USAID
FROM THE AMERICAN PEOPLE

USAID's Malaria Action Program for Districts

Annual Report

PY2 October 1st to September 30th, 2018

Submission Date: October 30th 2018

Contract Number: AID-617-C-16-00001

Activity Start Date and End Date: October 1st 2017 to September 30th 2018
COR Name: Gloria Sebikaari

Submitted by: Sam Gudoi, Chief of Party
Malaria Consortium
Plot 3 Katonga Road, Nakasero, Kampala
Tel: +256 3123303500;
Email: s.gudoi@malariaconsortium.org

Copied to: kampalausaidPPD-IPreports@usaid.gov

This document was produced for review by the United States Agency for International Development Uganda Mission (USAID/Uganda).

ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin Combined Treatment
ANC	Antenatal Care
ASSIST	Applying Science to Strengthen and Improve Systems
BS	Blood Slide
CDCS	Country Development Cooperative Strategy
CDFU	Communication for Development Foundation Uganda
CLA	Collaborative Learning and Adaptation
CQI	Collaborative Quality Improvement
DHMT	District Health Management Team
DHIS	District Health Information System
DHO	District Health Office
DHT	District Health Team
DHO	District Health Office
DO	Development Objective/s
DOT	Directly Observed Treatment
DQA	Data Quality Assurance
EQA	External Quality Control
GoU.	Government of Uganda
HC	Health Centre
HF	Health Facility
HMIS	Health Management Information System
HUMC	Heath Unit Management Committee
HW	Health Worker
iCCM	Integrated Community Case Management
IDI	Infections Disease Control
IDRC	Integrated Diseases Research Collaboration
IMM	Integrated Malaria Management
IP	Implementing Partner
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment
IR	Intermediate Results
ISS	Integrated Supportive Supervision
IVM	Integrated Vector Management
LDHF	Low Dose High Frequency
LLIN	Long Lasting Insecticide-treated Nets
M&E	Monitoring & Evaluation
MAPD	USAID's Malaria Action Program for Districts
MC	Malaria Consortium
MCH	Maternal Child Health
MCSMGT	Malaria Clinical Services Mentorship Guidelines & Toolkit
MIP	Malaria in Pregnancy
MIS	Malaria Indicator Survey
MMS	Medicine Management Supervisors
MOH	Ministry of Health
MRC	Malaria Research Center
mRDT	Rapid Diagnostic Tests for Malaria
NMCP	National Malaria Control Program
NMS	National Medical Stores

PA	Professional Association
PBF	Performance Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PFP	Private for Profit
PMI	Presidents Malaria Initiatives
PNFP	Private not for Profit
PSM	Procurement and Supply Management
PY	Program Year
QI	Quality Improvement
QIF	Quality Improvement Framework
QIM	Quality Improvement Methods
RBM	Roll Back Malaria
RHITES	Regional Health Integration to Enhance Systems
RRH	Regional Referral Hospital/s
SBC	Social Behavior Change
SBM-R	Standards Based Management & Recognition
SME-OR	Surveillance Monitoring Evaluation and Operational Research
SMS	Short Messaging System
SP	Sulfadoxine Pyrimethamine
SPARS	Supervision Performance Assessment Recognition Strategy
TASO	the AIDS Support Organization
ToT	Training of Trainers
TRP	Technical Resource Persons
TWG	Thematic Working Group
UHSCP	Uganda Health Supplies Chain Project
UMRSP	Uganda Malaria Reduction Strategic Plan
USAID	Unites States Agency for international Development
VHT	Village Health Team
WHO	Word Health Organization

Table of Contents

Acronyms and Abbreviations 3

1. ACTIVITY OVERVIEW/SUMMARY 6

1.1 Activity Description/Introduction 7

1.2 Results to Date 8

2. ACTIVITY IMPLEMENTATION PROGRESS 11

2.1 Summary of Implementation Status 15

2.2 Progress Narrative 23

3. ADAPTIVE MANAGEMENT APPROACH AND GUIDING PRINCIPLES .... **Error! Bookmark not defined.**

3.1 Collaboration and Stakeholder Engagement 25

3.3 Learning and Adaptation 26

3.4 Inclusive Development 27

4. LEADERSHIP DEVELOPMENT 28

5. MANAGEMENT AND ADMINISTRATIVE ISSUES **Error! Bookmark not defined.**

6. PLANNED ACTIVITIES FOR NEXT QUARTER PY2, INCLUDING UPCOMING EVENTS .... **Error! Bookmark not defined.**

8. SUMMARY FINANCIAL MANAGEMENT REPORT **Error! Bookmark not defined.**

9. ANNEXES .... **Error! Bookmark not defined.**

Annex A: Special Reporting Requirements - Health .... **Error! Bookmark not defined.**

Annex B: Success Story Template .... **Error! Bookmark not defined.**

Annex C: Special Reporting Requirements of Activities Undertaking Construction **Error! Bookmark not defined.**

6.1 Annex D: PY2 Work Plan Performance Matrix .... **Error! Bookmark not defined.**

6.2 Annex E: April- June 2018 MAPD Q3 PY 22018: Activity Outputs Additional Information **Error! Bookmark not defined.**

6.3 Annex F Learning Questions .... **Error! Bookmark not defined.**

1. ACTIVITY OVERVIEW/SUMMARY

Activity Name:	USAID's Malaria Action Program for Districts (MAPD)
Project/s:	Resilience and Health Systems Projects
Activity Start Date and End Date:	August 2016 to September 2021
Name of Prime Implementing Partner:	Malaria Consortium (MC)
Contract Number:	*AID-617-C-16-00001*
Name of Sub-awardees and Dollar Amounts:	Jhpiego, Banyan Global, Deloitte, Infectious Disease Institute (IDI), infectious Diseases Research Collaboration (IDRC), Communication for Development Foundation Uganda (CDFU)
Major Counterpart Organizations:	MAPD works in close collaboration with other USG mechanisms including RHITES, Global Fund, as well as the MoH – NMCP, RHD, Child Health and Community Divisions, and District Health Management Teams.
Geographic Coverage Changes (districts):	49 Districts across 5 regions; West Nile (Arua), Bunyoro (Hoima), Rwenzori (Kabarole), Central 2 (Kampala) and Central 1 (Masaka)
Reporting Period:	October 1st 2017 – September 30th 2018

USAID's Malaria Action Program for Districts (hereafter referred to as the project, or MAPD) is a five year USAID-funded project led by Malaria Consortium and implemented in partnership with Jhpiego, Banyan Global, Communication for Development Foundation Uganda (CDFU), Deloitte Uganda, Infectious Diseases Institute (IDI) and Infectious Diseases Research Collaboration (IDRC). USAID engaged Malaria Consortium under contract number AID-617-C-16-00001AID on August 19, 2016. The project covers 47 districts in central, mid-western and west Nile regions of Uganda, with a total estimated population of 13 million people, through reducing malaria related morbidity and mortality, with special focus on women and children. The project implements evidence-based high impact activities, working with the National Malaria Control Program (NMCP) and the District Health Management Teams (DHMTs) and following the relevant national policies and guidelines, PMI's Uganda Malaria Operational Plans (MOPs) and USAIDs County Development Cooperation Strategy 2016-2021.

MAPD's interventions are aimed at achieving the following results;

Result 1: Effective malaria prevention programs implemented in support of the Uganda National Malaria Reduction Strategic plan 2014-2020.

- high quality, accessible programs for prevention of MIP implemented
- initiatives to promote net use and access to LLINs implemented

Result 2: Effective malaria diagnosis and treatment activities in support of the Uganda National Malaria Reduction Strategic plan 2014-2020.

- implementation of iCCM supported in high malaria endemic areas
- diagnostic capacity improved
- service providers' capacity for management of uncomplicated malaria cases and severe malaria cases improved
- Strengthen capacity of district supervisors / Improve referral system

Result 3: Build capacity of the National Malaria Control Program (NMCP) and District Health Management Teams (DHMTs) to effectively manage malaria activities and sustain malaria gains.

- Capacity of the DHMTs to effectively manage and sustain malaria activities in the focus areas built.
- Value for money through increased cost efficiency in delivery of malaria services in focus areas
- Capacity of NMCP to effectively manage and sustain national malaria activities built

Cross Cutting themes: These include social and behavior change (SBC), youth and gender integration, monitoring evaluation, surveillance and collaboration, learning and adaptation to harness synergies.

The project's impact will be seen in reduced morbidity and mortality resulting from malaria infection. During the FY 18 MAPD contributed to reducing new malaria infections, increased access to treatment and reduced death.

