



PRESIDENT'S MALARIA INITIATIVE



USAID's Malaria Action Program for Districts

Year I Report

October 1, 2016 – September 30, 2017



USAID's Malaria Action Program for Districts will improve the health status of the Ugandan population by reducing childhood and maternal morbidity and mortality due to malaria. This project, valued at more than \$41 million and made possible by the generous support of the American people, is led by Malaria Consortium and implemented in partnership with Jhpiego, Banyan Global, Communication for Development Foundation Uganda (CDFU), Deloitte Uganda and Infectious Diseases Institute (IDI). The project will support the Government of Uganda over a period of five years in reducing deaths from malaria among the general population, especially children under five years of age.

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I. ACRONYMS

ANC	Antenatal care
ACTs	Artemisinin-combination therapies
CDFU	Communication for Development Foundation Uganda
CHD	Child Health Division
DEOs	District Education Officers
DHIS	District health information system
DHT	District health team
DHMT	District health management team
DHOs	District Health Officers
DQA	Data quality assessments
EPI	Expanded program for immunization
EQA	External quality assurance
FANC	Focused antenatal care
HF	Health facilities
HFA	Health facility assessment
HMIS	Health management information system
HW	Health workers
iCCM	Integrated community case management
IDI	Infectious Diseases Institute
IPC	Interpersonal communication
IMM	Integrated management of malaria
IPC	Interpersonal communication
IPTp	Intermittent preventive treatment in pregnancy
JMS	Joint Medical Stores
LDHF	Low dose high frequency
LLIN	Long-lasting insecticide-treated nets
LQAS	Lot quality assurance sampling
M&E	Monitoring and evaluation
MIP	Malaria in pregnancy

MOES	Ministry of Education and Sports
MOH	Ministry of Health
MOU	Memorandum of Understanding
mRDT	Malaria rapid diagnostic tests
NMCP	National Malaria Control Program
NMS	National Medical Stores
PBF	Performance-based framework
PPF	Private for profit
PNFP	Private not for profit
RHD	Reproductive Health Division
RPMT	Regional performance monitoring and reporting team
SBCC	Social behavior change communication
SBM-R	Standards-based management and recognition
TA	Technical assistance
TWG	Technical working group
TRP	Technical resource person
UCC	Universal coverage campaign
VHT	Village health teams

II. EXECUTIVE SUMMARY

USAID's Malaria Action Program for Districts (MAPD) is a Ugandan-led, systems-thinking approach promoting results-driven activities that create opportunities for the 14 year old girl by making health systems more responsive to her needs, accessible, accountable and inclusive, while also improving social support and making her household more resilient. The project is organized along three result areas and several intermediate result areas that are aligned to the UMRSP 2014-2020, PMI/MOP Objectives, and USAID's CDCS 2016-2021 guiding principles and IRs.

MAPD's prevention interventions (Result 1) contribute to UMRSP's Objectives 1, 2 and 3, NMCPs/USAID's MOP prevention of malaria in pregnancy (MIP) and long-lasting insecticide-treated net (LLIN) objectives, and CDCS IR 1.3, and IR 2.2.1. Case-management activities feed into UMRSP objectives 2 and 3, and PMI's/UMRSP Test Treat and Track objectives and CDCS's Sub IR 2.2.1. MAPD's third result area, capacity building, links with UMRSP objectives 4, 5 and 6 and NMCPs/PMI's objectives of health system strengthening and capacity building. This feeds in to CDCS sub-IR 3.1, 3.2.1, 3.3.1, 3.3.2, 3.3.4, and 3.3.5. Please refer to Annex I for objectives and IRs in full.

During MAPD's first year, the project rapidly completed its start-up activities and conducted capacity building, health system strengthening, and activity implementation in all districts. It successfully set up its project structure, built relationships, forged partnerships and implemented activities at central, district, health facility and community levels.

- **Start-up Activities:** Set up a central office (Kampala) and five regional offices including human resources (recruitment orientation and capacity building), structures, IT and all functional requirements. Developed strategic documents, plans, protocols and SOPs for clarity and uniformity. Conducted project research to guide context specific, up-to-date project strategies, such as a gender analysis, youth analysis, SBCC analysis and health facility assessment (HFA). Developed effective and workable partnerships with key stakeholders.
- **Central-level activities:** Key relationships fostered and image and credibility of MAPD demonstrated through technical and management know-how. Technical assistance (TA) provided for development of guidelines (malaria in pregnancy (MIP), school distribution of long-lasting insecticidal-treated nets (LLINs), laboratory), clinical care and best practice, as well as leadership and management through Thematic Working Groups (TWGs), Roll Back Malaria (RBM) meetings and other coordination mechanisms organized by MAPD or others. MAPD also supported the Uganda Malaria Reduction Strategic Plan 2014-2020 mid-term review and provided two seconded staff members to bolster in-house expertise and intra-departmental linkages. Capacity of trainer of trainers (ToTs) developed in MIP, diagnostics, clinical audits and IMM.
- **District-level activities:** Project launch activities to district leadership (political and health related) to promote ownership and buy in. District level malaria analysis, planning and performance frameworks developed for promoting malaria prioritization, resource and activity alignment. Capacity built of District Health Management Teams (DHMTs) and selected Technical Resource Persons (TRPs) in all districts. Structure and process for performance-based sub-grants/sub-contracts developed and districts on board. Partnership building with district/regional IPs and other actors through meetings, planning sessions etc.

- Health facility level activities: The HFA identified existing practices and service gaps, and formed the base for targeted activities and capacity building targets. An LLIN quantification was done to identify gaps in stocks and, therefore, distribution, and LLINs provided to counter the need of public facilities. Coordination meetings held to address longer-term issues and develop sustainable solutions. Guidelines distributed at HF level and HW oriented in their use, as well as in IMM and clinical audits. Additional support conducted in facilities reporting high numbers of severe cases and/or deaths.
- Community-level activities: Identification and sensitization of key influencers; community dialogues set up in 22 districts as planned, and in communities that suffered from increased malaria cases/deaths. Radio broadcasts at local level rolled out across all districts, with television adverts at central and district level, as well as malaria messaging played on televisions at HFs. Roll-out of iCCM was delayed due to commodity availability; implementation will now occur in Year 2. School LLIN distribution plan discussed, (Ministry of Education and Sports and Ministry of Health (MOH)) and guideline and plan developed for the distribution of 600,000 LLINs through 2,654 schools in 22 districts.

The project's theory of change for year one was for high quality and effective technical cross-cutting inputs delivered at scale through a strengthened district health system, with support from a responsive NMCP, will result in reduced childhood and maternal morbidity and mortality due to malaria. The main project strategies are described below:

Capacity Building/Quality Improvement: The projects' main focus is at the district level, though central level capacity is developed through provision of TA for guideline and policy development, promotion of best practices, and for coordination and leadership through TWGs and other coordination mechanisms. At district level, capacity has been built at the individual and institutional level through catch up orientations for year 1 only, Low-Dose, High-Frequency (LDHF) training and standards based management and recognition (SBM-R) mechanisms. LDHF is an on-site HW mentoring methodology, while SBM-R is an approach for service delivery quality improvement at HF level through supportive supervision. Quality improvement is measured against set standards, premised on international standards, national guidelines and protocols. Quality improvement is conducted through tried and tested methods and in collaboration with USAID IPs that have extensive experience in investigating and rolling out health improvements in Uganda.

District Ownership: To promote quality enactment and sustainability of project goals and activities, district prioritization and ownership is key. The project is engaging district leadership to plan, enact, oversee and monitor all project promoted activities.

Data Improvement: This is being achieved through capacity building of district HMIS officers and malaria focal points in data quality assurance checks, and DHMTs and HF staff in data use and follow-up. Through data quality assessments the project also improves data quality, inclusiveness, validity, reliability, timeliness and use of HMIS data from HFs for planning. In addition, through sub-contracts with professional associations, the project is strengthening the collection, reporting and mainstreaming of private sector malaria data into the health management information system (HMIS).

Evidence-based Interventions: The project promotes adoption of evidence based interventions through development and dissemination of guidelines that are in line with current WHO and MOH recommendations, and by conducting, or supporting others to conduct relevant, key scientific monitoring, evaluation and operational research.

Collaboration, Learning and Adaptation: The project integrates strategic collaboration, continuous learning, and adaptive management in all aspects of its project cycle. Strategies include forging strong participatory partnerships, and supporting coordination, promoting a strong evidence base (see above), and iterative project adaptation based on monitoring and evaluation to ensure relevance.

Measuring Performance: The project results are measured using existing systems e.g. HMIS, Malaria Indicator Surveys, Demographic and Health Surveys, as well as its own dipstick surveys and internal monitoring mechanisms, such as progress reports and HF assessments.

Project Interventions:

Result 1: Effective malaria prevention programs implemented in support of the National Malaria Control Strategy

Intermediate result 1.1, high quality, accessible programs for prevention of MIP implemented. Capacity building of providers on updated WHO based guidelines and promotion of intermittent preventive treatment of malaria in pregnancy (IPTp) to communities, providers and policy makers.

Intermediate result 1.2, initiatives to promote net use and access to LLINs implemented. Support Universal Coverage Campaign (UCC) by improving and scaling up routine distribution channels. This addresses inequities associated with distribution estimates and mechanisms and contributes to the achievement of universal coverage by maintaining net coverage. National continuous distribution guidelines would help bring all fragmented guides together (ANC, EPI, schools, repurposing etc.); SBCC to improve net use and care. Piloting of school-based LLIN distribution will identify if this is an effective mechanism to promote LLIN coverage (including net use) in the community by reaching those not attending HFs, engaging the youth, and using children as change agents.

Result 2: Effective malaria diagnosis and treatment activities implemented in support of the National Malaria Control Strategy

Intermediate result 2.1, implementation of iCCM in highly endemic central region districts supported. Improved services and access for children under five years through improving VHT performance and supervision; effective SBCC.

Intermediate result 2.2, diagnostic capacity improved. Performance improved through capacity building, regular laboratory external quality assurance (EQA) of malaria microscopy, supportive supervision, peer reviews, improving private sector care, reporting through sub-contracts, and SBCC to encourage testing before treating.

Intermediate result 2.3 and 2.4, service providers' capacity for management of uncomplicated malaria cases (2.3) and severe malaria cases (2.4) improved through dissemination of policies/guidelines and tailored capacity building interventions, including clinical audits.

Result 3: Build capacity of the NMCP and DHMTs to effectively manage and sustain malaria activities

The project will provide TA to both district and central levels, with focus on districts, supporting the country's decentralization structure and *modus operandi*. NMCP leadership and oversight capabilities will be built, and district level planning, implementation, and review abilities and functionality bolstered. Improved data and decision making at both levels will occur enabling the health system to be responsive to needs. The capacity of the private sector in these issues will be improved through performance based subcontracts.

Main challenges experienced in Year 1 included implementation delay of nearly six months as contractual limitations on supporting GoU staff affected all activities (the project scope is focused on district capacity strengthening and ownership, which requires participation of district staff). However, USAID was responsive and this responsibility has now been removed from the contract. Delayed MOH guideline approvals have limited roll out of LLIN strategies and laboratory capacity building efforts, although the latter is now approved. In addition, the lack of iCCM non-malaria commodities have held back iCCM interventions. The program has now succeeded in having these commodities adopted into the National Medical Stores (NMS) supply chain for HFs and is rolling out iCCM in eight districts in Year 2 (from two districts in Year 1).

Recommendations:

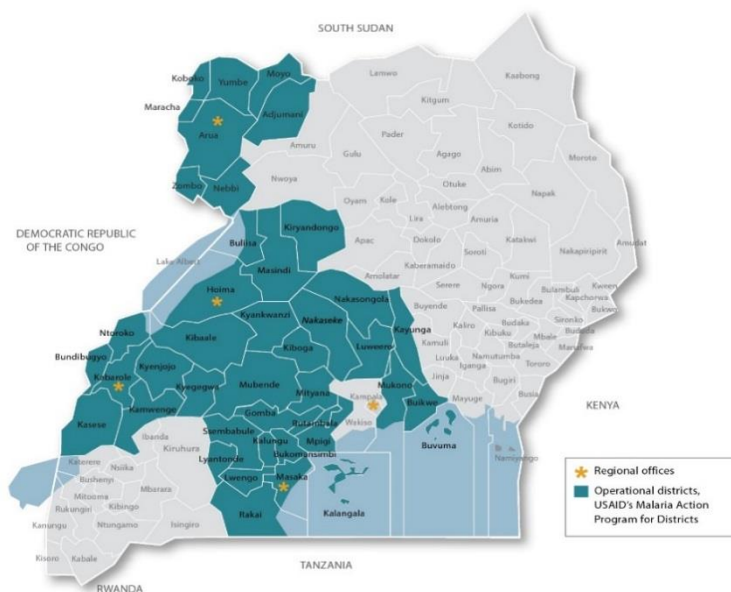
- Integrate activities for cost and time effectiveness such as MIP and IMM on-the-job coaching and supervision and engage more with districts to bolster project ownership and accountable leadership
- Increase number of level 1 and 2 microscopists in the country to permit for quality malaria diagnosis EQA
- Add technical officers, communication officers and HR officer to project staff so to allow for effective implementation while maintaining quality
- Maximize projects' learning and adaptation tool to share best practices with extended stakeholders e.g. other sectors that affect malaria control as well as health and malaria actors.
- Focus SBCC efforts at the inter-personal level, engaging positive deviants and influential champions as identified by communities
- Gender and youth integrations are woven throughout programming and documented effectively to drive adoption at national level.

III. INTRODUCTION

Project overview

USAID's Malaria Action Program for Districts (MAPD) is leading PMI's support to GOU's National Malaria Reduction Strategic Plan, working alongside the NMCP and District Health Management Teams (DHMTs) in 47 (originally 43) focus districts of Uganda. Currently at the end of its first year, this project is supporting the Government of Uganda for a period of five years (2016-2021) to reduce morbidity and mortality among the general population, especially among children under five years of age, with a programming focus on the 14 year old girl. The project is implementing results-oriented, field-tested strategies contributing to the reduction of malaria and its social and economic effects.

The map below shows the project regional offices and its 47 districts. The project's original scope at time of project commencement was 43 districts; however, the government registered five new districts within our operational area. HFs and population remain the same. During Year 1 the number was 48, but Kiruhura District will be covered by RHITES SW in Year 2.



In line with the Ministry of Health (MOH) policies and guidelines, PMI objectives and USAID's CDCS 2016 - 2021 the project is working to achieve three objectives:

- Effective malaria prevention programs implemented in support of the National Malaria Reduction Strategy Plan (UMRSP 2014-2020);
- Effective malaria diagnosis and treatment activities implemented in support of the National UMRSP
- Capacity of the National Malaria Control Program (NMCP) and District Health Management Teams (DHMTs) built to effectively manage malaria activities and sustain malaria gains

IV. TECHNICAL ACHIEVEMENT BY RESULT AREA

IV.I Result I: Effective malaria prevention programs implemented in support of the National Malaria Control Strategy

Intermediate Result I.I: High quality, accessible programs for prevention of MIP implemented

Output I.I.I: Finalized and disseminated guidelines, advocating for support and prioritization for MIP and IPTp

Activity #	IR/Output	Target	Achieved	% Performance	Comment/s
I.I.I.1	Provide TA to NMCP and RHD to finalize MIP guidelines revision (and incorporate into RHD revised guidelines' focused antenatal care (FANC) module)	N/A	Addendum document and circular finalized and reproduced	N/A	Approved 2014 MIP guidelines addendum and MOH memo were reproduced
I.I.I.2	Disseminate updated MIP guidelines : Disseminated MIP guidelines addendum and MOH Memo to each health facility	43 District 495 DHT HW 4,000	46 districts 444 DHT members HW 5,781	104% 90% ¹ 145%	New districts were created in FY 15/16 Dissemination was initially planned for 22 districts (those not previously supported by Stop Malaria Project), but this was changed to cover 43 (the number of districts of MAPD at the time of dissemination), but by end of dissemination the number was 46
I.I.I.3	Advocate SP for IPTp and folic acid transition from 5mg to 0.4mg by NMS, in partnership with RHD	N/A	2 meetings	N/A	Meetings held with the commodity securities group, pharmacy division of the MOH and NMS. Outputs: see narrative
I.I.I.4	Support implementation of MIP guidelines, working through national monthly MIP meetings	12 180	10 monthly meetings 48 district quarterly meetings	83	The meetings involved RHD, NMCP, IPs and other stakeholders. This collaboration is essential for improved quality of managing malaria in pregnancy

MAPD reproduced the revised guidelines and ministerial circular. The guidelines have been incorporated into the Sexual Reproductive Health and Rights policy guidelines and the Reproductive Health Division (RHD) revised focused antenatal care (FANC) module. The project then conducted orientation to central level facilitators who cascaded this down to district health team (DHT) members, who in turn

¹ There were gaps in the full DHMT staff requirement in this region and some competing activities led to incomplete participation, however all relevant key personnel were reached.

reached health workers (HWs) at public, private not for profit (PNFP) and private, health facilities offering ANC services. MAPD supported at all levels. See next section for details

Commodities: The project used the monthly MIP TWG and quarterly commodity security group’s meetings to advocate for availability of MIP commodities including LLINs for ANC, SP for IPTp, and folic acid 0.4mg for prevention and management of anemia in pregnant women. As a result, the National Medical Stores (NMS) have ensured availability of SP at their central stores, and districts have been encouraged to prioritize forecasting and placing orders for SP.

TWG: The project supported the development of the terms (TOR) for the MIP TWG detailing the RHD, NMCP and MIP stakeholders’ scope and responsibilities, and gaining consensus on action plans. MAPD also organized coordination meetings between NMCP’s and RHD’s MIP focal point officers to harmonize collaboration, e.g. co-chairing of the TWG. The project supports these monthly forums in terms of coordination, communication, and being the secretariat. The monthly National MIP TWG meetings achieved the following;

- Dissemination of the addendum to the Malaria in Pregnancy Policy guidelines and ministerial circular to districts supported by the project and the RHITES
- Supported malaria in pregnancy interpersonal communication by reviewing the health worker MIP counseling flip chart, which is now ready for production, dissemination and use
- Advocacy for MIP commodities – the TWG invited the pharmacy division and NMS, JMS, TASO (Global fund) and the UHSC to participate in the meetings. As a result, the QQPUs pledged to monitor the supply of SP and folic acid. They provide monthly updates to the TWG and NMCP. TASO and JMS provide information of the status of LLINs for ANC
- Supported the NMCP ‘touch down’ strategy through the involvement of selected DHOs in the TWG meetings.
- Supported monitoring and evaluation of prevention of MIP services through engagement with IPs, district health officers, RHD and NMCP.

