The Republic of Uganda

Seasonal Malaria Chemoprevention(SMC) Programming & Implementation in East and South African Countries- Uganda Experience

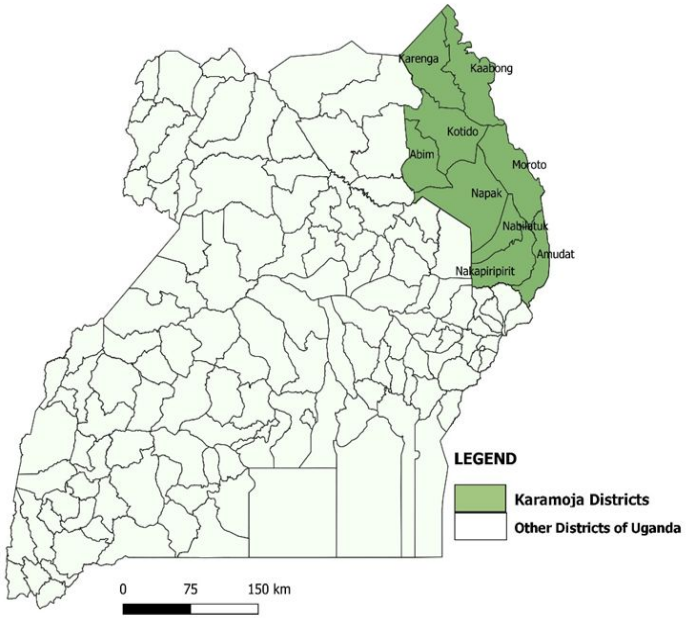
Digitized tools and integration for improved efficiencies and outcomes of Malaria prevention services in a changing environment.

Ministry of Health –National Malaria Elimination Division(NMED)
Presentation to;

The SMC Alliance &AMP Joint Meetings:

Venue: Speke Resort Munyonyo

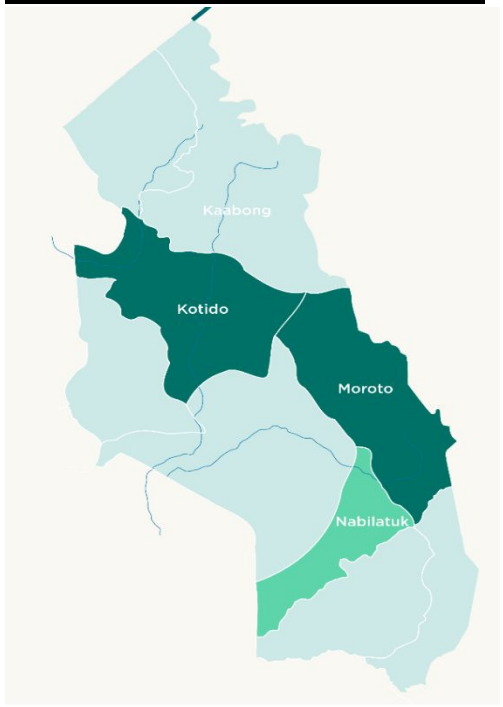
Date : Tuesday 24th February 2026



Seasonal Malaria Chemoprevention implementation progress from 2021 to 2025

Round –One(1) 2021

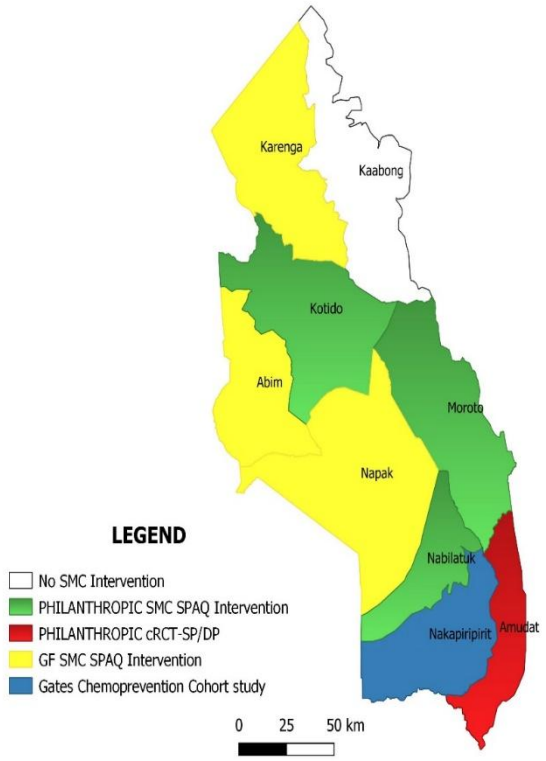
Target :80,000



Children reached: 83,100 (103%)

Round –Two(2) 2022

Target :230,000



Children reached: 211,600(92%)