1.2 Performance Analysis to Date

USAID/Uganda Performance Analysis Table											
Development Objectives 1 & 2: Community and Household Resilience in Select Areas and Target Populations Increased & Demographic Drivers											
CDCS Links[1]	**Indicator**	**Baseline data**		**FY 2017**		**Quarterly Status – FY 2018**				**Annual Performance Achieved to Date (in %)**	**Comment(s)**
		Year	**Value**	**Annual Cumulative Planned target[2]**	**Annual Cumulative Actual**	**Q1**	**Q2**	**Q3**	**Q4**		
Intermediate Result (IR): Effective malaria prevention programs implemented in support of the National Malaria Control Strategy											
1.3.1	Sub-IR: IR 1.1: Management of malaria in pregnancy (MIP) improved										
	Proportion of women attending ANC who received ITNs at ANC clinics	2016	75%	85%	63%	78%	52%	62%	70%	66%	MAPD is strengthening the LLINs supply chain system integrating it into the Essential Medicines system. Mechanism for providing PNFPs with LLINs requires strengthening
	Proportion of women who received two or more doses of IPTp for malaria during ANC contacts during their last pregnancy in intervention districts	2016	61%	85%	60%	73%	65%	63%	69%	68%	SP stocks had a negative effect on this indicator. MAPD is supporting the SP supply chain through forecasting, redistribution and

[1] Identify CDCS IRs or Sub IRs where applicable, for example 3.2.2 or 1.1, etc. Only list CDCS results where your Activity can contribute results (and where aligned within the approved AMELP).
[2] When applicable

											medicines management.
	Proportion of women who received three or more doses of IPTp for malaria during ANC contacts during their last pregnancy in intervention districts	2017	2%	30%		4%	15%	37%	37%	25%	Uptake of IPT3+ has increased and reporting into the DHIS2 has improved. National level is 17%
	Number of health workers trained in the control of malaria in pregnancy	2016	0	4,000	5,781 (145%)	2,627	2,527	2,368	898	8,420 (168%)	Used LDHF, IMM and grand rounds to reach a wider audience.
1.3.1,3.3.2	Sub-IR:1.2: Access and Use of malaria prevention interventions increased										
	Number of insecticide treated nets (ITNs) purchased in any fiscal year with USG funds that were distributed in this reported fiscal year	2016	0	1,852,544	1,306,378			847,627	215,122	1,062,820	MAPD is strengthening the routine LLINs' supply chain leveraging on the existing EMS supply chain
Intermediate Result (IR): Effective malaria diagnosis and treatment activities implemented in support of National Malaria Strategy											
1.3.1, 3.3.1	Sub-IR: Diagnostic capacity improved										
	Number of laboratory health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) and microscopy) with USG funds	2016	0	1200	760	160	161	19	0	63%	The project target will be achieved in FY 19
	Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) with USG funds(i.e. non laboratory staff)	2016	0	4,500	2,423	0	485	16	957	54%	This is an ongoing activity and the target will be achieved in FY19
	Proportion of malaria suspected cases tested for malaria	2016	81%	85%	84%	54%	88%	95%	95%	95%	MAPD continues to advocate for availability of RDTS and monitor testing rates
1.3.1, 3.3.1	Sub IR 2.3: Service providers' capacity for malaria case management improved										
	Proportion of patients at health facilities who received a negative diagnostic test for malaria	2016	36%	15%	39%	38%	16%	14%	12%	20%	Target for FY 19 is 5%

	who received an antimalarial drug										
	Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	2016	0	14,000	14110	2,790	2,911	2368	260	100%	100% coverage of all public and PNFP health facilities

1.3 Contribution to CDCS Results Framework Progress Narrative

MAPD contribution to goals and results reflected in the CDCS results framework

MAPD has 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, accessible, accountable, and inclusive while also improving social support and making her household more resilient.

MAPD works within all 15 of CDCS's guiding principles and contributes to the CDCS 2.0 Intermediate Results (IR), such as;

- IR 1.3: Enhanced prevention and treatment of HIV, Malaria and other epidemics and the most vulnerable;
    - Sub IR 1.3.1 – Prevention and treatment scaled up
    - Sub IR 1.3.2 – New infections reduced
- IR 2.2.1. Child health services are strengthened
- IR 3.1: Leadership in development supported, with focus on;
    - Sub IR 3.1.1 – Local solutions to leadership practices identified
    - Sub IR 3.1.2 – Leadership practices cultivated
- IR 3.2.1: Inclusive participation in decision making processes will be increased
- IR 3.3: Key elements of systems strengthened;
    - Sub IR 3.3.1 – Availability of skilled and motivated workforce increased
    - Sub IR 3.3.2 – Availability and management of quality commodities improved
    - Sub IR 3.3.4 – Availability of and functionality of infrastructure enhanced.
    - Sub IR 3.3.5 – Availability and utilization of quality data at all levels of decision-making increased

Description of findings in the analysis conducted on Activity level on contributions to PMP and PAD MEL plan indicators

Malaria Prevention: MAPD has contributed to the prevention of malaria in pregnancy by rolling out the policy on giving 3 or more doses of intermittent preventive treatment to pregnant women (IPT3+) in over 1,400 HFs in the project focus area. As of the most recent quarter (July – Sept 18), the 37% of women attending ANC had received 3 or more doses of IPTp.

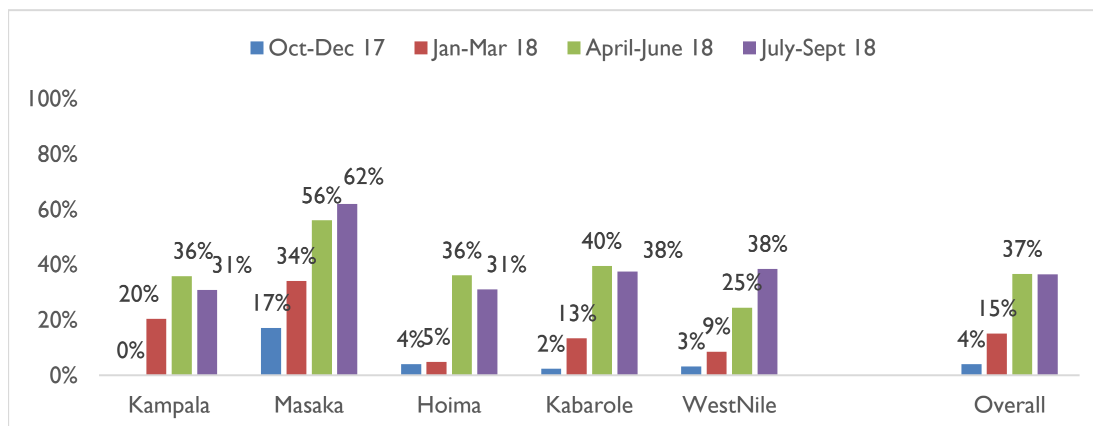


Figure: Proportion of pregnant women attending ANC who have received **three or more** doses of IPTp, *Source: HMIS*

Malaria Case Management: MAPD has contributed to improving case management of malaria in its focus districts; which includes improving testing malaria suspects before treatment and adherence to the test and treat policy. As of the quarter June to Sept 2018, 95% of suspected malaria cases visiting health facilities were tested for malaria.

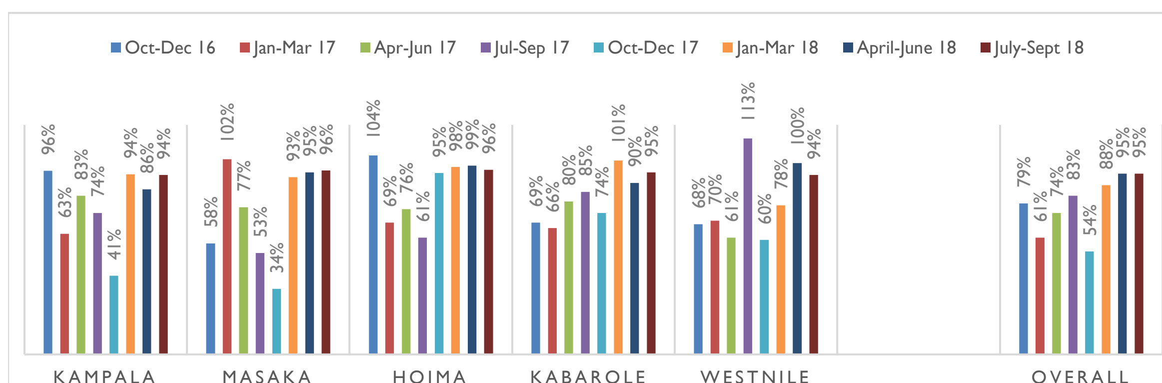


Figure: Proportion of malaria suspected cases tested for malaria before treatment, *Source: HMIS*

In addition, appropriate treatment practices for both positive and negative malaria cases has improved in the project area. For instance, the proportion of malaria negative cases that are not given antimalarial drugs has improved to 88%. (See graph below)

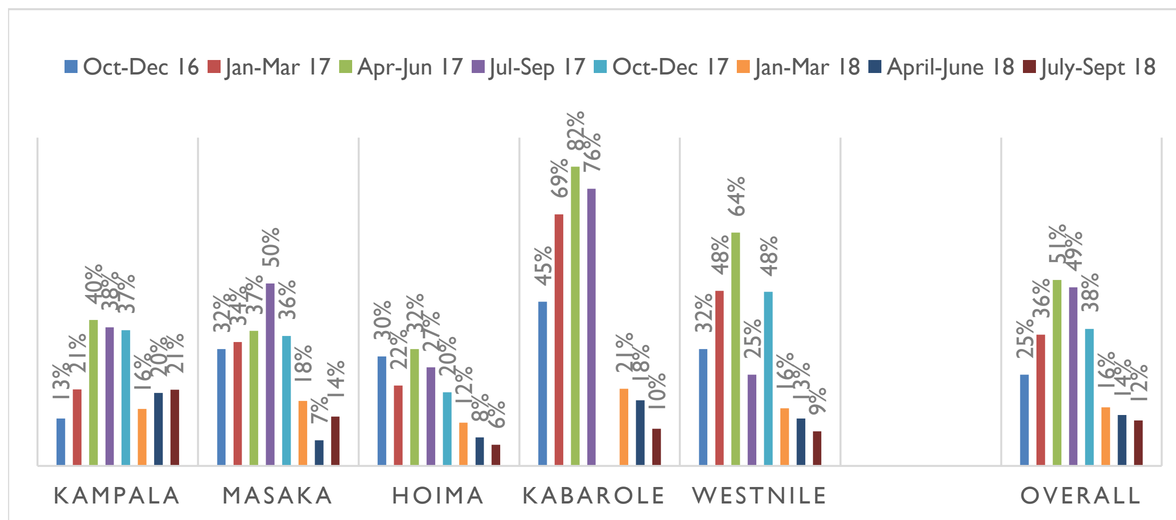


Figure: Proportion of patients at health facilities who received a negative diagnostic test for malaria who received an antimalarial drug, *Source: HMIS*

Key challenges MAPD has experienced during the year and how the challenges are being addressed –

Most challenges center around stocks which MAPD does not directly provide – bar LLINs to public HFs.