As the secretariat of the MIP TWG, MAPD ensured minutes are shared within 24 hours and action points are followed up before next meeting. This has improved follow-up of decisions, accountability and importance of discussions. For example, monitoring SP stocks by National Medical Stores (NMS) has become more regular through these accountability mechanisms.

At district level, the project supported and participated in quarterly integrated health sector review meetings.

Output 1.1.2: Performance of districts’ and health facilities’ staff improved

Activity #	IR/Output	Target	Achieved	% Performance	Comment/s
1.1.2.1	Conduct MIP catch-up trainings - incl. district trainers	130	599	460%	Combined with IMM training to ensure cost-effectiveness and to highlight integral importance of MIP in Malaria control. The original target is very low at 150.

I.1.2.2	Orient staff on LDHF, SBM-R, approaches	70	70	100	This is a pool of national and district IMM trainers
I.1.2.3	Conduct LDHF cycles for identified health facilities	4000	5781	145	Used the LDHF approach to train health workers on the revised MIP guidelines
I.1.2.4	Conduct SBM-R supervision visits in health facilities	22 districts			2730 support supervision done by DHTs (done in all districts)
I.1.2.5	Train private sector ANC staff and private midwives on revised IPTp guidelines	0	0	0	Will begin in PY2

The project strengthened the NMCP, RHD, DHTs, and HWs to implement MIP activities at the national, district and health facility levels. NMCP, RHD staff and national IMM coaches were trained in LDHF and SBM-R.

30 national and central regional levels coaches were equipped with MIP content and skill sharing techniques who then, in collaboration with MAPD staff, trained 444 district health teams (DHTs) to work as district technical resource persons (TWRPs) in MIP as part of IMM integrated activity. An achievement of 90% of the target. 1,325 (100% of target) HFs were reached, resulting in a total of 5,781 health workers trained in MIP. Of the 5,781 health workers trained, 5,624 were from public facilities and 157 were from private not for profit (PNFP).

Table 1: Orientation in MIP in focus districts

Region	# Districts	DHT			Health Facilities			Health Workers				
		# Oriented	Target	Target Achieved %	# Reached	Target	Target Achieved %	# Oriented	Target	Target Achieved %	% HWs Female	% Youth (10-30 yrs)
Arua	8	88	88	100%	302	300	101%	1818	673	270% ²	50%	48%
Hoima	9	99	99	100%	212	206	103%	889	845	105%	68%	50%
Kabarole	9	77	77	100%	300	300	100%	1208	664	182% ¹	58%	44%
Kampala	12	116	108	107%	288	290	99%	994	1,096	91%	75%	44%
Masaka	9	64	99	65% ³	223	225	99%	872	722	121% ¹	65%	43%
Total	47	444	495	90%	1,325	1,321	100%	5,781	4,000	145%¹	63%	46%

² The original target was under estimated, as there were more HW providing ANC in lower HFs than expected

³ There were gaps in the full DHMT staff in this region and some competing activities lead to under participation, however all key relevant personnel were reached

Output I.1.3: SBCC effectively employed in MIP¹

The original target was under estimated, as there were more HW providing ANC in lower HFs than expected.

¹ There were gaps in the full DHMT staff requirement in this region and some competing activities led to participation that was not full, however all key relevant personnel were reached.

Activity #	IR/Output	Target	Achieved	% Performance	Comment/s
I.1.3.1	Implement IPC activities - SMS reminders to pregnant women (and their entourage) and support to ANC health workers	N/A	0	0	Procurement of the service provider has been completed
I.1.3.2	Implement community mobilization activities - organize for skits and educational videos viewings at health facilities	96	48 health facilities	50% (though this was a planned reduction in target)	<p>TV screens installed in 48 health facilities. The project is piloting this approach in these 48 health centers in year one for a period of three months and will expand to 96 districts in year 2 depending if the intervention proves effective</p> <p>Messages: net use, MIP, test and treat. Educational videos used by health workers to conduct health talks in the facility on a biweekly basis.</p> <p>Skits have not been set up; will be in PY2 linked to IPC development at HFs and linking community with HF</p>

The project, in collaboration with the NMCP, RHD and USAID's Communication for Healthy Communities (CHC), reviewed current MIP communication materials. As the MAPD's SBCC survey showed that health workers were a main trusted source of health information, the project looked to improve communication through this medium. Television screens airing messages on prevention of MIP were installed in 48 HFs. The television screens and messages are formulated to facilitate HW interpersonal communication (IPC) sessions. HW received on-job coaching on how best to use television messages, which will be complemented by supervision support and wider IPC methods in PY2, as well as monitoring television guide use.

Output I.1.4: Strengthened M&E of MIP activities

Activity #	IR/Output	Target	Achieved	% Performance	Comment/s
I.1.4.1	Work with NMCP to review tools to accurately track IPTp3+ data	N/A	N/A		Health Information department agreed to incorporate the IPTp3+ indicator in the HMIS 105 and DHIS2.

1.1.4.2	Advocate and support IPTp3+ reporting into HMIS	N/A	N/A		This is expected to be in place during Q1 PY2.
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The project advocated for the inclusion of an IPTp3+ indicator into the HMIS 105 and DHIS reporting system. This need was highlighted at different thematic working groups (MIP, SMEOR, Malaria Case Management) and at Maternal Child Health (MCH) cluster meetings. Meetings were also held with the Health Information Department, Director General MOH, the Program Manager NMCP, the Assistant Commissioner RHD, and the Director of the Disease Control Division of the MOH. The need was also highlighted at various stakeholder meetings.

The tool for capturing IPTp3+ has been drafted and shared with the Health Information Department of the MoH, who have agreed to include it as advocated for.

MIP Success stories

The MoH sent a circular to District Health Officers (DHOs) in 2015 following the revision of the 2012 MIP guidelines. However, the DHOs did not take any action. With the projects input and active dissemination of the actual guidelines, and on-job coaching of HWs the guidelines were adopted and the uptake of two or more doses increased, reaching the project’s Year 1 target of 70% by September. See Figure 1 (Data Source: DHIS 2).

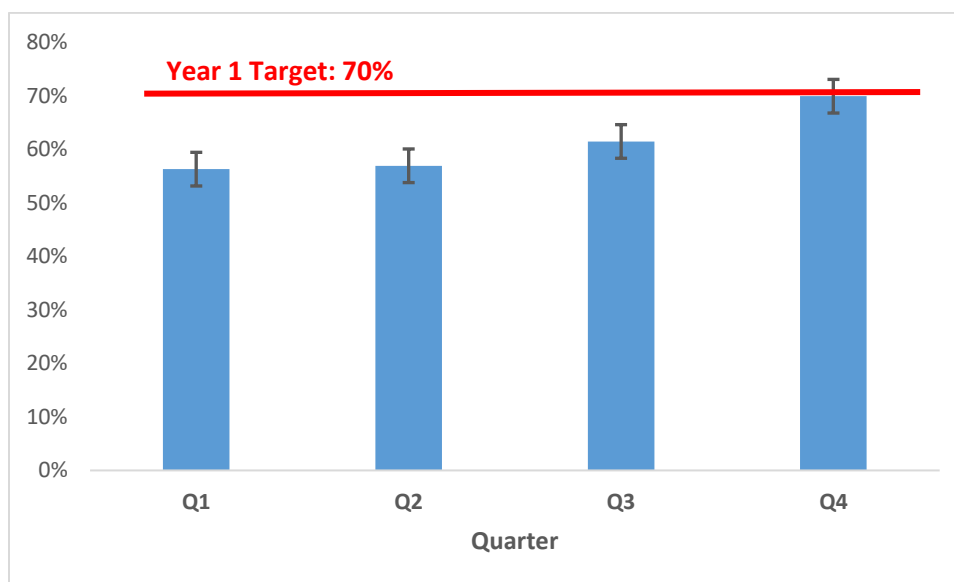


Figure 1: Proportion of pregnant women attending ANC1 who have received two or more doses of IPTp

By project region, uptake of two or more doses of IPTp improved across all project regions with three out five project regions (Arua, Kabarole and Masaka) surpassing the project Year 1’s target of 70%. In Arua, uptake has increased from 58% to 83%, in Kabarole from 69% to 85%, in Masaka from 55% to 73%, Kampala from 51% to 61% and in Hoima from 52% to 58%. Work in Year 2 will focus on the two regions that have not yet reached the target. According to HFA results though, these two regions are

not performing badly in comparison to rest, which is perhaps due to community awareness or acceptance.

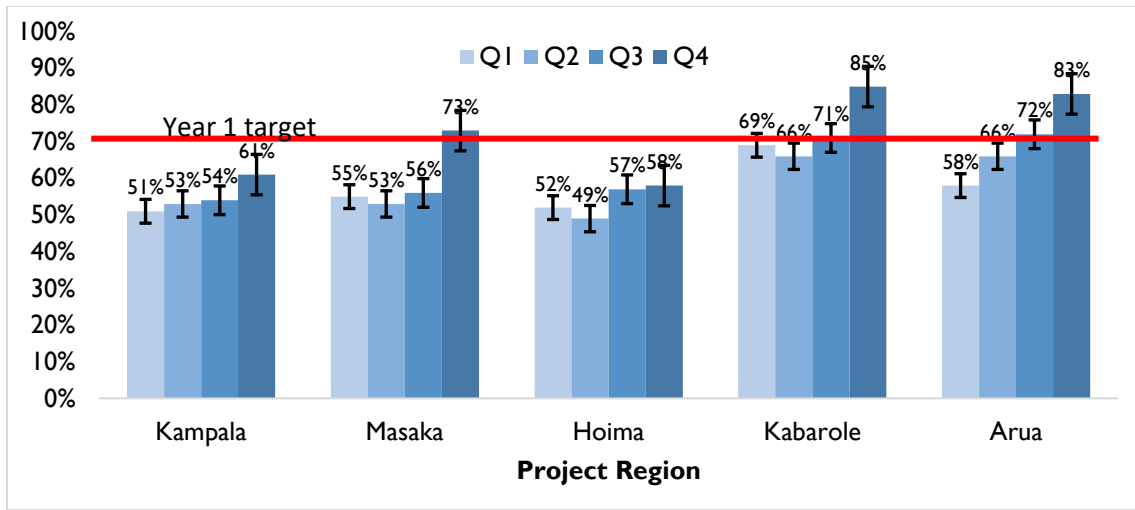


Figure 2: Proportion of pregnant women attending ANCI who have received two or more doses of IPTp by region

In addition, ANC health workers have started providing three or more doses of IPTp! Data cannot be displayed per region yet because we are awaiting inclusion of the variable; however, data from a MAPD provided data collection tool (based on the tool to collect IPTp2) in Masaka region indicated that 28% of ANC women were given three or more doses in the quarter April to June 2017, as shown in Figure 3.

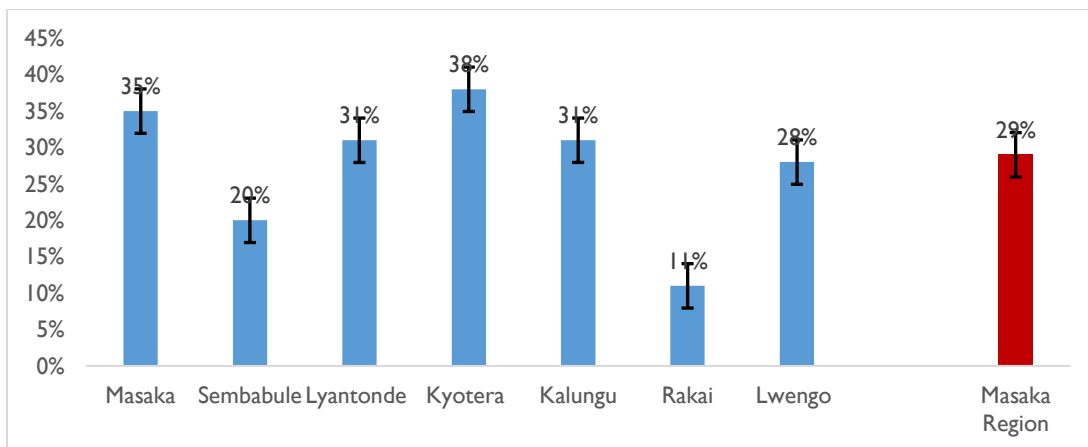


Figure 3: Proportion of pregnant women attending ANCI who have received three or more doses of IPTp in Masaka region

Challenges

Some of the identified challenges hampering MIP services uptake include:

Stock outs of LLIN for ANC continuous distribution reported in the fast half of the project year. This was rectified in Q3, working with The AIDS Support Organization (TASO) and Joint Medical Stores (JMS) to distribute PMI procured LLINs. See *LLIN section for more details*.

Delayed inclusion of IPTp3+ indicator into the HMIS 105 hampers collection and aggregation of data on this indicator.



MAPD Technical Officer conducting support supervision while distributing IPTp3+ forms and LLINs at Arua Police HC III, an integrated ANC clinic

Highlights for PY2 work plans

i. Implementation of updated guidelines for IPTp, including reporting

- Support the NMCP and Pharmacy division to carry out national quantification of MIP commodities and develop a comprehensive commodity plan (Procurement Supply Chain Management plan).
- Support the NMCP and districts to monitor the implementation of the revised MIP guidelines through MIP TWG and stakeholder's meetings at national and regional levels.
- Hold semi-annual MIP stakeholders' meetings to develop effective coordination and partnership among MIP/malaria stakeholders.
- Support implementation of MIP guidelines, working through district quarterly MIP meetings involving the DHT, health facility and ANC in charges, and implementing partners.
- Reproduce and disseminate MIP standard operating procedures.

ii. Improved performance of health workers

- Conduct MIP LDHF cycles for 1600ANC providing health facilities.
- Conduct 5,600 quarterly SBM-R supervision visits to health facilities – MIP standards.
- Train 400 private ANC staff including private midwives on the revised MIP guidelines

iii. Support demand and utilization of MIP services through innovative SBCC

- Support Implementation of IPC activities at health facility level
- Roll out the mHealth platform to send SMS reminders to pregnant mothers and their partners, and health workers
- Address Gender and Youth issues through all SBCC mechanisms (see Gender and Youth analyses)

iv. Support MIP services quality documentation and reporting

- Enable district biostatisticians, HMIS officers and assistants to ensure high quality MIP data management and use.
- Facilitate district biostatisticians and HMIS officers/assistants to extract IPTp3 data from the ANC registers, aggregate it and transmit to the resource center for entry into the DHIS2.
- Support district health officers to conduct monthly MIP data review meetings with in-charges and HMIS officers.
- Support with provision of tools as needed.

Intermediate Result 1.2: Initiatives to promote net use and access to LLINs implemented

Output 1.2.1: Finalized and disseminated routine LLIN guidelines

Activity #	Activities	Outputs/ Target	Achieved	%	Comment/s
Result 1: Effective malaria prevention programs implemented in support of NMCP					
1.2.1.1	Support the NMCP to develop a continuous LLIN distribution strategy	A routine/ continuous LLIN distribution strategy developed	A half day consensus meeting of national stakeholders held	NA	The ANC LLIN distribution guideline 2015/6 is still in draft, and there is no guideline yet on EPI, School LLIN distribution guideline, has been worked on and is nearly finalized The lack of finalized guidelines has made it hard to synthesize them into one comprehensive guideline
1.2.1.2	Advocate for adoption of NetCalc tool by NMCP				Was not done as this year had UCC. Will do in PY2

NMCP received funding for development of the LLIN distribution strategy under DfID/WHO/UNICEF's joint capacity development project. Guidelines are currently fragmented and as EPI distribution only began in 2016 there are no guidelines. Distribution through schools is also a new concept. MAPD would like to promote comprehensive guidelines for all continuous LLIN distribution mechanisms.

Output 1.2.2: LLINs distributed through campaigns and health facilities

Activity #	Activities	Outputs/ Target	Achieved	%	Comment/s
Result 1: Effective malaria prevention programs implemented in support of NMCP					

Activity #	Activities	Outputs/ Target	Achieved	%	Comment/s
I.2.2.1	Support NMCP to distribute 1,000,000 LLINs through UCC	1,000,000 nets distributed through UCC	1,053,000 distributed	105	<ul style="list-style-type: none"> 21 District task force meetings (7 per district) in 3 West Nile districts. 15 sub-county task force meetings were constituted per sub-county So that <ul style="list-style-type: none"> MAPD supported the distribution of 1,053,834 LLINs in Arua, Koboko and Nebbi
I.2.2.2	LLINs to pregnant women through ANC and to children under 12 months through EPI	Estimated 800 health facilities distributed with LLIN in Year 1	1,308 health facilities received nets out of the total 1,473 (88%) supported facilities	164	This activity is continuous. The target of 800 was an estimate made before the project conducted a LLIN quantification on which the distribution was actually based
I.2.2.3	Conduct Malaria in Pregnancy training catch up - LLIN distribution, use and record keeping modules				Linked to MIP section above
I.2.2.4	Conduct quarterly SBM-R supervision visits in health facilities - LLIN modules				In PY 2
I.2.2.5	Quarterly health facility outreach to distribute LLINs in the community (7 districts)	None	None	0	In the review period, the country distributed nets through UCC, reaching all households with 1 net per 2 people in each HH. Thus, the purpose of this community intervention was addressed, and the activity was not implemented to avoid duplication.

LLINs distributed through Universal Coverage Campaign (UCC)

Direct Distribution Support: The project distributed 1,053,834 LLINs through UCC in three districts in West Nile Region; i.e. Arua, Koboko and Nebbi. The project's supported these districts to produce accurate and workable micro-plans, registration, SBCC (including demonstrations) and in the actual distribution. The table summarizes the number of LLINs distributed by the project per district. See Table 2 for details.