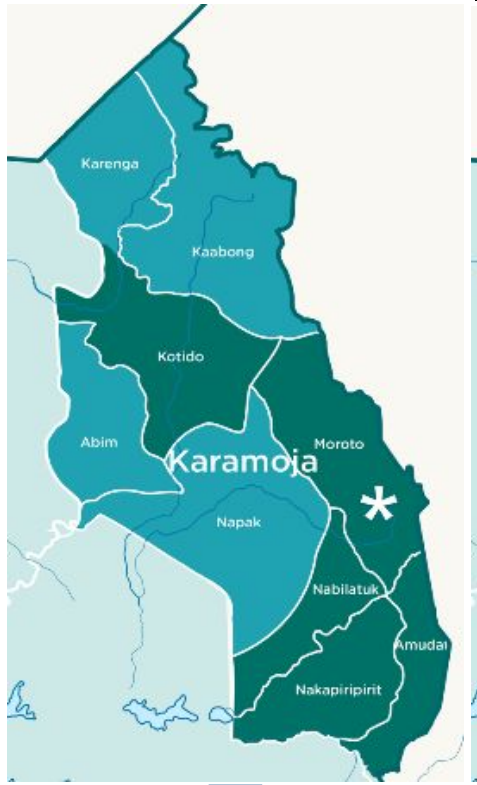
Round- Three(2) 2023

Target :250,000

Children reached: 261,136 (102%)

Round- Four(4) 2024

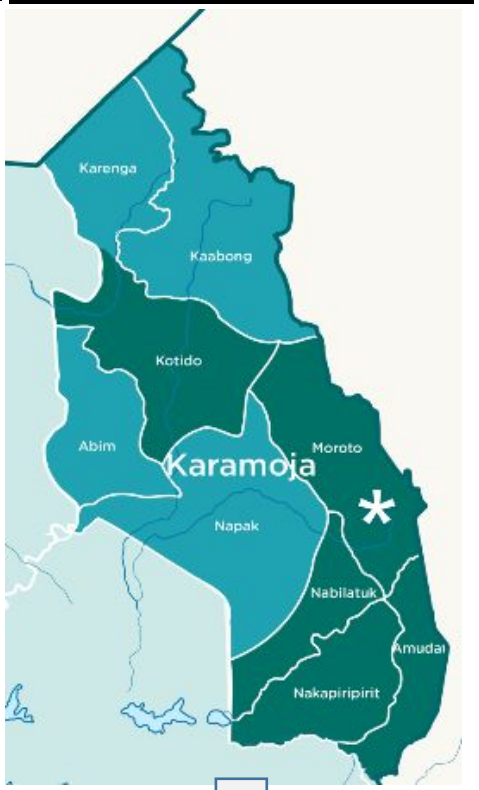
Target :280,000



Children reached: 286,635 (101.5%)

