conditions, one of them should be selected. For IRS, priority should be given to districts classified as VH and H, respectively, considering available resources. As the third-ranked priority, in districts classified as M, sub-counties classified as H, VH, and, if feasible and applicable, IRS should be implemented. Lastly, in districts classified as L, if there are sub-counties classified as M, H, VH, and if feasible and applicable, IRS can be implemented. In VL endemic areas, foci classified as hot spots where resources are available and IRS is feasible and applicable, it may be considered
		IRS	RU	RU*	RU*		
	SPS	larval source management	U, SU, RU*	U, SU, RU*			Given that Indoor Residual Spraying (IRS) is not feasible in the Karamoja region and considering high endemicity, alongside the use of LLINs, LSM can be prioritized during the dry season in both urban and rural areas of Karamoja. In other districts, LSM should be implemented in dry seasons in accordance with WHO guidelines—specifically in areas where breeding sites are few, fixed, and financially manageable. This makes LSM particularly suitable for urban and suburban areas during the dry season, where breeding sites are often artificial. In rural areas, where most breeding sites are natural, the implementation of LSM should be guided by feasibility, cost-effectiveness, and consistency with WHO recommendations. Cost-effectiveness remains a key consideration in any decision to scale up LSM interventions and the selection of active ingredients.
Prevention	**SEC**	IPTp for all pregnant women	ALL	ALL	ALL		
		IPTi in eligible infants	ALL	ALL			
		SMC during high transmission season	ALL	ALL			
		Vaccine	ALL	ALL			
Surveillance	**SPS**	Case classification and foci classification			ALL	ALL	

	SPS	Active and reactive case findings			ALL	ALL	
	SPS	Malaria Epidemic Rapid and Effective Response (MERER)	ALL	ALL	ALL	ALL	Establish Malaria Epidemic Rapid Response Hub (MERH) at the subregional level. In line with WHO guidelines, considering local situation and feasibility to reduce burden of malaria in epidemic affected areas whenever applicable combination of Mass Drug Administration (MDA) and vector control interventions may be applied (preferably IRS as the fist option and LLINS as the second option) LSM can be added as complementary measure if based on WHO guidelines it is cost effective and feasible.

SEC: Strengthening effective coverage; SPS: Strategic paradigm shift; UR: Urban; SUR: Sub-urban; RU: Rural; ALL: Urban, Sub-Urban, Rural

Table 3: Intervention packages by objective for each stratum

<table>
<tr><th></th><th>high</th><th>Moderate</th><th>Low</th></tr>
<tr><td rowspan="3">Objective 1</td><td colspan="3">SEC: Universal access to quality-assured and effective treatment, including MFTs
SPS: Quality-assured malaria species diagnosis for suspected severe cases at HCIII–HCIV and hospitals.
SPS:24,2 hours initiative
SEC: IPTP and vaccines</td></tr>
<tr><td colspan="2">SEC: Routine mRDTs and Quality microscopy</td><td>SPS: Quality Microscopy and highly sensitive mRDTs</td></tr>
<tr><td colspan="2">SPS: Community Case Management (CCM) for all ages, prioritizing high-impact IRS areas
SPS: IPTi in schools, SMC in <10 years</td><td>SPS: Active Case Detection through CHEWS and VHTs(ICCM plus)</td></tr>
<tr><td rowspan="3">Objective 2</td><td>SEC: IRS campaigns; mass ITN campaigns where IRS is not feasible</td><td>SEC: Mass ITN campaigns</td><td rowspan="2"></td></tr>
<tr><td colspan="2">SEC: LSM in eligible areas (urban, sub-urban, eligible rural, cattle corridors)</td></tr>
<tr><td colspan="3">SEC: Routine ITNs as the mainstay, with expanded routine distribution (ANC, EPIs, Schools, SMART discharge)</td></tr>
<tr><td rowspan="3">Objective 3</td><td colspan="3">SEC: Routine surveillance systems (monthly and weekly)
SEC: Malaria Epidemic Rapid and Effective Response (MERER)
SPS: Integrated sentinel site surveillance on efficacy, epidemiology, molecular, entomological, meteorological, and emerging biological threats across district clusters.
SPS: Operational research on new tools and program designs such as spatial emanators, drugs, elimination demonstration projects, etc</td></tr>
<tr><td rowspan="2">SEC: Readiness in case of IRS withdrawal, considering commodity buffer stocks</td><td colspan="2">SPS: Foci mapping & targeted interventions (vector control, case management, SBCC, etc.)</td></tr>
<tr><td></td><td>SEC: HMIS enhancements for individual case data
SPS: Case-based surveillance, including case notification, investigation, classification, foci investigation, classification and response</td></tr>
</table>

SEC: Strengthening Effective Coverage (Existing intervention)
SPS: Strategic Paradigm Shift (New or Modified intervention)

5.2. Implementation Structure and Roles

The UMESP 2026–2030 will be implemented through a decentralized and multisectoral model aligned with Uganda's governance structures and anchored in district-led accountability, national stewardship, and whole-of-society engagement. The structures below ensure that malaria elimination is nationally led, district-driven, community-owned, and multisectoral with clear roles and responsibilities at each level to deliver tailored, evidence-based interventions.

- **At the national level**, the Ministry of Health, through the National Malaria Elimination Division (NMED), will provide overall stewardship by setting policy, technical guidance, and standards; coordinating partners through technical working groups; mobilizing resources; and overseeing national monitoring and evaluation. Cross-thematic working teams will guide implementation across strata, while the MoLG will ensure malaria elimination is embedded in District Development Plans, budgets, and community structures such as the Parish Development Model. Within NMED, dedicated units for capacity building, logistics, and operations will streamline the delivery of interventions. Other ministries (including Finance, Education, Agriculture, Water, and Environment) will support through resource mobilization, school-based programmes, and integration of vector management into their sectoral activities.
- **Regional referral hospitals and health management teams** will act as hubs for technical support, supervision, mentorship, and complex case management, bridging national policies with district execution.
- **At the district level,** District Health Teams (DHTs) will serve as the anchors of implementation and primary units of accountability. They will lead annual District Malaria Action Plans (DMAPs), coordinate partners, manage funds, supervise facilities and communities, and report timely and accurate data.
- **Sub-county and parish structures** will oversee frontline service delivery, with Health Sub-Districts supervising health centres and Village Health Teams (VHTs). VHTs/CHWs will deliver iCCM, distribute LLINs, provide testing and treatment, conduct referrals, mobilize communities, and feed real-time surveillance data into national systems. The PDM and Local Economic Development structures will drive social mobilization, service uptake monitoring, and community feedback through scorecards and dialogues.
- **At the community and household level**, citizens are central to prevention, diagnosis, treatment, and surveillance. Cultural and religious institutions will complement this by mobilizing communities, shaping behaviour change, and sustaining ownership.
- **Private sector and non-state actors** will remain key partners. Accredited private facilities, pharmacies, and drug shops will expand access to testing, treatment, and surveillance data. Corporate actors will support resource mobilization and workplace programs, while CSOs will drive community mobilization, accountability, advocacy, and independent monitoring. Academia and research institutions will conduct operational research and support independent evaluations.

5.3. Phasing of Implementation

Implementation will be rolled out in three overlapping phases to ensure a systematic and adaptive approach, allowing for learning and course correction.

Table 4: Phasing of Implementation

	Timeline	Focus
Phase 1	2026 –2027	Foundation and Scale-Up: Roll out stratified District Malaria Action Plans, deploy digital surveillance and supply chain systems nationally, and conduct intensive capacity building for DHTs and VHTs.
Phase 2	2028 –2029	Intensification and Targeting: Intensify interventions based on performance data, launch targeted elimination campaigns in low-burden districts, and scale up innovative public-private partnership models.
Phase 3	2030	Verification and Transition: verify pre-elimination status in Targeted districts and sub-counties, document lessons learned and prevent reversal of gains.

This phased approach (Figure 4) will be guided by annual operational cycles that include national performance reviews, joint district-level planning workshops, and mid-year performance assessments, ensuring the strategy remains on track.

5.4. Partnership and Coordination Mechanisms

a. Partnership Mechanisms

Strong partnerships and structured coordination are crucial for maximizing resources, harmonizing interventions, and ensuring shared accountability. A National Malaria Elimination Task Force (NMETF), chaired by the DGHS, will provide overall oversight, meeting regularly to review performance and guide adjustments. Technical Working Groups (TWGs) on vector control, case management, surveillance and M&E, SBCC, epidemic preparedness, and programme management will deliver specialized guidance and track progress.

Intersectoral collaboration will engage Education, Agriculture, Water, Environment, and Local Government to integrate malaria control into school health, agricultural extension, and environmental management. Development partners will align investments through the Health Sector Working Group, Costed Optimized Operational Plans (COOPs), and joint annual reviews, using national systems for planning, procurement, distribution, and reporting. The private sector will be engaged through a dedicated forum that brings together corporate actors, pharmaceutical firms, and providers to improve commodity access, workplace programs, and data sharing. Communities and CSOs, including VHTs, will be integrated into planning and review processes, while SBCC platforms will be co-created with local stakeholders to drive behaviour change and supportive policies.

b. Partnership Coordination System

All partnerships will follow the "*Three Ones" principle*: one national malaria plan (UMESP), one coordinating body (NMED), and one monitoring and evaluation framework. The NMETF, with clear terms of reference, will coordinate programme performance and link to the Communicable Disease Technical Working Group. Existing TWGs will continue to provide technical oversight, while strata-specific subcommittees will design and review tailored packages for high-, moderate-, and low-burden settings.

Civil society and parliamentary actors, including CSOs, the Uganda Civil Society Alliance Against Malaria (UCAAM), and the Uganda Parliamentary Forum on Malaria (UPFM), will be supported to enhance participation, alignment, and capacity. At the district level, DHTs will convene quarterly reviews with partners, CSOs, and private sector actors to track progress against District Malaria Action Plans (DMAPs), align footprints, and resolve operational bottlenecks. Governance tools, including TWG and strata subcommittee charters, will define scope, deliverables, decision rights, and reporting lines to the NMETF, ensuring clear accountability throughout the system.

5.5. Procurement and Supply Chain Management

Commodity security is a cornerstone of UMESP implementation. The strategy focuses on strengthening NMS and JMS to ensure an uninterrupted supply of quality-assured diagnostics, medicines, vaccines, and ITNs; expanding digital systems, such as eLMIS and DHIS2, to integrate malaria logistics within broader health systems; and improving forecasting, quantification, and distribution to minimize stockouts. Regulatory oversight will be enforced through the National Drug Authority for quality assurance and post-market surveillance, while district-level capacity in stock management and pharmacovigilance will be strengthened to ensure reliability at the last mile.

5.6. Risk Management

Malaria elimination faces biological, programmatic, financial, and environmental risks. The risk management matrix identifies key risks and mitigation measures:

Table 5: Key programme risks for the UMESP and mitigation measures

Risk	Mitigation Strategy
Funding Gaps/ Donor Withdrawal	Expand domestic resource mobilization through targeted advocacy and integration into district budgets; foster co-investment by the private sector; develop and pilot innovative financing mechanisms (e.g., malaria bonds, levies).
Drug or Insecticide Resistance	Invest in robust entomological and genomic surveillance to monitor trends in real-time. Implement the national resistance management plan, which includes rotating insecticide classes for IRS, scaling up next-generation nets (e.g., PBO/dual-AI), and ensuring rational use of drugs.
Commodity Stockouts	Strengthen supply chain forecasting using digital tracking systems (eLMIS). Maintain national and regional buffer stocks for essential commodities. Diversify procurement sources to reduce dependency on a single supplier.
Climate Shocks & Epidemics	Operationalize the Malaria Early Warning System (MEWS) by integrating climate and case data. Pre-position buffer stocks of commodities and establish trained Rapid Response Teams in high-risk, epidemic-prone zones. Strengthen cross-border surveillance with neighbouring countries.

Community Resistance or Apathy	Implement culturally responsive and equitable social and behaviour change (SBC) strategies with integrated advocacy to support positive health behaviours. Prioritize the engagement of trusted local influencers and community leaders and integrate inclusive community feedback mechanisms to surface and resolve concerns in real-time. These approaches must be grounded in principles of equity, human rights, gender equality, and inclusion to foster trust, ensure community ownership, and enhance the effectiveness of malaria interventions.