Table 2: Number of LLINs distributed through UCC in three West Nile districts

District	Persons Registered	HH Registered	Nets Distributed	Persons for LLIN	Distribution coverage%
Arua	1,122,362	208,345	606,320	623,534	97
Koboko	291,160	45,078	145,120	161,755	90
Nebbi	564,592	104,641	302,454	313,662	96
Total	1,978,114	358,064	1,053,894	1,098,952	95

General Support The project also supported the UCC in project regions. Overall, close to 13 million LLINs distributed, resulting in a 99% coverage (ownership) of those registered; far above the national 85% target (see figure below).



LLIN demonstration: the team demonstrating how to hang a LLIN in Bundimurombi II village Kirumya subcounty in Bundibugyo district

LLINs for continuous distribution through ANC/EPI clinics

MAPD initiated and supported quantification of LLINs at health facilities. LLINs should be in the facilities to be given to people through ANC/EPI mechanisms, as though UCC LLIN distribution coverage is impressive, continuous mechanisms are still needed to maintain community LLIN coverage levels. As seen in table 3 below, a gap of 293,880 in stocks for the next quarter was highlighted through this exercise (through calculated LLIN need for the quarter vs actual stock).

Table 3: LLINs gaps for Health Facility continuous distribution.

Region	# HFs provided with LLINs			Total LLINs Distributed		
	PNFP	Public	Total	PNFP	Public	Total
Kabarole	48	174	222	10,469	47,577	58,046
Hoima	21	197	218	4,434	64,228	68,662
Kampala	81	365	446	14,274	81,843	96,117
Masaka	61	196	257	8,184	32,103	40,287

West Nile	21	142	163	3,958	26,793	30,751
Total	232	1,074	1,303	41,336	252,544	293,880

Following identification of this LLIN gap, MAPD convened a stakeholders meeting with PMI, USAID, NMCP, TASO and JMS to find timely and long-lasting solutions. As a result, responsibility for LLIN provision was divided as such: 63 districts supported by USAID/PMI through MAPD (47) and RHITES, while the remainder are supported by Global Fund/TASO. MAPD distributed 252,544 LLINs to its supported districts.

It was also noted that planning and distribution of LLINs was not fostering district ownership or accountability leading to many implementation bottlenecks. MAPD worked closely with the DHOs for the delivery of its LLINs and has integrated LLINs within district work-plans and performance management plans.



MAPD distributing LLINs to HFs reaching the smaller Islands in Kalangala district Lulamba HCIII

Output 1.2.3: LLINs distributed through schools

Activity #	Activities	Outputs/Target	Achieved	%	Comment/s
1.2.3.1	Train school- LLIN strategy	40 district trainers - 2 per each of 20 districts	Not yet started.	0%	National Guideline approval has been lengthy and is not yet finalised by the MoH. As it is an entirely new strategy at a large scale, stakeholder consultations are ongoing. The project has developed the plan for roll-out of the guidelines when approval is finalized and shared with stakeholders.
1.2.3.2	Train school teachers on school-based distribution of LLINs	2,000 trainees	• None	0%	Training will be conducted once the guidelines are ready.

1.2.3.3	Register and verify pupils in PI & P4 for LLIN	Registers of eligible children	Not yet started	0%	Results are based on actual implementation which is awaiting on availability of approved implementation guidelines.
1.2.3.4	Sensitize children and parents on net use				<ul style="list-style-type: none"> Pending guideline approval
1.2.3.5	Distribute LLINs in school and conduct LLIN stock reconciliation	600,000 Nets distributed	Not yet started.	NA	<ul style="list-style-type: none"> This result from actual implementation is awaiting on approval of guidelines by MoH. 589,767 nets are estimated for distribution based on data on school enrolment from MoES. This will be validated through onsite registration of pupils which will provide actual number of registered pupils.
1.2.3.6	Share distribution data with the District Education and Health Offices				Pending implementation (as above)
1.2.3.7	Collect, compile and analyze LLIN distribution data from schools				

The roll-out activities planned for, included district TOT (1.2.3.1), training school teachers (1.2.3.2), registration of pupils (1.2.3.3) and distribution of nets to beneficiary pupils (1.2.3.5) however the slow attainment of guidelines approval has hindered activity achievement. Thus, the activities have been re-programmed in Year 2. The project, has however promoted collaboration between the Ministry of Education and Sports (MoES) and MoH, as well as District Education Officers (DEOs) and DHOs to strengthen coordination and joint responsibility of this activity. Working with the MoES, the project has identified an estimated 2,654 schools for this activity, from which 7,962 teachers will be trained – 3 per school. While activities have been delayed, the project will work with the MoH and MoES to reschedule distribution in the third quarter of Year two (April to June 2018) as this might be more appropriate timing considering that Uganda is just completing UCC distribution in 2017.

Highlights of PY2

Finalized and disseminated guidelines, advocating for change

- Dissemination of school net guideline, development and dissemination of integrated guidelines (including disposal).

LLINs distributed through health facilities and campaigns

- Distribution of nets through ANC/EPI (1,010,176), schools (649,117) and outreaches (25,500).
- District ownership of net programs improved through district run quantification and need assessments, and accountability improved through performance reviews.
- Collaboration and integration of all actors improved through collaboration and sharing lessons, tools and reviews.
- Improved community net use using lessons from SBCC analysis and IPC.
- EPI LLIN data included in HMIS tools
- A LLIN durability study done.

IV.II Result 2: Effective malaria diagnosis and treatment activities implemented in support of the National Malaria Strategy

Intermediate Result 2.1: Implementation of iCCM in hard-to-reach and highly endemic central region districts supported

During PY1, the project set out to implement iCCM in two districts of Kayunga and Buikwe.

Output 2.1.1: ICCM guidelines finalized and disseminated

#	Activities	Outputs/ Targets	Achievement	%	Comments
2.1.1.1	Disseminate iCCM policy and guidelines	1-day national stakeholders' workshop conducted	2 district-level meetings were conducted	200%	MAPD disseminated to district-level for 2 districts- Buikwe and Kayunga selected for iCCM roll-out during project Year 1 So 2 district level activities were held rather than 1 central one
2.1.1.2	Track progress of iCCM commodity integration into NMS procurement and distribution systems	Support Child Health Division (CHD) to conduct 6 bi-monthly iCCM Task Force meetings	3 Task Force meeting supported.	75%	ICCM task force only meets quarterly, supported 3 as 1 was not conducted.
2.1.1.3	Support the district to distribute iCCM commodities and other supplies	Number of ACT doses distributed: 2,750 yellow pack & 1,900 blue pack 400 packets of mRDT	None	0	Implementation of this activity did not take place due to lack of non-malaria commodities to complete VHT pack. As per MoH guidelines requirement of complete VHT pack/medicines boxes before implementation, this activity could not be implemented. These commodities have been adopted in the HF essential kit after advocacy efforts of the project.

The project could not conduct roll out of iCCM, as MoH only allows iCCM roll-out (including preparations and orientation) when the full package of medicine boxes are in place. A lack of non-malaria commodities hindered this for the project. At project set-up, it was anticipated that non-malaria commodities (antibiotics for pneumonia, ORS & zinc for diarrhea etc.) would be provided through the Ministry of Health supply chain system, however this was not seen to be the case. Through advocacy and negotiation, MAPD secured inclusion of non-malaria commodities for the initially indicated 2 iCCM districts to the NMS supply chain funded by Global Fund and in-country development partners, mainly UNICEF/DFID. Given that Global Fund grants will last for only 2 years, MAPD will continue to engage GoU and/or UNICEF/DFID for continuation of support. In PY2, the districts will be supported to conduct quantification of needed non-malarial commodities and a cost description will be done to give partners including the government a sense of the costs involved.

However, orientation meetings in Buikwe and Kayunga (the first of the iCCM districts) were conducted and DHMTs engaged and are on board. MAPD also discussed issues of commodities with the district to try and find locally driven solutions.

Highlights of PY2

iCCM implementation

- Effective iCCM rolled out in eight districts
- iCCM commodities fully adopted into essential medicines kits of HFs and procurement and distribution systems of NMS and JMS. (plan comes into effect in January 2018)
- Village Health clubs supporting iCCM.
- Women, Youth and PWD support groups at community level.
- SMS platform for caregivers.
- Improved reporting to HFs
- Collaboration and cross sharing done with iCCM implementers

Intermediate Result 2.2: Diagnostic capacity improved

Output 2.2.1: Laboratory staff performance improved

Activity 2.2.1.1: Conduct catch up training of trainers' courses in malaria-microscopy for identified DHMTs

#	Activities	Targets	Achievements	%	Comments
2.2.1.1	Conduct catch up ToT trainings, including SBM-R orientation, for identified RPMTs and DHMTs	70-DHMTs	66-DHMTs	94%	Targeted all available National trainers
2.2.1.2	Adapt malaria microscopy curriculum to the LDHF approach				Done
2.2.1.3	Conduct fresh and catch-up trainings for lab staff on malaria microscopy, by facilitators from RPMT/DHMT TOT training	300 Lab staff	300 Lab staff	100%	Done
2.2.1.4	Conduct LDHF cycles for identified lab facilities - malaria microscopy modules				Delayed due to late approval of MoH strategy. Will be done In PY2
2.2.1.5	Conduct SBM-R supervision visits in lab facilities				

Development and Review of diagnosis guidelines

MAPD engaged and supported the MOH to develop a national malaria diagnosis-training guide and review/finalize the national quality assurance manual, in line with existing national documents⁴.

⁴ Health Sector Quality Improvement Framework and Strategic Plan, 2015/16 – 2019/20

The Quality Improvement Methods: A manual for health workers in Uganda
Strategy for Improving Health Service Delivery 2016-2021

Stakeholder guideline development sessions were held with specialists from referral hospitals, reference labs, district hospitals, partner organizations, universities and the MOH. The developed documents will ensure standardization and uniformity of training and quality assurance systems in the country and provide guidance to districts and multiple partners engaged in malaria diagnosis.

Building the capacity in diagnostics service

In collaboration with MOH/NMCP, the project conducted three training of trainers (TOT) courses in malaria-microscopy for 66 identified Laboratory Personnel from the DHMTs, see figure 5. A four-day orientation was then conducted to two district trainees (including the district laboratory focal person) from 24 districts (where training gaps had been identified through MAPDs health facility assessment). This improved capacity for malaria External Quality Assurance (EQA) and Quality Control (QC) including performing second level reading of EQA slides, techniques of training, mentorship coaching and malaria microscopy equipment maintenance. The training was based on the revised MOH-approved training of trainers' curriculum for malaria microscopy and RDT use. The national team of malaria microscopy trainers will remain available to all trainees for ongoing consultation and mentorship.

Table 4: Number of laboratory TOTs oriented in project regions

Region	# Districts	Laboratory TOT Orientations				
		# Oriented	Target	Target Achieved %	% TOTs Female	% Youth (10-30 yrs)
Arua	8	19	19	100%	5%	11%
Hoima	9	8	8	100%	38%	0%
Kabarole	9	18	18	100%	17%	6%
Kampala	12	6	6	100%	17%	33%
Masaka	9	15	15	100%	40%	7%
Total	47	66	70	94%	21%	9%

Activity 2.2.1.2: Adapt malaria microscopy curriculum to the LDHF and SBM-R approaches

The malaria microscopy curriculum for laboratory staff was adjusted to the LDHF approach so malaria microscopy is integrated into the health facility LDHF cycles and SBM-R quarterly visits.

Activity 2.2.1.3: Conduct catch up trainings for lab staff on malaria microscopy

The project, in collaboration with the DHMTs, conducted onsite facility-based mentorship in malaria microscopy for laboratory staff in both public and PNFP facilities. This was a 3-day activity facilitated by district trainers with technical oversight from the project team, the Central Public Health Laboratories (CPHL) and MOH laboratory technologists.

Table 5: Number of laboratory staff oriented in laboratory diagnostics

Region	Laboratory HWs Orientations
--------	-----------------------------

	# Districts	# Oriented	Target	Target Achieved %	% HWs Female	% Youth (10-30 yrs)
Arua	8	70	70	100%	18%	40%
Hoima	9	50	50	100%	42%	58%
Kabarole	9	70	70	100%	33%	53%
Kampala	12	50	50	100%	17%	44%
Masaka	9	60	60	100%	45%	56%
Total	47	300	300	100%	31%	49%

The orientation focused on accurate detection of malaria parasites, performing basic care and maintenance of microscopes and implementation of EQA for malaria. MAPD, NMCP and CPHL teams offered technical support during these district orientations.

Output 2.2.2: Regular laboratory EQA of malaria diagnostics conducted

#	Activities	Output/Targets	Achievements	%	Comments
2.2.2.1	Train laboratory staff as WHO-certified malaria microscopy experts (incl. mRDT QC)	20	12 Lab staff	60%	20 was planned to be reached though 2 trainings. However only one was possible this year due to availability of WHO trainers Only 1 male lab staff reached level 2 Need to strengthen
2.2.2.2	Support DHMTs to implement EQA	458 DHMTs	458 DHMTs	100%	6 facilities per district was chosen based on HF volume. Roll out in PY2
2.2.2.3	Support DHMTs to disseminate EQA results at district and HF levels				Will occur in PY2

Activity 2.2.2.1: Train laboratory staff as WHO-certified malaria microscopy experts (including mRDT quality control)

USAID's Malaria Action Program for Districts (MAPD) in collaboration with WHO and AMREF, and working with the national standards set by the CPHL, conducted a five-day External Competency Assessment for Malaria Microscopists (ECAMM) in Uganda to strengthen Malaria Microscopy EQA in the Country.

Results: one laboratory staff member was able to score level 2, six laboratory staff were able to score level 3 and five laboratory staff scored level 4. Only 2 of these staff were female (16%). Efforts to further improve these scores will occur in PY2 to make effective EQA possible.

Activity 2.2.2.2: Support DHMTs to implement EQA in 25 districts and introduce EQA for malaria in 22 districts

MAPD supported 458 DHMTs to start implementing malaria microscopy, and mRDT EQA. This will ensure overall improvement of blood slide/mRDT reading accuracy, leading to the clinician's confidence in using microscopy and mRDT results from their facilities to make treatment decisions.

Additionally, MAPD has procured twenty-one (21) Olympus CX21 binocular microscopes. The microscopes will be placed at regional reference laboratories to strengthen diagnostic capacity and malaria microscopy and mRDT EQA activities. This will ensure improved malaria microscopy diagnostic accuracy and strengthen malaria Microscopy EQA in the region.

OUTPUT 2.2.3 mRDTs in public sector strengthened

Done in conjunction with IMM capacity building which will start PY2 Q1.

Output 2.2.6 Strategic SBCC deployed

#	Activities	Output/Targets	Achievements	%	Comments
2.2.6.1	Implement IPC activities - support health workers in communication on the test and treat	All Facilities	0	0	Done in conjunction with IMM and also with SBCC IPC support which will start PY2
2.2.6.2	Implement community mobilization activities - create a toll-free "Fever Line" community member can call to get fever management advise	Set up	Done	100%	Set up at end of PY1: too soon for monitoring/ effectiveness data

Activity 2.2.6.2 Implement community mobilization activities

A toll free line (**0800200055**) has been set up by the project, providing post-training SMS support to training activities, as well as a toll-free line to the various components of fever case management to health workers and the community. 366 trainees who attended laboratory diagnosis, and 208 lab staff and DHMT that support the malaria Microscopy EQ, have been enrolled to receive SMS quizzes and reminders.



Participants practicing blood smear preparation at Hoima RRH



Practical session on use of mRDTs during the IMM training in Mukono district

Success Stories

Dorothy Namaganda and Nambaale John Bechmans work at Kalisizo Hospital, Kyotera district and they participated in the ToT course 2017. After attending the training, they started detecting three (3) different species of malaria they had been missing out. This is what Dorothy had to say, “I used to think diagnosis of malaria is easy before attending this training. However, I have gained experience in examination of malaria slides especially differentiating malaria species.” Dorothy has been able to share with the project technical team some of the species they have collected and we plan to use their site to collect more slides during the creation of the National Slide Bank.

Indicators of success

Suspected malaria cases tested: Proportion of malaria suspected patients tested for malaria at health facilities is an important indicator to measure effect by project activities implemented. Overall, this indicator has improved from 79% in quarter one to 83% in quarter four, Figure 7.

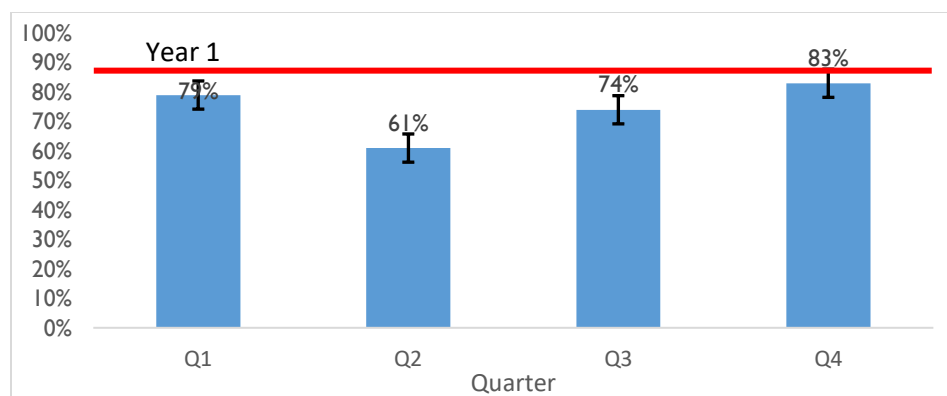


Figure 4: Proportion of malaria suspected patients tested for malaria at health facilities

Intermediate Result 2.3: Service providers' capacity for management of uncomplicated malaria cases improved

Output 2.3.1: Treatment policy and guidelines finalized and disseminated

The integrated malaria management (IMM) guidelines that were recently developed (2016) by the NMCP and partners are being disseminated with support of project resources as described below.

Activity #	IR/Output	Comment/s
2.3.1.1	Review and seek approval of revised guidelines for uncomplicated malaria	By time of MAPD the 2016 IMM guideline developed and up to standard, although some revisions to tailor it to different staff cadre are under discussion
2.3.1.2	Hold dissemination meetings at national and district levels	See above
2.3.1.2	Disseminate guidelines to HFs through ISS; distribution of policy memo	

Output 2.3.2: HW performance in managing uncomplicated malaria improved

The project, the NMCP and RHD division collaborated on a capacity building framework and developed a malaria clinical services toolkit. This was used to equip 599 national and district staff in IMM and LDHF and SBM-R techniques. National trainers from NMCP/RHD, Mulago national referral hospital and key implementing Partners, with support from MAPD built the capacity of district technical resource persons (TRPs) so that one TRP supports three health facilities.