Round- Five(5) 2025

Target :394,328

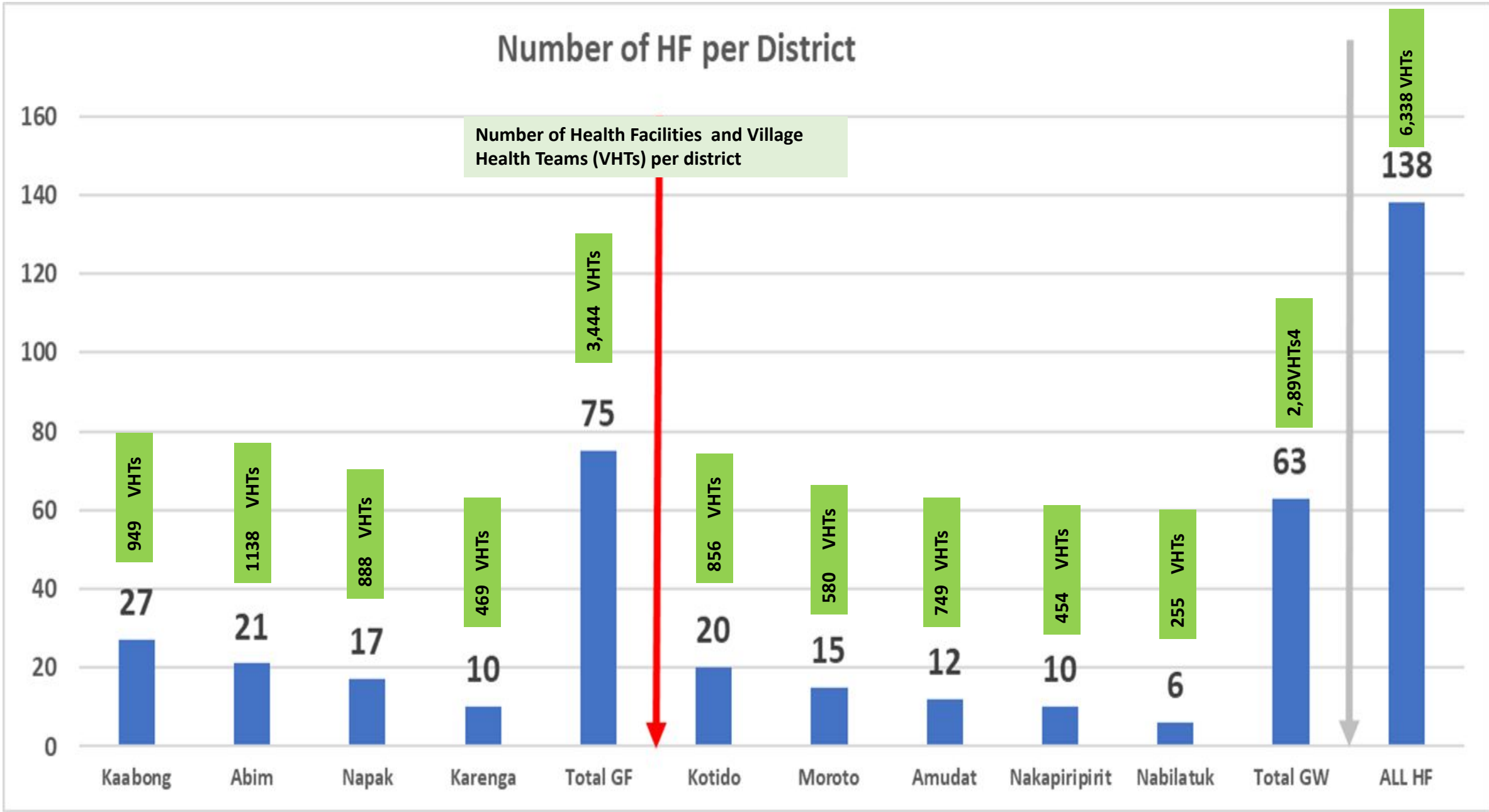


Children reached: 381,809 (97%)

Intergration has been a key approach to SMC implementation since its inception, there has been progressive adaptation of digitized tools from 2023 and expansion of scope to include age 5-10 years in 4 districts in 2025.

Seasonal Malaria Chemoprevention adaptation process

	Processes/key steps	Context	Adjustments /means of adaptation
1	Planning and enumeration	Disparities in data (projected UBOS data)	Planning is based on district led data collection through routine enumeration.
2	Procurement and supply chain management.	SPAQ and most of the SMC related supplies are not part of the existing essential medicines list.	Sought for the DGHS authorization for the expedited inclusion of SPAQ into the essential medicines list
3.	Community engagement	New geography for SMC implementation, with highly mobile communities.	Engaged key influential groups that are highly recognized by the community; Manyata, kraal, cultural, and political leaders
4	Training	No existent capacity to implement SMC within the set timeline.	Expedited guidelines' development and dissemination through cascaded trainings from National ,district Health Facility &Village levels
5.	SP+ AQ administration	Mode of delivery was door-to-door using exiting community health workers called Village Health Teams (VHTs) - HC I in the health structure.	Engaged local and technical leadership to identify and recruit reliable, trusted and effective VHTs
6	Improved case management and Pharmacovigilance.	Weak pharmacovigilance efforts under case-management Vs needed level of safety monitoring associated with SMC	Adapted the National Pharmacovigilance system to monitor for anticipated side effects and adverse events associated with SMC.
7.	Support supervision and quality assurance.	Inadequate competent and committed health workforce to supervise and reinforce quality of SMC implementation.	Promoted and embraced a district led support supervision.
8	Monitoring and evaluation	No SMC country specific impact assessment indicators.	DHIS-2 Malaria indicators adapted for impact assessment.
9	Payments of Supervisors,HWs and VHTs	Having to pay all actors at the various levels of implementation on time to minize chances of demotivation	Utilized the cashless payment approach to reach all actors on time.



Number of VHTs and Health Facilities supporting SMC has not changed since the start of full scale implementation in 2023 to 2025; Note the 4 districts Napak, Abim, Karenga &Kaabong are currently covering the age group of 5-10 years

INTERGRATION – a)SUPPLY CHAIN MANAGEMENT

Delivery ,storage and reverse logistics management of SMC & ICCM commodities is done concurrently.

b) Community sensitization , mobilization & engagement:

Using the various channels (Media, community dialogues, interpersonal communication etc integrated messages for all Malaria interventions are shared with communities during SMC implementation

Intergration –Trainings, guidelines and tools.

1) Guidelines &tools designed to facilitate delivery of other services ;Integrated community case Management, immunization ,ITNs' use.

2) Trainings are not focused on SMC as standalone but include modules that facilitate the delivery of other: Malaria interventions, diseases.

Support Supervision

During supervision, the teams follow up the performance of other interventions; ITNs hang up and use.