5.7. Capacity Development

The success of UMESP 2026–2030 depends on strengthening human, institutional, and technological capacity, coordinated by a dedicated Capacity Development Unit within NMED. A national human resource needs assessment will guide the recruitment and deployment of critical cadres, such as laboratory technicians, entomologists, and surveillance officers. Meanwhile, continuous professional development and refresher training for VHTs and CHEWs will reinforce frontline skills.

Institutional capacity will be bolstered through upgraded reference laboratories, sustained integrated surveillance sites in defined clusters, and improved infrastructure, transport, and ICT for NMED and DHTs. Technological capacity will be advanced by expanding DHIS2 for real-time surveillance, integrating mobile reporting, and scaling up eLMIS for community-level commodity tracking. Partnerships with academia, the private sector, CSOs, and community systems will further drive skills development, innovation, and coordinated action. Together, these investments will ensure Uganda has the workforce, resilient institutions, and modern tools required to achieve malaria elimination.

6. Budget and Financing

6.1. Costing Approach

The costing of the UMESP was conducted through a consultative process with key stakeholders, adopting the health system provider perspective to determine resources required for delivering elimination interventions at scale. The ingredient costing approach was used, and the delivery pathway for prioritized activities was mapped, with resource needs, costs, and timelines identified. The costing took into consideration the relevant and incremental costs of program implementation. Existing long-life assets, such as structures, were regarded as sunk costs and not reflected in these resource estimates. Other costs, such as vehicles and trucks, were annualized over the plan period, and the proportion of health facility workforce costs attributable to malaria was estimated.

The costing exercise took into consideration epidemiological data from DHIS2, nationwide surveys, MIS data, and other relevant sources. The scope and scale of services were deliberated and agreed upon by the various thematic TWGs. The indicative costs of the supplies and medicine were based on the country's major procurement mechanism. Program costs are based on the GoU standing orders.

Key Assumptions and data sets:
2024 population census; Inflation of 3% was factored in for cost estimates beyond year 2, LLINs for the mass campaigns are planned to be distributed with one net targeted to cover 1.8 persons in each household; Routine nets in ANC and EPI were based on the number pf pregnant mothers and children under 1 year respectively; mRTD were estimated based on an assumption of testing 98% of the projected malaria cases per year; IRS was planned for the high burden districts; Larviciding targeted for the urban and cattle corridor and Malaria vaccination was to be scale up to cover 80% of the eligible U5 population.

6.2. Costing Scenarios

a. Scenario Description

The costing analysis for the Uganda Malaria Elimination Strategy (2025–2030) modelled three implementation scenarios aligned with the national goal of achieving a low malaria burden status by 2030. The cost structure reflects strategic priorities across the four objectives: case management and chemoprevention, vector control, surveillance and response, and health systems strengthening. Each scenario represents a distinct pathway:

- **Scenario 1: Full-Scale Implementation:** The full-scale scenario represents the fastest pathway to malaria elimination, frontloading investments to sharply reduce transmission within the first three years. Over half of the total costs (62%) are allocated to vector control, primarily through the rapid expansion of IRS, LLIN campaigns, and larval source management in urban and cattle corridor districts. About 21% support case management and chemoprevention, ensuring universal access to diagnosis, effective treatment, and preventive therapies, including vaccines. The remaining 17% covers surveillance, epidemic preparedness, and system strengthening to sustain gains. This scenario offers the highest impact through the comprehensive, simultaneous deployment of proven interventions, but requires strong domestic commitment and coordinated partner financing. ***Scenario 1 offers the highest returns but requires substantial domestic resource mobilization and coordinated donor alignment.***

- **Scenario 2: Moderate Scale-Up:** The moderate scale-up scenario assumes gradual expansion of interventions aligned with incremental fiscal growth. Vector control remains the largest cost component (50%) through phased IRS and targeted LLIN campaigns in high-transmission

districts. Case management is estimated at 26% and targeted for clinical services as transmission declines. Allocations for surveillance (8%) and systems strengthening (16%) increase modestly, with a focus on governance, accountability, and adaptive management. This scenario offers a balanced approach, maintaining steady progress while remaining financially feasible under current budget realities. ***Scenario 2 strikes a balance between ambition and feasibility, relying on predictable, incremental financing growth and government co-funding, and offers the best option for this strategic period.***

- **Scenario 3: Resource-Constrained Implementation:** This scenario maintains a core package of essential interventions, prioritizing case management (41%) and vector control (42%), while investments in surveillance and systems fall below 10%. Limited institutional capacity for coordination and rapid response heightens the risk of stagnation or resurgence in areas with high disease burden. While basic service delivery is preserved, this scenario is the least cost-efficient and least sustainable in the long term due to reduced operational reach and weak surveillance. ***Scenario 3 maintains essential services under tight budgets but risks slowing or reversing gains due to limited resources and operational capacity.***

b. Cost Distribution by Strategic Objective

Across all scenarios, the largest expenditure shares are attributed to Vector Control (Objective 2) and Case Management and Chemoprevention (Objective 1). These two pillars account for 85–90% of total resources, highlighting the centrality of integrated vector management, diagnosis, and treatment in the malaria elimination pathway.

Table 6: Costing by scenario

Objective Area	Scenario 1 (Full Scale)	Scenario 2 (Moderate Scale-Up)	Scenario 3 (Resource-Constrained)
SO1: Case Management and Chemoprevention	21%	25%	41%
SO2: Vector Control	62%	50%	42%
SO3: Surveillance, M&E, and Epidemic Preparedness	6%	8%	8%
SO4: Health Systems Strengthening, Coordination, and Commodity Security	11%	17%	9%
Total Estimated Cost (USD '000)	**1,549,536**	**1,176,183**	**871,961**

This UMESP selects Scenario 2: Moderate Scale-Up

6.3. Resource estimates

The resources estimated for the full implementation of the malaria interventions were $1.176 billion over the five-year period. The resources are projected to grow from US$202.4 million, peaking at US$250.1 million, and then declining to US$241.3 million in the fifth year. The decline in resource need is attributed to the effectiveness of interventions projected to reduce the incidence and prevalence of Malaria. The resources would be allocated as follows: 50% towards prevention interventions, 26% towards case management interventions, 8% to the SMEOR, and 17% towards program overheads and management.

Table 7: Summary of budget by objective (US$ '000')

	2025/26	2026/27	2027/28	2028/29	2029/30	Totals	%
Objective 1:	60,657	59,977	62,956	60,239	61,830	305,660	26%
Objective 2:	88,986	135,385	118,303	124,021	119,216	585,911	50%
Objective 3:	17,423	16,826	20,519	16,286	18,419	89,472	8%
Objective 4:	35,418	37,977	39,670	40,209	41,865	195,139	17%
	202,484	**250,166**	**241,448**	**240,754**	**241,331**	**1,176,183**	

The resource allocation in line with the service platforms reflected the largest allocation of 40% of the resources earmarked for interventions at the community level, with 34% at the central level. The district-based and facility-level interventions were allocated 9% and 16% respectively. It should be noted that the central level allocation includes the pooled procurement of medicines and health supplies, which are used at the facility levels. The private sector is allocated 1% mainly as seed investments to encourage adherence to national standards and reporting formats.

Table 8: Summary of Resource estimates by broad delivery platforms (US$ 000')

Platforms	2025/26	2026/27	2027/28	2028/29	2029/30	TOTALS	
	US $ in "000"						
Central level	74,351	75,226	84,929	81,236	83,318	399,060	34%
District level	19,700	20,917	20,789	21,292	22,877	105,575	9%
Facility	35,387	38,157	39,563	37,976	41,193	192,276	16%
Community	71,056	113,932	94,557	97,976	91,469	468,991	40%
Private sector	1,989	1,934	1,610	2,275	2,473	10,281	remaining
	202,484	250,166	241,448	240,754	241,331	1,176,183	

The major cost drivers for the plan period include investments in IRS interventions, LLIN routine and targeted mass campaigns, and malaria test kits, as shown in the table below.

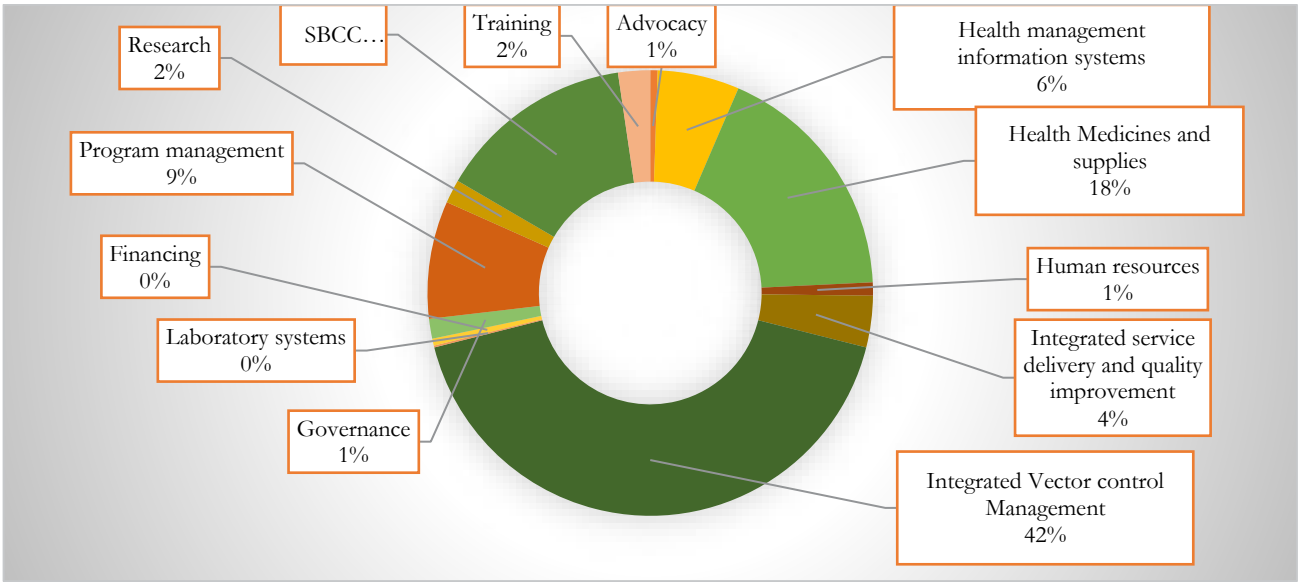
Table 9: Major cost drivers

Cost Drivers	US $ '000"
•Vector Control	
•Targeted IRS for the 66 districts.	249,720,459
•LLIN Routine and targeted Mass campaigns	188,945,158
• Larviciding	36,971,087
•Vaccines	8,327,391
•Drugs and diagnostics	
•Test Kits	121,717,930
•Anti-Malarial	86,517,698
Total allocations	692,199,722

6.4. Distribution of costs by module

The resources are distributed among the various modules as illustrated. The module for Integrated Vector Control and Management has the largest allocation, at 42%, followed by Health Medicines and Supplies, with 18%. The remaining modules share the remaining allocation.

Figure 4: Resource allocations as per modules



6.5. Financing Outlook and Transition Pathway

Uganda's path to malaria elimination requires a phased financing transition guided by three principles:

a. **Predictability:** Secure multi-year domestic and partner commitments for uninterrupted implementation.
b. **Progressivity:** Increase domestic allocations annually, aligned with fiscal space and efficiency gains.
c. **Partnership:** Align donor and private investments with national priorities and sustainability goals.

The Government's financing share should grow from 28% in 2025 to 50% by 2030, supported by savings from improved procurement, targeted vector control, and digital surveillance. Partner contributions will remain stable but gradually shift from commodity procurement to support for systems, research, and innovation. Public-private partnerships (PPPs) and blended financing will play a growing role, linking malaria control to corporate health programs, insurance products, and climate-smart initiatives, such as water and environmental management.

a. **Alignment of Financing with Strategic Priorities:** Malaria financing mirrors Uganda's strategic priorities, with vector control and case management absorbing 85–90% of total costs across all scenarios. IRS, LLINs, and larval source management remain resource-intensive and must be predictably financed. Sustained investment in case management and chemoprevention ensures universal access to diagnosis and treatment. Meanwhile, surveillance and system strengthening—though lower-cost—are essential for targeting, accountability, and program efficiency.

b. **Domestic Resource Mobilization and Fiscal Space:** Transitioning to elimination demands expanded fiscal space and stronger domestic financing. Currently, external partners cover the majority of the costs for vector control and commodities. The Government should progressively increase its share by integrating malaria interventions into national and district budgets under the PHC and Essential Medicines frameworks, with dedicated lines for IRS, LLIN replacement, and surveillance.