Supply system issues affecting the IPTp3+ policy: The project's prevention of malaria in pregnancy interventions have been affected by stock out of SP/Fansidar in most MAPD Health Facilities. In the quarter June to Sept 2018, 15% of all health facilities reported stock out of Fansidar, with some regions reporting up to 20% and some districts reporting severe shortages: Koboko: 68%, Kiryandongo: 54%, Buliisa: 42%. This affects prevention of malaria during pregnancy. In PY3, the project will continue advocacy efforts in all central platforms for improved supply mechanisms, monitoring of stocks at HF level and redistribution where necessary.

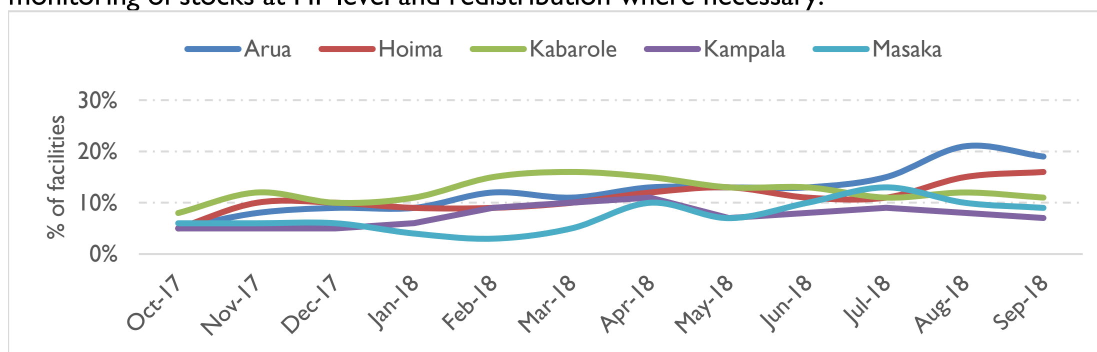


Figure: Trends in stock out of Fansidar in the project focus districts, *Source: HMIS*

Challenges in maintaining adequate stock of LLINs at health facilities: The project's prevention of malaria in pregnancy interventions have, also, been affected by PNFPs not ordering/prioritising LLINs, difficulties in reporting EPI LLIN provision, and some HW practice of not giving women who received a LLIN during the UCC. These have been addressed through mentorship, and working with the DHMTs and PNFPs. In PY3, the project will continue to reinforce LLIN as a key malaria commodity, improve distribution mechanisms, and ensure adequate reporting and timely ordering.

Challenges in ICCM non-malarial commodities

There is an on-going challenge in the start-up of this activity in MAPDs new iCCM 5 districts due to lack of non-malarial commodities to complete the iCCM package. MAPD is working with the MOH's Child Health Division, districts and other key iCCM stakeholders to address this challenge. MOH and NMS have included the 5 new iCCM MAPD districts to benefit from the GFF iCCM commodities. MoH does not permit non complete iCCM to occur in these districts e.g. starting with malaria case management.

2. ACTIVITY IMPLEMENTATION PROGRESS

2.1 Summary of Implementation Status

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
IR 1.1: High quality, accessible programs for prevention of MIP implemented.	1) Support the NMCP and Pharmacy Division to develop and implement MIP commodities comprehensive plan 2) Conduct advocacy for MIP commodities – LLINs, SP, folic acid 0.4 mg through bi-annual stakeholders' meetings and quarterly commodity security group meetings 3) Support implementation of MIP guidelines, working through national MIP TWG meetings. 4) Support IPTp DOT services through procurement and distribution of safe water storage vessels and dispensing caps 5) Conduct follow up of the implementation of MIP guidelines 6) Implement the m-health intervention to send SMS reminders to couples, pregnant women, and HWs. 7) Procure and distribute MIP counseling charts to ANC providing facilities.	The MOH pharmacy division was facilitated to develop and cost the MIP pharmaceutical and commodities 2018-2020 plan Through advocacy MAPD got the MOH PS and DG to issue circulars for prioritizing MIP commodities in the annual quantification and bi-monthly requests 12 MIP TWGs hosted; key achievement is adoption of the WHO 2016 guidance for a positive pregnancy experience. 1100 water vessels, 10000 tumblers and 125 cartons of water treatment tablets procured and distributed to 1140 public and PNFP health facilities 5793 health workers in followed up to ensure adherence 981 health workers in 443 health facilities trained. 8808 mothers enrolled to receive SMS reminder to attend ANC, use an ITN and take SP to prevent malaria in pregnancy 2000 MIP counseling charts distributed to health facilities and District Health Teams (DHTs). National and district TOTs conducted for Health worker (HW) interpersonal communication (IPC).	3.3.2 3.3.2 3.1.1 3.3.2 1.3.1 3.3.1 1.3.1 1.3.1 3.3.1 3.3.1
1.2 initiatives to promote net use and access to LLINs implemented	1) Support NMCP to develop integrated routine LLIN distribution guidelines. 2) Disseminate the national routine LLIN distribution policy guidelines to the DEOs, DHTs and HFs. 3) Support NMCP to quantify and develop national plan/Strategy for routine LLINs distribution. 4) Support Districts to quantify & develop comprehensive plan for routine LLIN distribution.	School LLIN distribution guidelines completed School LLIN distribution policy guidelines disseminated at all levels NMCP involved in the quantification and distribution of routine LLINs DHOs quantify LLIN needs and coordinate the distribution of nets to health facilities	1.3.1 3.3.2 3.3.2 3.1.1 3.3.1

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
	5) Strengthen IVM TWG and other forums 6) Baseline Assessment of LLIN coverage (ownership and proper use). 7) Support districts to conduct refresher orientation of school teachers and HWs in malaria prevention and control (routine school net distribution including data management). 8) Support NMCP to conduct bi-annual joint review and planning (MoH & MoES) for routine LLIN distribution. 9) Support Districts to conduct routine LLIN distribution through EPI, ANC and Schools (Malaria Clubs and Malaria Challenges). 10) Support Districts to conduct facility outreach activities (ANC and EPI LLIN distribution) in hard to reach areas. 11) Orientation of teachers in formation of malaria/health school clubs to promote net usages. 12) Conduct community and school sensitization of LLIN use, care and disposal for parents and pupils. 13) Support Districts to conduct post school LLIN distribution SBCC. 14) Conduct baseline assessment for school LLIN distribution. 15) Conduct evaluation of school LLIN distribution services.	Through IVM TWG School LLIN policy guidelines were reviewed and approved Trained 13446 teachers and health workers trained in school LLIN distribution. Dissemination conducted done to 13446 district, sub county and health facility staff and leaders Distributed 416,305 LLINs to ANC/EPI clinics in 49 districts. Distributed 646515 LLINS to pupils in 2883 schools. 473 pregnant women received ANC outreach services – LLINs and SP School health clubs formed in 29 schools in Kalangala district Done in 2883 schools during LLIN distribution Done through radio talk shows and IPC in schools and communities Done Done	3.1.2 1.3.1 1.3.2 3.3.2 1.3.1 1.3.2 1.3.1 3.2.1 3.2.1 3.2.1 1.3.2

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
IR 2.1 Implementation of iCCM	1) Print and disseminate iCCM guidelines. 2) Advocate for integration of iCCM commodities into essential medicines kits of HFs and procurement & distribution systems of NMS & JMS. 3) Baseline Assessment on ICCM: 4) Create and support iCCM sub-county health committee to oversee implementation. 5) Conduct district iCCM TOT orientation in new districts. 6) Support DHMT to supervise iCCM implementation in 8 districts 7) Conduct National continuous quality improvement for iCCM 8) Support HF to supervise iCCM implementation 9) Support to iCCM in existing Village Health Clubs. 10) Support monthly reporting of data from VHTs to HFs.	iCCM guidelines still under revision. ICCM curriculum revised Done through commodity security group and MCH cluster, and district level NMS procurement meetings. Conducted in 8 districts 53 iCCM sub county health committees formed Completed ToT for 33 district trainers 3055 VHTs supervised Participated in National Community Supply Chain TOT 463 Health facility In-charges and health assistants trained 1514 VHTs trained to support 771 village health clubs Done via supervision and review meetings	2.2.1 3.3.2 3.1.1 3.2.1 2.2.1 3.3.1 3.1.2 2.2.1 2.2.1 3.2.1 3.2.1
IR 2.2 Diagnostic capacity improved	1) District-based malaria microscopy training for laboratory staff 2) Conduct WHO malaria microscopy certification 3) Conduct post training onsite follow up support to laboratory staff in all 47 districts 6 weeks after the training. 4) Development and Management of Malaria Microscopy Slide Bank. 5) Support DHMTs to implement EQA in 47 districts 6) Introduce field-based quality control for mRDTs at community and lower level health facility levels. 7) Conduct health worker training in mRDT using LDHF	340 staff trained on malaria microscopy 24 laboratory staff received WHO certification in malaria microscopy 320 trainees received SMS quizzes and reminders post-training Procured 5 microscopes, certified 24 laboratory staff, Diagnostic Task force set up (NMCP and IPs) Monthly EQA for mRDT done in 48 districts Piloted the quality control in 74 sites 1458 health workers trained in mRDT	3.3.1 1.3.1 3.3.1 3.3.1 1.3.1 1.3.1 3.3.1 3.3.1 3.3.1