Activity #	IR/Output	Target	Achieved	Comment/s
2.3.2.1	Conduct Integrated Management of Malaria training catch-up - management of uncomplicated malaria modules	4000	15 (%)	Capacity built of core HW team at facility level so roll down to others in their facilities. This could only begin in the very end of Q4 due to waiver request implementation barriers. Catch-up will occur quickly via on job coaching in Q1 PY2
2.3.2.2	Conduct LDHF cycles for identified health facilities - management of uncomplicated malaria modules			PY2 Q1.
2.3.2.3	Conduct quarterly SBM-R supervision visits in health facilities - management of uncomplicated malaria modules			After completion of above

Intermediate Result 2.4: Service providers' capacity for management of severe malaria cases improved

Output 2.4.1: Severe malaria policy guidelines finalized and disseminated

Activity #	IR/Output	Target	Achieved	Comment/s
2.4.1.1	Support update of guidelines to include dosage for Inj AS and disseminate revised guidelines	1	N/A	There is no stand-alone severe malaria guideline, this is in part of IMM with inj AS included.

Output 2.4.2: HW performance improved

Activity #	IR/Output	Target	Achieved	Comment/s
2.4.2.1	Conduct Integrated Management of Malaria training catch-up - management of severe malaria modules	4000	599	See uncomplicated malaria section as integrated in IMM.
2.4.2.2	Conduct LDHF cycles for identified health facilities - management of severe malaria modules			To be done in PY2 Quarter 1
2.4.2.3	Conduct quarterly clinical audits at HF	280	1024	Original target was very low, and not based at HF level, but more at district trainer level. MAPD actually went to HF level.

The implementation strategy was revised to include training of facility-based clinical auditors and actual conduct of clinical audits at health facilities (not in PY1 plan). Routine clinical audits will occur from this activity using the now enabled facility-based clinical auditors. 1024 clinical auditors were oriented, please see Table 6.

Table 6: Number of facility-based clinical auditors oriented

Region	# Districts	HW Auditors Oriented				
		# Oriented	Target	Target Achieved %	% HWs Female	% Youth (10-30 yrs)
Arua	8	192	194	99%	51%	44%
Hoima	9	151	150	101%	65%	55%
Kabarole	9	188	188	100%	55%	42%
Kampala	12	314	321	98%	73%	43%
Masaka	9	179	178	101%	68%	41%
Total	47	1024	1031	99%	60%	42%



A team of IMM trainers examining a sick child at Koboko HC IV during IMM training

Indicators of Success

Adherence to malaria negative results: Overall, the number of patients who were tested negative for malaria, but given an antimalarial varied from 20% to about 70%. Caution has to be taken with this indicator because it was affected by inconsistencies resulting from use of outdated tool in some health facilities, please see full table in Appendix 2. MAPD will try to collect the right information during HF HMIS outreach activities in start of PY2 as well as engaging Division of Health Information to correct this.

Support to areas experiencing above normal cases and deaths

Hoima: The MoH epidemiological report week 30 (August 2017) reported high malaria deaths in Hoima Region. 627 severe cases presented (June-August), of which, 18 died = 3% CFR (case fatality rate). In response, the project conducted a mortality audit in Hoima Regional Referral Hospital (RRH) where most deaths occurred, this revealed that inadequate quality of hospital healthcare was a major contributor to the mortalities and so MAPD engaged the Hoima DHT RRH teams to address quality of treatment and care issues in the hospital through improved management, institutionalization of clinical audits and death reviews and improved reporting. To identify communities most affected by this upsurge, line-listing of severe malaria admissions and analysis of weekly surveillance data of the region was done. Half of the deaths came from Buhanguzi County in Hoima District, where a transient local epidemic had occurred in three sub-counties between June and August 2017 contributing to the majority of deaths. The project supported and led community dialogue SBCC meetings in affected sub-counties to investigate underlying reasons and promote positive behavior change.

Rwenzori: 64 cases presented in June-August 2017 period; of which 42 died = 38% CFR. The project supported Fort Portals RRH, similarly to that of Hoima. The mortality audit revealed poor quality of medical records and healthcare, and while all patients were treated with IV Artesunate and blood transfusion as needed, none were assessed nor treated for other major complications of severe malaria, such as renal failure, pulmonary edema and hypoglycemia. Clinical audit identified very weak system issues in the hospital, and it was also noted that the deaths had not been reported in the weekly mTRACK surveillance reports. Analysis of weekly surveillance data from the region identified that the deaths came from three districts – Bundibugyo, Kamwenge and Kyenjojo districts. In each of these, the deaths came from three sub-counties that experienced an epidemic. Bad recording has made it impossible to track 30 deaths, however, MAPD triggered community action in the affected sub counties.

Intermediate Result 2.5: Strengthen the capacity of district supervisors to monitor malaria activities at facility level and community levels and improve the referral system between community and facility

OUTPUT 2.5.1 Referral Strengthened

This activity was not implemented in year one, as sustainability concerns are still being investigated in similar projects in the country. It is planned to be rolled out in year two especially in areas implementing iCCM.

OUTPUT 2.5.2 District capacity to monitor malaria activities strengthened

375 DHMT members and HW orientated in HMIS skills and importance. Data for decision making has been an integral component of all interactions with the districts, and performance plans have been drawn up.

Highlights of PY2

Diagnostics

- Continued development e.g. improving level of WHO ECAMM

- EQA operationalized in all facilities
- Commodities tracked via assessments, SBM-R and reviews
- Malaria Microscopy Slide Bank up and running
- RDT capability and adherence improved via LDHF and SBM-R
- Field-based quality control for mRDTs at community and lower level health facility levels
- Private sector performance improved through sub-contracts

Case Management (uncomplicated and severe)

- Skills and motivation improved via LDHF and SBM-R, clinical audits, performance based sub-grants
- Malaria case management job aids, toolkits and updates, in response to updated service delivery guidelines available at HFs
- Malaria commodities and pharmaceutical needs quantification done and advocacy for improved commodities.
- HF and district level supply chain improved (consumption data, orders, redistribution)
- Improved test adherence through SBM-R and improved accountability (linking HF data with lab and stock data)
- Job aids for differential diagnosis of fever to help reduce assumptions of malaria
- Monthly supervision review visits to hospital and HCIVs
- SBCC on test adherence, timely treatment seeking, adherence to medicines, using positive deviants, community groups, HWs (Supervision to improve HW IPC) and media
- Toll free line for fever advice
- Data disaggregation for severe and uncomplicated malaria
- Efficacy studies

IV.III Result 3: Capacity of NMCP and DHMTs to manage and sustain efficient malaria activities in focus districts built

Intermediate Result 3.1: Capacity of DHMTs to effectively manage and sustain malaria activities in the focus areas built

Activity #	IR/Output	Target	Achieved	Comment/s
OUTPUT 3.1.1	District leadership and coordination for malaria programming improved			
3.1.1.1	Conduct joint baseline capacity assessments of DHMT capacity			To be done in PY2
3.1.1.2	Provide TA to districts to develop capacity development activities			Done through orientation of LDHF and SBM-R and development of tools
3.1.1.3	Conduct bi-annual externally validated self-assessments and joint reviews			PY2
3.1.1.4	Hold annual meeting to reward performance and set new targets			Due to delays in waiver this will be done in PY2.

3.1.1.5	Support dissemination of lessons learned at local, regional and national levels	As above (implementation delays didn't allow for this to be meaningfully done in PY1)		
OUTPUT 3.1.2	Quality, validity, reliability, timelines and use of HMIS data from HFs improved			
3.1.2.3	Provide TA to RPMT to support DHMTs to improve timely data analysis	Na	376 DHMTs/HWs orientated in HMIS (8 per district)	RPMTs don't function anymore as GF support was not renewed.
OUTPUT 3.1.3	Uncomplicated and severe malaria surveillance strengthened at district level			
3.1.3.1	Develop DHIS2 modules for use of malaria data for action	To be incorporated in PY2		
3.1.3.2	Support the use of data from sentinel sites for malaria surveillance (CDC reference centers and AFI units) for improved decision-making	Pending approval of Surveillance sub-contract from USAID		

District entry and stakeholders consensus meetings for project start-up were conducted for all the 48 supported districts. Through these meetings, the project secured partnership with all the districts and signed MOUs. The MAPD HFA identified needs at facility level and district level capacity to lead quality services within their facilities was also done through training of DHMT members and TRPs (MIP, Clinical Audits, HMIS). Malaria and performance plans were conducted with the districts prioritizing malaria, analyzing needs and deciding on action points.



A pregnant woman receives preventive malaria treatment

Intermediate Result 3.2: Value for money: increased cost efficacy in delivery of malaria services in focus areas

Activity 3.2.1.1: Develop a grant and contracting strategy and get USAID approval

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
Activity 3.2.1.1:	Develop a grants and contracts manual	1	1	100%	Draft sub-grants and sub-contracts manual developed and approved by USAID

The grants and sub-contracts manual was developed using USAID MAPD Solicitation, the USAID MAPD contract and USAID regulations. The sub-grants and sub-contracts manual received approval from USAID on 14th April 2017.

Activity 3.2.1.2: Analyze capacity assessment results to select PFPs, PNFPs and public health facilities for engagement in PBF efficiencies

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
Activity 3.2.1.2:	Analysis of facility assessment results	n/a	done	100%	The results were analyzed and categorized
3.2.1.3	Conduct in depth infrastructure needs assessment and develop bills of quantities				Pending the above. Will be done in PY2
3.2.1.4	Award and manage construction contracts				

The health facility assessment results were analyzed and categorized, providing a basis for health facilities to be targeted for infrastructural needs assessments as well as for in-kind grants.

Activity 3.2.1.5: Conduct in-depth infrastructure needs assessment and develop bills of quantities

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
Activity 3.2.1.5:	Conduct in-depth infrastructure needs assessment and develop bills of quantities.	n/a		10%	Renovation concept has been developed.
Sub-activity 3.2.1.5.1:	Identification of eligible medical Professional Associations	n/a	12	100%	Professional associations identified and listed
Sub-activity 3.2.1.5.2:	Develop a targeted RFP for medical professional Association	1	1	100%	RFP has been developed and advertized in the newspapers.

In PY1 a renovation concept was developed for the review and approval by USAID, consultations were made with districts regarding their renovation needs, and coordination with the Ministry of Health's Engineering and Infrastructure Division was done (through meetings and TWGs).

Sub-activity 3.2.1.5.1: Identify eligible professional associations including UPMA, UPMPA and others

The project identified 12 appropriate medical professional associations identified, of which four responded to the request for proposals. Eligibility was based on their professional mandate and coverage in respect to the project areas of operation and their capacity to contribute to the project objectives.

Two of the professional associations that responded were eligible:

- Uganda Pediatrics Association
- Uganda Private Midwives Association

Sub-activity 3.2.1.5.2: Develop a targeted request for proposals for professional medical associations

A targeted RFP was developed for professional medical associations to apply in support of the project objectives. The RFP was advertized in two local dailies. In the first quarter of PY2, applications will be reviewed to assess the applicants' capacity to manage and deliver services as reflected in the RFP solicitation. This will include critically examining their areas of operation, comparative advantage and their overall associations mandate.

Activity 3.2.1.6 Award and manage sub-contract to PFP HFs to increase equitable access to malaria services

This activity will be carried out in PY2 of the project.

Activity 3.2.1.7: Implement performance-based in-kind grants through MOUs with DHMTs

A standard tool to assess the DHMTs has been developed and will be used during the assessment (start of PY2). Currently, procurement considerations are in place for a consultant to undertake the assessment of the 47 DHMTs.

Intermediate Result 3.3: Capacity of NMCP to effectively manage and sustain national malaria activities built

Output 3.3.1: NMCP effective leadership strengthened

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
3.3.1.1	Support NMCP in leadership, management, coordination and monitoring	N/A		Good	Through TWG, RBM and meetings
3.3.1.2	Support NMCP in implementing and revising national malaria M&E plan			N/A	This activity became obsolete due to the development of this in 2014
3.3.1.3	Support the mid-term review of the Uganda Malaria Reduction Strategic Plan			Good	Provided TA and supported 2 external consultants

MAPD seconded two key staff to the NMCP/RHD; an MIP Specialist and a Senior Advisor Entomology. The positions have strengthened, and will continue to strengthen the technical and programmatic capacity of the NMCP/RHD to plan, manage, evaluate and coordinate MIP and malaria entomology activities, as well as improve cohesion between departments, e.g. NMCP and RHD. MAPD is drafting a detailed approach to maximize these efforts. MAPD actively improved the quality and outputs of the UMRSPs mid-term review through support from project staff and enabling of external consultants.

Output 3.3.2: Improve quality, validity, reliability, timeliness and use of malaria data at national level

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
3.3.2.1	Support improvement of the HMIS system	N/A		Good start	National and district staff orientated Advocated for inclusion of missing indicators
3.3.2.2	Provide TA to NMCP to improve district data collection and use				Linked NMCP/RHD with districts through planning meetings including analysis of district data

379 personnel including DHOs, malaria focal persons, HMIS focal persons and high volume facilities records assistants were orientated in the importance of data collection and use and in HMIS. This enabled malaria data quality improvement and promoted data use at HF and districts for surveillance, progress monitoring and planning.

OUTPUT 3.3.3 Coordination by NMCP improved

3.3.3.1 Support NMCP to conduct and coordinate RBM partnership meetings

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
3.3.3.1	Support NMCP to conduct and coordinate RBM partnership meetings	RBM meetings	3	100%	Need to further develop these in PY2

MAPD participated and supported RBM coordination mechanisms (3), allowing sharing, alignment, and collaboration between a wide range of key malaria players and for NMCP to coordinate national action.

Main malaria control strategies emphasized included:

- Integrated Vector Management (IVM): IVM strategy and guidelines, school based LLIN distribution guidelines and insecticide resistance management plan. Key strategies under development include LLIN repurposing strategy, with clear SBCC messages and IRS exit strategy, including sustainability planning.
- Case Management: Strengthen test-and-treat strategy to ensure optimal use of ACTs, learning from the success in Mpigi district who have mitigated ACT wastages. Need to ensure RDT

stocks security. With regard to iCCM, need to focus on moderate to high malaria burden districts, evaluation of iCCM process, output and impact to provide evidence for its effectiveness and integration of iCCM data into national reporting.

- Malaria in Pregnancy (MIP): continued strengthening of NMCP and RHD, with the later in implementation leadership. IPTp strengthening requires SP commodities security, rational quantification systems and commitment to procurement, given the increased projected need, in line with revised MIP guidelines addendum for IPTp3+.
- Private Health sector support: Case management strengthening in private health sector includes training of health workers and support supervision lead by DHO.
- Program Management: Key priorities include UMRSP mid-term review, partner and stakeholder mapping, including private sector, as well as partner coordination to avoid services duplication and harness synergies to increase programs' effectiveness and impact.
- M&E: effective monitoring and evaluation of NMCP interventions to measure progress and ensure accountability.

MAPD ensured follow-up of priority areas relevant to the project, with key action points, e.g. the organization and hosting of the aforementioned national LLIN continuous distribution strategy meeting, the plan to distribute ANC/EPI LLINs, and convening district malaria work plans development.

3.3.3.2 and 3: Support NMCP to conduct and coordinate national malaria TWG meetings

Activity #	IR/Output	Target	Achieved	% performance	Comment/s
3.3.3.2	Support NMCP to conduct and coordinate national malaria TWG meetings				Supported all main malaria TWGs, also liaising with Gender Based Violence TWG for gender related issues.
3.3.3.3	Support review of TORs for TWGs and annual self-assessments				TORs done for MIP case management and SME-OR TWG

MAPD has been included in national level TWGs, namely in MIP, MCM, M+E, IVM and SBCC. MAPD staff have been taking an active and leading role in these meetings and have worked with the NMCP to promote leadership and management through development of TORs, plans, and action point follow-up. The Project Management TWG of NMCP has not been revitalized, but MAPD will be in discussions to get this platform up and running as well as take an active lead in its operation.

3.3.3.4 Support the development of the Global Fund concept note

The project supported prioritization of the Global Fund concept note through an RBM forum in January 2017.



Delivering nets at the last mile

Success Story

a. Strengthening capacity of DHT to plan for malaria prevention and control programme

In the planning workshops conducted jointly by MAPD and DHMTs in the month of July 2017, the statements below made by DHMT representatives applauded the unique approach and empowerment MAPD brought them through the planning activity.

“We have learnt a lot from this joint planning workshop. On my behalf of my colleagues, I take this opportunity to thank MAPD for convening us for this joint planning. Not many NGOs have this approach.” **DHO, Kyenjojo, Rwenzori Region**

The expression implies both the uniqueness and the appeal of MAPD’s approach in dealing with the DHMTs.

“We are amazed and also shocked to have come to this workshop to learn what we have always known and spoke about how “malaria is the leading cause of morbidity and mortality”, but we did nothing in our plans to take action. We are ashamed that we watched our people suffer and die of malaria. I pledge commitment to providing leadership for implementation of Uganda Malaria Reduction Strategic Plan, and I call upon my colleagues here to do the same.” **DHO, Arua, West Nile Region**

Highlights PY2

- Hold bi-annual DHO meetings for strategic problem solving facilitated by NMCP
- Hold annual district planning meetings and budgeting
- Widen stakeholder group at district and national level to effectively prioritize malaria e.g. political and religious leaders, members of other sectors
- Strengthen national collaboration and coordination (TWG, including Project Management, RBM meetings, etc.)
- Capacitate district level coaches to ensure supervision and follow up
- Integrate QI models with USAID’s ASSIST project

- Improve data quality and use: capacity building of biostatisticians and HW
- Promote use of data at all levels
- Conduct semi-annual regional data review meetings
- Improve national data portals and alerts
- Provide tools for data improvement
- Private sector services and reporting improved through sub-contracts and oversight by professional associations
- DHMT's and HF performance improved via performance based in-kind grants
- Increased interactions with other IPs and wider actors for CLA, TA and collaboration

V. CROSS - CUTTING ACTIVITIES

Health workers capacity development

4.1.1.1 Develop Low-Doses-High-Frequency capacity reinforcement modules and tools

A malaria services tool kit was developed providing a mechanism for building competencies of health workers through a modularized mentoring support at HF. This will be used from Q1 of PY2. This activity is linked to **4.1.1.2 Develop Standard-Based Measure and Recognition support supervision standards and tools** which will be finalized in PY2.