   Performance-based financing can reward districts achieving elimination milestones, while the Parish Development Model offers avenues to integrate malaria prevention into community development. Private sector contributions through workplace programs, insurance, and CSR initiatives will further enhance sustainability. In the long term, earmarked revenues from environmental or health-related levies can reinforce a domestic funding base.

c. **Partner Realignment and Transition Planning:** As Uganda advances toward elimination, partner roles should evolve from primary funding to strategic co-financing and technical assistance. Continued support from the Global Fund and PMI will sustain vector control and commodity supplies, while GAVI and UNICEF support the rollout of vaccines. WHO, GIZ, and other technical partners can strengthen systems and multisectoral collaboration.

   A phased transition plan should align donor contributions with national priorities and ensure domestic financing gradually replaces external funding. By 2030, Uganda should aim to finance at least 50% of its core malaria program domestically, supported by predictable partner commitments.

d. **Efficiency, Value for Money, and Sustainability:** Maximizing efficiency within limited fiscal space is essential. Intensive IRS and LLIN operations should focus on persistent high-burden districts, while surveillance-driven, focal responses maintain gains elsewhere. Community-based delivery through Village Health Teams can expand coverage and reduce duplication.

   Further efficiencies can be achieved through pooled procurement, strengthened supply chains, and support for local production of vector control commodities. Digital innovations in surveillance and data analytics will improve targeting, transparency, and accountability. PPPs offer opportunities to leverage private resources for IRS, larviciding, and logistics, reinforcing long-term sustainability.

6.6. Risk Mitigation and Contingency Financing

Underfunding risks reversing progress and increasing treatment costs. Uganda should establish a National Malaria Elimination Contingency Fund to ensure emergency financing during budget shortfalls. Embedding malaria within broader health and economic security frameworks will enable access to cross-sectoral contingency resources. Multi-year financing agreements with partners can further reduce volatility and ensure continuity of core interventions such as IRS, LLIN distribution, and surveillance.

6.7. Policy Imperative

Sustained financing for malaria elimination is a high-return investment, yielding savings in treatment costs and productivity gains. While the full-scale scenario offers the most efficient route to elimination, the moderate scale-up provides a pragmatic, sustainable path. Strategic choices should weigh financial realities against the economic and human costs of inaction. The policy imperative is to frontload investments that drive rapid transmission reduction, reinforce efficiency, and progressively expand domestic financing. Aligning malaria elimination with Vision 2040, the UHC Roadmap, and the Parish Development Model will ensure malaria-free communities directly contribute to Uganda's social and economic transformation.

7. Monitoring, Evaluation, Learning, and Accountability (MELA) Framework

The MELA framework ensures that the Uganda Malaria Elimination Strategic Plan (UMESP) 2026–2030 is implemented with rigor, transparency, and accountability. It provides mechanisms for tracking progress, generating evidence, promoting adaptive learning, and strengthening accountability at all levels. The framework is guided by five principles:

a) Alignment with national and global commitments (HSDP IV, UHC, WHO Global Technical Strategy).

b) Integration into existing systems (DHIS2, eCHIS, eLMIS, HMIS, EMR) to avoid duplication.

c) Decentralization by empowering districts to lead data use and decision-making.

d) Equity and inclusivity by ensuring data disaggregation by age, sex, geography, and vulnerability group.

e) Transparency and accountability by linking results to financing, performance reviews, and citizen engagement.

7.1. Tracking and monitoring of implementation

The UMESP 2026–2030 outlines the MELA processes, indicators, and targets for tracking Uganda's progress toward malaria elimination. Table 8 presents the priority performance indicators, while the full list is provided in Annex 3. To support equity tracking, indicators will be disaggregated by age, sex, and population group where possible.

Table 10: Performance Framework Key Indicators

Code	Indicator Name	Baseline (2024)	Mid-term Target (2028)	End-term Target (2030)
G1	**Goal 1: Achieve zero malaria deaths**			
G1.1	Number of reported malaria deaths (all ages)	15,945.0	7,972.5	0.0
G1.2	Malaria case fatality rate	1.0	0.5	0.0
G1.3	Proportion of all reported deaths attributed to malaria (%)	5.3	2.8	0.0
G1.4	In-patient malaria deaths (rate per 100,000 person per year)	5.4	3.0	0.0
G1.5	Proportion of districts achieving zero malaria deaths (%)	0.0	50.0	100.0
G2	**Goal 2: Reduce national malaria incidence by ≥75% (per 1,000 population)**			
G2.1	Confirmed malaria incidence (per 1,000/year)	274.0	150.7	100.0
G2.2	Malaria test positivity rate (TPR) (%)	42.2	25.0	18.0
G2.3	Parasite prevalence in children under 5 years (%)	12.5	6.9	3.1
G3	**Goal 3: Attain pre-elimination status in at least 19 districts**			
G3.1	Number of districts reporting ≤1 confirmed case per 1,000 population per year	0.0	10.0	19.0

G3.2	Number of districts reporting zero malaria deaths	0.0	10.0	25.0
G3.3	Proportion of districts achieving zero malaria deaths (%)	0%	50%	≥100%
G3.4	Number of districts classified as high transmission	66.0	40.0	0.0
G3.5	Number of districts classified as Moderate transmission	59.0	56.0	62.0
G3.6	Number of districts classified as low transmission	20.0	50.0	84.0
SO1	**SO1: Universal access to case management and chemoprevention**			
SO1.1	Proportion of suspected malaria cases tested for malaria (all sectors) (%)	90.0	95.0	95.0
SO1.2	Proportion of suspected cases tested per national policy – private sector (%)	93.0	95.0	95.0
SO1.3	Proportion of suspected cases tested per national policy – public sector (%)	93.0	95.0	95.0
SO1.4	Proportion of suspected cases tested per national policy – community level (%)	84.0	90.0	95.0
SO1.5	Proportion of confirmed malaria cases in children under five treated within 24 hours from the onset of fever (%)	50.0	60.0	70.0
SO1.6	Proportion of confirmed malaria cases treated according to national guidelines (all sectors) (%)	96.0	98.0	99.0
SO1.7	Proportion of confirmed cases treated per policy – private sector (%)	97.0	99.0	99.0
SO1.8	Proportion of confirmed cases treated per policy – public sector (%)	99.6	99.0	99.0
SO1.9	Proportion of confirmed cases treated per policy – community level (%)	91.0	95.0	95.0
SO1.10	Proportion of all malaria cases reported from the community level (VHTs/CHWs) (%)	15.0	30.0	50.0
SO1.11	Proportion of severe malaria cases among all confirmed cases (%)	4.4	2.2	1.5
SO1.12	Proportion of pregnant women receiving ≥3 doses of IPTp (IPTp3+) (%)	72.0	80.0	90.0
SO1.13	Proportion of eligible children in SMC districts who completed all scheduled SMC cycles (%)	90.0	95.0	98.0
SO1.14	Proportion of eligible children who received the first dose of the R21 malaria vaccine (%)	0.0	80.0	90.0

SO1.15	Proportion of eligible children who received at t least three doses of the R21 malaria vaccine (%)	0.0	68.0	80.0
SO2	**SO2: Vector control coverage and use**			
SO2.1	Proportion of households with at least one ITN for every two persons (%)	53.7	70.0	90.0
SO2.2	Proportion of population that slept under an ITN the previous night (%)	75.6	85.0	90.0
SO2.3	Number of targeted districts covered by Indoor Residual Spraying (IRS)	20.0	50.0	66.0
SO2.4	Proportion of pregnant women who slept under an ITN the previous night (%)	65.0	80.0	90.0
SO2.5	Proportion of children under five who slept under an ITN the previous night (%)	68.0	85.0	90.0
SO2.6	Proportion of targeted districts where IRS was implemented in the previous 12 months (%)	35.0	100.0	100.0
SO2.7	Proportion of targeted population protected by IRS districts (%)	85.0	90.0	100.0
SO2.8	Proportion of targeted local governments (districts) that implemented larval source management (LSM) within the last 12 months (%)	12.0	34.0	72.0
SO3	**SO 3: Surveillance, Monitoring, and EPR**			
SO3.1	Proportion of expected health facility reports submitted to DHIS2 (%)	85.0	90.0	95.0
SO3.2	Proportion of expected reports submitted on time (%)	78.0	85.0	90.0
SO3.3	Proportion of targeted district cluster-sentinel sites that conducted integrated malaria surveillance data reviews within the last 12 months (%)	30.0	60.0	90.0
SO3.4	Proportion of targeted districts conducting entomological surveillance as per guidelines (%)	30.0	50.0	100.0
SO3.5	Proportion of estimated malaria cases detected through the national surveillance system (%)	50.0	70.0	100.0
SO3.6	Proportion of malaria epidemics detected in time (%)	75.0	80.0	100.0
SO3.7	Proportion of malaria epidemics detected and responded to per EPR guidelines (%)	30.0	50.0	90.0

SO4	**SO4: Governance, Financing, Multisector Collaboration**			
SO4.1	Proportion of non-health private sector entities certified as 'malaria-smart' (%)	0.0	50.0	85.0
SO4.2	Proportion of districts with malaria integrated into their sector plans	TBD	70.0	100.0
SO4.3	Proportion of the NSP budget funded from domestic sources (%)	15.0	30.0	50.0
SO4.4	Proportion of districts allocating funds to malaria (code 000064) (%)	TBD	50.0	95.0
SO4.5	Proportion of NSP malaria budget funded from all sources (%)	74.0	80.0	90.0
SO4.6	Proportion of planned activities fully implemented (%)	49.7	70.0	90.0
SO4.7	Proportion of available annual workplan budget absorbed (%)	50.0	85.0	95.0
SO4.8	Proportion of planned advocacy and SBCC initiatives implemented (%)	11.0	75.0	100.0

7.2. Monitoring, Evaluation, Research, Learning, and Adaptation (MERLA) Framework Components

The MELA system combines routine surveillance, periodic evaluations, operational research, and accountability mechanisms to drive the elimination of malaria.

1. Surveillance for elimination

Surveillance will serve as a core intervention in the elimination agenda, functioning not only as a tool for monitoring but as an active driver of response. Uganda will adopt a comprehensive, integrated system designed to detect every infection, investigate each case, and mount targeted responses to prevent onward transmission. By positioning surveillance as a frontline intervention, Uganda will progressively shift from control to elimination, ensuring that every case is detected, every hotspot is mapped, and every transmission chain is interrupted.

- **Routine Surveillance.** Universal, parasite-based diagnosis will be enforced across all public, private, and community providers, with mandatory reporting into the national HMIS. The integration of digital tools, including eCHIS for VHTs and mobile-based reporting platforms, will ensure the real-time capture of case data. Stock monitoring of RDTs and ACTs will be embedded to maintain uninterrupted diagnosis and treatment capacity.
- **Case-Based Surveillance.** In low-burden and elimination-targeted districts, surveillance will shift to a case-based approach. Every confirmed case will trigger an investigation, which includes reviewing travel history, tracing household and community contacts, and conducting a risk assessment at the local level. Rapid responses—such as focal IRS, reactive case detection (RACD), or larval source management—will be deployed within defined timelines to cut transmission chains. District health teams will be capacitated to conduct these investigations, with automated alerts supporting timely notification and follow-up.

- **Sentinel Surveillance.** A national network of integrated sentinel sites will generate high-quality, real-time intelligence across ecological zones. Sites will routinely monitor epidemiological indicators, entomological indicators (sporozoite rate, species composition, biting behavior, density, invasive species), therapeutic efficacy of ACTs, molecular markers of resistance, genomic surveillance, and meteorological data to forecast epidemic risks.
- **Genomic Surveillance.** As part of integrated surveillance, routine parasite and vector genotyping will be institutionalized to detect emerging drug and insecticide resistance, track parasite diversity, and map transmission dynamics at fine geographic resolution. Partnerships with regional and global laboratories will enhance analytical capacity and facilitate integration into decision-making.
- **Community-Based Surveillance.** VHTs and community structures will play a frontline role in detecting fever cases, linking households to testing, and reporting community-level events such as suspected malaria deaths. Community participation will be enhanced through engagement, awareness campaigns, and local feedback systems.
- **Data Integration and Use.** All surveillance streams (including routine, case-based, sentinel, genomic, and community) will feed into the National Malaria Data Repository, generating automated dashboards and alerts for district and national decision-makers. Stratification updates will be based on surveillance outputs, ensuring interventions remain adaptive to changing epidemiology.
- **Evaluation and Feedback.** Continuous assessment of surveillance performance will be undertaken through bi-annual surveillance assessments, annual reviews, data quality audits, and cross-district learning exchanges. Feedback loops between national and subnational levels will ensure that data translates into a rapid, actionable response.