Integrating other Interventions into SMC Implementation

Picture –one(1)

Picture –Two(2)

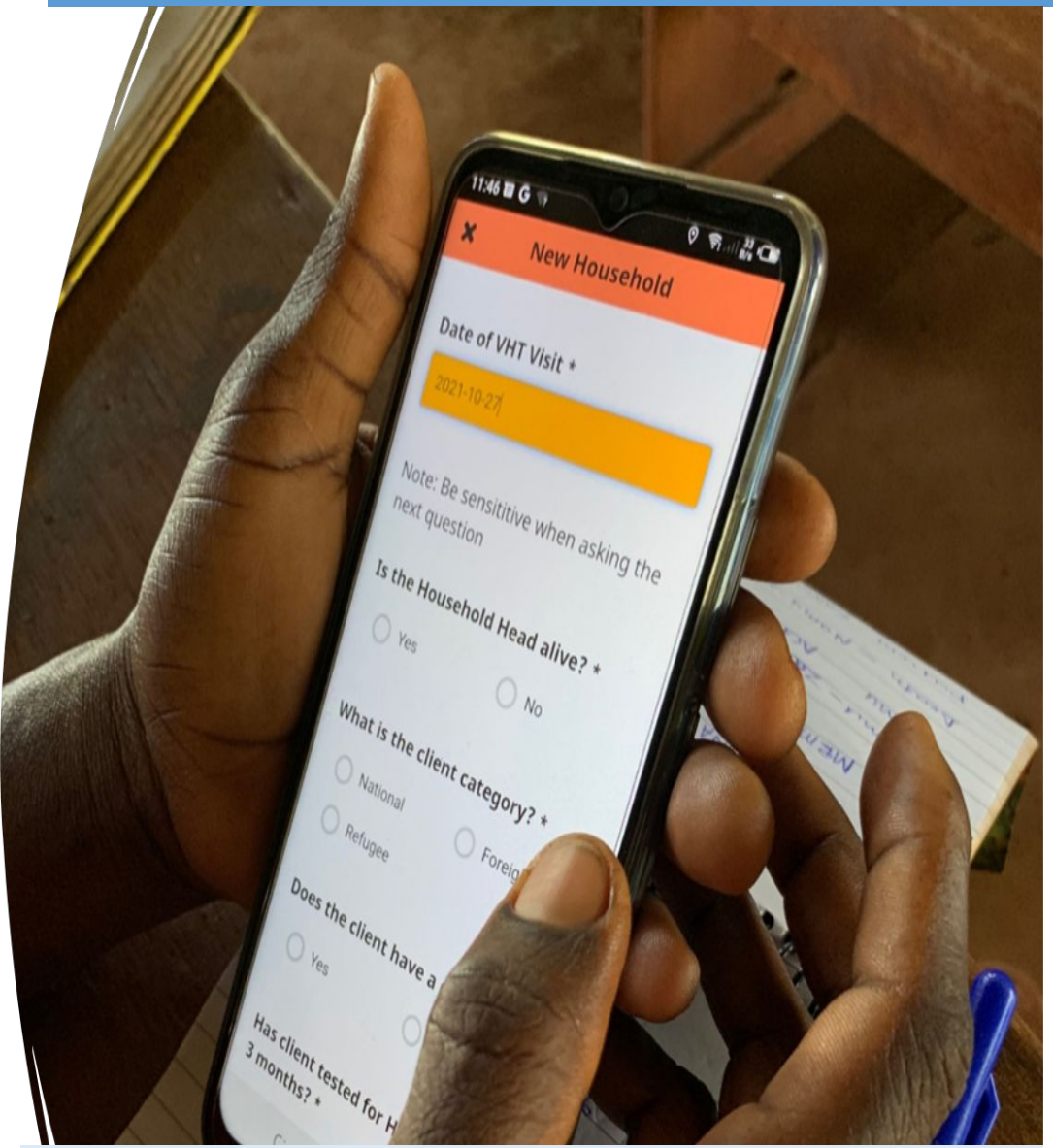
Picture Three(3)

Picture 1: VHTs screen for fever , test and treat Malaria , Diarrhea and Pneumonia and do referrals for those with danger signs.

Picture 2: During the House to house SPAQ administration for SMC, the identified Zero dose and under immunized children are vaccinated by Vaccination teams .

Picture 3: SMC delivery as a platform for mapping and targeting Malaria Hot spot & underserved areas with Community

Digitization:



One of the Health workers collecting and submitting SMC Support supervision data

Support supervision tools ;

- Ministry of health, district and health facility tools are digitized .
- During SMC VHT supervisors report electronically.
- Data is collected by ODK and it populates into a dashboard and used to monitor the SMC implementation process.

End of round (EOR) and End of Cycle Survey(EOC)

- These are conducted electronically .

Ministry of Health repository.

- SMC data submitted to the electronic malaria data repository at MOH.

All community health interventions are to be integrated with in the current Electronic community health system(e-CHIS).

- e- CHIS is now available in 20 districts with about 15,000 VHTs.

Plan to fully digitize SMC, ICCM ,ITNs, immunization and nutrition.