Focus for PY2

Improved quality of care through LDHF, SBMR of IMM, diagnosis and IPC.

Tried and tested effective strategies rolled out through quality improvement mechanisms e.g. ASSIST model

Social Behavioral Change and Communication

Activity 4.2.1.1: Conduct contextual analysis:

A contextual analysis was carried in all project regions to contextualise, and make relevant, MAPDs SBCC strategy.

Activity 4.2.1.2: Develop a communication strategy and campaign operational plan

The project provided TA to MOH and CHC and a national malaria campaign ‘**chase malaria**’ was developed and aired. MAPD helped launch this at the 2017 World Malaria Day celebrations. This national campaign covers aspects of net use, malaria in pregnancy, test and treat and IRS. Building on this campaign and its contextual analysis, MAPD developed a ‘**protect your dreams**’ campaign, which was described by MOH, NMCP and CHC as adding ‘*a motivational component to the "chasing" especially at the community level as you motivate households to take action against Malaria.*’. MAPD will review this campaign to ensure it addresses health inequities related to gender, youth and socioeconomic status.

Developed key project documents

- Communication Policy finalized
- SBCC strategy finalized and approved by MOH and Malaria TWG
- Branding and marking guide developed and submitted to USAID/PMI
- Key message guide developed and submitted to USAID/PMI
- Key influencers training strategy and curriculum
- Project brief developed and approved by USAID/PMI

Development of the Project Interpersonal Communication Strategy

The project IPC strategy centres on key influencers. The key influencers approach has been introduced to the District Health Team (DHT) members in all the planned 27 districts. A total of 108 Key Influencers and Peer Champions have been selected and equipped with skills and tools.

Activity 4.2.1.3: Conduct dipstick surveys to monitor the campaign

Conducted key dipstick surveys to inform the SBCC campaign. Key tasks included:

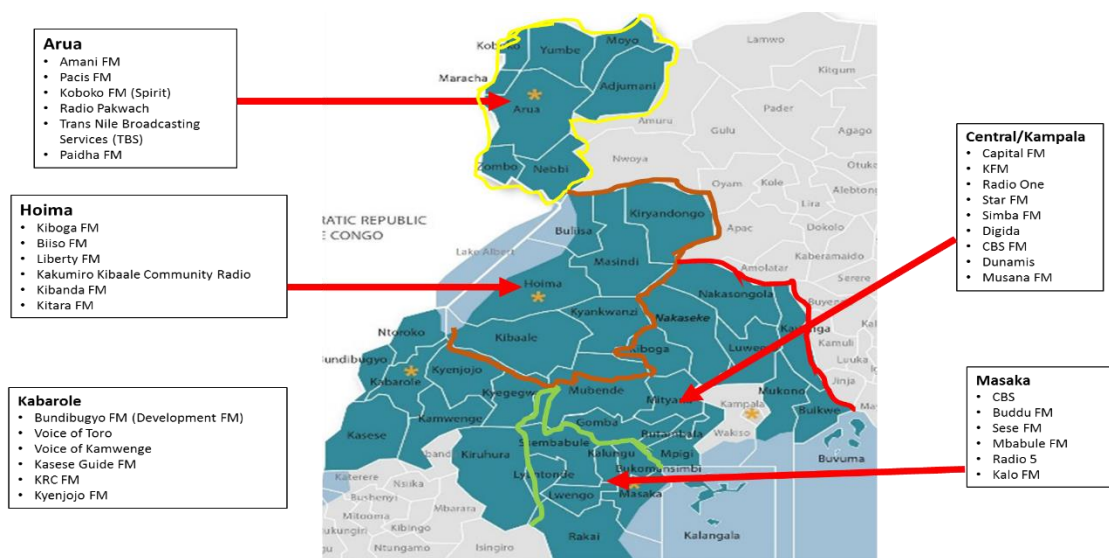
- Conducted the concept testing of the SBCC campaign big idea
- Conducted the pretesting of the SBCC campaign (radio and print)

Activity 4.2.1.4: Roll-out mass media campaign (using CHC messages and designs)

Produced campaign materials

- Designed 3 posters for the SBCC campaign
- Produced three radio adverts in 10 languages
- Revised the radio adverts as per the concept testing, pre-testing and recommendations from MOH and USAID
- Radio adverts aired on 38 local radio stations
- Produced 3 TVCs in two languages
- Broadcast on 2 TV networks
- Broadcasting of malaria TV messages in 48 health facilities

Rollout the Project SBCC campaign



Supporting the NMCP

MAPD extensively supported the NMCP with the UCC net distribution campaign, World Malaria Day, the national communication strategy update and dissemination, and the revitalization of the SBCC TWG.

Activity 4.2.1.5: Coordinate community dialogues

26 district Health Educators (DHEs) (including 10 females) i.e. 1 per district have been orientated and equipped in Masaka, Hoima and Rwenzori regions. 108 Key Influencers (63 male, 45 female) in Masaka

(40), Hoima (36) and Rwenzori (32) developed IPC skills to conduct 304 community dialogues on LLIN use, IPTP, testing, and treatment to 7,984 people. 76 malaria village health clubs have also been formed and established.

Activity 4.2.1.6: Success stories and airing recognition messages

Submitted 4 success stories and 2 Facebook stories to USAID/PMI. Please see Annex 3 for success stories.



Health camp for Buganda King's visit in Ntwetwe HC IV



Health camp for Buganda King's visit in Ntwetwe HC IV



One of the community dialogues attended by the PMI team at Kisenyi Primary School

PY2 Highlights

- Community level IPC
- Community mobilization through interactive participatory channels e.g. music and dance
- HF IPC
- School champions
- Messaging development for gender and youth considerations
- SMSs for patients and HWs
- Showcasing success in national and international conferences.

Gender and Youth

Activity 4.3.1.1: Conduct gender and youth analysis

Gender analysis

MAPD conducted a gender analysis to identify gender-related gaps/challenges, and to identify possible differential effects of the project on women, men, boys and girls. The analysis was done in six districts selected from three regions of operation. Two districts per region were visited, covering both urban and rural areas, i.e. West Nile (Moyo and Yumbe), Mid-western (Kabarole and Hoima), and Central (Masaka and Bukomansimbi). On approval by USAID, a detailed gender integration plan will be developed from the analysis recommendations. The analysis presents evidence that gender inequalities limiting women's decision-making power and access to resources have negative implications for malaria prevention, treatment and control in Uganda. Increasing male engagement in malaria prevention and control, including improving their own treatment-seeking behaviors, is needed going forward.

Youth analysis

Similar to above, a youth analysis was done in 6 districts i.e. West Nile (Arua and Koboko), Mid-western (Kasese and Bundibugyo), and Central (Mukono and Buikwe). The districts were selected for their diverse characteristics and included urban and rural ones. The report is being finalised. Preliminary

findings and recommendations have been used to inform staff and to influence the PY2 plan. Special attention to the needs of adolescents, especially pregnant teens, is required at health facility and community levels.

Activity 4.3.1.2: Develop Gender and Youth Strategy and Action Plan

Drafts have been developed; these drafts await approval before the finalization of the above two reports.

Activity 4.3.1.3: Review all current malaria protocols and guidelines for gender and youth, depending on NMCP review schedule

Will start in PY2.

Activity 4.3.1.4: Build capacity of project team, DHMTs, NMCP and VHTs in youth and gender

- Assessed MAPD staff knowledge and capacity on gender integration
- Reviewed the project plans, strategies and tools and provided gender and youth integration input
- Oriented MAPD staff in Gender and Positive Youth Development

Activity 4.3.1.5: Host youth and gender forum focused on malaria

Discussions were held with: USAID/Uganda's Gender Advisor and the Project Development Officer, Mercy Corps, the Uganda National Health Consumers/Users Organization, Uganda Youth Network, Makerere University, Ministry of Gender, Labor and Social Development's Senior Youth Officer and the Ministry of Health's Gender Focal Person. The purpose of these meetings was to learn about available resources and opportunities for collaboration.

Activity 4.3.1.6: Establish and work with existing girls' and boys' clubs within or out of schools

Pending school LLIN approval as a gateway.

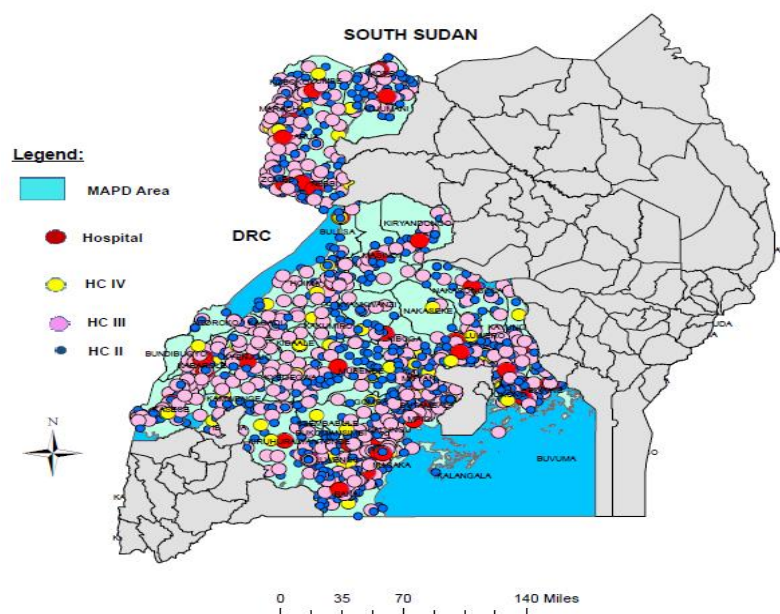
PY2 Highlights

- Sharing of analysis with stakeholders, including USAID, IPS and beneficiaries, to direct improved programming
- Adoption of youth positive development strategies
- Analyzing HF data by gender and youth

Monitoring and Evaluation

Activity 4.4.1.1: Conduct an integrated malaria control capacity assessment of all health facilities

MAPD's HFA assessed 1,620 facilities (1,107 public, 299 PNFPs and 214 PFPs). This assessment covered 95% of public facilities in the focus area, 97% of PNFPs and around 50% of the PFPs that report into DHIS2.



The HFA determined training targets for the project based on HW number: **14,000** HWs and **2,000** laboratory personnel, of which 9,600 health workers are from public facilities, 2,600 from PNFPs and about 1,800 from PFPs, while 1,400 laboratory personnel were in public facilities, 350 in PNFPs and 250 in PFPs. Based on these results, the project set training targets for health workers, IMM, MIP, HMIS and laboratory as summarized in Table 7 below.

Table 7: Training targets for health workers in the project region

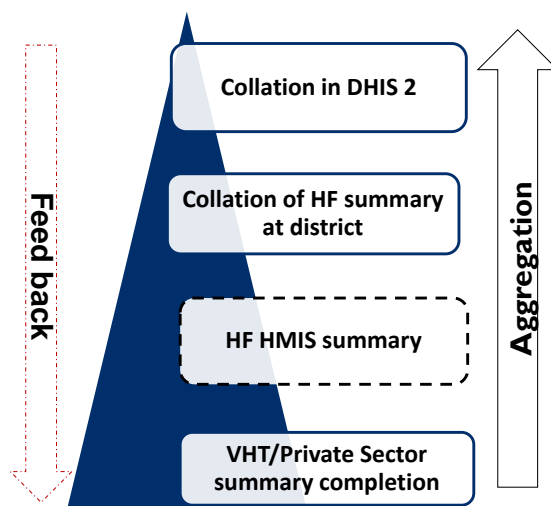
Project Year	Type of training	Targets to be trained
Year 1	IMM	4,000
	MIP	4,000
	HMIS	1,000
	Laboratory	500 (though adapted to 300 on lab needs assessment)
Year 2	IMM	5,000
	MIP	5,000
	HMIS	2,200
	Laboratory	1,500
Year 3	IMM	5,000
	MIP	5,000
	HMIS	1,600
	Laboratory	2,000
Year 4	IMM	9,000
	MIP	9,000
	HMIS	2,000
	Laboratory	500
Year 5	IMM	5,000

	MIP	5,000
	HMIS	1,600
	Laboratory	1,500

During PY1, the project designed a comprehensive results-oriented monitoring, evaluation and learning (MEL) system to ensure that results are tracked at output and outcome level, linking theory of change to project results areas. Emphasis was placed on measuring project progress against set targets, epidemic response and generating data necessary for the compiling and timely submitting of reports to USAID Uganda and other stakeholders.

Data Collection

The project collected data from both primary and secondary data sources. Primary data was collected from internal programming activities such as health worker orientation activities, assessments and routine learning activities. The health facility assessment was conducted to map health facilities in the focus area and benchmark the availability of key malaria supplies in those facilities. Dipstick surveys were also conducted, to understand the reach of Social Behavioral Change and Communication campaigns. Secondary data was collected from the Health Management Information System which is collated and entered in the DHIS2 system. Secondary data was also collected from summary reports, such as drug stock status reports at health facilities.



Data analysis

The project routinely analyzes data at various levels to enhance evidence based decision making. The results obtained are summarized using different descriptive statistics and used to assess progress and performance. The focus of data analysis is comparing expected results against achieved, understanding reasons for variances, and comparing performance at different intervals (quarterly, semi-annually and annually) as well as across regions and districts. Where available, data is disaggregated by gender, age and district.

Surveillance: A partner was identified to support MAPD's work in surveillance, monitoring and evaluation, as active and relevant surveillance is key to our program's successes. This process commenced in February 2017 and a formal request for contracting officer approval to sub-contract Infectious Diseases Research Collaboration (IDRC) has been submitted.



HMIS data cleaning exercise in Masaka, where MAPD supported the MoH and districts to clean malaria data for the quarter

Environmental compliance

Assessment of this could not occur in PYI due to implementation delays while waiting for permissions to work with GoU.

Project Performance Indicators

This page summarizes project key indicators. It provides the baseline values, target for PYI, actual values by quarter and the overall project five year target.

Table 8: Project Indicators

Indicator	Baseline Value (Oct 15 – Sep 16)	Year I target	Actual: Year I (Oct 16 – Sep 17)					Year 5 Target	Data source
			Q1	Q2	Q3	Q4	Year I		
Malaria in Pregnancy									
Number of health workers trained in the control of malaria in pregnancy	0	4000	0	0	5640	141	5781	14,000	Activity reports
Proportion of pregnant women attending ANC I who have received two or more doses of IPTp	58%	70%	56%	57%	61%	70%	61%	95%	HMIS

Proportion of malaria suspected cases tested for malaria	129% ⁵	85%	79%	61%	74%	83%	74%	85%	HIMS
Proportion of patients at health facilities who received a negative diagnostic test for malaria who received an antimalarial drug ⁶	36%		34%	37%	51%	35%	39%	15%	HMIS
Access and use of malaria prevention interventions									
Number of insecticide treated nets (ITNs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	0		0	1,852,544	0		1,852,544	5,480,000	
Proportion of children under five who slept under an ITN the previous night in intervention			NA	NA	NA	NA		85%	Household survey
Malaria diagnosis and treatment									
Percentage of children under five presenting with fever in last 2 weeks who first sought treatment from a VHT	TBD		NA	NA	NA	NA		TBD	Household survey
Number of health workers trained in iCCM	0	0	0	0	0	0	0		Project reports
Diagnostic capacity improved									
Number of laboratory health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) and microscopy) with USG funds	0	370	0	0	0	366	366 ⁷	2000	Project Reports
Number of health workers trained in malaria laboratory	0	4500	0	0	0	366	965	16000	Project Reports

⁵⁵ This is above 100% as some people skip the OPD registration and go straight to the lab, so the numerator can be larger than the denominator. MAPD will support stopping of this practice

⁶ The data is slightly unreliable for Q3 and Q4 as the wrong form was provided which did not capture this well.

diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds									
Service Provider's capacity for malaria case management									
Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	0	0	0	0	0	0	0	14000	Project Reports
District Supervisors' capacity to monitor malaria activities									
Score in percent of the combined areas of capacity building amongst the districts to improve the referral system during the reporting period		TBD	NA	NA	NA	NA	NA	TBD	Project Reports
Percentage of lower level health facilities (HC II and HC III) that referred children to higher facilities (HC IV and hospitals) for management of severe malaria		TBD	NA	NA	NA	NA	NA	TBD	HMIS
Milestones achieved to manage and sustain malaria activities in the districts		TBD	NA	NA	NA	NA	NA	TBD	Project reports
Score in percent of stakeholders (districts and health facilities) that met their performance requirements as per their performance-based grants and subcontracts targets during the reporting period		TBD	NA	NA	NA	NA	NA	TBD	Project reports
Score in percent of the key areas of capacity building amongst the NMCP staff to effectively manage and sustain national malaria activities		TBD	NA	NA	NA	NA	NA	TBD	Project reports
Cross cutting									

Number of health workers trained in conducting clinical audits	280 ⁸		0	0	0	1024	1024		Training registers and project reports
Number of health workers/records staff trained in HMIS	533		0	0	0	379	379 ⁹	1600	
Number of health facilities reached with support supervision for MIP									Project reports

⁸ The YR1 target is low (280) as was based for for district trainers only. MAPD went to HF so had wider reach.

⁹ The target for year 1 of 533 is 1600/3 years after which a review will be done for new targets. The target was not quite reached due to implementation permission delay. Those missed will be covered in PY2

VI. CHANGES TO YEAR I WORK PLAN/ INNOVATIONS/ LESSONS

Changes to work plan

The number of districts under the project's scope increased from 43 to 48 (although one has been dropped for PY2 as it will be supported by RHITES SW: Kiruhura). MAPD also extended all its core activities to all its 48 districts, rather than a proportion of them as planned. For example, MIP, IMM and laboratory support was planned in 22 districts, but was actually implemented in all 48 districts. MAPD also extended its support past the DHMT level (as originally planned) and actively supported down to the facility level for activities such as MIP and clinical audits. Furthermore, the HFA revealed more HF within MAPD's districts than originally indicated in the assumptions of work-plan PY I, so MAPD expanded its reach as required.