2. Monitoring and Evaluation

Monitoring will rely on dashboards and automated analytics tailored to different system users, enabling real-time tracking and dissemination of prioritized indicators. Routine data quality assessments, combined with supportive supervision at the facility, district, and national levels, will inform action plans, strengthen accountability, and close performance gaps. National and district scorecards will be widely shared, including through platforms such as the ALMA scorecard, to enhance transparency and guide corrective actions with all stakeholders.

Evaluation will include quarterly and annual programme reviews convened through the TWG to assess progress and guide course correction. A mid-term review (2028) will assess progress, financing efficiency, and readiness for elimination, while an end-term review (2030) will evaluate impact, verify achievement of zero deaths and incidence reduction targets, and inform the development of the next national plan. Advanced modelling and analytics will be used throughout to identify transmission drivers, optimize intervention mixes, estimate impact, and refine resource allocation.

3. Learning and Research

Uganda will pursue an operational research agenda focused on vector behaviour, drug resistance, vaccines, diagnostics, and elimination strategies, complemented by implementation research to test scalable models in elimination demonstration zones. Evidence generation will be strengthened through partnerships with research and academia, the WHO, and regional networks, while structured learning

exchanges across districts, regions, and neighbouring countries will support adaptation and continuous improvement.

4. Mutual and Social Accountability Framework

The successful transition from malaria control to elimination requires more than technical interventions and financial resources; it demands a robust system of accountability that is both mutual and socially driven. This framework ensures that all stakeholders, from national policymakers to community members, are mutually responsible for their commitments and that citizens are empowered to hold service providers and leaders accountable as well as perform their obligations.

This Framework is anchored in four foundational principles that, together, foster a culture of shared responsibility and continuous improvement. It is fundamentally driven by transparency and access to information, ensuring all malaria-related data, budgets, and performance results are publicly available in accessible formats. This transparency enables inclusive participation, actively engaging communities, civil society, the private sector, and marginalized groups in planning, monitoring, and review processes. The framework is built on the concept of mutual responsibility, defining clear roles for both duty-bearers and rights-holders to create a partnership for progress. Ultimately, these elements are directed toward action and remediation, ensuring that accountability leads not just to the identification of gaps but to concrete solutions and tangible improvements in service delivery and outcomes.

Components of the Framework

The framework will operate at four interconnected levels: national, subnational, and community (See Annex 8).

Cross-Sectoral Level: Accountability is anchored in mutual commitment and review. Key ministries sign a Multisectoral Performance Compact committing to specific malaria-related actions. Progress is reviewed quarterly by the Inter-Ministerial Steering Committee, which identifies and resolves bottlenecks, ensuring that non-health sectors actively contribute to malaria elimination. Performance is tracked through sector-specific indicators to promote shared responsibility.

National Level: Accountability at this level is driven by public transparency and high-level scrutiny.

- Annual Malaria Accountability Forum: Co-chaired by the Ministry of Health and the Uganda Parliamentary Forum on Malaria (UPFM), this event publicly reviews the National Malaria Scorecard. Ministries, agencies, development partners, the private sector, and CSOs present results and commitments, reinforcing mutual accountability for financing and results.
- Public Performance Dashboard: A real-time, online dashboard linked to the National Malaria Data Repository will display key indicators, funding flows, commodity stocks, and incidence trends, enabling transparent tracking by all stakeholders.
- Joint Sector Reviews: Malaria performance will remain a standing agenda item in Health Sector Joint Annual Reviews, ensuring alignment with the "Three Ones" principle and sustained national prioritization.

Subnational Level: At this level, accountability is strengthened through local oversight and competitive performance.

- LG Malaria Accountability in the Social Services Committee: Chaired by the Social Services Committee Chairperson and comprising DHOs, CSOs, private sector, and media, DMACs will quarterly review District Malaria Action Plan (DMAP) performance, interrogate scorecards, validate data, and address bottlenecks in financing, commodities, or staffing.
- Performance-Based League Tables: Districts will be ranked quarterly using composite indicators (e.g., reporting completeness, LLIN use, case fatality rate). Results will be published to stimulate healthy competition and drive improvement.
- Service Compacts: Each health facility will publicly display its service commitments alongside community responsibilities, establishing clear mutual expectations.

Community Level: Accountability at the community level is based on direct feedback and joint action.

- Community Scorecard Meetings: Facilitated by VHTs/CHEWs and CSOs, these meetings bring together community members, health workers, and leaders to assess malaria services, examining waiting times, stock-outs, and staff conduct, and jointly develop village or parish action plans.
- Participatory Public Expenditure/commodity Tracking: Health Unit Management Committees (HUMCs), CSOs, and Parish Development Model committees will track malaria resources from district to community level, ensuring transparency, reducing leakages, and empowering communities as frontline drivers of service quality

5. MERLA Governance and Institutional Arrangements

The MERLA framework will be coordinated through a multi-level governance system that ensures accountability, effective use of evidence, and continuous learning. At the national level, the SMEOR TWG, chaired by NMED with participation from MoH, UBOS, academia, and partners, will provide oversight and technical guidance. At the subnational level, District Malaria Action Committees will review local data and adjust interventions accordingly. Community structures (including VHTs, PDM committees, and CSOs) will be engaged in participatory monitoring and feedback loops to strengthen local ownership. An Annual National Malaria Forum will convene all stakeholders to review performance, share lessons, and reinforce accountability across the programme.

7.3. Digital Transformation

Digital technologies will drive the MERLA system by enabling real-time reporting, seamless integration, and evidence-based decision-making. The strategy prioritizes full interoperability of DHIS2, eCHIS, eLMIS, and EMRs to create a unified malaria data ecosystem. Geospatial mapping and predictive analytics will be applied to identify hotspots and guide targeted interventions. Mobile data collection tools will be rolled out to VHTs for timely community-level surveillance, while dashboards and visualization tools will be scaled up at district and facility levels to support analysis and action. Interoperability with civil registration and vital statistics (CRVS) will be expanded to strengthen mortality reporting and improve accountability.

7.4. Data Quality and Use

Data quality and use will be strengthened through institutionalized routine DQAs at national and district levels, ensuring accuracy and reliability across all reporting systems. Health workers, VHTs, and district teams will receive continuous training and mentorship in data entry, analysis, and application. National

and district data review committees will validate and interpret surveillance data, translating findings into timely action. A strong culture of evidence-based use will be promoted, ensuring that data directly inform district malaria action plans, guide resource allocation, and drive accountability at all levels.

7.5. Data management process and roles

Uganda's malaria data management follows a structured cycle (collection, aggregation, analysis, quality assurance, and use), ensuring that information generated at the community and facility levels informs district and national decision-making. Uganda's 2024 national surveillance assessment highlighted persistent weaknesses: inconsistent data quality and timeliness, fragmented community reporting, and siloed entomology, drug efficacy, and vector control datasets with limited NMED ownership. Strengthening integration, responsiveness, and linkages between data and action is therefore a core objective of this UMESP.

- **Data Collection.** At the community level, VHTs and CHWs capture data on testing, treatment, referrals, and prevention in standardized registers. Health facilities (HCII–HCIV and hospitals) record outpatient, inpatient, laboratory, and commodity data, including confirmed malaria cases, severe malaria, malaria in pregnancy, and medicine use.
- **Aggregation and Reporting.** Facility in-charges compile monthly summaries for submission to District Health Offices. District biostatisticians verify the completeness, timeliness, and consistency of data before uploading it to DHIS2, while district malaria focal persons provide oversight on malaria indicators and utilize the data for planning and resource allocation.
- **Consolidation and Analysis.** At the national level, the National Malaria Elimination Division (NMED) consolidates reports, supervises data quality, and produces malaria bulletins. The MoH Resource Centre maintains DHIS2 and ensures interoperability with eLMIS, entomological, and genomic databases. Technical Working Groups (TWGs) review and analyse data to inform stratification, intervention design, and policy adjustments.
- **Data Quality Assurance.** Routine DQAs at facilities and districts compare registers, reports, and DHIS2 entries, with issues documented in improvement plans. District and national teams provide supportive supervision, feedback, and corrective action through standardized action plans.
- **Data Use and Feedback.** Data informs District Malaria Action Plans, epidemic detection, hotspot identification, and adjustments to interventions. Routine data review meetings at all levels document gaps, assign responsibilities, and track follow-up actions to ensure effective implementation. Nationally, NMED and MoH utilize consolidated data for policy development, programmatic stratification, donor reporting, and program performance reviews. Partners (including CSOs, academia, and the private sector) generate complementary data (TES, IRS/ITN campaigns, genomics) that NMED integrates into the national system.

7.6. Data Management System

Malaria data in Uganda is generated through multiple systems that often operate in parallel, requiring stronger integration for effective use. The Health Management Information System (HMIS/DHIS2) remains the backbone, capturing routine case, testing, and treatment data from public and selected private facilities. However, several complementary streams need to be aligned with HMIS for a unified system.

The Logistics Management Information System (eLMIS) tracks commodity availability, consumption, and distribution, while community information systems capture VHT-reported malaria cases and treatments, though reporting is often irregular and partner-dependent. Entomological and vector control databases contain data on vector bionomics, insecticide resistance, IRS, and LLIN campaigns, typically managed outside national platforms. Therapeutic efficacy and genomic surveillance data are generated by research institutions and partners but are not systematically integrated into national databases. Additionally, partner-led monitoring platforms, maintained by CSOs and implementing agencies, often operate independently and are not fully aligned with national standards. Finally, surveys and special studies (including the Malaria Indicator Survey, Demographic and Health Surveys, and other research) provide periodic, complementary insights.

The harmonized data management system will bring these streams together, ensuring comprehensive, timely, and reliable information for planning, decision-making, and accountability in malaria elimination.

ANNEXES

Annex 1: Implementation Plan

Strategy	Activity	Responsible Actor(s)*	Timeline (Year)
SO 1: Universal Case Management & Chemoprevention			
Strengthen prompt parasite-based diagnosis	Ensure uninterrupted access to quality-assured RDTs and microscopy commodities at all levels	NMED (Diagnostics Unit); NMS; District Health Teams (DHTs); Facility In-Charges; VHTs/CHWs; Partners (WHO, CHAI)	2026–2030
	Build capacity of ≥90% lab staff in microscopy/RDT use (refresher every 2 yrs)	NMED (HRH/Training); Regional Referral Hospitals; DHT Lab Focal Persons; Professional Councils	2026–2030 (refresher 2027 & 2029)
	Introduce external quality assurance (EQA) schemes in all districts	NMED Lab Reference Centre; UVRI; DHT Lab Focal Persons; WHO/CDC	Pilot 2026 → Scale 2027–2030
	Targeted SBCC for early care-seeking (24 h)	NMED ACSM Desk; DHT Health Educators; Parish Development Model Committees; CSOs/FBOs	2026–2030
Improve prompt access to quality-assured treatment	Maintain ACTs/severe malaria medicines at all facilities	NMED Procurement/Supply; NMS; DHT Stores; Private Wholesalers (NDA-regulated)	2026–2030
	Institutionalize 24/2-hour protocols for severe malaria	NMED Case Mgmt Unit; DHT Clinical Mentors; Hospital Medical Supers; VHT Coordinators	Roll-out 2026–2027 → Sustain 2028–2030
Expand CCM/iCCM, incl. the private sector	Expand iCCM through VHTs/CHEWs; Roll out CCM for all ages in priority areas; Map/accredit private providers; Integrate private reporting to DHIS2/eCHIS	NMED Community Health Desk; DHT/VHT Coordinators; NDA; Private Provider Associations; CSOs	Mapping 2026–2027 → Accreditation 2027–2028 → Sustain 2029–2030
Protect high-risk groups	IPTp ≥90%; Expand SMC; Pilot IPTsc/IPTi; Scale R21 vaccine	NMED RMNCAH & Case Mgmt Units; DHT RMNCAH Focal Persons; ANC/MCH Clinics; VHTs; GAVI/WHO/UNICEF	IPTp/SMC 2026–2027 → IPTsc/IPTi Pilot 2028 → Vaccine 2026–2030