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
IR 2.3: Service providers' capacity for management of uncomplicated malaria cases improved	1) IMM tool kits finalized and produced for use to equip HWs with skills: 2) Update and reproduce Job Aid for differential diagnosis and treatment of febrile illness with negative results. 3) Conduct quarterly clinical audits at HF to implement clinical audit action plans 4) Health facility mentorships conducted for health workers 5) Integrated support supervision (ISS) conducted	IMM toolkit finalized and approved by PMI Job aids updated, process for printing started Clinical audits done in 125 HC IVs and hospitals Death audit done in 3 RRHs 8329 health workers in 1201 health facilities were mentored in delivery of malaria services 1131 health facilities supervised by DHTs 4 times in the year	3.3.1 1.3.1 1.3.1, 3.3.1 1.3.1, 3.3.1 3.3.1 1.3.1
IR 2.4: Service providers' capacity for management of severe malaria cases improved	1) Orient HWs at hospital and HCIV in severe malaria and facilitation skills: 2) Mentorships in severe malaria modules. 3) Conduct monthly supportive supervision meetings at Hospitals and HC IVs	202 hospital and HC IV health workers trained as mentors for high volume sites with focus on severe malaria 125 HCIV and Hospitals received mentorships with focus on severe malaria modules. Integrated support supervision meetings conducted in 125 HCIV and Hospitals), with focus on severe malaria	1.3.1, 3.3.1 1.3.1, 3.3.1 3.1.2
IR 3.1 capacity of the DHMTs to effectively manage and sustain malaria activities in the focus areas built.	1) Hold biannual DHO meetings for strategic problem solving facilitated by NMCP. 2) Conduct joint baseline capacity assessments of DHMT capacity 3) Hold annual district planning meetings and budgeting. 4) Conduct advocacy meetings with RDC, CAO, Secretary for Health, Councilors. 5) Conduct advocacy meetings with Religious and other influential leaders/influencers 6) Support quarterly DHMT meetings (Performance Review Meetings). 7) Conduct an integrated malaria service delivery provider practices and client satisfaction survey at selected HFs. 8) Conduct routine data quality assessments: 9) Conduct data dissemination meetings at district level and at all MRCs 10) Provide feedback to the DHMT and health facility staff on key malaria surveillance indicators	Biannual meetings held with 47 District Health Officers commenced Annual planning meeting held in 47 districts Completed in all the 49 districts Completed in 26 districts Done quarterly in 49 districts. This involved review of key performance indicators, highlighting and clarifying any challenges. These were done in a sample of 160 health facilities and findings used to inform interventions towards improving data quality DQA for HMIS data conducted. Done in 34 districts where MRCs are located Done through quarterly performance review meetings.	3.1.2 3.1.1, 3.1.2 3.1.1, 3.1.2 3.2.1 3.1.1, 3.1.2 3.2.1 3.3.5 3.3.5 3.3.5, 3.1.2

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
IR 3.2: Improved efficiency in delivery of malaria services in focus areas	1) Conduct in-depth infrastructure needs assessment to identify beneficiaries for renovation. 2) Carry out renovation works at identified HFs. 3) Contracting of Professional Associations 4) Implement performance based in-kind grants through Sub grant agreements with DHMTs 5) Implement performance based in-kind grants with Public and PNFP facilities	88 health facilities across the 5 regions assessed 16 health facilities earmarked for renovation 2 professional associations contracted Identification of need by indicator progress (all higher level HFs) done. Health facilities to receive in-kind grants identified	3.3.4 3.3.4 3.3.1 3.1.2 3.3.1
IR 3.3: Capacity of NMCP to effectively manage and sustain national malaria activities built	1) NMCP staff to participate in the semi-annual regional meetings. 2) Organize malaria grand rounds – Regional Referral Hospitals (RRH) 3) Support annual Scientific Research Colloquium under the UMRC. 4) Support NMCP to coordinate national malaria TWG activities	NMCP staff participated in 10 regional meetings 1308 health workers in 9 hospitals and training institutions oriented on malaria policies, through grand rounds Completed MAPD supported MIP, iCCM, MCH, SBCC, IVM, SME-OR, MIS TWGs	3.1.2 3.3.1 3.1.2
IR 4.1: Health facilities capacity for quality services delivery development	1) Collaborative Quality improvement (CQI) through activities supported 2) Health workers malaria mentorship package developed (see 2.3/2.4)	Collaborative QI implemented in 74 health facilities – noticed improvement in malaria indicators Mentorship guide reviewed and approved by PMI	1.3.1, 3.3.1
IR 4.2.2 SBCC	1) Roll out campaign 2) Collect success stories	Mass media campaign – 61 talk shows, 7.5 million people reached "Giving malaria the boot" world cup campaign – 25 districts, 197000 people reached IPC activations implemented in 26 districts TV sets installed in 25 health facilities, 84 key influencers trained and supported. 914 Village Health Clubs Regional advocacy meetings for 26 districts, 134 cultural leaders oriented, 79 religious leaders oriented 140 provider IPC TOTs 32 Facebook and 8 success stories	3.3.1 1.3.2 1.3.2 1.3.2 3.3.1

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
	3) Implement school heath (LLIN) SBCC	282 national and regional TOTs for school SBCC, 1736 teachers and sub county leaders oriented in school SBCC	3.2.1 3.3.1
4.3: Gender and Youth	Gender and youth mainstreaming into malaria interventions aligned to USAID's Gender Equality and Female Empowerment (GEFE) Policy and the Youth in Development Policy.	Disseminated MAPD gender analysis results to different stakeholders at national level and regional level, including project staff. Reviewed project strategies, tools and activities and provided gender and youth integration input.	3.2.1
4.4.1 Routine Monitoring & Evaluation	1) Monitoring of key malaria commodities	The project monitored availability of key malaria commodities including RDTs, SP and ACTs. Overall mRDTs have been available at facilities throughout the project districts. SP stock out on the other hand varied between 10% and 20% with some districts reporting severe shortages: Koboko: 68%, Kiryandongo: 54%, Buliisa: 42%, etc.). On the contrary, ACTs have been available through-out the year in all health facilities in the project districts. For all, malaria commodities, Regional offices worked with DHMTs to redistribute from highly stocked health facilities to those affected by stock out, and MAPD has been working with MoH and UHSP.	3.3.5
	2) Support the roll out of the HMIS on job mentoring	Using DHIS2 data, the team identified facilities with poor quality data and conducted an assessment in a sample of these facilities to understand the causes of such poor quality data. Findings showed that most of these facilities were using outdated tools. Mentorships have been conducted on using the most update versions of the affected malaria data reporting tool. The updated HMIS 033B weekly epidemiological form was also provided to all affected facilities.	3.3.5
	3) Improve data quality and establish data quality control mechanisms	District data review meetings were conducted in several districts. Participants included health facility in-charges, records personnel and DHMT members. The meetings	3.3.5

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
		reviewed existing data and identified challenges in collecting, reporting and using data. Issues identified included lack of feedback on data reported, knowledge gaps in reporting regarding test and treat policy, gaps in human resources at facilities, outdated tools and in some districts poor mobile phone network. Actions with corresponding timelines were developed for all districts and continue to be followed up.	
	4) Data verification	The team conducted a data verification in a number of districts. A verification is often conducted when a district or health facility shows persistently high test positivity rates. This is the first response in epidemic detection and response. It allows the project to interpret data accurately and forms the basis for appropriate intervention development. In the past year, some facilities in the project districts have reported malaria epidemics but with data verification and deeper analysis, they were not epidemics but instead data issues.	3.3.5
	5) Conduct regular HMIS data support supervision	Support supervisions were conducted in several health facilities located the operational area. In these supervisions, HMIS data was reviewed starting from what is recorded in the OPD registers, the aggregation and what was reported into DHIS. Based on the findings, action points were developed, but all targeted towards improving the quality of the data.	3.3.5
	6) Ensure availability of tools and commodities	Stemming from data reviews and facility data support supervisions, the project realized the need to provide the most update HMIS 033B weekly epidemiological and surveillance tool. A significant number of project supported facilities were affected. For example, majority of facilities showing poor quality data in the DHIS 2 system attributed this challenge to use an outdated tool.	3.3.5