VII. COLLABORATION, LEARNING, AND ADAPTION

Evidence-based learning

Under the project several surveys have been conducted, data from which has been used to critically assess proposed implementation strategies and approaches, in order to improve implementation and results. The surveys undertaken were:

Analysis	Main Function
Health facility assessment	Mapped facilities and service gaps, to direct needs-based targeted action
SBCC analysis	Investigated effectiveness of current communication methods, localized malaria practices and barriers, and best practices for context specific SBCC
Gender analysis	Identified gender-based barriers to access to health and malaria control and proposed improved methods of service delivery
Youth analysis	Identified barriers to access health and malaria control as felt by youth and proposed improved methods of service delivery

Once these have been reviewed and approved by USAID, the project will adapt its internal programming and share its findings and implementation experiences with key players, including USAID IPs.

Routine data use and dissemination

The project has a system where real-time information on routine progress indicators and completed survey estimates is housed. The progress of the project and its success stories are shared with USAID on a weekly, monthly and quarterly basis. These are also shared through quarterly regional and annual project review meetings (with project staff, ministry of health officials through RBM meetings, implementing partners and other key stakeholders). At the district level, knowledge and data is shared through district coordination meetings, implementing partners meetings, regional coordination meetings, and project performance review meetings. Performance is shared with health facilities on a set of selected indicators, including: (i) coverage of IPT2 amongst pregnant women attending ANC, (ii) malaria

testing before treatment, (iii) adherence to negative malaria results by health workers, and (iv) weekly malaria deaths.

Innovation Successes and Lessons

Successes include: distribution of 1,852,544 LLINs; providing up-to-date, WHO-recommended guidelines to 5781 HWs, prior to MAPD support; a communication from the Ministry of Health to the districts to carry out this activity, which had previously been unfulfilled; and fulfilling all laboratory capacity building efforts for the year, although guideline development delayed implementation until the end of Q3.

The project adopted some innovative mechanisms that proved successful during PY1, which helped it to achieve the above-mentioned successes. Examples of these are:

- Real collaboration with district leadership and district led approaches, which supported the effectiveness of activities, ownership, accountability and sustainability. The districts were involved in planning, organizing and leading orientations and supportive supervision, which facilitated an effective roll-out and local monitoring efforts. Involving the regional referral hospitals was viewed to be a relevant use of local resources as well as a good approach to developing capacity at regional level.

The project's on-the-job mentorship approach was seen to be a much more effective solution to building effective capacity for a large number of people, compared with in-classroom training. Linking district-selected and well respected TRPs enabled improved scope, reach and follow up. Having health workers themselves act as TRPs is also a good approach for building on-site capacity, motivation, accountability and sustainability, as these district-owned resources are expected to continue delivering services beyond the life of the project.

The project's approach to encouraging the use of interpersonal communication to promote behavior change, such as community dialogues and the use of TVs at HFs, was appreciated by the communities. However, it is too early to evaluate their effectiveness for driving improved malaria prevention and control.

SMS platforms are an innovative communication approach for providing follow up after orientation, and for use by project partners. SMS will be used to notify people of upcoming activities, such as orientations, supervision visits and EQA slide collection; provide service reminders to HWs; and for sending alerts if unusual malaria events are identified. Building upon the already established mTRAC platform, districts should continue using the SMS approach to link with health facilities.

The project seeks to learn from performing districts and health facilities by continuously identifying high performing health facilities and districts, evidenced by routine HMIS data and other project generated data. For example, Mpigi district has improved test and treat rates and ACT stocks, and Lwengo HF (Masaka) has achieved good results in IPTp3.

The projects learning cycle for PY2 can be seen in Annex 4.

Collaboration

1) Technical assistance/collaboration

The project supported RHITES-EC with TA in how to undertake LLIN quantification. The project also supported RHITES-E with HFA tools.

2) Collaborative improvement with USAID ASSIST project

The project is collaborating with USAID's ASSIST project in terms of service quality improvement methodologies. To promote best practice in and beyond its regions, MAPD will document and share its positive practices with a wide range of stakeholders in PY2.

3) HMIS data improvement

To improve HMIS data quality and use, continuous collaboration with other implementing partners is essential, such as USAID's SITES project. With such collaborations the project can learn and also share lessons learned in working on and improving HMIS data, thereby fostering optimal integration for data improvement.

VIII. BUSINESS MANAGEMENT

Project team and office set up

Personnel

All staff (including key personnel) have been recruited. Staff comprise 50 Malaria Consortium staff with 20 partner staff, making a total of 75 staff as per the planned organogram. The staff are distributed across the five regional offices and Kampala main office, with two staff recruited on secondment to MOH.

Recruitment, retention and resignation

- MAPD recruited 100% of the positions listed in the organogram, and achieved this in a record time of 45 days per position.
- Retention has been excellent, rated at 100% with no resignations as of 30th September 2017

Performance management and staff development

- Despite two staff who are still in their probation periods, all staff have passed probation and are thus confirmed in their positions.
- Objectives for the remaining period have been set and are being monitored as they await performance appraisal in March 2018.
- During the period, staff were trained on USAID contract management and project management, and three staff (Project Internal Auditor, Logistics Manager and Senior Accountant) received training in Procurement Audit, Control and Monitoring.
- All staff have identified their development needs. These are documented and are being followed through.

Disciplinary

- No disciplinary case has been handled in the past year.

Project governance and management mechanisms

Subcontracts are in place with all the project sub-contracted partners, as outlined in the proposal and PYI plans. The project has adopted a one-team approach, with shared resources and management structures as outlined in the project organogram.

Key coordination meetings have been held as planned. For the purpose of reporting and learning, MAPD has held several internal meetings, including both scheduled weekly, monthly, quarterly and annual program review meetings, as well as ad-hoc meetings as and when the need arose. Minutes of these meetings are filed for record.

Policies have been developed and are in place, such as AMELP, grants manual, capacity building strategy, communication policy and detailed work-plans.

Property control, assets/procurement

Assets

Assets have been categorized according to MAPD Project contract and the Malaria Consortium Assets Manual as Fixed Assets, property and other equipment (consumables). Assets include those tangible products with value equal to or in excess of USD 1500. For the period under review, MAPD assets are valued at USD 397,065, property is valued at USD 395,979 and other equipment (consumables) are valued at USD 10,319.

Information

All information is kept on password-protected computers and is backed up regularly. The project designed a hard copy filing system and electronic system for data storage. The electronic system was designed to have 'ready to use' information on key project indicators. All data collected through the field activities is entered into the electronic system and stored on servers at the project's office. Only authenticated users with different access rights, based upon their roles, will have access to the hard copies and electronic data systems.

Procurement, assets tracking and property control

All procurement is guided by procurement policy approval thresholds that have been put in place. In July 2017, MAPD moved from a manual procurement system to an electronic procurement system using the NAV procurement system. Assets are also now entered and tracked through the NAV procurement system. This innovation has enhanced efficiency, with respective officers with authorization rights easily monitoring the movement of project assets.

Monthly asset verification is completed by finance personnel in every region, signed off and then sent to the assets office for compilation into the MAPD general list, and filed for the record.

Risk management

Year 1			
Risk Type	Risk Description	Impact in Year 1	Risk Addressed
Operational	Project does not have the scope for direct provision of commodities	Delayed start-up of iCCM for the whole year Delayed reactivity to identified LLIN need at HF level, (2 months delay)	YES. i) Commodities now included in NMS supply for HFs and iCCM scope is planned to increase from 2 districts in Yr 1 to 8 districts in Yr 2. ii) secured permission to receive LLINs through JMS and distribute these to public HFs.
Operational	Inadequate estimates	Have had to increase project scope (from 22 to 48 districts) Have had to adapt targets in order to measure performance accurately	YES. Project scope widened to all project districts. This has been tailored for in the budget and staffing for PY2 Completed HFA to map HF in MAPD locations, providing accurate targets.
Operational/ Reputational	Key stakeholders don't buy-in or participate in project goal achievement.	Was not experienced.	Project launch activities, close activity planning, prioritization, implementation and coordination has enabled good perceptions and relationships with key stakeholders.
Year 2			
Risk Type	Risk Description	Expected Impact in Year 2	Mitigation
Strategic	Private sector engagement fails to reach key actors in a meaningful way	Inadequate progress to address quality of malaria services in this sector (impact); mitigation	Intensified engagement with stakeholders including professional associations, statutory councils, DHMTs and District Health Supervisory Authorities

Quality management

The project has been, and continues to be, effective and efficient in terms of its design, planning and implementation, keeping efforts, activities and internal capacity relevant to the attainment of its outputs, outcomes and goals. It does this through: the alignment of activities to its approved work-plan; drawing up time-framed and budgeted quarterly and monthly work-plans, with needs-based activities contextualized to regions and districts; having in-house technical expertise to support field-based implementation; central and district capacity building; and partnership building. Risk management tools are used to predict and minimize poor quality outputs and outcomes, which are updated regularly or during an event of change. The project has a collaborative approach to implementation, ensuring those with ultimate responsibility e.g. the MOH/Districts, take an engaged and active lead. Quality is assessed through outcome indicators, activity performance reports, quarterly progress reviews and reports, extensive field visits, external STTA, HF questionnaires, and community feedback mechanisms via dialogues and dipsticks. Project research, such as the ones listed in the learning section, ensure the relevance of project inputs to beneficiaries and the project's ultimate goal. Active and participatory planning sessions have helped the project to tie into the priorities and expectations of the districts, and community engagement and studies have helped do this at the community level.

A review process has been put in place, involving technical advisors/specialists, government partners, and the donor in the review and validation of reports, data and other project outputs (stories, other communication materials, manuals and job aids). Clear procedures, such as data collection and analysis guidelines, reporting guidelines and templates, and review and approval processes, will be laid out to ensure the quality of data, reports and communication materials produced by the project. Project staff will receive an induction on quality control (generally and adapted to their scope of work) at the onset of their employment and will regularly be reminded about the procedures to follow.

Data quality is reached via double data entry with discrepancies checked, harmonized and corrected. Also, a comprehensive data quality assurance plan detailing procedures and methods for managing data incompleteness and outliers was developed. The National HMIS data was reviewed against ADS 201 data quality criteria and corrective measures undertaken as required. During quarter June to September 2017, the project ensured that cleaning malaria data was done as part of the integrated data cleaning exercise undertaken by the MOH Division of Health Information.

The electronic data capture system was designed to have inbuilt data quality checks, in order to minimize transcription errors and increase validity and reliability. The database was accessed by authorized personnel only, increasing data security and reducing the risks of data manipulation issues. Whenever possible, the study team did double data entry of questionnaires from activities concerning indicators of the project, in order to check for the accuracy of entries made and to ensure completeness of the data entry process. All entered data was backed up on a secure server. All project hard-copy forms with sensitive information are confidentially stored in secure, locked files that are only accessible by the responsible project team members.

IX. CHALLENGES

- The MAPD contract prevented payment of any kind to government officials. This meant that MAPD was not able to carry out the majority of its activities as they involved payments to government officials. As a result all activities were delayed. MAPD sent a request to USAID on January 9, 2017 requesting for this change in contract and received approvals on June 27, 2017. The rate of implementation in year 2 will be faster than in year 1 because this constraint has been addressed.
- Recruitment of DCoP and DFA was a lengthy process and Malaria Consortium covered these positions with its internal staff to ensure effective project development. The DCoP was in place 6 months after project start, and the DFA 9 months. The original candidates (identified in 2014) turned down the job offers which were made after contract award in 2016.
- Approvals of guidelines has delayed roll out of certain activities. The laboratory guidelines and strategy were only agreed upon in June 2017 meaning all laboratory activities could only start at the end of quarter 3. However, the project has done well to complete its planned activities. The school guideline is yet to be approved despite many coordination meetings and relevant partners' verbal agreements and buy-in provided.
- Non-Malaria commodities have been a major limitation to iCCM roll out in PY1. Strategies are in place to overcome this hurdle for PY2.

X. COST CONSIDERATIONS

The total obligation for the period under review is **\$, 10, 806,360**. The total expenditure for the period amounts **\$6,286,728** all of which were allowable costs and this representing % **58** burn/spend rate. This underspend results from the 6-month implementation delay linked to contract modification in terms of supporting GoU officials. As indicated above under section IX MAPD has accelerated its implementation and will address this underspend in PY2.

During the period under review, the project reported zero disallowed costs and no fund wastage, the monthly and quarterly financial reports were all reported on time. Cost saving initiatives undertaken and results included:

- Cost saving on the purchase of motor vehicles
- Savings through combined IMM trainings

RECOMMENDATIONS

- Integrate activities for cost- and time- effectiveness such as MIP and IMM on-job coaching and supervision and engage more with districts to bolster project ownership and accountable leadership
- Increase number of level 1 and 2 microscopists in the country to permit for quality malaria diagnosis EQA.

- Add Technical Officers, Communication Officers and HR officer to project staff so to allow for effective implementation while maintaining quality.
- Maximize projects' learning and adaptation tool so to share best practices with extended stakeholders e.g. other sectors that affect malaria control as well as health and malaria actors.
- Focus SBCC efforts at the inter-personal level engaging positive deviants, and influential champions as identified by the communities
- Gender and Youth integrations are woven through out programming and documented effectively to drive adoption at national level.

Please see Annex 5 for PY2 Work Plan Chart

ANNEX I: OBJECTIVES, GUIDING PRINCIPLES AND IRS

Annex IA: Vision, Goals and Objectives of UMRSP 2014-2020

Vision: The vision is to have a “malaria free Uganda”.

Mission: The mission of the Ministry of Health’s National Malaria Control Programme is **to provide quality assured services for malaria prevention and treatment to all people in Uganda.**

Goals

- 1) By 2020, reduce annual malaria deaths from the 2013 levels to near zero¹
- 2) By 2020, reduce malaria morbidity to 30 cases per 1000 population²
- 3) By 2020, reduce the malaria parasite prevalence to less than 7%³

Strategic Objectives

The following objectives will lead to the achievement of the above goals:

- 1) By 2017, achieve and sustain protection of at least 85% of the population at risk through recommended malaria prevention measures;
- 2) By 2018, achieve and sustain at least 90% of malaria cases in the public and private sectors and community level receive prompt treatment according to national guidelines;
- 3) By 2017, at least 85% of the population practices correct malaria prevention and management measures;
- 4) By 2016, the programme is able to manage and coordinate multi-sectoral malaria reduction efforts at all levels;
- 5) By 2017, all health facilities and District Health Offices report routinely and timely on malaria programme performance;
- 6) By 2017, all malaria epidemic

Annex IB: PMI goals, objectives and strategic areas

Under the PMI Strategy for 2015-2020, the U.S. Government’s goal is to work with PMI-supported countries and partners to further reduce malaria deaths and substantially decrease malaria morbidity, towards the long-term goal of elimination. Building upon the progress to date in PMI-supported countries, PMI will work with NMCPs and partners to accomplish the following objectives by 2020:

- 1) Reduce malaria mortality by one-third from 2015 levels in PMI-supported countries, achieving a greater than 80% reduction from PMI’s original 2000 baseline levels.
- 2) Reduce malaria morbidity in PMI-supported countries by 40% from 2015 levels.
- 3) Assist at least five PMI-supported countries to meet the World Health Organization’s (WHO) criteria for national or sub-national pre-elimination.

These objectives will be accomplished by emphasizing five core areas of strategic focus:

1. Achieving and sustaining a scale of proven interventions
2. Adapting to changing epidemiology and incorporating new tools
3. Improving countries' capacity to collect and use information
4. Mitigating risk against the current malaria control gains
5. Building capacity and health systems towards full country ownership

Annex IC: USAID's CDCS 2017-2021 Guiding principles and IRs relevant to MAPD

	Guiding Principle	MAPD contributes by/through:
1	Apply a holistic approach to collaborating, learning and adapting	Integrated CLA with IPs, MoH and Districts TA to other malaria IPs e.g. RHITES QI Collaboration with ASSIST Community feedback via dialogues/surveys
2	Ensure broad and inclusive stakeholder engagement throughout the program cycle	Organizing multi-stakeholder planning, implementation, performance, research, best practice, reviews at central and district level. Improving efficiencies and working of TWG, RBM, and district reviews
3	Harness youth-appropriate approaches so that they are included in all activities	Incorporating positive youth development in program, orientating and empowering district and national stakeholders and including youth as a stakeholder. Investigating youth as a vulnerable group for malaria.
4	Infuse and prioritize inclusive development – including but not limited to gender empowerment – throughout the portfolio to empower women, youth, indigenous peoples, LGBTI and People with Disabilities	Outreaches for groups including women, youth and PWDs, gender and youth lens on activities and awareness raising of youth and gender considerations in malaria. Youth and Gender specialist to provide TA to IPs, and national structures through creation of TWG, gender and youth forums.
5	Seek to 'do business differently' when current mechanisms, concepts, operations and tools do not work	Constant evaluation of implementation methods, outputs and impact to lead into improvements with a drive to think out of the box and find creative workable solutions
6	Prioritize partnerships that enable Ugandan-led development	Strengthening capacity of local systems, institutions and individuals
7	Pursue integrated approaches at various levels when and how it makes sense	Integration with others e.g. malaria IPs, MCH programs e.g. PEPFAR, as well as GF, MOED, MOGL, and all MOH bodies, as well as political and influential entities. Seek collaboration with other sectors.
8	Reinforce strategic choices with selectivity and focus in multiple dimensions	Selective areas (within its already selective scope of malaria program focusing on the most vulnerable) e.g. iCCM and school nets
9	Maintain a problem-driven focus, while ensuring all program approaches analyze and adjust to the local context, at whatever level is required	Being dynamic, reflexive and adaptive, being data driven problem analysis, both for routine program activities and for responses to increased severe cases/mortality. Improving data quality and use for decision making at the district and central level.