Strategy	Activity	Responsible Actor(s)*	Timeline (Year)
SO 2: Integrated Vector Management			
Achieve universal ITN coverage	Mass ITN campaigns; Procure & distribute ITNs; Maintain continuous channels; ACSM on correct use; Engage private sector	NMED Vector Control; NMS; DHTs; Parish Committees; Private Distributors; CSOs	Mass 2026 & 2029; Continuous 2026–2030
IRS in prioritized districts	Conduct IRS in eligible high-burden districts; Focal IRS in moderate/low; ACSM for IRS uptake; Scale IRS/fumigation in urban areas via the private sector; Build local IRS capacity; Implement IRS transition plans	NMED IRS Unit; DHT IRS Teams; Parish Leaders; Partners (PMI/CHAI); CSOs	Annual cycles 2026–2030
Larval Source Mgmt & new tools	Deploy Environmental LSM; Community-led environmental campaigns; Pilot/adopt outdoor tools (spatial emanators)	NMED Environmental Health; Municipal Councils; DHT Environmental Officers; Local Gov't Works/Water Depts; Research Institutes	LSM 2027–2030; Campaigns 2027–2030; Pilots 2027–2028 → Scale 2029–2030
Multisectoral integration	Advocacy & stakeholder engagement; Strengthen collaboration across sectors (WASH, agriculture, housing, education); Engage PPPs & CSOs for IVM implementation	MoH/NMED; MoLG; MoWE; MoES; MoFPED; DHT Councils; Private Sector & CSOs	2026–2030
SO 3: Surveillance, Monitoring & Evaluation & Operational Research			
Integrated SME Framework	Develop/update surveillance guidelines & SOPs; Train/mentor surveillance cadres; Provide ICT infrastructure; Enforce mandatory private sector reporting	NMED Surveillance Unit; HMIS Division; DHT Biostatisticians; VHTs; Partners	Guidelines 2026–2027 → Training 2026–2030 → ICT Roll-out 2026–2028 → Enforcement 2027–2030

Strategy	Activity	Responsible Actor(s)*	Timeline (Year)
Strengthen surveillance systems	Establish case-based surveillance in low areas; Village/zone line-listing for foci; Integrated sentinel sites; TES/genomic surveillance/ ex-vivo assays for susceptibility testing; Annual insecticide resistance monitoring; Entomological surveillance; Malaria death surveillance; Routine community data collection; Build elimination surveillance capacity	NMED; UVRI; DHTs; Regional Hospitals; VHTs; Research Institutions	Phased 2026–2030 (Case-based from 2027; Sentinel sites start 2026; TES/IR yearly; Capacity build 2026–2029)
Improve data systems	Enhance eHIS/HMIS/EMR; Integrate malaria data across sectors; Expand eCHIS nationwide; Operationalize National Malaria Data Repository	MoH Digital Health; NMED; DHTs; PDM Committees	eHIS/HMIS upgrade 2026–2027; eCHIS rollout 2026–2028; Repository operational 2027–2030
Strengthen data quality & use	Develop National DQA workplan; Conduct quarterly DQAs; Institutionalize malaria surveillance reviews; Two-way feedback; Cross-thematic dashboards; Disaggregated analysis; Train district/facility staff in data use	NMED M&E; DHT Biostatisticians; Facility HMIS Clerks; Partners	2026–2030
Epidemic preparedness & response	Develop EPR guidelines/SOPs; Maintain district EPR plans; Implement malaria early warning systems; Establish detection mechanisms; Pre-position commodities; Deploy Rapid Response Teams; Conduct post-epidemic evaluations	NMED EPR Desk; Public Health EOC; OPM; DHT RRTs; Regional Hospitals	Guidelines 2026; Plans 2026; Drills annually 2027–2030
Research & innovation	Establish malaria research agenda; Support pilot/testing of new tools; Set up elimination demo zones; Conduct routine reviews (Annual, Mid-Term 2028, End-Term 2030)	NMED Research Desk; UVRI; Makerere Univ; WHO/RBM/CHAI; DHTs	Agenda 2026; Pilots 2026–2030; Reviews 2026–2030
SO 4: Governance, Financing & Multisectoral Collaboration			
Strengthen programme management	Build management capacity (national & district); Maintain functional TWGs & committees	NMED HRH/Planning; MoLG; DHTs; Regional Hospitals; Partners	Training 2026–2028 → Sustain 2029–2030

Strategy	Activity	Responsible Actor(s)*	Timeline (Year)
Enhance coordination & partnerships	Strengthen CSO & Private Sector coordination; Ensure partner alignment via joint planning	NMED Private Sector Desk; UCAAM; Employer Associations; Partners; DHT Community Focal Points	2026–2030
Mobilize sustainable financing	Increase domestic budget allocations; Leverage innovative financing (bonds, levies, CSR)	MoFPED; NMED; End Malaria Council; Private Sector	2026–2030
Ensure commodity security & accountability	Strengthen supply chain management; Conduct quarterly supportive supervision; Annual district performance reviews; Publish annual programme reports	NMED Procurement; NMS; NDA; DHT Stores; Facility In-Charges	2026–2030
Advocacy, communication & social mobilization	Policy landscape analysis; Mass/social media campaigns; Engage leaders & grassroots; Commemorate malaria observances	NMED ACSM Unit; DHT Health Educators; CSOs; Media Council	2026–2030

*Levels of responsibility: *National (NMED, MoH Depts, NMS, UVRI, MoFPED, MoLG, MoWE, MoES); Sub-national (DHTs, Regional Hospitals, Parish Development Committees, Facility In-Charges, VHT/CHEWs); Other actors (WHO, RBM, PMI, CHAI, Malaria Consortium, UNICEF, GAVI, End Malaria Council, CSOs/FBOs, Private Sector, Research Institutions).*

Annex 2: Performance Framework (Key Indicators)

Code	Indicator Name	Operational definition	Indicator Type	Disaggregation	Source	Frequency	Level	Responsible
G1	Goal 1: Achieve zero malaria deaths							
G1.1	Number of reported malaria deaths (all ages)	N: WHO point estimate of malaria deaths D: None	Impact	(Age group (<5,5-15,>15), Sex	World Malaria Report	Annual	National	Programme Manager, DHO
G1.2	Malaria case fatality rate	N: Number of deaths due to malaria D: Total inpatient confirmed malaria cases	Impact	(Age group (<5,5-15,>15), Sex	HMIS	Annual	National, District	Programme Manager, DHO
3	Proportion of all reported deaths attributed to malaria (%)	N: Reported patients admitted to hospital and people in the community who died from malaria x 100 D: Reported number of all-cause deaths	Impact	None	HMIS	Annual	National, District	Programme Manager, DHO
G1.4	In-patient malaria deaths (rate per 100,000 person per year)	N: Number of in-patient malaria deaths x 100,000 D: Total population	Impact	(Age group (<5,5-15,>15), Sex	HMIS & Census & District Data	Monthly	National, District	Programme Manager, DHO
G1.5	Proportion of districts achieving zero malaria deaths (%)	N: Number of districts that reported zero confirmed malaria deaths D: Total number of districts that reported malaria cases	Outcome	Annual	HMIS	Annual	National	Programme Manager, DHO

G2	Goal 2: Reduce national malaria incidence by ≥75% (per 1,000 population)							
G2.1	Confirmed malaria incidence (per 1,000/year)	N: Number of confirmed malaria cases x 1 000 D: Population at risk (number of people living in areas where malaria transmission occurs)	Impact	(Age group (<5,5-15,>15), Sex	HMIS & Census & District Data	Annual	National, District, Subcounty	Programme Manager, DHO
G2.2	Malaria test positivity rate (TPR) (%)	N: Number of confirmed malaria cases (by microscopy or RDT) x 100 D: Number of patients who received a parasitological test	Impact	Type of Testing	HMIS	Annual	National, District, Sub-County	Programme Manager, DHO
G2.3	Parasite prevalence in children under 5 years (%)	N: Number of children aged 6-59 months with malaria infection detected by rapid diagnostic test or microscopy D: Total number of children aged 6-59 months tested for malaria parasites by rapid diagnostic test or microscopy	Impact	None	Surveys	Every 2-3 years	National, Regional	Programme Manager, DHO
G3	Goal 3: Attain pre-elimination status in at least 19 districts							
G3.1	Number of districts reporting ≤1 confirmed case per 1,000 population per year	N: Number of districts with less than 1 case per 1000 D: None	Impact	None	HMIS	Annual	District, Subcounty	Programme Manager, DHO
G3.2	Number of districts reporting zero malaria deaths	N: Number of districts reporting zero malaria deaths D: None	Impact	None	HMIS	Annual	District, Subcounty	Programme Manager, DHO

G3.3	Proportion of districts achieving zero malaria deaths (%)	N: Number of districts that reported zero confirmed malaria deaths X 100 D: Total number of districts that reported malaria cases	Impact	Annual	HMIS	Annual	National	
G3.4	Number of districts classified as high transmission	N: Number of districts categorized as High transmission D: None	Impact	None	HMIS	Annual	District, Subcounty	Programme Manager, DHO
G3.5	Number of districts classified as Moderate transmission	N: Number of districts categorized as Moderate transmission D: None	Impact	None	HMIS	Annual	District, Subcounty	Programme Manager, DHO
G3.6	Number of districts classified as low transmission	N: Number of districts categorized as low transmission D: None	Impact	None	HMIS	Annual	District, Subcounty	Programme Manager, DHO
SO1	**SO1: Universal access to case management and chemoprevention**							
SO1.1	Proportion of suspected malaria cases tested for malaria (all sectors) (%)	N: Number of all suspected malaria cases that received a parasitological test across all sectors x 100 D: Number of all suspected malaria cases that present across all sectors	Outcome	Type of Testing	HMIS	Annual	District, Subcounty	Focal person-Diagnosis
SO1.2	Proportion of suspected cases tested per national policy – private sector (%)	N: Number of all suspected malaria cases that received a parasitological test at private sector sites x 100 D: Number of all suspected	Outcome	Type of Testing	HMIS	Annual	District, Subcounty	Focal person-Diagnosis

		malaria cases that present at private sector sites						
SO1.3	Proportion of suspected cases tested per national policy – public sector (%)	N: Number of all suspected malaria cases that received a parasitological test at public sector health facilities x 100 D: Number of all suspected malaria cases that present at public sector health facilities	Outcome	Type of Testing	HMIS	Annual	District, Subcounty	Focal person-Diagnosis
1.4	Proportion of suspected cases tested per national policy – community level (%)	N: Number of all suspected malaria cases that received a parasitological test in the community x 100 D: Number of all suspected malaria cases in the community	Outcome	Type of Testing	HMIS	Annual	District, Subcounty	Focal person-Diagnosis
SO1.5	Proportion of confirmed malaria cases in children under five treated within 24 hours from the onset of fever (%)	N: Number of children aged <5 yrs with confirmed malaria who received a recommended antimalarial within 24 hrs from the onset of fever. D: Total number of children aged <5 yrs with confirmed malaria	Outcome	None	Surveys	Every 2-3 years	National, Regional	Focal person-Case Management

SO1.6	Proportion of confirmed malaria cases treated according to national guidelines (all sectors) (%)	N: Number of reported patients with confirmed malaria who received antimalarial treatment according to national policy across all sectors D: Total number of reported malaria cases across all sectors	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal person-Case Management
SO1.7	Proportion of confirmed cases treated per policy – private sector (%)	N: Number of reported patients with confirmed malaria who received antimalarial treatment according to national policy in the private sector D: Number of confirmed malaria cases at private sector sites	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal person-Case Management
SO1.8	Proportion of confirmed cases treated per policy – public sector (%)	N: Number of confirmed malaria cases treated who received first-line antimalarial treatment according to national policy at public sector health facilities D: Number of confirmed malaria cases at public health facilities (found by both passive and active surveillance)	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal person-Case Management

SO1.9	Proportion of confirmed cases treated per policy – community level (%)	N: Number of reported patients with confirmed malaria who received antimalarial treatment according to national policy in the community D: Total number of reported confirmed malaria cases in the community	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal person-Case Management
SO1.10	Proportion of all malaria cases reported from the community level (VHTs/CHWs) (%)	N: Number of confirmed malaria cases reported from the community D: Total number of reported confirmed malaria cases across all sectors	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal Person-ICCM
SO1.11	Proportion of severe malaria cases among all confirmed cases (%)	N: Number of inpatient cases with a discharge diagnosis of malaria D: Total number of confirmed cases during the reporting period	Outcome	(Age group (<5,5-15,>15), Sex	HMIS	Annual	District, Subcounty	Focal person-Case Management
SO1.12	Proportion of pregnant women receiving ≥3 doses of IPTp (IPTp3+) (%)	N: Number of pregnant women attending antenatal clinics during a specified period who received three or more doses of intermittent preventive treatment for malaria D: Number of first antenatal clinic visits during the specified period.	Outcome	None	HMIS	Annual	District, Subcounty	Focal person-Chemoprevention