Activity Result Areas	Summary of planned activities in work plan for the reporting year	Actual key activities/tasks conducted during the year	Link to CDCS
	7) Data use for decision making	The team ensure that DHMT meetings and discussions are informed by data. The district biostatisticians are encouraged to conduct simple analyses of the data to provide a picture of the malaria situation in the district. This was done during DHMT meetings. Overall, 10 DHMT meetings (2 per region) to discuss and make decisions based data were made.	3.3.5
4.4.2: Surveillance and operational research	1) Conduct surveillance of antimalarial drug efficacy surveillance at 3 sites 2) Evaluate durability, use and effectiveness of LLINs 3) Establish surveillance at 14 additional sites 4) Collaborate with existing inpatient sites 5) Support Data use at District 6) Support other HF to improve malaria case management and reporting 7) Monitor the surveillance system	Approval from National Drug Authority received this quarter. Finalized the LLINs durability protocol and submitted it to the Institutional review board for ethical approval. 14 new MRC supported: Collected and analyzed data from 27 existing MRC. Provided support supervision for 31 HF with focus on data quality and use, including epidemic detection and line listing to determine the source for action Trained HW in HMIS inpatients malaria surveillance for 4 hospitals (2 hospitals already trained last quarter). Supported Data collection analysis and reporting from 6 hospitals. 76 lab personnel from 20 MRC were trained on microscopy & conducted BS EQA in 20 HF. Held session with 388 staff on malaria case management practices. Support supervision for 20 HF done with focus on test treat compliance. Distributed HMIS 032 referral forms at 20 HF in 20 districts. Held HMIS workshop for 48 HW from 16 MRC from Lango region. Held meetings for 63 DHT in 23 districts to support HMIS in the districts with resources & supervision	3.3.5 3.3.5 3.3.5 3.3.5 3.3.5 1.3.1 3.3.5 3.3.5

2.2 Progress Narrative

IR 1.1: High quality, accessible programs for prevention of MIP implemented. The IR is on track in terms of annual activity plan implementation. The project implemented all the planned activities by end of year. The performance of IPTp2 and 3 indicators in the project are stands at 66% and 37% respectively. The performance of the IPTp3 indicator was affected by under and non-reporting in the first half of the year and later on Sulfadoxine Pyrimethamine (SP) stock outs at HF level reaching up to 24% in Central 2 and Hoima regions. The SP stock out is a result of limited HF budgets as SP is a credit line item and not prioritized by the health facility in charges during their annual quantification exercise with NMS. MAPD through advocacy positively influenced this issue, and the permanent secretary MOH instructed DHOs and NMS to prioritize SP in their budgeting, quantification and ordering. MAPD also supported intra and inter district redistribution and preparation of emergency orders to NMS, and supported the NMCP to develop a distribution plan for the PMI SP donation to MoH. In PY3 the project will invest more efforts in strengthening health worker skills in MIP service delivery and MIP commodities management to ensure availability and utilization of these commodities.
IR 2.1 Initiatives to promote net use and access to LLINs implemented. The project delivered LLINs to health facilities and primary schools. However, overall annually only 61% of pregnant women received an LLIN at first ANC visit/children at DPT3 (though this is 70% at last quarter). The project distributed 1,062,820 LLINs through ANC/EPI and schools. There was a delayed quantification and distribution in the first quarter of the year to HFs. MAPD has strengthened the LLIN supply chain system with increased district involvement in the quantification, distribution and monitoring of use.
IR 2.1 Implementation of iCCM. iCCM activities have occurred in all 11 MAPD iCCM districts, and MAPD has been working to strengthen district level capacity to manage iCCM. There is an on-going challenge in the start-up of this activity in 5 districts due to lack of non-malarial commodities to complete the iCCM package. MAPD is working with the MOH's Child Health Division, districts and other key iCCM stakeholders to address this challenge. MOH and NMS have included the 5 new iCCM MAPD districts to benefit from the GFF iCCM commodities
IR 2.2 Diagnostic capacity Improved The project is on track with this area both in terms of implementing annual work plan activities, and indicators. The interventions have contributed to increased malaria testing rates and quality of testing. Progress has been made towards setting up a malaria slide bank and EQA has been institutionalized. The main challenges faced during the year include inadequate supply of microscope slides as a result of inconsistent supply by the NMS, poor quality microscopes and lack of EQA tools. MAPD has engaged with districts to quantify, order and properly track the malaria laboratory commodities, is using the in-kind grants to provide microscopes to the high volume facilities and is using the existing hub facilities to provide copies of EQA tools.
IR 2.3 and 2.4 Service providers' capacity for management of uncomplicated and severe malaria cases improved. The project is on track with this activity both in quarter and annual targets**.** The project has finalized the development of the IMM mentorship package. The guide has been reviewed by PMI/USAID and MAPD is engaging with MoH to have it approved for use for mentorship. The main interventions during the year targeting uncomplicated malaria were on site skills building through mentorship and integrated support supervision, 8329 health workers were mentored and health workers in 1131 health facilities supervised. Clinical and death audits, supervision meetings have been used to improve severe malaria case management. The main challenges faced during the year include persistently high positivity rates in most of the MAPD districts, under-reporting of deaths due to malaria and high number of deaths in the Mid-West regions. These are being addressed through on-going MAPD support (mentorships, supervision, and clinical audit follow-ups) as well as improving data recording, reporting and strengthening the referral system. MAPD continues to strengthen uncomplicated case management to avoid complications of severe malaria. Through death audits clinical teams have been strengthened to ensure that severe malaria management protocols and standards are adhered to. All malaria deaths are reported and comprehensive death audits conducted promptly.

IR 3.1 Capacity of the DHMTs to effectively manage and sustain malaria activities in the focus areas built. The project reached its annual work plan activities for FY 18 and is on track with its project life targets. MAPD supported bi-annual DHO meetings, advocacy meetings with administrative, political and religious leaders; quarterly district performance reviews and participatory district planning. MAPD has created a pool of district mentors to sustain the capacity building of health workers. MAPD supported data improvement including data quality assessments, and setting-up and strengthening of surveillance centers. MAPD has lobbied and been able to get districts allocate funds to malaria control and prevention in the annual district budgets. The main challenges in this area is the weak leadership capacity at district and sub district levels, inadequate political commitment to malaria control and the lack of data use culture. MAPD is overcoming this challenge through DHMT leadership and management development, through mentorship to improve districts capacity to manage malaria programs.
IR 3.2 Improving efficacy in delivery of malaria services. The project is not reaching its annual target in this activity area, though significant advancements have been made this year. The project conducted in depth infrastructure assessment in 88 health facilities in 31 districts. MAPD has selected 16 most in need health facilities to benefit from infrastructure improvement works. The project sub contracted 2 professional associations (Uganda Pediatric Association and Uganda Private Midwives Association) to improve private sector malaria care, and another 3 associations are in process. The project has delayed in implementing in-kind grants for DHMTs, public and PNFP health facilities. The main challenges faced in implementing this activity include delays in submitting assessments from districts and state of infrastructure buildings and pre-existing documents. The project has completed all the procedures and infrastructure projects and in-kind grants will be implemented in FY19
IR 3.3 Capacity of NMCP to effectively manage and sustain national malaria activities built. The project is on track in this regard. MAPD has supported NMCP staff to be involved key malaria activities at district level including malaria performance reviews and annual district planning workshops. MAPD supported grand rounds at regional referral hospitals and health training institutions to disseminate malaria policy guidelines and inculcate good malaria medical practice in students. Through this grand round approach MAPD has equipped 1308 health workers and nursing/medical students with knowledge and skills to enable them provide malaria services in accordance with national standards. MAPD has actively participated in as well as led malaria related MOH technical working groups, supported the Technical Advisory Committee for Malaria Indicator Survey (MIS), participated in the RBM meetings and been a key participant at the national level malaria data cleaning exercises. MAPD also supported the World Malaria Day, Launch of Uganda Parliamentary Forum on Malaria (UPFM) Mass Action against Malaria (MAAM), Science Colloquium, as well as taking 2 Village Health Team members to London to represent youth malaria workers at the Malaria Summit April 2018. Challenges have been encountered in terms poor quality of data collected and entered into the DHIS2. The project has vigorously support malaria HMIS data cleaning exercises while building the capacity of health facility staff to improve recording and reporting. The project also advocated for reporting of the IPTp3 indicator into the DHIS2 and obtained a circular from the DGHS to DHOs to ensure that IPTp3 data is captured into the DHIS2.
IR 4 Cross-Cutting: The SBC activity implementation is on track in regards to the annual FY18 work plan. MAPD rolled out a campaign using a multi-pronged approach of mass media, 'giving malaria the boot' campaign, IPC activations, installation of TV sets at the high volume health facilities, using key influencers and formation of 914 village health clubs. The project implemented activities aimed at increasing awareness of project malaria activities among district, cultural and religious leaders. Facebook and success stories were documented and submitted to PMI/USAID. The SBC activity provided support to the school LLIN distribution intervention.
Gender and Youth is on tracking in implementing the FY18 work plan and met all targets, while M&E has supported HMIS health facility mentorships and DQAs, tool provision (HMIS 033B to all HFs) and stock tracking.

2.3 Partnership, Collaboration, and Stakeholder Engagement

MAPD used various avenues to promote sharing and learning as well as promote effective learning, program change, resource use and avoidance of duplication of intervention in FY 18

Malaria district Review Meetings: MAPD used district and regional performance review meetings to engage with NMCP, districts and implementing partners. This involved sharing work plans, results and lessons learnt during implementation.

Malaria supply Chain Management: MAPD worked with MoH and UHSCP to develop the 2018-2021 malaria commodities Quantification and Supply Chain Plan. Activities undertaken include support to SPARS program in Kalangala district, and UHSCP shared ICCM tools for use by MAPD and other implementing partners.

Quality Improvement: MAPD worked with ASSIST to implement collaborative quality improvement (CQI) in 74 health facilities across the project area. This CQI intervention has been embraced by the districts and will be integrated into routine quality improvement interventions, and has been seen to improve adherence to guidelines and indicators in participating HFs.

Lab support to the RHITES: MAPD provided technical assistance to the RHITES projects in the areas of malaria microscopy EQA and RDT field stability monitoring. Laboratory staff from the RHITES projects were enrolled into the WHO microscopy certification program.