10	Build in – don't bolt on – Science Technology, Innovation and Partnership (STIP)	Through conducting in-depth surveillance studies, and building national capacity for calling for, supporting, conducting, using and sharing scientific evidence
11	Apply a facilitative approach to development, and minimize direct service provision over time	Supporting existing systems through TA rather than direct service provision from the start, and by phasing out involvement over time based on capacity built.
12	Emphasize operational considerations throughout the strategy lifecycle	Operational improvements to the project by analyzing processes and impact as well as building operational capability in the districts.
13	Incorporate anti-corruption mechanisms across the portfolio	Anti-corruption mechanisms through its financial accountability functions.
14	Model strategic communications for transparency and accountability, stimulating others to do the same	Open transparency with districts and central level on project scope, budgets, cost of doing business, etc. Encouraging continued and open dialogue through working closely as a partner rather than an outside entity.
15	Foster leadership as a lever for change – within the Agency, with partners and with stakeholders	Developing leadership within itself, the districts and central level.

IRs

MAPD RESULT AREA	CDCS IRS	
1	1.3	Enhanced prevention and treatment of HIV, malaria and other epidemics among the most vulnerable
	2.2.1	Child health services are strengthened
2	2.2.1.	Child health services are strengthened
3	3.1	Leadership in development Supported
	3.2.1	Inclusive participation in decision making processes will be increased
	3.3.1	A skilled and motivated workforce
	3.3.2	Availability and adequate management of quality commodities
	3.3.4	Availability and functionality of infrastructure
	3.3.5	Availability and effective utilization of high-quality data

ANNEX 2: MALARIA MORBIDITY, TESTING AND TREATMENT PRACTICES


Region	Number suspected to have malaria (fever)	Number tested for malaria	Number positive	Test positivity rate	Number negative	Negative treated with ACTs
Kampala						
Oct 16 – Dec 16	701,908	672,442 (96%)	202,027	30%	198,781	61,694 (31%)
Jan 17 – Mar 17	502,541	422,742 (63%)	194,826	46%	227,916	47,079 (21%)
Apr 17 – Jun 17	761,571	628,522 (83%)	364,016	58%	264,506	10,699 (52%)
Jul 17 – Sep 17	432,547	320,261 (74%)	149,323	46%	170,938	65,673 (38%)
Masaka						
Oct 16 – Dec 16	339,367	197,279 (58%)	104,564	53%	92,715	35,424 (41%)
Jan 17 – Mar 17	320,051	201,875 (102%)	114,166	57%	87,709	35,424 (40%)
Apr 17 – Jun 17	410,645	317,405 (77%)	188,474	59%	128,931	49,759 (39%)
Jul 17 – Sep 17	295,821	156,119 (53%)	81,160	52%	74,959	37,233 (50%)
Hoima						
Oct 16 – Dec 16	267,017	278,965 (104%)	118,622	43%	160,343	48,655 (30%)
Jan 17 – Mar 17	469,689	193,566 (69%)	82,711	43%	110,855	23,961 (22%)
Apr 17 – Jun 17	472,752	359,105 (76%)	221,626	62%	137,479	44,056 (32%)
Jul 17 – Sep 17	338,381	206,787 (61%)	94,310	46%	112,477	30,611 (27%)

Kabaroole*						
Oct 16 – Dec 16	421,894	289,739 (69%)	156,240	54%	133,499	60,678 (45%)
Jan 17 – Mar 17*	313,609	192,298 (66%)	95,498	50%	96,800	66,695 (69%)
Apr 17 – Jun 17*	356,213	286,735 (80%)	140,459	49%	146,276	119,651 (82%)
Jul 17 – Sep 17*	243,178	206,550 (85%)	260,732	55%	115,065	87,940 (76%)
Arua*						
Oct 16 – Dec 16	678,469	462,260 (68%)	240,742	52%	221,518	72,786 (33%)
Jan 17 – Mar 17*	581,991	324,076 (70%)	144,666	45%	179,410	87,411 (49%)
Apr 17 – Jun 17*	777,476	476,662 (61%)	260,732	55%	215,930	140,131 (65%)
Jul 17 – Sep 17*	668,993	756,167 (113%)	234,116	31%	522,051	131,427 (25%)

* Data inconsistencies resulting from use of outdated tool in some facilities in Q3 and Q4.


ANNEX 3: SUCCESS STORIES

I) Malaria in pregnancy (draft for Q4)



USAID
PRESIDENT'S MALARIA INITIATIVE

USAID's Malaria Action Program for Districts




UKaid
from the British people

SUCCESS STORYUganda | October 2017

Mothers receive the right number of IPTp doses to prevent malaria in pregnancy

USAID's Malaria Action Program for Districts in Uganda has been improving the uptake of intermittent preventive treatment for malaria by pregnant women visiting antenatal centers. This has been achieved through the dissemination of updated guidelines, and cascaded training and on-the-job mentorship of health workers across its 47 program districts.



A pregnant woman receives preventive malaria treatment

RISKS OF MALARIA IN PREGNANCY

Malaria infection during pregnancy poses substantial risks for the mother, the fetus and the newborn. In 2016, over 280,000 mothers in Uganda suffered from malaria in pregnancy despite the fact that it can easily be prevented by a mother taking the recommended doses for intermittent preventive treatment of malaria in pregnancy (IPTp). Three or more IPTp doses improve pregnancy outcomes including birth weight, maternal anemia as well as reducing infant and maternal mortality.

LIMITED IMPLEMENTATION

In 2015, the Ministry of Health revised the Sexual and Reproductive Health Rights guidelines in line with World Health Organization's recommendation that three or more doses of sulphadoxine-pyrimethamine were provided to pregnant mothers (IPTp3) starting from 13 weeks of gestation, and provided an addendum to the 2012 National Malaria Control Policy to this effect. Unfortunately, following the addendum, health workers failed to implement the change due to limited dissemination of the guidelines and lack of training.

DISSEMINATION, TRAINING, MENTORING

In April 2017, USAID's Malaria Action Program for Districts project began disseminating these guidelines, and organised training and mentoring of health workers on both the policy and addendum.

The project conducted on-the-job mentorships of health workers in 47 districts in Uganda using a cascade approach. The project began at the national and district levels with training of trainers who then conducted on-the-job mentorships at health facilities. These mentorships equipped service providers with knowledge on the revised policy, including administering of IPTp as directly observed treatment, the number of doses recommended to provide continuous preventive effect, dosage frequency, recommended folic acid dosage, management of malaria in pregnancy for both uncomplicated and severe malaria, and other services that should be made available to pregnant mothers attending antenatal clinics.

The cascaded on-the-job training approach enabled the project to reach over 5,000 health workers in 47 districts over a period of three months.

At the health facilities, trainees were drawn from antenatal clinics and other departments. This will ensure continuation of service provision in case of health worker transfers within the facility as well as transfers to other health facilities. Both public and private not-for-profit facilities were included in the training.

To ensure the quality of the trainings and mentorships, the project team and a member of the district health management team visited two facilities per district to appraise the implementation of the addendum. The team also used the visits as an opportunity to continue engaging health workers on issues around quality management, supplies, recording and reporting, as well as communicating with pregnant mothers and their spouses on malaria prevention and the importance of attending antenatal clinics.

MORE PREGNANT WOMEN BEING TREATED

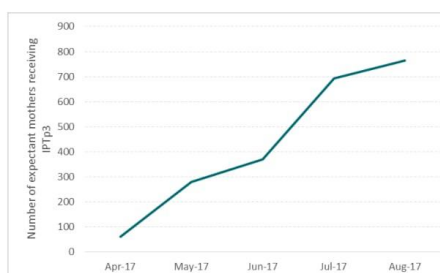
Prior to the training and on-the-job mentorship program, there was no record of expectant mothers receiving three or more doses of IPTp. However, since the training/mentorships, health workers are providing three or more doses (IPTp3) to women attending antenatal clinics.

IPTp3 uptake is documented in all project districts. However some of the most notable successes are evident in the data from seven districts (Bukomansimbi, Kalangala, Kalungu, Kirukura, Lwengo, Lyantonde, Masaka, Rakai and Ssembabule) located in Masaka region showing an increasing number of women receiving IPTp3, from 61 in April 2017 to 765 in August 2017.

The training and mentorships in Masaka region have already proved highly effective over the four month period post training. The graph demonstrates a significant and positive change, an increase in uptake of three or more doses of IPTp among women attending antenatal clinics.

IDENTIFYING GAPS

The trainings also enabled districts to realize gaps they had in essential commodities for optimal provision of antenatal services. Dr Ntoroko, District Health Officer for the Masaka District commented that until this training, he had not known that there was more that could be offered to protect pregnant women from malaria other than long lasting insecticidal mosquito nets.



Number of pregnant women receiving at least three doses of IPTp in seven districts of Masaka region, April to August 2017

LESSONS AND NEXT STEPS

Using the cascade approach to training allowed USAID's Malaria Action Program for Districts project to reach a high number of health workers in a relatively short time (5,781 in three months), ensuring the success of the intervention.

The project will continue training, drawing on the lessons learned from the impressive successes demonstrated in the Masaka region so that these will also be replicated in other regions.

Having successfully improved IPTp uptake through training and mentorship of health workers, the project will now focus on improving quality of care given to pregnant women.

This success story is published as part of a series from the USAID's Malaria Action Program for Districts project. For more information, see www.malariaconsortium.org/resources/publications/977/ or contact: Dr Sam Gudoï, s.gudoï@malariaconsortium.org

USAID's Malaria Action Program for Districts aims to improve the health status of the Ugandan population by reducing childhood and maternal morbidity and mortality due to malaria. The project will support the Government of Uganda for a period of five years, focusing in particular on children under five years of age and pregnant women.

This project, made possible by the generous support from the American and British people, is implemented by Malaria Consortium in partnership with Jhpiego, Banyan Global, and Communication for Development Foundation Uganda (CDFU), Deloitte Uganda and Infectious Diseases Institute (IDI).

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II) West Nile LLIN distribution



USAID's Malaria Action Program for Districts



SUCCESS STORY

Uganda | March 2017

Delivering nets at the last mile: success through promoting a culture of net use

In February and March 2017, USAID's Malaria Action Program for Districts distributed 1,000,000 long-lasting insecticidal nets to 1,978,114 persons in three districts in Uganda. A focus on promoting positive behavior change on net use led to the successful delivery of the campaign.



BACKGROUND

Arua, Koboko and Nebbi are three districts located in West Nile Region, Uganda, with a population of over 1.5 million. In these districts, like in most parts of the country, malaria is a serious public health problem. In 2016, over 700,000 confirmed or suspected malaria cases were reported to public health facilities in these three districts.

USAID's Malaria Action Program for Districts conducted a long-lasting insecticidal net (LLINs) distribution campaign in February and March 2017 as part of its objectives to increase the impact and reach of malaria prevention services. The project took a four steps' approach in conducting the LLINs distribution campaign: 1) community sensitization 2) a community-led registration of households, 3) data-entry and verification, and 4) community-led distribution. During community sensitization, emphasis was placed on social behavior change communication (SBCC) to reach all targeted communities with relevant and effective messages on use of LLINs.

PROMOTING A CULTURE OF NET USE

Prior to household registration, the project team convened a regional advocacy meeting in Arua district with local leaders from the three districts. These included district health officers,

resident district commissioners, district health team, chief administrative officers and local council (LC) V chairpersons. Local leaders' understanding of malaria prevention and their engagement in promoting positive behavior towards malaria prevention was key to the campaign's success.

During this meeting, the project team shared malaria prevention strategies and messages to the local leaders who would then share these with their own communities.

The leaders committed to promoting a culture of net use, highlighting that a significant change in mindset and behavior towards prevention can lead to a 'malaria-free world'. They shared a vision of a malaria-free district, where communities would have higher levels of productivity, due to less money lost on treating malaria and more time spent on income-generating activities. Leaders also raised the need for adequate community-led mobilization for household registration and subsequent LLINs collection, as well as working with the local *wanaichi* to create a net use culture.

SUCCESSES AND IMPACT

The high turnout of community members to receive their nets can be credited to the effective community-led mobilization, impact of the malaria messages promoting positive

prevention behaviors like net use. In Nebbi district, for example, leaders indicated that sensitizing the community before the

problems of malaria [for a long time] and case numbers had become so high that we could not manage with the current drugs in the hospitals. So I think with this, it is going to improve our



(Left to right): A mother in Rhino Camp receives an LLIN; A demonstration on how to use an LLIN; A beneficiary registering to receive LLIN at Aii vu sub county, Terego village in Arua District

distribution was key to its success:

“... you will realise on the day of distribution that there is going to be high turnout of community members [...] this has been shown in registration after community’s sensitisation by political leaders and other stakeholders. When you look at the registration, you just feel very happy that these people have been sensitised. So the registration was 100 percent. Everybody registered because they understood why nets are being distributed to them. So that has been a very big achievement.”

- Olweku Fred Jibril, Secretary for Social Services, Nebbi district

The campaign in the three districts reached 98 percent of households registered during the pre-campaign registration; 91 percent of the population was sleeping under a net - (data reported by the district supervisors in the three West Nile districts in the wave 1 review meeting).

The net distribution campaign was welcomed by the community members and health workers alike. Below are what some of beneficiaries had to say:

“...On behalf of my people, we are very happy for this service, in fact, we have been having

health.”

- Achong Emmanuel, area LCI Oufa Village, Aiiyu Sub County

“The reason why I have come for the net is because we have so many mosquitoes and there is a high rate of malaria, as we are along the river. The mosquitoes are very many. Without nets, there is no sleep here...”

- Net recipient, Rhino Camp

LESSONS AND NEXT STEPS

An SBCC approach before the net distribution campaign allowed community leaders and members to be engaged in education around malaria prevention.

Community involvement is instrumental in ensuring a well-supported distribution and to achieve a high proportion of immediate net uptake and sustained use of nets.

USAID’s Malaria Action Program for Districts will continue to run an SBCC campaign promoting the correct and consistent use of nets using a community led approach championed by the local council leaders in order to create a culture of net use.

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III) West Nile LLIN distribution use of WhatsApp



USAID's Malaria Action Program for Districts

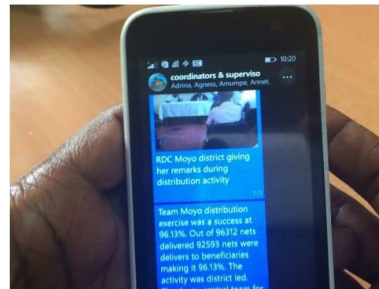


SUCCESS STORY

Uganda | March 2017

Innovations in the net distribution coordination: the use of WhatsApp

The second Uganda universal net coverage campaign, launched in February 2017, saw the innovative use of the messenger application – WhatsApp – improve central coordination, make decision-making quicker, and promote information sharing during the campaign.



BACKGROUND

In 2013-14, Uganda launched its first universal net coverage campaign that aimed to provide long-lasting insecticidal nets to millions across the country. During the campaign, subcommittees were created to ensure central coordination of various aspects of the distribution, such as technical, logistics, behavior change communication and social mobilization. However, coordination among the subcommittees was a challenge that limited full stakeholder engagement during the universal net coverage.

The second universal net coverage campaign was launched in February 2017. The National Malaria Control Programme, supported by USAID's Malaria Action Program for Districts sought to improve communication between subcommittees through the innovative use of the smartphone messaging application, WhatsApp. The application was used to coordinate responses during the 2017 campaign – whereas during the 2013-14 campaign, email and mobile phones were used as the main communication platform.

INNOVATIVE USE OF 'WHATSAPP'

The use of WhatsApp for troubleshooting was found to be effective, particularly to

address issues around data verification, changes in delivery and other schedule deadlines, and to share and discuss ways to overcome these challenges. The national and district distribution teams set up a WhatsApp group which consisted of National Malaria Control Program team leaders, district supervisors, coordinators and sub-county supervisors.

One of the most valuable uses of WhatsApp was its ability to share photos easily to show emerging issues. For example, staff took pictures of damaged bales and shared them with the group and instant solutions were given. The group was constantly kept up-to-date on emerging issues, and or discussions where started involving staff with different technical specialties to address a wide range of issues. Sharing photos of successes also served as a morale booster. WhatsApp was also useful in instances when team leaders needed to communicate with their team using the audio function. Individuals were able to send messages by recording their own voice, and complement this with pictures and videos, which succeeded in conveying messages more clearly and timely than other methods.

WhatsApp has proven to be a simple communication tool that can reach many

individuals and groups at once, thus keeping district officials, implementing staff and all involved in the distribution and up-to-date with plans and developments in the campaign. The messenger application is installed on most smartphones and is now used by all age groups, making it easy to use and cost-effective.

SUCCESSSES

One of the features that made WhatsApp unique and effective during the project's February 2017 distribution was called 'broadcast group', which made it possible to send a message to several people at the same time. District supervisors and coordinators were able to make quick decisions on field challenges using this function.

Supervisors used the audio function to communicate with their team by recording voice messages rather than sending a written message, to save time and to relay messages more clearly.

The group feature was also used for communication with teams in remote locations and where network connections were often unreliable; using WhatsApp, the messages were received as soon as team members were able to access a network connection.

"WhatsApp is almost free and is consequently a very good solution for me with a limited budget. Here I can reach my 22 sub-county supervisors, using less than 1kb of data, which is a lifesaver if I had to call all 22 supervisors and deliver the same message."

– Julius Lukwago, District Coordinator, Lira

"WhatsApp is instant and a simple tool for providing information and coordination; in my case, I simply voice record instructions and share them on the chat group."

– Geoffrey Ssenyumwa District, Coordinator, Apac

"I love its flexibility in sharing multimedia, delivery of text, voice, picture and video

messages and also emojis. It thus permits me to be versatile and [expressive] in my content."

– Jude Okiria, District Coordinator, Nebbi

LESSONS AND NEXT STEPS

- ▶ Communication, providing information and coordination are important aspects in the net distribution campaigns, and WhatsApp offers a solution by providing quicker access to multiple people at once and better access to supervisors, who may be often hard to reach, sub-county teams and central coordinating committees.
- ▶ Various campaign subcommittees have different needs, and using WhatsApp groups enables content to be tailored appropriately to subcommittees. This has made decision-making faster, has encouraged better information sharing and transparency, and has made emergency response work across many levels easier.
- ▶ The WhatsApp feature that teams found most useful was the ability to send voice recordings to WhatsApp contacts and groups. While this does not replace real-time conversations, they made communication easier for people. In addition, hearing the voice of a supervisor was more personal and motivating.
- ▶ The WhatsApp function to share current location has helped track the user's location at a particular time. This has been useful in emergency cases where users needed to be located, as well as for supervisors who need to track the coverage of subcounty teams.
- ▶ WhatsApp has proved to be a beneficial tool to reach and send information to a wider group, as seen during the 2017 net distribution campaign. We are now exploring the possibility of sending malaria newsletters and videos, pictures, text and links via WhatsApp for easier communication and dissemination amongst the malaria-implementing partners.