SO1.13	Proportion of eligible children in SMC districts who completed all scheduled SMC cycles (%)	N: Number of children who received the full number of courses of SMC in a transmission season D: Number of children requiring SMC(eligible)	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-Chemoprevention
SO1.14	Proportion of eligible children who received the first dose of the R21 malaria vaccine (%)	N: Number of eligible children who received the first doses of malaria vaccine x 100 D: Total number of eligible children	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-Chemoprevention
SO1.1	Proportion of eligible children who received at least three doses R21 malaria vaccine (%)	N: :Number of eligible children who received ≥3 doses of malaria vaccine x100 D: Total number of eligible children who received the first dose	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-Chemoprevention
SO2	**SO2: Vector control coverage and use**							
SO2.1	Proportion of households with at least one ITN for every two persons (%)	N: Number of households with at least one ITN for every two people D: Total number of households surveyed	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-ITNs
SO2.2	Proportion of population that slept under an ITN the previous night (%)	N: Number of individuals who slept under an ITN the previous night D: Total number of individuals who spent the previous night in surveyed households	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-SBCC

SO2.3	Number of targeted districts covered by Indoor Residual Spraying (IRS)	N: Number of districts targeted for IRS in the NSP D: None	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-IRS
SO2.4	Proportion of pregnant women that slept under an ITN the previous night (%)	N: Number of pregnant women who slept under an ITN the previous night. D: Total number of pregnant women within surveyed households	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-SBCC
SO2.5	Proportion of children under five who slept under an ITN the previous night (%)	N: Number of children under five years old who slept under an ITN the previous night D: Total number of children under five years old who spent the previous night in surveyed households	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-SBCC
SO2.6	Proportion of targeted districts where IRS was implemented in the previous 12 months (%)	N:Number of districts where IRS was conducted within the previous 12 months. D:Number of districts targeted for IRS during the same period, as defined in the NSP	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Programme Manager
SO2.7	Proportion of targeted population protected by IRS districts (%)	N: Number of persons living in households that received at least one round of IRS within the last 12 months D: Number of persons	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-IRS

		living in areas targeted for IRS						
SO2.8	Proportion of targeted local governments (districts) that implemented larval source management (LSM) within the last 12 months (%)	N: Number of targeted local governments (districts) that implemented at least one form of LSM intervention D: Number of local governments (districts) targeted or planned for LSM implementation, as defined in the NSP.	Outcome	None	HMIS & Census & District Data	Annual	National,District, Subcounty	Programme Manager
SO3	**SO 3: Surveillance, Monitoring, and EPR**							
SO3.1	Proportion of expected health facility reports submitted to DHIS2 (%)	N: Number of reports received from health facilities in a specified period x 100 D: Number of reports expected from health facilities in the same specified period	Outcome	Public, Private, Community	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-SMEOR
SO3.2	Proportion of expected reports submitted on time (%)	N: Number of reports received from health facilities by the reporting due date in a specified period x 100 D: Number of reports expected from health facilities in the same specified period	Outcome	Public, Private, Community	HMIS & Census & District Data	Annual	National,District, Subcounty	Focal person-SMEOR

SO3.3	Proportion of targeted district cluster-sentinel sites that conducted integrated malaria surveillance data reviews within the last 12 months (%)	N: Number of targeted sentinel sites that implemented at least two types of malaria surveillance activities within the last 12 months: D: Total number of sentinel sites targeted for integrated malaria surveillance as per the NSP	Outcome	None	HMIS/Reports	Annual	National	Focal person-SMEOR
SO3.4	Proportion of targeted districts conducting entomological surveillance as per guidelines (%)	N: Number of targeted districts that conducted the planned entomological surveillance activities during the previous 12 months. D: Total number of districts targeted for entomological surveillance as per the NSP	Outcome	None	HMIS/Reports	Annual	National	Focal person-SMEOR
SO3.5	Proportion of estimated malaria cases detected through the national surveillance system (%)	N: Number of all (confirmed and presumed) malaria cases identified through active and passive surveillance and reported over 1 year D: Estimated number of malaria cases over 1 year	Outcome	None	HMIS/Reports	Annual	National	Focal person-SMEOR
SO3.6	Proportion of malaria epidemics detected in time (%)	N: Number of malaria epidemics detected in time as per the guideline D: Total number of malaria epidemics that occurred	Outcome	None	HMIS/Reports	Annual	National	Focal person-EPR

SO3.7	Proportion of malaria epidemics detected and responded to per EPR guidelines (%)	N: Number of malaria epidemics that were detected and responded to in accordance with national guidelines D: Total number of malaria epidemics that occurred	Outcome	None	HMIS/Reports	Annual	National	Focal person-EPR
SO4	**SO4: Governance, Financing, Multisector Collaboration**							
SO4.1	Proportion of non-health private sector entities certified as 'malaria-smart' (%)	N: Number of non-health private sector entities that were certified or recognized as 'malaria-smart' X100 D: Total number of non-health private sector entities targeted by NMED	Outcome	Annual	HMIS	Annual	National	Focal person-Private Sector
SO4.2	Proportion of districts with malaria integrated into their sector plans	N: Number of districts whose sector development or annual plans include malaria-related interventions X 100 D: Total number of districts	Outcome	Annual	District Development Plans	Annual	National, District	Focal person-Multisectoral
SO4.3	Proportion of the NSP budget funded from domestic sources (%)	N: Total amount of domestic funding disbursed for malaria programme implementation X 100 D: Total approved NSP budget (costed malaria strategic plan)	Outcome	Annual & Cumulative	HMIS	Annual	National	Programme manager, DHO
SO4.4	Proportion of districts allocating funds to malaria (code 000064) (%)	N: Number of districts allocating funds to malaria	Outcome	Annual	District budgets	Annual	National, District	Focal person-Multisectoral, DHO

		D: Total number of districts						
SO4.5	Proportion of NSP malaria budget funded from all sources (%)	N: Total funds mobilized for malaria programme implementation from all sources (domestic and external). D: Total malaria resource requirement as outlined in the NSP	Outcome	Annual	Programme Report	Annual	National	Programme manager, DHO
SO4.6	Proportion of planned activities fully implemented (%)	N: Number of planned annual malaria activities fully implemented D: Total number of malaria activities planned for implementation	Outcome	Cumulative	Programme Report	Annual	National, District	All focal persons, DHOs
SO4.7	Proportion of available annual workplan budget absorbed (%)	N: Total funds expended on malaria programme implementation D: Total funds released or made available for the malaria annual workplan	Outcome	Annual	Programme Report	Annual	National, District	Programme manager, DHO
SO4.8	Proportion of planned advocacy and SBCC initiatives implemented (%)	N: Number of planned advocacy and SBCC initiatives implemented within the reporting period. D: Total number of advocacy and SBCC initiatives planned for implementation	Outcome	Annual	Programme Report	Annual	National, District	Focal person-Advocacy

Annex 3: Key Performance Indicator Matrix

Strategic Objective 1: Achieve universal access to timely and quality malaria case management services

Result Area	Indicator	Baseline	Target 2030	Means of Verification	Responsible Entity
Quality diagnosis	% of malaria cases tested before treatment	98%	≥98%	HMIS/DHIS2	NMED, DHTs
Quality treatment	% of confirmed cases receiving ACTs	96%	≥99%	HMIS/DHIS2	NMED, DHTs
Community access	% VHTs trained and active in iCCM	65%	90%	CHW reports	NMED, CHD

Strategic Objective 2: Expand coverage and uptake of effective malaria prevention interventions

Result Area	Indicator	Baseline	Target 2030	Means of Verification	Responsible Entity
LLIN/IRS coverage	% of population protected by vector control	85%	95%	Campaign reports	Vector Control Division
IPTp uptake	% of pregnant women receiving 3+ doses of IPTp	60%	90%	ANC registers	RMNCH, NMCD
SMC implementation	% eligible children receiving full SMC cycles	0%	85%	SMC reports	NMED, DHTs

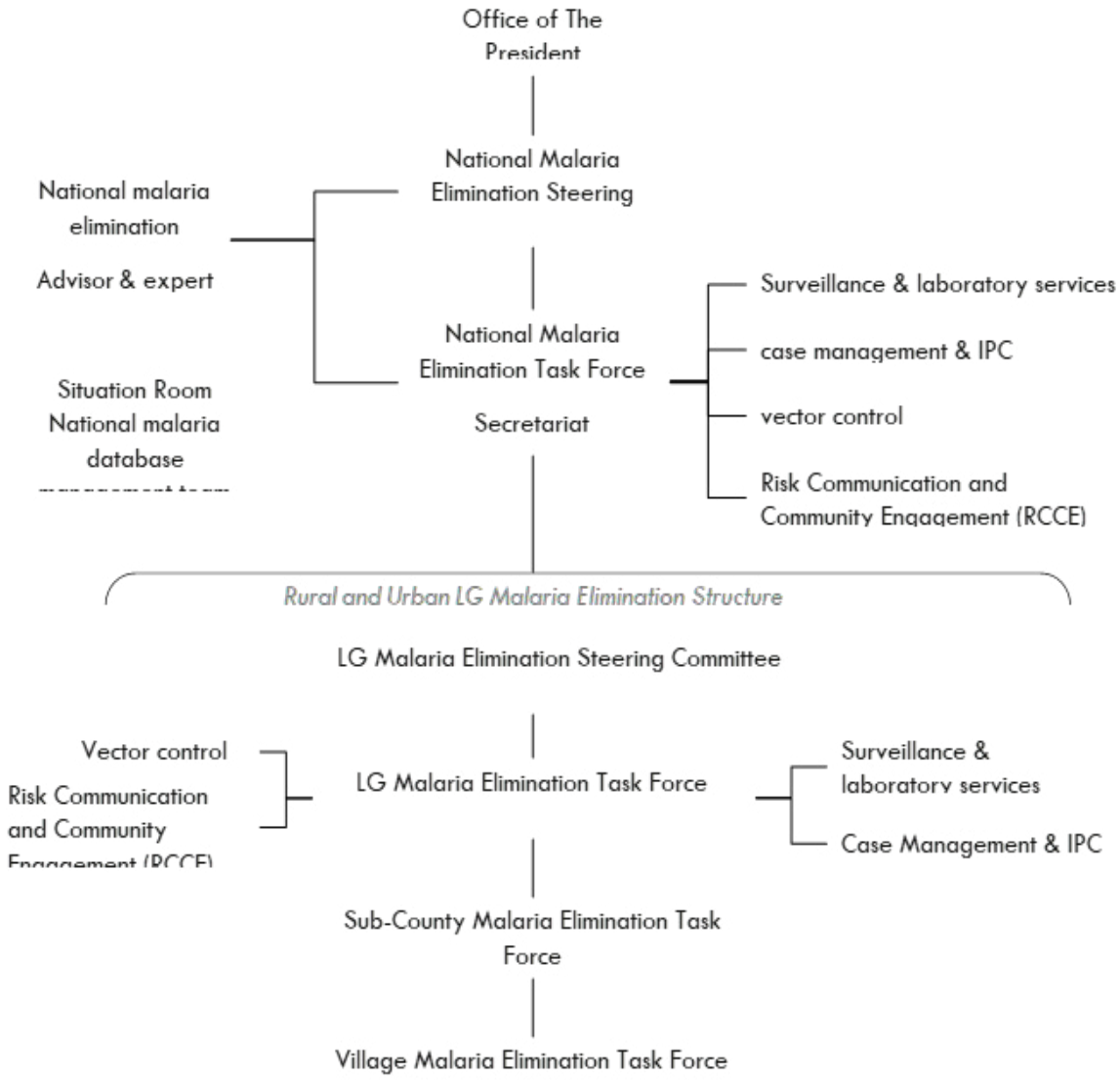
Strategic Objective 3: Strengthen surveillance, monitoring, evaluation, and operational research

Result Area	Indicator	Baseline	Target 2030	Means of Verification	Responsible Entity
Surveillance coverage	% of health facilities reporting timely & complete data	82%	≥95%	DHIS2	NMCD, DHOs
Private sector integration	% private providers reporting malaria data	40%	85%	Private sector reports	NMCD, HFA
Entomological surveillance	# functional sentinel sites	7	15	Vector surveillance reports	EPR Unit