Shared field visits and Data reviews: the project has invited RHITES to visit its program sites as well as visiting theirs, this initiative has been strengthened through monthly data review meetings between the organizations and other key members.

Shared Surveillance data MAPD shares its monthly surveillance data with all key partners (it would be good to quickly specify who these key partners are, I agree and add annexes or summaries of this data), as well as holding HF based dissemination meetings.

Sharing up-to date research and technological developments: MAPD supported the wide dissemination of current malaria research and developments through the Malaria Day Science Colloquium

Community Involvement and Feedback MAPD generates community dialogues that investigate and find local solutions to malaria issues driving CLA at a community level. It also links the communities and the HFs with joint dialogues and information sharing, as well as integrating findings within review meetings and its own activities.

MAPD participation and Technical Assistance in stakeholder partnership meetings MAPD supports MIP, MCM, SME-OR, IVM, iCCM and SBCC Thematic Working Groups, as well as participating in a RBM meetings. MAPD has supported attendance to central level forums by district leadership promoting inclusive decision making and participation as well as leadership.

Sharing of MAPD learnings and analyses: MAPD developed a summary of its program surveys and had a facilitative inclusive dissemination of its gender analysis results to different stakeholders at national level.

2.4 Learning and Adaptation

The narrative should specifically report on a) increased ability of USAID implementing partner to respond to the needs of target groups by using learning, b) instances of learning applied to influence decision making, resource allocation, and contextual shifts, and c) increased efficiency in intervention implementation.

Clinical audits conducted together with hospital staff can ensure regular facility led audits. The team conducted clinical audits at Kabarole Regional Referral Hospital with hospital staff at the start of the year. Following the initial audit, the hospital administration has been able to conduct subsequent audits without promptings from project team. Findings from one of the hospital run audits led to the investigation of hotspots for malaria deaths in one of the rural sub counties in the district. The project team was able to have targeted SBCC in that area focusing on severe malaria and treatment seeking behaviors.

Engaging DHMTs in reviewing routinely reported data can improve program performance. The project team jointly reviewed data with Lwengo district DMHT. Following this meeting, the district followed up with affected health facilities'. Routine data from this district showed improvement in malaria case management. For example, proportion of patients with negative test results given an antimalarial reduced from above 30% in Jan 2018 to less than 10% in the subsequent months. Data reviews with DHMTs are currently conducted in all project districts.

Redistribution of some malaria commodities is possible within the district. Regular analysis of HMIS data and field visits to health facilities often showed stock outs of SP. The project has supported the districts to redistribute SP from over stocked facilities to those understocked. Guidelines on drug redistribution exist but these are not widely implemented.

2.5 Inclusive Development

Gender is one of the most powerful social determinants of health risks, results, and outcomes. Inequalities between women and men usually result in different levels of exposure and vulnerability to disease, different responses to ill health, different health outcomes, and different consequences. Youth integration, and youth appropriate programming is key as Uganda's population is youth heavy. The project built on the strong foundation for effective gender and youth programming formed in year one through gender and youth analyses as well as staff training. All activities were informed by the project's gender and youth analyses which generated valuable findings and results about how the project could integrate gender and youth concerns for better programming and results. The analyses findings, including recommendations were also shared with stakeholders at national and local levels.

In light of the learning from the gender and youth analyses and previous implementation experiences, the program reviewed and provided gender and youth integration input on various government and project strategies, guidelines, approaches tools and activities. Gender and youth integration tools were also developed including the gender and youth integration checklist to support the integration of gender and youth considerations throughout the program's planning, executing, monitoring, evaluating and learning activities. Talking points for community mobilisers including leaders and community workers as well as health service providers were also developed to help address gender and youth related barriers identified during the gender and youth analyses.
In order to build capacity for youth inclusion, at district level, the project conducted youth integration orientation for district service delivery supervisors in two regions during the year. This was aimed at improving the integration of youth concerns in malaria interventions, through the positive youth development approach. The participants included members of the district health management teams and district community development officers to harness synergies between the community development and health departments for better inclusion and results.

MAPD also brought the voices of the youth, women and men to the district health management team members and local leaders through gender and youth forums that followed a series community dialogues where health system-based gender and youth related challenges were identified. These dialogues also helped to identify, understand and address community dynamics affecting access to services by women and youth at community level. The action plans developed during the gender and youth forums and dialogues provide a great opportunity for continued engagement within communities and between communities and service providers on ways to address gender and youth related barriers.

During MAPDs school LLIN distribution school children were empowered with malaria knowledge, LLIN knowledge and are being empowered to become change agents within their households and communities.

2.6 Science, Technology and Innovation Impacts

Describe briefly in the table below if the activity has implemented any STI activities during the year.

Activity Result Area	Science, Tech, Innovation activity/task description	Planned outcome	Achievements
R1 1.1	SMS to promote ANC attendance	Improved no of visits per woman	Progress stalled by MoH – MAPD is negotiating for permissions
R2 2.1.	SMS follow up to trainees	Improved knowledge retention	Correct response rate has reached 79% at end of PY2

2.7 Transparency and Accountability

The narrative should in maximum 300 words provide a brief progress update on the following Guiding Principles:

13. Incorporate anti-corruption mechanisms across the portfolio
14. Model strategic communication for transparency and accountability

The narrative should specifically report on a) what interventions were implemented to achieve the Guiding Principles 13 and 14, and b) how did those interventions lead to improved transparency and accountability.

INSERT BRIEF NARRATIVE ON TRANSPARANCY AND ACCOUNTABILITY, LESS THAN 300 WORDS.

During the period under review, MC oriented its staff and subcontractors on Reporting and Preventing Fraud. MC shared the USAID guidelines with all partners and offices, and displayed these guidelines in all offices. MC also developed the plan on combating trafficking in persons and shared the plan with all staff and subcontractors.
Project staff and contractors are well informed and aware of the consequence of not adhering to the guideline and procedures to follow if fraud occurs.
MC has a whistleblowing policy and staff are aware of the hotline to use in case there is an incidence that needs to be investigated.

3. LEADERSHIP DEVELOPMENT

Leadership development activity	Planned outcome in the year	Indications/examples of outcomes
Activity I District Planning and review session	District Malaria Plan District Malaria Budget	Increased ownership through district driven malaria plans and budgeting. Improved malaria indicators
Activity 2: HW development (including technical resource people, mentors and supervisors)	Improved technical know-how and leadership Improved data driven and adaptive action at district level Increased demand from HWs for system improvements	Technical resource personal (DHMTs) closer to HW and system challenges and expressing this more in review meetings. Political leadership demanding malaria data and corrective action in some districts e.g. Kabarole.
Activity 3: Community dialogues	Increased community participation and leadership Increased community demand for accountability of services and systems Increased demand for quality malaria services	Improved prevention adopted
Activity 4 Community and organizational system linkages e.g. Linked community dialogues and HW and DHMTs School children as change agents, linked to school management, community dialogues, HFs etc. Youth participation and gender issues promoted.	Just starting so no outcomes expected in this quarter.	Examples in future: Increased accountability and quality service demand Increased service responsiveness
Activity 5 Staff Development Provided leadership coaching on: Time-Management, Project Management and Mediation provided to all managerial staff (field and Capital)	Improved time management, and capacity to manage teams and projects	

4. ENVIRONMENTAL COMPLIANCE

All activities with **a Negative Determination with Condition** are required to report on implementation of mitigation measures quarterly and annually. The post award orientation provided the Implementing Partner with Initial Environmental Examination (IEE) documents that clarifies requirements and expectations. Further guidance can be found in the Environmental Procedures Best Practices Review. The environmental compliance reporting refers to Environmental Monitoring and Mitigation Plan that all activities with a Negative Determination with Condition are expected to develop. The report must answer the following questions:

- What were the required mitigations?
- What were the mitigations implemented during the reporting period?
- How/when was the implementation of mitigations monitored by the IP?
- Any other significant environmental issues encountered and corrective actions taken.

INSERT BRIEF NARRATIVE ON ENVIRONMENTAL COMPLIANCE UPDATES, LESS THAN 500 WORDS. MAPD does not have a IEE. However, the project takes environmental compliance seriously and has improved waste management during LLIN distributions, and ensured environmental aspects in its renovation plans.

5. AWARD-SPECIFIC REPORTING REQUIREMENTS

Include any award-specific reporting requirements. Each Implementing Partner must comply with both general and award-specific requirements. These requirements will often be reported separately. The award document and/or the post-award orientation will provide the Activity with this information. For the annual report, this section is the opportunity to summarize or highlight updates on the award specific requirements. Examples of where the Implementing Partners are expected to report on compliance are to the Quality Assurance Surveillance Plan, Geographic Information Systems, VAT reporting, Foreign taxes, Anti-trafficking certification, Internship programs, Lot Quality Assurance sampling results, and transition awards etc.

INSERT TEXT ON AWARD-SPECIFIC REPORTING REQUIREMENTS.