Key Achievements ; Integration

1. Improved services' delivery and utilization.

- Case Management –screening of sick children ,test, treat and linkage /referral integrated into SMC implementation
  - Prompt care and treatment seeking by children with fever, better access to care.
  - Timely and completed referral for patients with danger signs and fever causing illnesses.
- Immunization – during enumeration 240,523 children in2,929 village at risk children (Underimmunised,zero dose identified & reached
  - **20,071 (8%) children who missed OPV3;**
  - **10,396 (4%)** children who missed DPT1
  - **20,416 (9%)** children who missed IPV2
  - **21,149 (9%)** children who missed MR1;
  - **54,435 (23%)** children who missed MR2
- Reduce ITNs abuse /misuse & better care
  - House holds with their ITNs hanged up.
  - Improved ITNs Care
  - Identification and linkage of Pregnant women and children < 5years to ANC/EPI clinics for ITNs under routine distribution.

2. Reduced stock –outs especially at community level.

- ICCM commodities
  - Improved availability and access to ICCM commodities especially anti-malarials. (stock outs are greatly minimised)
  - Facility –community distribution of commodities

3. Improved data /information management and utilization

- Malaria Vaccine data Validation integration into SMC implementation improved the capture of data into DHIS2
  - There was 16% increase in Malaria Vaccine data captured into DHIS-2.
- Enhanced quantity and quality of documentation and reporting collection and report.
  - Distributed HMIS tools & reduced stock outs of data tools
  - Health facility data quality assessments

4) Community sensitization ,mobilization and engagement

- Increased frequency of engaging and sensitizing communities and the leaders.
  - Better acceptability of SMC , other malaria interventions and vaccination.
  - Increased demand and utilization.

5) Supervision ,monitoring and oversight

- SMC delivery /implementation as an opportunity to identify and address health systems and performance gaps
  - Use of and updating of Malaria surveillance board .
  - Implementation status for previous actions/recommendations
  - Follow up CMEs , health education sessionsetc.

Key achievements

Adaptation of digitized tools

Improved oversite and monitoring the quality of SMC implementation.

- Digitized tools and dash board facilitate timely identification and response to implementation gaps .
- Improves the quality SMC implementation

Contribution to readily available alternatives of data sources.

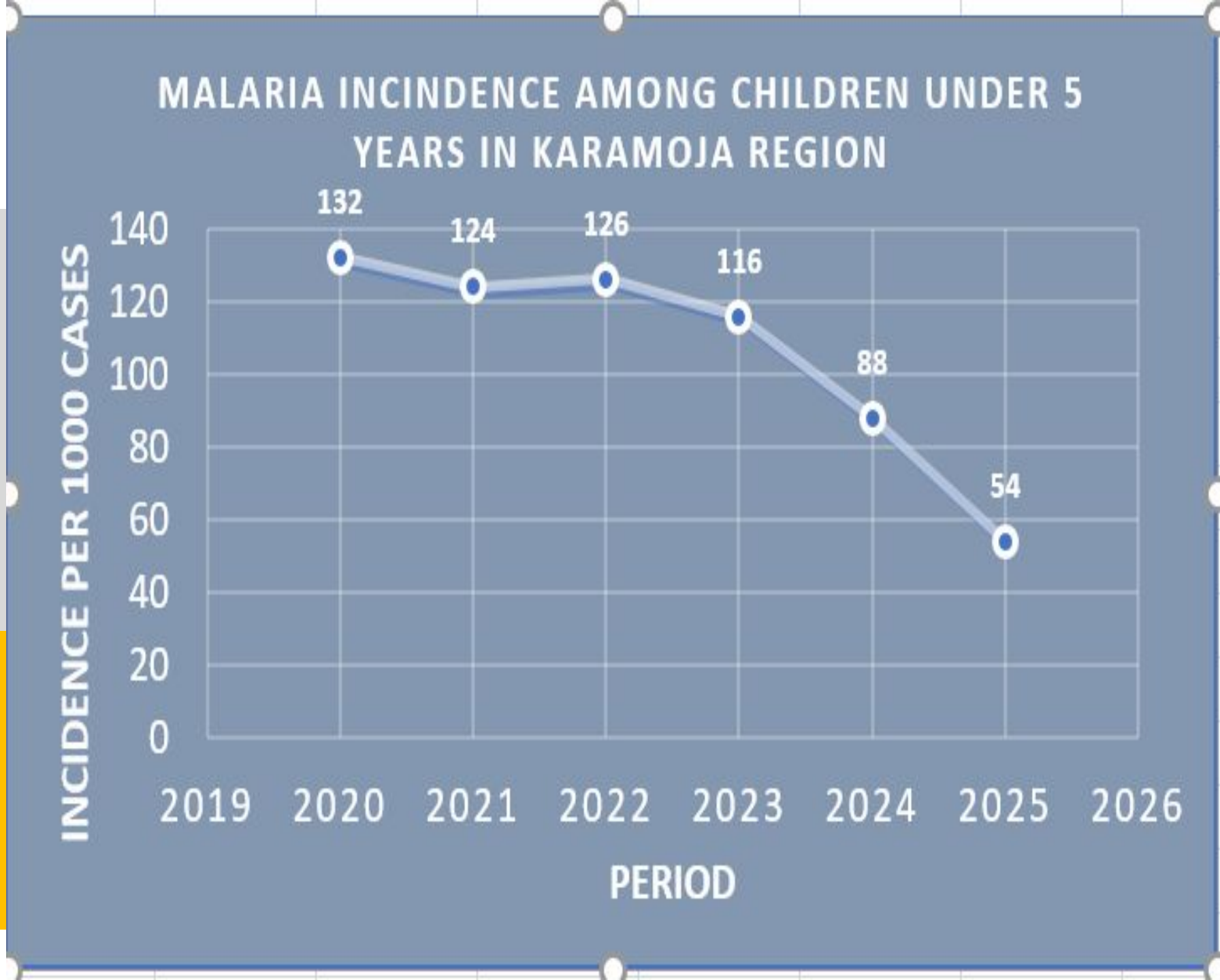
- **Data collected during campaigns (SMC) through digitized tools supports planning and decision making for;**
  - **Other Malaria interventions-ITNs, ICCM**
  - **Other diseases' program interventions –Immunization, Nutrition etc.**