Strategic Objective 4: Ensure effective program coordination, capacity, integration, and sustainable financing

Result Area	Indicator	Baseline	Target 2030	Means of Verification	Responsible Entity
Coordination	% of districts with functional malaria coordination committees	50%	90%	DHMT assessments	NMCD, MOH
Integration	% of malaria activities integrated in RMNCH/HIV services	TBD	75%	Facility assessments	MOH Programs
Financing	% of malaria financing from domestic sources	15%	30%	Budget review	MoFPED, NMCD

Annex 4: Proposed Elimination Organogram



Annex 5: Cost Constrained Scenario Analysis

Financing Scenarios Summary (2025–2030)

Financing Element	Scenario 1: Full-Scale Implementation	Scenario 2: Moderate Scale-Up	Scenario 3: Resource-Constrained Implementation
Total Estimated Cost (USD '000)	**1,749,536**	**1,240,243**	**871,961**
Projected Domestic Contribution	35% (USD 612 million)	30% (USD 372 million)	25% (USD 214 million)
Projected Partner Contribution	65% (USD 1,137 million)	70% (USD 868 million)	75% (USD 642 million)
Domestic Financing Growth Target (2025–2030)	Increase from 28% to 35% of annual malaria budget by 2030	Increase from 25% to 30% by 2030	Maintain baseline at ~25%
Key Domestic Financing Sources	Ministry of Finance (MoFPED) allocations; PHC grants; NMS budget lines for LLINs, IRS, and diagnostics; Local Government contributions via PDM	MoFPED allocations; performance-based financing; partial cost recovery for vaccines; LG contributions	Minimal MoFPED allocation; reliance on routine PHC and Global Fund top-ups
Key Partner Financing Sources	Global Fund (IRS, LLINs, diagnostics, M&E); PMI (IRS, case management); GAVI (malaria vaccine rollout); WHO and GIZ (technical assistance)	Global Fund and PMI (co-financing of IRS and LLINs); GAVI (vaccine scale-up); UNICEF and WHO (systems strengthening)	Global Fund and PMI cover essential commodities and IRS; reduced systems and surveillance funding
Private Sector and PPP Mechanisms	Public–Private Partnerships (PPPs) for larviciding, logistics, and workplace programs; CSR contributions from large employers; insurance-linked malaria cover	PPPs for larviciding and vector control in cattle corridors; malaria coverage in health insurance plans	Ad-hoc private donations and limited CSR engagement
Innovative and Blended Financing Options	Consider Health and environmental levies earmarked for vector control; climate finance integration (Green Climate Fund, GCF); malaria bonds	Blended financing pilots through World Bank, African Development Bank, or regional health initiatives	Not applicable; limited capacity for co-financing or leverage
Transition Milestones (Domestic vs Partner Share)	2025: 30% domestic / 70% partner Up to 2030: 50% domestic / 50% partner	2025: 25% domestic / 75% partner Up to 2030: 40% domestic / 60% partner	Maintain ~25% domestic / 75% partner throughout 2025–2030
Sustainability Risk	Moderate: requires high absorptive capacity and robust coordination	Low: gradual, achievable financing growth	High: dependence on donor funds; risk of reversal
Strategic Implication	Accelerated elimination through shared investment and innovation	Steady progress with fiscal realism and efficiency gains	Slower progress; limited system resilience and higher long-term costs

Annex 6: Comparison of Uganda Malaria Elimination Strategy Costing Scenarios

Intervention Area	Scenario 1: Full-Scale Implementation	Scenario 2: Moderate Scale-Up	Scenario 3: Resource-Constrained Implementation
Expected Outcomes by 2030	Malaria burden reduced to low levels nationally; strong foundation for pre-elimination phase.	Significant burden reduction and progress toward nationwide low transmission.	Moderate reduction in malaria incidence; slower progress toward elimination.
Strategic Objective	Achieve low malaria burden status in all districts by 2030 through intensive, nationwide implementation.	Reduce malaria burden so that low levels by 2030.	Achieve gradual burden reduction in high-burden districts by 2030 within available financial and operational resources.
Implementation Intensity	Vigorous and comprehensive rapid nationwide scale-up of all interventions within the first three years.	Moderate and phased prioritizing high and moderate-burden districts for gradual coverage expansion.	Minimal and selective focusing on essential, cost-effective interventions in priority areas.
Geographic Coverage by 2030	All 146 districts attain low malaria burden status.	66 high-burden to moderate, moderate to low-burden districts.	66 high-burden districts transition to moderate burden levels.
Implementation Timeline	Intensive investment and activity during the first three years (2025–2027), followed by consolidation and surveillance.	Balanced investment throughout the five-year period (2025–2030).	Incremental progress across 2025–2030, guided by resource availability.
Interventions			
Indoor Residual Spraying (IRS)	Rapidly scale up IRS in all 66 high-burden and moderate-burden districts within the first three years, maintaining annual coverage thereafter.	Gradual IRS expansion to all 66 high-burden districts by 2030, prioritizing areas with persistent transmission.	Progressive IRS expansion to 66 high-burden districts by 2030, contingent on resource availability.
Larval Source Management (Larviciding)	Implement annual larviciding in all urban centers and cattle corridor districts for five consecutive years.	Implement annual larviciding in urban centers and cattle corridors for five years, focusing on high-transmission zones.	Implement annual larviciding in 50% of urban centers and selected cattle corridors over five years.
Long-Lasting Insecticidal Nets (LLINs) – *Mass Campaigns*	Conduct mass LLIN distribution campaigns in moderate- and low-burden districts to sustain universal coverage.	Conduct mass LLIN campaigns in moderate-burden districts to maintain coverage.	Conduct two nationwide LLIN campaigns during the five-year period.
Routine LLIN Distribution	Maintain routine LLIN distribution in all districts, complemented by innovative channels such as school-based and antenatal programs.	Maintain routine LLIN distribution in all districts, integrating community and school-based innovations.	Maintain routine LLIN distribution through existing systems, with limited innovation and outreach.
Malaria Vaccine (RTS,S or R21)	Implemented out to reach 80% coverage of eligible populations by 2030.	Implement phased scale-up to achieve 50% coverage by 2030.	Implement limited roll-out targeting 30% coverage by 2030.

Annex 7: Detailed Stratified Implementation Framework

Strategic Intervention	Very High (> 500)	High (250500)	Moderate (100250)	Low (< 100)	Pre-Elimination (< 10)
1.1 Diagnostics & Treatment (T3 & MFT)	· Universal T3 (public / PNFP / private) with HRP2-resistant Pan-RDTs · Strengthen microscopy QA/QC at HC II+ · Secure ACTs, injectable artesunate & severe-malaria stocks with 3-month buffer · Implement MFT rotation by TES/genomics	· Universal T3; reinforce microscopy QA/QC · Maintain stock buffers; implement MFT rotation · Engage private providers in T3 reporting	· Universal T3; strengthen private-sector adherence to T3 · Ensure uninterrupted diagnostics & drugs	· Universal T3; guarantees 100 % testing of fevers. · - pre-position supplies	· Passive case detection at facilities; reactive case investigation with ACD · Ensure 100 % commodity availability for any detected case
1.2 Community Case Management (iCCM)	· Scale iCCM to all ages (60,000 VHTs/CHEWs) · Quarterly test-and-treat outreaches · Extend CCM to schools & accredited drug shops · Secure dedicated line-items in district/PDM budgets	· Seasonal community test & treat campaigns · CCM for all ages; school & shop expansion	· Optimize iCCM for U5s; extend to older children per local data · CCM in schools & shops	Maintain iCCM for U5s with prompt referral systems	· Transition VHTs to surveillance agents for reactive detection, case follow-up, and referral
1.3 Severe Malaria Management	· 24/2-hour survival protocol at HC III+ & community levels · 100 % injectable & rectal artesunate availability · Routine death audits & "medical emergency" declaration	· 24/2-hour protocols; reduce referral delays · Quarterly death audits	· Adherence to 24/2-hour protocols. · - quality-of-care audits	Treat all severe cases as sentinel events requiring investigation	· Any severe case triggers immediate system investigation and response

Strategic Intervention	Very High (> 500)	High (250500)	Moderate (100250)	Low (< 100)	Pre-Elimination (< 10)
1.4 Chemoprevention & Vaccines	· SMC (≤ 10 yrs) every transmission season · IPTp3+ ≥ 85 % via facility & community · PDMC in referral hospitals · R21 vaccine coverage ≥ 80 % · Pilot school/infant IPT based on evidence	· SMC in eligible districts · IPTp3+ ≥ 85 % & PDMC · R21 ≥ 80 % coverage · Pilot school/infant IPT	· IPTp3+ ≥ 85 % & PDMC · R21 rollout per local burden; consider school IPT	IPTp3+ ≥ 85 % & PDMC only	Chemoprevention is not routine; focus on prompt case management
1.5 Drug-Resistance & QA	· Annual TES & genomic surveillance at 30 sites · Enforce monotherapy ban & ACT quality sampling · Routine QA/QC for diagnostics	· TES Annual; strengthen pharmacovigilance in public & private sectors Institutionalize QA/QC	· Monitor treatment failures; QA/QC and pharmacovigilance	Immediate investigation of any treatment failure for resistance	All failures trigger system-wide response; QA/QC paramount
1.6 Private-Sector Engagement	· Map/register private outlets; onboard to DHIS2/eCHIS Train in T3 & SOPs Pilot self-testing "Malaria Safe" campaign	· Map/register & train private providers. · - Strengthen digital reporting incentives	· Accreditation and quality · -Improve partnerships for private clinics/shops	Ensure linkage of private reporting to national surveillance	Mandate immediate reporting of all private -Sector suspected/confirmed cases
2.1 Universal LLIN Coverage	· Mass PBO/dual-AI net campaigns every 3 yrs Continuous ANC/EPI/school distribution · Intensive ACSM for > 90 % use · Durability monitoring & replacement	· Mass PBO/dual-AI nets; continuous channels · ACSM for > 90 % use	· Mass nets (PBO or standard per resistance data). · - continuous distribution	Routine continuous distribution only Mass campaigns triggered by surveillance alerts	Targeted LLIN distribution to vulnerable groups and active foci
2.2 Targeted IRS	· Annual IRS in VH/H districts for ≥ 5 yrs, rotating insecticides · Build district spray capacity; institutionalize in schools/prisons	· Annual rotational IRS; district capacity building	· Focal IRS in persistent hotspots identified by micro-stratification	Reactive IRS for outbreak response	Reactive focal IRS as part of the immediate case investigation

Strategic Intervention	Very High (> 500)	High (250500)	Moderate (100250)	Low (< 100)	Pre-Elimination (< 10)
2.3 Larval Source Management (LSM)	· Targeted LSM in urban/irrigation hotspots · Community clean-ups, eco-larvicides, drone-mapping · Integrate with municipal WASH planning	· Targeted LSM in suitable localities	· LSM in identified hotspots, integrated with local development plans	LSM deployed only for outbreak containment	Focal LSM during case investigations to eliminate breeding sites
3.1 Routine Surveillance & Data Systems	· Strengthen DHIS2/eCHIS reporting completeness ≥ 90 % · NMDR-powered dashboards and district scorecards · Detailed case-investigation modules	· As VH/H, plus private-sector DHIS2 integration	· Focus on private-sector reporting to DHIS2/eCHIS	Weekly reporting reviews by DHT	Case-based surveillance: 72-hr notification, investigation & classification
3.2 Sentinel & Entomological Surveillance	· 30 integrated sentinel sites for ento/TES/genomics · Train VCOs in resistance monitoring	· 30 sentinel sites; quarterly resistance monitoring	· 30 sites; track early resurgence signals	Sentinel sites monitor receptivity and importation risk	Sentinel focuses on vector presence in receptive areas
3.3 MEWS & Epidemic Preparedness	· Fully operational MEWS with automated alerts · Pre-position buffer stocks & RRTs; establish regional hub	· MEWS operational; district RRTs trained	· Strengthen outbreak detection & rapid response	All MEWS alerts trigger immediate DHT investigation	Each new local case invokes emergency response SOPs
4.1 District-Led Planning & PDM Integration	· Develop stratified DMAPs, integrate into PDM budgets with LEDIC support	· Same as VH/H	· Same as VH/H	DMAPs emphasize epidemic preparedness	DMAPs transition to Malaria Elimination Action Plans
4.2 Sustainable Financing	· 25 % domestic funding increase; malaria bond; commercial levy; CSR mobilization	· Domestic & private sector resource mobilization	· Advocate for sustained domestic line-items	Secure contingency funds for outbreak response	Ring-fenced elimination budgets; maintain minimal recurrent financing