MAPD has delivered all contractual obligations on time e.g. financial reports, VAT reports, project indicators, project narratives,

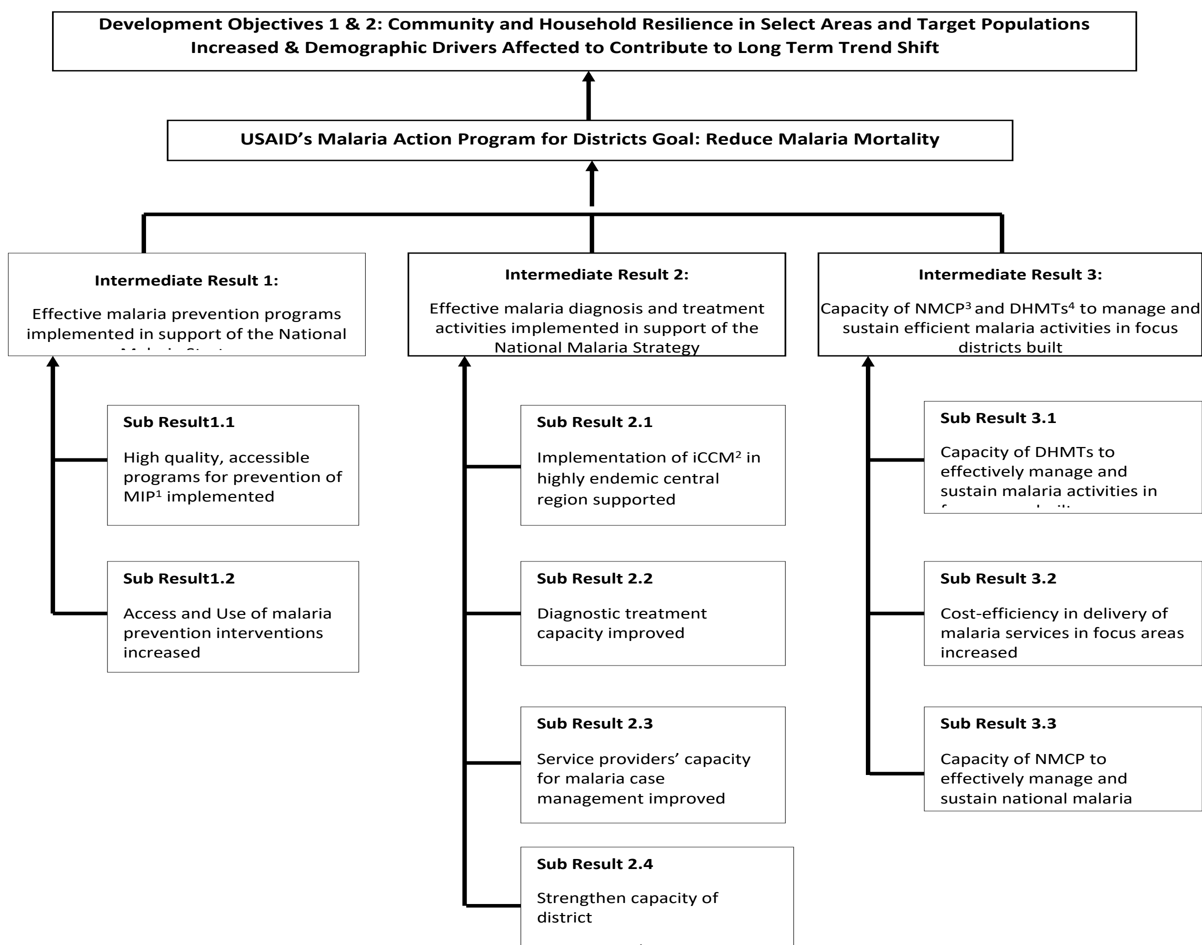
6. ACTIVITY MEL PLAN UPDATE

The brief update (no more than 500 words) on the Activity Monitoring, Evaluation and Learning Plan should respond to the following questions:

a) Has the Learning Agenda been updated or has there been any insights generated during the year to illuminate answers to the learning questions?

b) Are there any changes that need to be made to the Activity MEL plan to align it to CDCS 2016-2021 and PMP?

INSERT BRIEF NARRATIVE ON AMELP UPDATES, LESS THAN 500 WORDS.
In line with the Uganda Malaria Reduction Strategy 2016-2021, the USAID's Malaria Action Program for Districts is designed to contribute to the reduction of malaria mortality. The project now contributes to development objectives (DOs) 1 & 2 of CDCS 2016-2021 as shown in Figure 1. No changes to MEL or learning agenda done.



7. SUMMARY FINANCIAL MANAGEMENT REPORT

Monitoring financial conditions is one of the most important, yet often neglected areas of management reporting. The **information contained in this section is utilized to make management decisions**, particularly as it is related to future work on and funding for the project. It provides a valuable and timely snapshot of financial conditions, and complements (but does not replace) the SF-425.[3]

Activity Financial Analysis

Award Details:

a. Total Estimated Cost	$41,452,706			
b. Start/End Date	August 19, 2016	August 18, 2021		
c. Total Obligated Amount	$23,871,687			
d. Total estimated cost share (if applicable)	NOT APPLICABLE			
e. Total estimated leverage (if applicable)	NOT APPLICABLE			
f. Total Expenditure billed to USAID/Uganda	$17, 638,442			
g. Expenditure incurred but not yet billed	$1,149,970.10			
f. Total Accrued Expenditure (both billed and not yet billed); sum of lines f and g	$18,788,412.10			
	Actual spend for four quarters			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quarterly expenditure rate by funding source	$3,570,944.85	$3,204,291.57	$3547,555.46	3340529.85

Discuss issues such as: unexpected expenditures, material changes in costs due to considerations outside of the control of the project, cost savings and cost savings plans.

As anticipated from the previous quarter when the GoU 2019 budget was announced, there has been an increase in the cost of travel and transportation due to the increased taxes/services fees on fuel.

The project continues to explore means of minimizing costs, and has engaged some service providers on fixed term framework agreements for costs such as accommodation and other recurring expenses to lock in prices for periods of 6 months to a year mitigating unforeseen fluctuations in prices. The project negotiated with the Stanbic bank to manage escalating fees on mobile money transactions and obtained a reduced transactional charge from UGX 2000 to UGX 1500 per transaction. Considering the volumes of mobile money transactions, this contributes to a cost savings.

[3] Note: the financial data provided in this section is an estimate of the financial condition, and does not constitute the contractually required financial reporting as defined in the Award Notice.

8. MANAGEMENT AND ADMINISTRATIVE ISSUES

8.1 Key management issues

Describe briefly any key management issues such as Activity key staff changes, administrative and procurement issues, etc. Please also list all upcoming procurement actions that require A/COR approval/notification.

INSERT BRIEF NARRATIVE ON MANAGEMENT ISSUES, LESS THAN HALF PAGE.

MAPD has nearly 100 percent of staff in place. There was a lot of recruitment in PY2 due to additions in the work plan from PY1. 94 percent staff positions are covered and the remaining six percent are in final recruitment stages (reference checks and notice periods). Seven staff members have not been hired due to pending IRB approval for studies.

Retention has been fair. MAPD Malaria Consortium has lost one position due to death (Kampala Technical Officer), MAPD Jhpiego has had six resignations (Capacity Building Advisor, Senior Technical Advisor, Capacity Building Advisor – the replacement also left, Technical Officer Kabarole, Technical Officer Arua, Technical Officer Hoima), and MAPD Deloitte has had one resignation (Senior Grants Manager). All positions bar Senior Technical Advisor and Capacity Building Advisor have been filled. Additional staff in PY3 are linked to entomological surveillance

8.2 Resolved management issues

If issues were raised in the last report(s), please describe how the activity addressed them specifically.

INSERT BRIEF NARRATIVE ON ADDRESSED COMMENTS, LESS THAN HALF PAGE

NA.

9. PLANNED ACTIVITIES FOR NEXT YEAR (FY 19) INCLUDING UPCOMING EVENTS

Indicate opportunity/need for media and/or USAID/Uganda or other US Government involvement, particularly for USAID project monitoring site visits

INSERT BRIEF NARRATIVE ON PLANNED ACTIVITIES, LESS THAN HALF PAGE

Malaria in Pregnancy

- Support MIP commodities supply chain management, working with MMS under SPARS Strategy
- Training of district mentors in Malaria clinical services Mentorship at regional level.
- Support MIP TWG technical coordination for MIP and advocacy on needed resources

LLINS

- Support routine distribution of LLINs through ANC/EPI clinics

Case Management

- Implementation of iCCM in hard-to-reach and highly endemic districts supported
- Mentorships in diagnostic guidelines, testing technical quality, and reporting
- Conduct WHO Malaria Microscopy Certification Assessment
- Development and Management of Malaria Microscopy Slide Bank
- Support DHTs to implement EQA in 49 districts and all USAID's RHITES projects.
- Training of district mentors in Malaria clinical services Mentorship at National Level Conduct
- Conduct mentorship of health workers at health facilities
- Conduct integrated support supervision
- Conduct clinical audits in selected HCIV-Hospital levels

Capacity Development

- Conduct leadership development as based on DHMT capacity gaps
- Orientation of national stakeholders, National Mentors, DHMTs and HWs on Malaria Clinical Services Mentorship Guide and Toolkit
- Professional Associations operational.
- Infrastructure development of targeted HFs (*opportunity/need for media, USAID/GOU involvement*)

10. ANNEXES

10.1 USAID/Uganda Activity Work Plan Table

Instructions: Copy the currently concluding Activity Work Plan Table from the concluding year work plan.