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IV) Ground round



USAID's Malaria Action Program for Districts



SUCCESS STORY

Uganda | May 2017

Malaria attains a spot on district agenda

USAID's Malaria Action Program for Districts supported the Ministry of Health to organize a Grand Round meeting to sensitize district leaders on malaria control and highlight the need to allocate resources for malaria control in the Rwenzori region.



Health workers at the Grand Round meeting in Fort Portal Regional Hospital

BACKGROUND

District meetings serve as an important opportunity to discuss potential policy resolutions for malaria control. However, malaria is often given low priority in the district meetings in Rwenzori region, where HIV and maternal and child health programs have seen more presence in the region.

In order to bring malaria control higher up on the agenda, USAID's Malaria Action Program for Districts supported the Ministry of Health in organizing a Grand Round session, in which technical staff from the project sensitized district leaders on malaria control and highlighted the need to prioritize the issue.

The Grand Round in Rwenzori region is the first in a series of planned meetings to raise malaria issues in district meetings across Uganda to increase the opportunity for greater allocation of resources for malaria-related activities.

GRAND ROUND

The Grand Round is a formal meeting at which the district health workforce discusses and proposes solutions to priority health issues. The meetings are a core component of medical education today and serve as a place to present clinical problems and discuss current cases.

The Grand Round meeting held in Fort Portal Buhinga Regional Referral Hospital, was attended by medical doctors, clinical officers, senior nursing officers from the regional referral hospital, private

not-for-profit facilities, private for-profit facilities and public facilities that manage malaria.

At the meeting, a variety of presentations focused on the latest developments in malaria prevention and control, the status of malaria in different regions in Uganda and the challenges that hospitals currently face. The challenges highlighted were inadequate healthcare resources, a weak health system and a lack of understanding of malaria epidemiology.

The National Malaria Control Program led discussions on the malaria situation across Uganda and the current plans in place to prevent, control and treat malaria, such as the National Malaria Reduction Strategic Plan 2014-2020. Case studies of countries that reached elimination status were highlighted to emphasize the need for implementation and scaling-up of effective interventions for Uganda to reach elimination status.

"In other countries, they do mass drug administration, mass screening and treatment, and active case-finding, but we have not yet reached that level. We are working on the following strategies: net use, indoor residual spraying, case management, malaria in pregnancy, and behavioural change management. One challenge we face is that malaria does not rank high on the agenda of most foras, including health organisations and departments, and not even during continuous medical education sessions"

- Dr Opigo, NMCP Program Manager

Participants at the meeting discussed the impact of malaria control interventions and ways forward to tackle malaria in Uganda – such as the promotion of correct and consistent use of long lasting insecticidal nets (LLINs). For example, current efforts of the National Malaria Control Programme’s (NMCP) include a campaign to distribute over 24 million nets by September 2017 with support from the President’s Malaria Initiative and the Global Fund. Through this campaign, the NMCP aims to maintain the rate of households with at least two people sleeping under a net at 85 percent. USAID’s Malaria Action Program for Districts also plans to help deliver LLINs to mothers in antenatal and immunization clinics and children in primary schools so as to create a culture of net use.

Other malaria prevention efforts by the Ministry of Health were highlighted at the meeting. These include effective diagnosis and treatment through testing and treatment campaigns, and coordination of malaria communication activities, in particular social and behavioural change communication and social marketing.

At the end of the meeting, participants formally agreed to adopt and promote malaria control behaviours such as the use of LLINs and testing before treating, as well as increase budget and time allocations for malaria-related activities. Participants also agreed that effective malaria

interventions should be prioritized in forthcoming regional, district and health facility meetings and in health facility work plans.

“This [Grand] Round was very educational. It exposed me to the current malaria situation and the new interventions to control it, and it offered me a more thorough education than any continuous medical education meeting.”

- Dr Musinguzi, Surgeon at Kabarole Hospital. Grand Round meeting participant

NEXT STEPS

The Grand Round meeting in Rwenzori region demonstrated that increasing the healthcare workforce’s knowledge and understanding of the current malaria situation and the efforts in place for malaria control, can help them to prioritise malaria and mobilize decision making at the regional and district level.

To sustain the success of the Ground Round in Rwenzori region, the program will work with the NMCP to organize Grand Round meetings in each region in Uganda in order to increase the district health workforce’s focus on malaria in their region and districts.

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V) Malaria run



USAID's Malaria Action Program for Districts



SUCCESS STORY

Uganda | May 2017

Awareness raising activities increase community engagement in malaria prevention

In Uganda – where the malaria burden is among the highest in the world – raising public awareness of the disease is helping to contribute to the prevention and treatment of malaria in communities. For World Malaria Day 2017, USAID's Malaria Action Program for districts supported a malaria run which successfully promoted awareness of malaria prevention in the Rwenzori region.



District Health Officer, Dr Mugahi Richard, informing participants pre-run about malaria prevention and USAID's Malaria Action Program's work in the district

BACKGROUND

Uganda has the third highest number of malaria infections in Africa, as well as some of the highest reported malaria transmission rates in the world. The impact of the malaria burden in Uganda for communities and the society is large, with approximately 8.5 million people getting sick and 12,000 deaths in 2015 alone (Malaria Indicator Survey 2014-15).

USAID's Malaria Action Program for Districts is working in Uganda to improve malaria prevention in communities by improving knowledge, attitudes and behaviors towards malaria. On World Malaria Day on 25 April 2017, the project, together with the Uganda Ministry of Health (National Malaria Control Programme) took the opportunity to raise awareness about malaria prevention, testing and treatment.

In the run-up to a World Malaria Day event, the project supported the Ministry of Health to organise a number of activities hosted in Fort Portal Municipality, Kabarole district. The activities were carried out with district, cultural and religious leaders, social clubs, local businessmen and schools. Village health camps, TV and radio adverts and talk shows, and a malaria run were among the activities scheduled for the event to encourage

community engagement and extend the reach of malaria prevention messages in the community.

BRINGING THE COMMUNITY TOGETHER

USAID's Malaria Action Program for Districts supported the Ministry of Health to organise a five-kilometer malaria run across Fort Portal town on the 22 April 2017. The run aimed to raise awareness and motivate the community to prevent and control malaria.

The run was successful in gaining the support of His Royal Highness King of Toro Oyo Nyimba Kabamba Iguru IV who supported the run. A number of public figures also attended, including members of parliament, the district chairperson, and the National Malaria Control Programme. More than 500 people participated in the run – a success which was helped by the support of district leaders, as well as religious and cultural leaders, who promoted the activity and complemented by radio messages and use of experiential mobile film trucks.

"I was very happy because the king was involved and he told everyone to sleep under mosquito net in order to prevent malaria..."

Abdu Nsamba, boda boda rider



His Royal Highness, King Oyo, and NMCP Programme Manager, Dr. Jimmy Opigo, preparing to launch the run at Muchwa

RAISING AWARENESS FOR WORLD MALARIA DAY

The World Malaria Day event, which included the malaria run, was organized by the Ministry of Health in partnership with USAID's Malaria Action Program for districts, USAID/Communication for Health Communities (CHC), Uganda Health Marketing group and the Kabarole district local government.

The event brought together leaders from the ministry, the district leadership, cultural and religious leaders to reinforce the messages given during the run-up activities and to promote community action against malaria. The Hon. State Minister for Health - General Duties also gave an educational speech on malaria, encouraging people to use mosquito nets, and who applauded the children in the crowd as 'champions of change'.

"I urge you to embrace the campaign by sleeping under mosquito nets, avoiding stagnant water around your houses and testing for malaria before treatment"

*- His Royal Highness King of Toro Oyo
Nyimba Kabamba Iguru IV*

"I would like to call on everybody to embrace the vision of chasing malaria (Okubinga Malaria) using the proven malaria control interventions. We all need to ensure that all our households' members do not store the LLINs received, but use them as per the instructions given..."

- Sarah Achieng Opendi, Hon. State Minister for Health

The event began with a march past through the town to Boma grounds where activities to raise knowledge about malaria took place. Malaria messages were communicated through drama plays and through songs, poems and plays delivered by children.

A total of 699 people from the local communities were tested for malaria using rapid diagnostic tests, including children below five years of age. Those tested positive were treated with artemisinin combination therapy.

"[The event] helped me ... get information on how to sleep under a mosquito net. They also gave us free testing for cancer, malaria and HIV and free water. I thank the organizers because they did not charge us for the run and they also gave us free t shirts..."

- Musinguzi Peter, plumber in Muchwa

LESSONS AND NEXT STEPS

To build on the interest and momentum generated by the World Malaria Day activities, USAID's Malaria Action Program for Districts will continue to use the experiential communication approach and engage with key influencers to further raise awareness of malaria prevention in the Rwenzori region. The program will engage cultural leaders to lead the malaria control campaigns in the region and school children as change agents for net use.

Such awareness raising activities will support larger program efforts, such as a behavior change communications campaign designed to motivate caregivers to adopt malaria prevention practices. This campaign, which will launch in the second half of 2017, hopes to reach at least 13 million people across 43 districts in Uganda. The campaign aims to fill community knowledge gaps which can, in turn, result in a number of flow-through effects, such as improvement in school attendance for children and household financial security.

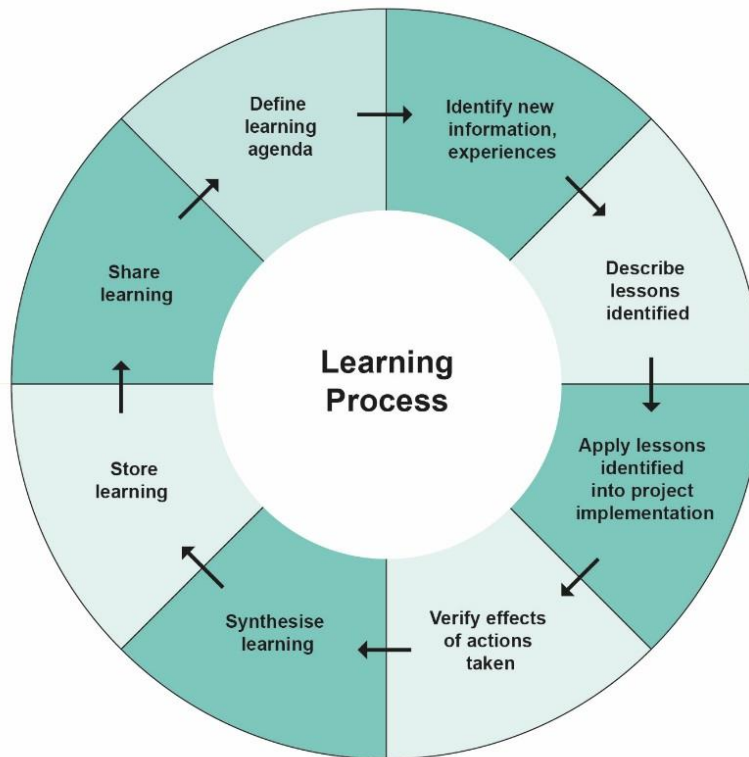
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ANNEX 4: LEARNING CYCLE



ANNEX 5: USAID’S MALARIA ACTION PROGRAM FOR DISTRICTS PROJECT IMPLEMENTATION PLAN

OCTOBER 1, 2017 TO SEPTEMBER 30, 2018

Activity #	Outputs and Activities	Timeline Year II - 2017/18											
		O	N	D	J	F	M	A	M	J	J	A	S
R 1: Effective malaria prevention programs implemented in support of the National Malaria Reduction Strategy Plan (UMRSP 2014-2020)													
IR 1.1 High quality, accessible programs for prevention of MIP implemented													
OUTPUT 1.1.1 Support the NMCP/RHD and districts to monitor the implementation of the review													
I.1.1.1	Support the NMCP and Pharmacy division to carry out national quantification of MIP commodities and develop a comprehensive commodity plan (Procurement Supply Chain Management plan)												
I.1.1.2	Conduct advocacy for MIP commodities – LLINs, SP, folic acid 0.4mg through bi-annual stakeholders’ meetings and quarterly commodity security group meetings												
I.1.1.3	Conduct quantification and procurement of IPTp DOT logistics – water, vessels and cups for 1,400 HFs and 400,000 pregnant women												
I.1.1.4	Conduct follow up of the implementation of MIP guidelines in the public and private sector												
I.1.1.5	Support implementation of MIP guidelines, working through national MIP TWG meetings												
OUTPUT 1.1.2 Performance of district and HF staff and facilities improved													
I.1.2.1	Conduct non-didactic training of ANC HWs to deliver quality MIP services												
I.1.2.2	Conduct Intensified Quality Improvement activities in HFs												
I.1.2.3	Implement Community IPTp in 8 selected districts (pilot)												
OUTPUT 1.1.3 Improved uptake and quality of services													
I.1.3.1	Conduct orientation of ANC HWs in Interpersonal Communication using the LDHF methodology												
I.1.3.2	Implement the mHealth intervention to send SMS reminders to couples, pregnant women and HWs												
I.1.3.3	Procure and distribute MIP counseling charts to ANC providing facilities												
I.1.3.4	Link with existing channels promoting ANC												
I.1.3.5	Encourage Ministry of Health to include a package of health services for men as part of ANC programs												
OUTPUT 1.1.4 SBCC effectively employed in MIP													
I.1.4.1	Conduct MIP service demand generation and behavior change and promote early ANC update through mass media (radio spots) health worker IPC and community dialogues												
I.1.4.2	Research in 10 districts will occur investing non-financial incentives to get women to attend ANC early												
OUTPUT 1.1.5 Strengthen M&E of MIP activities													
I.1.5.1	Conduct one-day orientation of health facility in-charges and ANC HWs in MIP data management use												

OUTPUT 1.2.5 Strengthened M&E												
1.2.5.1	Support DHTs/DEOs to conduct pre-distribution registration of pupils for school LLINs											
1.2.5.2	Conduct baseline assessment for school LLIN distribution											
1.2.5.3	Conduct evaluation of school LLIN distribution services											
1.2.5.4	Collect data on malaria burden among 5-14 year olds											
R 2: Effective malaria diagnosis and treatment activities implemented in support of the national UMRSP												
IR 2.1 Implementation of iCCM												
OUTPUT 2.1.1 iCCM guidelines finalized and disseminated												
2.1.1.1	Print and disseminate iCCM guidelines											
2.1.1.2	Advocate for integration of iCCM commodities into essential medicines kits of HFs and procurement and distribution systems of NMS and JMS											
OUTPUT 2.1.2 iCCM piloted in intervention districts (5)												
2.1.2.1	Baseline assessment on iCCM											
2.1.2.2	Create and support iCCM sub-county health committee to oversee implementation											
2.1.2.3	Provide technical assistance to CHD and NMCP to develop iCCM expansion plan											
2.1.2.4	Support sub-county health committee involvement in iCCM roll-out											
OUTPUT 2.1.3 VHTs equipped and supported												
2.1.3.1	Conduct district iCCM TOT orientation in new districts											
2.1.3.2	Support DHMT to supervise iCCM implementation in 8 districts (note this will start in iCCM areas set up in year 1 and then later in the 3 new ones)											
2.1.3.3	National continuous improvement for iCCM											
OUTPUT 2.1.4 Strategic SBCC applied for iCCM												
2.1.4.1	Support for iCCM in existing Village Health Clubs											
2.1.4.2	Pilot and SMS system											
OUTPUT 2.1.5 iCCM M&E strengthened												
2.1.5.1	Support monthly reporting of data from VHTs to HFs											
2.1.5.2	Support quarterly reporting of data VHTs- HFs											
2.1.5.3	Align VHT data collection forms to DHIS2											
2.1.5.4	Enhance HWs and VHTs iCCM data recording											
2.1.5.5	Collect, compile and disseminate iCCM success stories											

OUTPUT 2.4.1 Severe malaria police guidelines finalized and disseminated											
2.4.1.1	Update, print and disseminate of guidelines for severe malaria management (IMM, etc.)										
2.4.1.2	Review, update, print and disseminate job aids on severe malaria management										
OUTPUT 2.4.2 HW performance improved											
2.4.2.1	Orient HWs at hospital and HCIV in severe malaria and facilitation skills										
2.4.2.2	Conduct monthly supportive supervision meetings at hospitals and HC IVs										
2.4.2.3	Conduct quarterly clinical audits at HF to implement clinical audit action plans										
2.4.2.4	Quality Improvement Case-Management Meetings										
2.4.2.5	Monitor availability and use of injectable artesunate in HFs										
OUTPUT 2.4.3 Effective SBCC for Case Management effected											
2.4.3.1	Roll out campaign										
2.4.3.2	Strengthening capacity for HWs in BCC; adherence to test and treat										
2.4.3.3	Toll free line										
OUTPUT 2.4.4 Effective SBCC for Case Management effected											
2.4.4.1	Review current HMIS tools to disaggregate uncomplicated and severe malaria										
2.4.4.2	Compare HMIS and LMIS data										
2.4.4.3	Hotspots identified and responded to										
IR 3: : Build capacity of the NMCP and DHMTs to effectively manage malaria activities and sustain malaria gains											
IR 3.1 Capacity of DHMTs to effectively manage and sustain malaria activities in the focus areas built											
OUTPUT 3.1.1 Malaria prioritized by district leading to improved outcomes											
3.1.1.1	Conduct joint baseline capacity assessments of DHMT capacity										
3.1.1.2	Hold biannual DHO meetings for strategic problem solving facilitated by NMCP										
3.1.1.3	Conduct advocacy meetings with RDC, CAO, Secretary for Health, Councilors										
3.1.1.4	Conduct advocacy meetings with Religious and other influential leaders/influencers										
3.1.1.5	Create a pool of district trainers (TOTs)										
3.1.1.6	Support quarterly DHMT meetings (Performance Review Meetings)										
3.1.1.7	Hold annual district planning meetings and budgeting										
OUTPUT 3.1.2 Data use for decision making improved See M&E section											
OUTPUT 3.1.3 Private sector strengthened											