Strategic Intervention	Very High (> 500)	High (250500)	Moderate (100250)	Low (< 100)	Pre-Elimination (< 10)
4.3 Coordination & PPPs	· Strengthen MAAM-led multisector forums; formalize IRS/LLIN PPPs	· Strengthen MAAM coordination; PPP expansion	· PPPs for service quality improvement	Cross-border EAC/IGAD surveillance collaboration	Formalize cross-border data-sharing and elimination certification partnerships
4.4 ACSM & Community Mobilization	· Intensive multi-channel ACSM for nets, IRS, T3, SMC, R21; Parish Action Days; community scorecards	· Intensive ACSM for core interventions; use MAAM structures	· SBC via school clubs, faith-based channels to sustain high coverage	Vigilance campaigns for immediate fever reporting	Targeted alerts to travellers and mobile groups; community-led surveillance messaging

Annex 8: Key Stakeholder Map

Stakeholder	Core Role & Contribution
Ministry of Health (National Malaria Elimination Division)	Lead policy formulation, technical guidance, national partner coordination, oversight of implementation, and M&E.
Ministry of Local Government	Integrate DMAPs into District Development Plans and PDM budgets; facilitate district-level planning and resource allocation.
District Health Teams (DHTs)	Develop and implement stratified District Malaria Action Plans; supervise health facilities and VHTs; monitor performance.
Parish Development Model (PDM) Committees	Mobilize communities for net use, IRS, and case detection; monitor local implementation; channel community feedback.
Village Health Teams (VHTs)	Deliver iCCM; conduct active case finding and referrals; report data via eCHIS; lead community education and mobilization.
Civil Society Organizations & MAAM	Implement programs that advocate for accountability and financing, lead SBCC and community-inclusive dialogues, and monitor service quality and equitable access.
Private Sector (Telecoms, Banking, Agribusiness)	Provide CSR funding; support logistics and distribution; partner on IRS/LSM service delivery; engage in malaria bonds.
Academia & Research Institutions	Conduct operational and implementation research; manage entomological and genomic surveillance; evaluate new tools.
Development Partners (Global Fund, USG, WHO, UNICEF, Gavi)	Provide financial resources, technical assistance, and innovations; align support under the "Three Ones" coordination framework.
Regional Bodies (EAC, IGAD)	Coordinate cross-border surveillance and response; harmonize intervention packages; and facilitate the sharing of data and resources.

Annex 9: Risk Management Framework

The UMESP is anchored in a proactive and adaptive risk management framework designed to safeguard progress toward elimination. The framework identifies, assesses, prioritizes, and mitigates risks to ensure uninterrupted services, minimize the impact of shocks, enable timely reprogramming, and protect value for money. It aligns with national financial management controls, sector oversight, and global standards for malaria risk governance.

The NMED will maintain the national risk register, review the same during quarterly performance reviews, and escalates high-risk situations to the National Malaria Elimination Task Force (NMETF), which provides oversight and approves contingency actions. Technical Working Groups track thematic risks, while District Health Teams manage district-level logs and integrate mitigations into District Malaria Action Plans. Partners, CSOs, and the private sector report risks and progress through coordination platforms.

Key Risk Categories are.

- **Strategic & policy risks**: delays in adoption of new policies or tools.
- **Epidemiological risks**: outbreaks, importation, and asymptomatic reservoirs.
- **Resistance risks**: insecticide and drug resistance undermining IRS, LLINs, and ACTs.
- **Supply chain risks**: price shocks, shipping delays, and stockouts.
- **Climate shocks**: floods and droughts disrupting access and transmission patterns.
- **Community and social risks**: low LLIN use, IRS refusals, misinformation.
- **Data and IT risks**: poor quality, downtime, cybersecurity threats.
- **Human resources risks**: shortages and high turnover in key cadres.
- **Financial and compliance risks**: delayed disbursements, low absorption, and fraud.

Risk Management Process. Risks are continuously identified through data reviews, supervision, and community feedback. Each risk is scored for likelihood and impact, with residual scores determining priority (red, high, moderate, low). Triggers include epidemic thresholds, commodity stock levels, resistance markers, climate alerts, and lapses in data quality.

Mitigation and Contingency. Pre-approved surge packages (commodities, IRS/LLIN mop-ups, RCCE) can be deployed within 14 days, supported by a contingency budget line (3–5% of annual malaria funds). Reprogramming rules permit 10–15% reallocations nationally (5–10% at the district level). Buffer stocks, alternate procurement routes, RCCE activation, and Rapid Response Teams are core mitigation tools.

Monitoring and Learning. Districts conduct monthly risk reviews; national dashboards track and flag emerging threats; and an annual risk annex is published in the Malaria Performance Report. Independent assurance includes audits, data spot checks, and post-campaign surveys. After-action reviews ensure that lessons inform updated SOPs and adaptive practices.

This framework ensures malaria elimination efforts remain resilient, equity-sensitive, and adaptive, enabling Uganda to anticipate, manage, and overcome risks on the pathway to elimination.

Annex 10: Sustainability, Transition & Domestic Resource Mobilization

Purpose: Ensure sustainable malaria elimination by:

- Expanding domestic financing.
- Embedding malaria functions in PHC & community systems.
- Mobilizing private and innovative co-financing.
- Ensuring value-for-money and resilience.

Objectives by 2030

- +10% domestic share of malaria financing from 2024 baseline.
- 100% of district fund core recurrent costs (supervision, DQA, data reviews).
- Results-based financing institutionalized in ≥3 performance areas.
- Private Sector Malaria Forum established with annual co-financing commitments.

Transition Roadmap

Phase I (2026–27): Foundation & Co-Financing

® Annual malaria expenditure & gap analysis.

® Private Sector Forum & MoH–MoFPED taskforce launched.

® Results-based financing pilots in 30 districts.

Phase II (2028–29): Consolidation

® Districts fund routine surveillance & supervision.

® At least one vector intervention co-financed in ≥40% of districts.

® Scale national performance-based financing and pooled procurement.

Phase III (2030): Sustained Elimination

® Domestic financing covers all recurrent PHC-embedded functions.

® Partners focus on innovation, research, and surge response.

® Contingency arrangements for epidemics and climate shocks in place.

Key Enablers

- **Domestic Resource Mobilization**: budget lines in MoH/district votes; Parish Development Model; earmarks and efficiency savings; annual resource tracking.
- **Efficiency**: pooled tenders, optimized last-mile delivery, stratification-led targeting, integrated PHC supervision.
- **Integration**: malaria QA into PHC, VHT/CHW packages financed in district budgets, fully interoperable DHIS2/eCHIS/eLMIS.
- **Private Sector**: workplace programmes, CSR-driven LLIN/IRS campaigns, "Malaria Smart" company accreditation.
- **Innovation**: performance-based grants, malaria bond/social impact vehicles,
- diaspora/philanthropy.

Annex 11: Glossary of Key Terms

Case-based surveillance: A surveillance approach in low/pre-elimination settings where each confirmed case is individually notified (≤24h), investigated (≤48h), classified (indigenous/imported/induced), and linked to a **foci response** within 7 days.

Community-Led – Engaging communities in planning, implementing, and monitoring malaria programs to ensure culturally appropriate, sustainable, and locally owned interventions.

Completeness (reporting): Percentage of expected routine reports received in DHIS2/eCHIS within the reporting period; UMESP target ≥95% (WHO, 2018; MoH, 2025).

Epidemic threshold (malaria): A statistical alert level (e.g., CUSUM or mean + 2 SD using ≥3–5 years of data) beyond which an unusual increase is likely; triggers EPR actions (WHO, 2017; WHO, **2018).**

Equity – Ensuring all individuals, especially high-risk and marginalized groups, have fair access to malaria prevention, diagnosis, and treatment, addressing disparities caused by social, economic, or geographic factors.

Foci response: A targeted package (e.g., RACD/MSAT, vector control mop-up, RCCE) delivered to a transmission focus following case classification in elimination settings (WHO, 2017).

Incident case (confirmed): Fever case with parasitological confirmation (RDT/microscopy) consistent with national guidelines (WHO, 2022; MoH, 2025).

Inclusion – Guaranteeing that all individuals, including marginalized or vulnerable populations, can access and benefit from malaria services without discrimination.

Informal Settlements – Densely populated semi-urban areas with limited infrastructure and access to health services, where malaria risk may be higher due to environmental and living conditions.

Insecticide resistance: Reduced susceptibility of vectors to one or more insecticides, confirmed by WHO bioassays or molecular markers; programmatically addressed through **IRS rotation** and **next-gen LLINs** (WHO, 2019; WHO, 2022).

Multiple first-line therapies (MFT): Policy using more than one first-line ACT across facilities/geographies to slow resistance selection pressure (WHO, 2022).

Parasite prevalence (PfPR): Proportion of children (often 2–10 years or under-5s) with *P. falciparum* parasitemia by RDT/microscopy in a household survey, used for stratification.

Performance-based financing (PBF): Disbursements linked to agreed results (e.g., reporting completeness, stock-out zero days, IRS/LLIN coverage) with third-party verification.

Pre-elimination: Epidemiological stratum where incidence is sufficiently low to shift to case-based surveillance and foci management, with prevention of reintroduction as a goal (WHO, 2017).

Reactive Case Detection (RACD): Screening and testing of individuals around an index case's household or focus to identify residual transmission (WHO, 2017).

Remote and Rural Communities – Populations living far from health facilities or urban centres, often with limited access to malaria prevention, diagnostic, and treatment services

Resurgence: Rebound of malaria morbidity/mortality following a period of successful control, often due to reduced program intensity, resistance, or shocks (WHO, 2018; WHO, 2023).

Stock-out (0-day target): No days during the reporting period when a facility is out of a listed tracer commodity (RDT, ACT, injectable artesunate, LLIN); UMESP target ≥95% facilities with 0 days (MoH, 2025).

Surveillance as a core intervention: Positioning surveillance and monitoring and evaluation (M&E) alongside vector control and case management; resources scale with transmission reduction (WHO, 2018).

Vector control: Interventions that reduce human–vector contact or vector populations (LLINs, IRS, LSM), including **next-generation LLINs** with synergists or dual AIs

REFERENCES

1. African Leaders Malaria Alliance. (2024). Malaria scorecard guidance. ALMA.
2. Gavi, the Vaccine Alliance. (2023). Gavi Support for Malaria Vaccines: Policy Note. Gavi.
3. Global Fund. (2023). Modular framework handbook – Malaria interventions (incl. RSSH & transition guidance). The Global Fund.
4. Ministry of Health (MoH), Uganda. (2025). Uganda Malaria Programme Review 2025: Final report. Ministry of Health.
5. President's Malaria Initiative. (2024). Uganda Malaria Operational Plan FY2024. USAID/CDC.
6. RBM MERG. (2018). Household survey indicators for malaria control. RBM Partnership to End Malaria.
7. RBM Partnership to End Malaria. (2022). Applying the "Three Ones" for malaria programme coordination. RBM Partnership.
8. RBM Partnership to End Malaria. (2024). Sustaining malaria elimination: The role of resilient health systems. RBM Partnership.
9. Uganda Bureau of Statistics (UBOS) & ICF. (2020). Uganda Malaria Indicator Survey 2019. UBOS & ICF.
10. Uganda National Meteorological Authority. (2024). Annual climate summary 2024. UNMA.
11. UNICEF. (2023). Improving access to health services in hard-to-reach communities. UNICEF.
12. World Bank. (2023). Results-based financing for health: Lessons for malaria programmes. World Bank.
13. World Health Organization. (2017). A framework for malaria elimination. WHO.
14. World Health Organization. (2018). Malaria surveillance, monitoring & evaluation: A reference manual. WHO.
15. World Health Organization. (2019). Guidelines for Malaria Vector Control and a Manual for Developing National Malaria Strategic Plans. WHO.
16. World Health Organization. (2022). WHO guidelines for malaria. WHO.
17. World Health Organization. (2023). World Malaria Report 2023. WHO.

NATIONAL MALARIA
ELIMINATION DIVISION
Plot 6 Lourdel Rd, Nakasero
Toll Free: 0800-100-066,
Office: +256 417 712260
P.O. Box 7272 Kampala Uganda