USAID/Uganda Activity Work Plan Table – USAID's Malaria Action Program for Districts					
CDCS Links	**Results[4]**	**Performance indicators**	**Baseline value[5]**	**FY 17 (previous year) annual actual**	**FY 18 annual target**
	Goal: to improve the health status of the Ugandan population by reducing malaria transmission, morbidity and mortality				
1.3.1	**R 1: Effective malaria prevention programs implemented in support of the National Malaria Reduction Strategy Plan (UMRSP 2014-2020);**				
1.3.1	Sub IR 1.1 High quality, accessible programs for prevention of MIP implemented	Proportion of women who received two or more doses of IPTp for malaria during ANC contacts during their last pregnancy in intervention districts	61%	68%	85%
1.3.1 3.3.2	Sub IR 1.2 Access and Use of malaria prevention interventions increased (Initiatives to promote net use and access to LLINs implemented)	Proportion of women attending ANC who received ITNs at ANC clinics	75%	66%	85%
1.3.1, 3.3.1	**IR 2 Effective malaria diagnosis and treatment activities implemented in support of the National UMRSP**				
1.3.1 3.3.1	Sub IR 2.2 Diagnostic capacity improved	Proportion of malaria suspected cases tested for malaria	81%	95%	95%
1.3.1 3.3.1	Sub IR 2.3 Service providers' capacity for malaria case management improved	Proportion of patients at health facilities who received a negative diagnostic test for malaria who received an antimalarial drug	36%	20%	15%
3.1.2	IR 2.4 Strengthen capacity of district supervisors				
3.1.2	**IR 3: Build capacity of the National Malaria Control Program (NMCP) and District Health Management Teams (DHMTs) to effectively manage malaria activities and sustain malaria gains**				
3.1.2	IR 3.1 Capacity of DHMTs to effectively manage and sustain malaria activities in the focus areas built	Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	0	8,329	5,000
3.1.2 3.3.1	Sub IR 3.2 Improving efficacy in delivery of malaria services in focus area	Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) with USG funds(i.e. non laboratory staff)	0	340	500
3.3.5	Sub IR 3.3 Capacity of NMCP to effectively manage and sustain national malaria activities built	Outcome indicator	Baseline value	Previous year actual	Annual target

[4] List Activity goal, intermediate results, and sub intermediate results.

[5] Indicate year for baseline values.

10.2 Special reporting requirements

(AS APPLICABLE) of earmarks in Economic Growth, Health, Education and Gender

All of the following earmark indicators can be incorporated into the Activity Work Plan Table and Activity Performance Analysis Table.

HEALTH

A. MALARIA

The PMI Reporting Plan describes selected indicators, data needs, sources and tools to monitor and evaluate progress against the PMI objectives as outlined in the PMI Strategy 2015 – 2020 and is a companion document to the PMI Strategy. The indicators included in this reporting plan are the primary indicators that will be monitored to assess progress against PMI's goal and objectives. For each indicator, the definition, data source, and frequency of reporting are included in Appendix I.

Indicators:

1. Refer to Reporting Plan for the President's Malaria Initiative Strategy 2015 – 2020;
2. Required for all IPs receiving PMI funding;
3. Mission custom indicators determined at the time of AMEL Plan approval.

Databases Required:
Malaria indicators in PRS: Quarterly
Malaria PPR indicators PRS: Annually

Learning:
Quarterly evidence based learnings and success stories

GENDER

All people-level indicators must be disaggregated by sex and age. This applies to all USAID funded Implementing Partners and sub-awardees.

In addition, there are eight cross cutting standard indicators that cover gender equality, women's empowerment, gender-based violence, and women, peace and security. Implementing Partners are expected to collect data and report on one or more of the gender standard indicators if the activity produces data that contributes to the measurement of these indicators.

GNDR - 1	Number of legal instruments drafted, proposed or adopted with USG assistance designed to promote gender equality or non-discrimination against women or girls at the national or subnational level.
GNDR - 2	Percentage of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment).
GNDR - 4	Percentage of participants reporting increased agreement with the concept that males and females should have equal access to social, economic, and political resources and opportunities.

GNDR - 5	Number of legal instruments drafted, proposed, or adopted with USG assistance designed to improve prevention of or response to sexual and gender-based violence at the national or subnational level.
GNDR - 6	Number of people reached by a USG funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other).
GNDR - 8	Number of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations.
GNDR - 9	Number of training and capacity building activities conducted with USG assistance that are designed to promote the participation of women or the integration of gender perspectives in security sector institutions or activities.
GNDR - 10	Number of local women participating in a substantive role or position in a peacebuilding process supported with USG assistance.

10.3 Success story template

Partners are requested to submit at least one (1) success story (with a picture) per quarter; however, partners are welcome to submit more than one story each quarter.

Success Stories/Lessons Learned Template
One Story Per Template

Instructions: Provide the information requested below. Remember to complete the Operating Unit Standardized Program Structure selections in order that your program element selections are pre-populated in the FACTS drop-down menu. " * " indicates required fields.

* **Program Element:** Malaria/Health
* **Key Issues:** __Health Access

Title: MIP COUNSELLING GUIDE AN EFFECTIVE BEHAVIOUR CHANGE COMMUNICATION TOOL CONTRIBUTING TO A REDUCTION IN MALARIA IN PREGNANCY-STORY FROM KAMWENGE DISTRICT

Operating Unit: ____USAID/Uganda_____________

Please provide the following data:

* **Headline (Maximum 300 characters):** A good headline or title is simple, jargon free, and has impact; it summarizes the story in a nutshell; include action verbs that bring the story to life.

* **Body Copy (maximum 5,000 characters):** The first paragraphs should showcase the challenge encountered and the context of the foreign assistance program. Presenting a conflict or sharing a first-person account are two good ways to grab the reader's attention. Continue by describing what actions were taken and finally describing the result. What changed for the person or community? What was learned? How did this make a difference in the community or to the country overall? If this story is relating to a "best practice", what were the innovations in planning, implementation, or partnering that made it different? If this story is about an evaluation, what program adjustments were made?

INSERT BRIEF SUCCESS STORY WITH HEADLINE AND BODY LESS THAN 5000 CHARACTERS.

The content of this story is taken from Bigodi HCIII Kamwenge district.
At exactly 8:30 AM Namara Janet who is a midwife reports for duty at the maternity ward at Bigodi HCIII. On a daily basis, she works alongside another midwife or a nursing officer to provide ANC services to pregnant women. During ANC, she gives health education using the MIP counselling chart, checks the mothers' pregnancy health status, identifies mothers due for IPTp and administers IPTp. She ends her day with recording all the ANC attendance data in the ANC register.

"…. Before the Malaria Action Program for Districts (MAPD) project, we used to register very many cases of malaria in pregnancy with complications. Almost every month we would have a mother losing her pregnancy due to malaria complications. There was also too much work load at both the ANC clinic and the OPD section due to high numbers of malaria cases…" she said

USAID's Malaria Action Program for District a 5year project started in 2016 to support the National Malaria Control program in implementing the UMRSP in the malaria burdened districts of Western, Central and west Nile regions. One of the key objectives under the UMRSP being undertaken by MAPD is ensuring correct malaria prevention measures especially in the vulnerable groups i.e. pregnant mothers and children under five years are undertaken as per the WHO guideline

"……. MAPD project has helped us by providing this resourceful MIP counselling guide to use while educating pregnant women attending ANC. It has provided us with factual talking points, which are clearly demonstrated. We do not have to labor too much to explain. In fact, when we give health education using this guide, all mothers in that cohort keep coming back demanding for their IPTp and nets for those who missed out…" She explained

* **Pullout Quote (1,000 characters):** Please provide a quote that represents and summarizes the story.

INSERT PULL OUT QUOTE.

"……. MAPD project has helped us by providing this resourceful MIP counselling guide to use while educating pregnant women attending ANC. It has provided us with factual talking points, which are clearly demonstrated. We do not have to labor too much to explain. In fact, when we give health education using this guide, all mothers in that cohort keep coming back demanding for their IPTp and nets for those who missed out…" She explained

* **Background Information (3,000 characters):** Please provide whether this story is about a presidential initiative, key issue(s), where it occurred (city or region of country) and under what item(s) (Objectives, Program Areas, Program Elements) in the foreign assistance Standardized Program Structure. Include as many as appropriate. See Annex VIII of the Performance Plan and Report Guidance for a listing of Key Issues. See the list and definitions for the Standardized Program Structure. http://f.state.sbu/PPMDocs/SPSD_4.8.2010_full.pdf.

INSERT BACKGROUND INFORMATION.

This story is about preventing malaria in pregnancy a key PMI area within its MOPs. This example is from Bigodi HCIII Kamenev district

* **Contact Information (300 characters):** Please list the name of the person submitting along with their contact information (email and phone number).

INSERT CONTACT INFORMATION.
Daudi Ochieng
d.ochieng@malariaconsortium.org
Tel: 0772506404

10.4 Special reporting requirements of Activities undertaking construction

The below update should describe any challenges or delays in site works as well as progress made:

ACTIVITY NAME:	**Start Date:**	**End Date:**
Site Name:	**Total USD Cost:**	**% Completion Planned:** **% Completion Actual:**
Narrative Description of Progress Completed[6] in Current Quarter, referencing the Schedule of Works:		
NA		
Narrative Description of Work Scheduled for Next Quarter, referencing the Schedule of Works:		
Bid preparation		

[INSERT ADDITIONAL TEXT BOXES IN CASE OF MULTIPLE SITE WORKS UNDER THE ACTIVITY]

[6] In addition to the explanations for the level of performance, the Remarks Section should consider the following requirements:

1) USAID requires the Contractor to comply with standards of accessibility for people with disabilities in all structures, buildings or facilities resulting from new or renovation construction or alterations of an existing structure.
2) It is USAID policy that USAID-financed commodities and shipping containers, and project construction sites and other project locations be suitably marked with the USAID emblem.
3) The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID includes environmental sustainability as a central consideration in designing and carrying out its development programs.