Improved information /data managements and utilization.

- **Utilizing digitized tools helps timely documentation and reporting.**
- **Prompts data utilization and action**

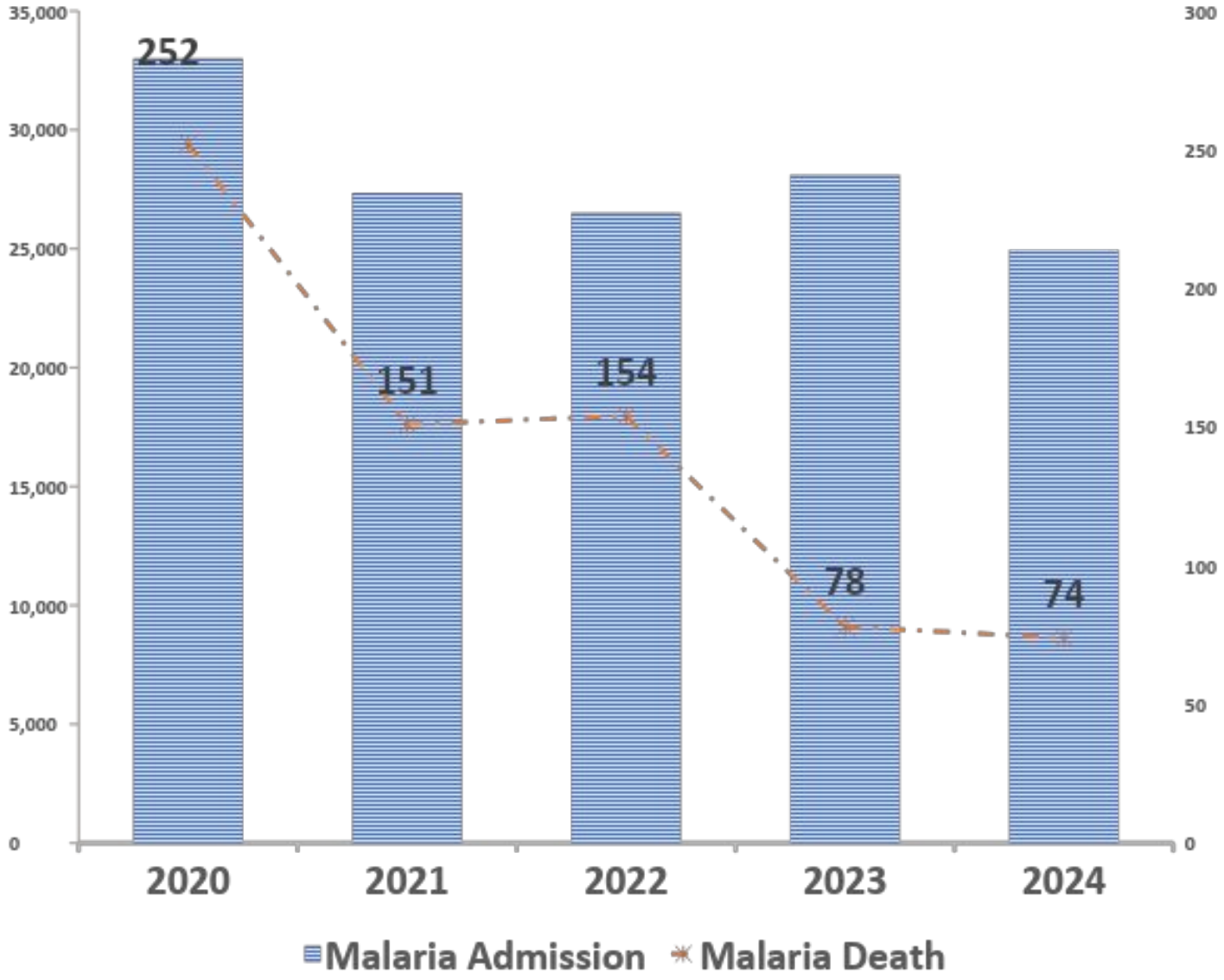
Note: These were achieved with minimal or no additional resources.

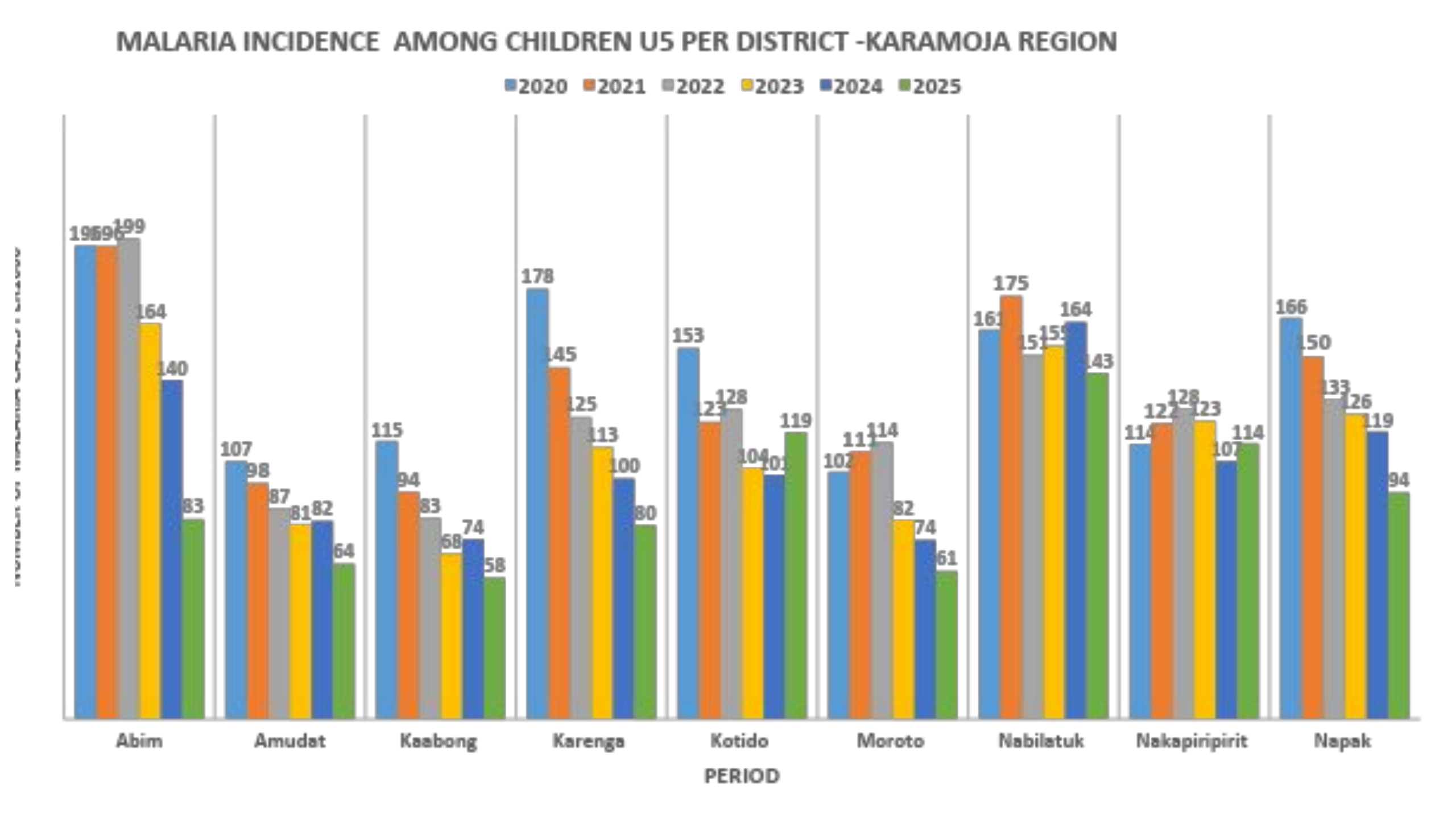
Malaria Incidence among Children < 5 Yrs in the 9 districts within Karamoja region (2024-2025):



Reduction in malaria deaths for U5s

- Mortality rates have reduced from 76% in 2020 before SMC to 29.6% in U5s by the 4th year of SMC implementation




MALARIA INCIDENCE AMONG CHILDREN U5 PER DISTRICT -KARAMOJA REGION
2020
2021
2022
2023
2024
2025
Abim
Amudat
Kaabong
Karenga
Kotido
Moroto
Nabilatuk
Nakapiripirit
Napak
PERIOD

Lessons learnt

Proper planning and coordination contributes to acceptability and successful implementation of integrated SMC campaigns.

Data informed decision-making guides the mapping of underserved and mobile communities and targeting of interventions like SMC and malaria vaccination to increase coverage.

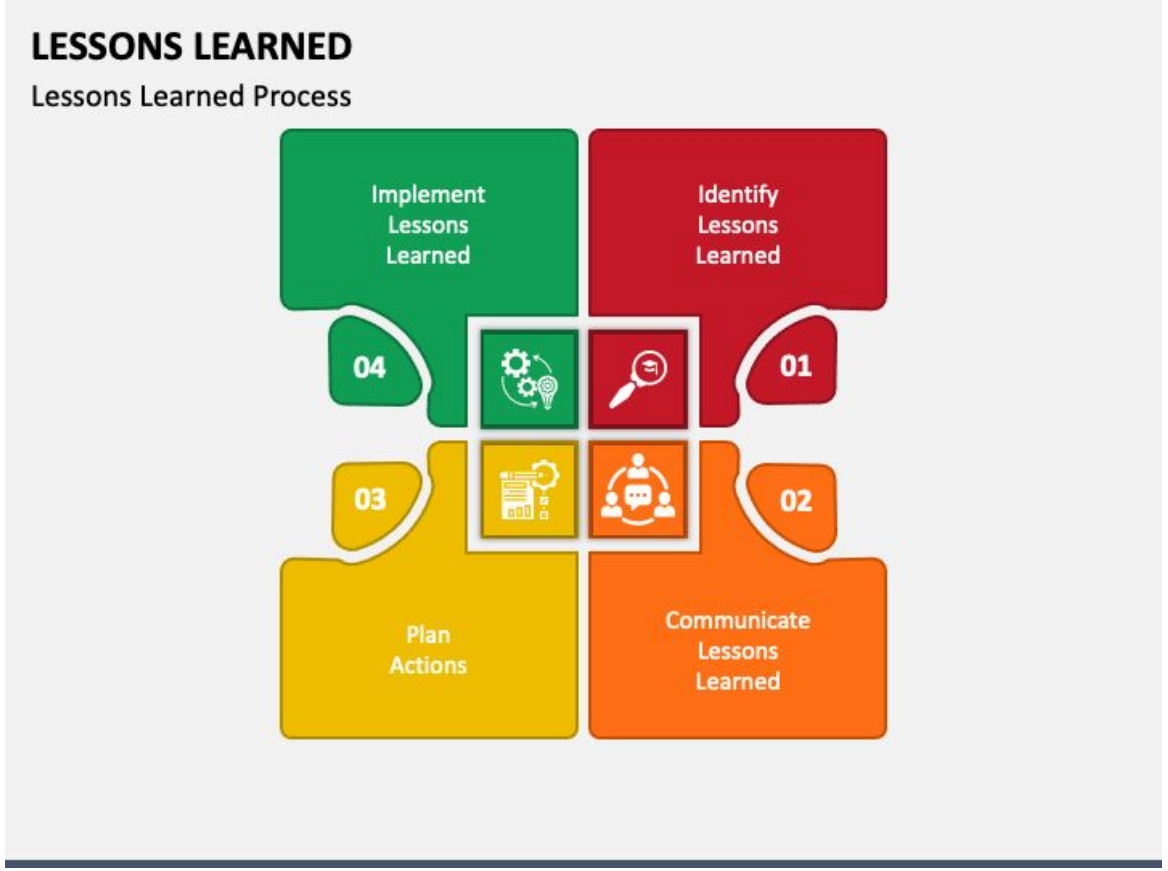
Use of existing health structure for implementation of new intervention is critical for ownership and sustainability

Provision of required tools and guidelines motivates sub-national health teams to willingly deliver integrated services during campaigns .

`Use of digitized tools during campaigns is possible if existing electronic structures are utilized and frontline providers are well facilitated .

Data during SMC and other campaigns is reliable alternative source of data for planning other health interventions.

Well planned & implemented integrated campaigns are efficient and effective



Challenges

Sub-optimal adaptation of digitized tools – some of the data collection under SMC is still paper based.

Limited sharing and access to the data collected during the integrated campaigns with resultant inadequate use.

Capacity gaps: lack of phones, inadequate skills, and low level of education among VHTs makes training difficult.

Stakeholder hesitancy to deliver integrated campaigns for fear of compromising the quality of implementation & achievement of targets .

Currently available guidelines and tools are not fully adjusted to accommodate the integration approach.

Limited knowledge and understanding of the integrated approach to programming.

Cost per child for SMC implementation is still high compared other countries with high number of children

Recommendations

- Deploy bottom-up approach of planning and proper coordination to ensure successful delivery of integrated campaigns.
- Guidelines and tools should be revised to support the delivery of integrated campaigns
- Capacitate sub-national teams to support integrated service delivery and utilize digitized tools /embrace digitized service delivery.
- Make information from the campaigns especially for those that integrated and digitized accessible to improve utilization.
- Government should appropriate funds for digitization of integrated health service delivery in the national budget.


Asante
Gracias
Merci
Thank You
OBRIGADO