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USAID's Malaria Action Program for Districts

Annual Report

PY4 October 1st 2019 to September 30th , 2020

Submission Date: October 30th 2020

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

Activity Start Date and End Date: August 19th, 2016 to August 18th, 2021
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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

NMCD	National Malaria Control Division
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

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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 August 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 – NMCD, RHD, Child Health and Community Divisions, and District Health Management Teams.
Geographic Coverage Changes (districts):	52 Districts across 5 regions; West Nile (Arua), Bunyoro (Hoima), Rwenzori (Kabarole), Central 2 (Kampala) and Central 1 (Masaka)
Reporting Period:	October 1st 2019 – September 30th 2020

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 52 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 (NMCD) 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 (NMCD) 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 NMCD 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 PY MAPD contributed to reducing new malaria infections, increased access to treatment and reduced death.

#	Performance indicator	Data source	Baseline Data		FY 2017		FY 2018		FY 2019		Quarterly Status - FY 2020				Annual Performance Achieved to Date (in %)	Comment(s)
			Year	Value	Annual Cumulative Planned target	Annual Cumulative Actual	Annual Cumulative Planned target	Annual Cumulative Actual	Annual Cumulative Planned target	Annual Cumulative Actual	Q1	Q2	Q3	Q4		
Development Objectives 1 & 2: Community and Household Resilience in Select Areas and Target Populations Increased & Demographic Drivers Affected to Contribute to Long Term Trend Shift																
Result 1: Effective malaria prevention programs implemented in support of the National Malaria Control Strategy																
	IR 1.1: Management of malaria in pregnancy (MIP) improved															
1	Proportion of women attending ANC who received ITNs at ANC clinics	HMIS	2016		85%	63%	85%	66%	85%	77%	84%	81%	78%	68%	**PY4: 78%** 92% of PY4 target is 85%)	Delays in supplying LLINs from JMS
2	Proportion of women who received three or more doses of IPTp for malaria during ANC visits during their last pregnancy in intervention districts	HMIS	2017	-			30%	29%	50%	60%	61%	68%*	70%*	IPT3:66% IPT4+: 72%	**PY4: IPTP3:51% IPTP4+ 58%** 100% of PY4 target :70% for IPTP3+	Following the revision of the HMIS reports we are using IPTp4+. IPTp3+ is 109%
3	Number of health workers trained in the control of malaria in pregnancy	Activity reports	2016	0	4,000	5,781	5,000	8,420	1000	3018	162	1047	680	1914	**PY4 1209** 380% of target is 1000)	Use of mentorship
	IR 1.2: Access and Use of malaria prevention interventions increased															
4	Number of insecticide treated nets (ITNs) purchased in any fiscal year with USG funds that were	Activity reports	2016	0	1,852,544	1,096,000		1,062,820	877,500	974,128	00	336,832	336,985	72,798 (distributed to 17 high burden	**PY4: 746,615** 85% of PY4	LLIN storages at National Level

	distributed in this reported fiscal year													district s)	target of 877,500	
5	Proportion of pregnant women who slept under an ITN the previous night in intervention districts	MIS/UD HS	2016	64%	85%	-	85%	-		Kampala 37.4% Masaka 58.4% Hoima 67.1% Rwenzori 84.7% West Nile 81.1% National 65%	NA	NA	NA	NA	-	Pending next survey
6	Proportion of children under five who slept under an ITN the previous night in intervention districts	MIS/UD HS	2016	62%	85%	-	85%	-		Kampala 52.4% Masaka 58.4% Hoima 67.1% Rwenzori 68.3% West Nile 64.1% National 60%	NA	NA	NA	NA	-	Pending next survey
Result 2: Effective malaria diagnosis and treatment activities implemented in support of National Malaria Strategy																
	IR 2.1: Implementation of iCCM in highly endemic central region district supported															
7	Percentage of children under five presenting with fever in last 2 weeks who first sought treatment from a VHT	iCCM records	2018	2%	50%	-	30%	-			NA	NA	NA	NA	-	Pending next survey
8	Number of health workers trained in iCCM	iCCM records	2018	0	8,773	-	30%	-		1,972	2,048	00	754	1,143	**PY4: 3,945** 200% PY4 target is 1,972	All VHTs in 13 districts received training
	IR 2.2: Diagnostic capacity improved															
9	Number of laboratory health workers trained in malaria laboratory diagnostics (rapid diagnostic tests	Activity reports	2016	0	370	366	500	340	1720	158	16	156	150	201	**PY4: 2,720**, 158% of PY4	Mentorships to continue in Q1.

	(RDTs) and microscopy) with USG funds														target of 1720	
10	Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds	Activity reports	2016	0	4,500	965	5,000	8,329		1547	78	591	868	660		
11	Proportion of malaria suspected cases tested for malaria	HMIS	2016	129%	85%	74%	85%	83%	95%	98%	78%	100%	99%	98%	**PY4:99%** 103% of PY4 target of 95%	Intensified mentorship
	IR 2.3: Service providers' capacity for malaria case management improved															
12	Proportion of patients at health facilities who received a negative diagnostic test for malaria who received an antimalarial drug	HMIS	2016	36%	15%	39%	15%	20%	5%	7%	8%	2%	2%	2%	**PY4; 2%** 103% of PY4 target of 5%	Increased data driven mentorship
13	Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds	Activity reports	2016	0	14,000	0	5,000	8,329	1720	4514	277	1125	1,169	???	**PY4: 2571,** 149% of PY4 target of 1720)	Integrated in mentorships

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

Please note that MAPD also adapted its programming to ensure continuation of essential services feeding into the above, (and beyond) during the COVID-19 outbreak within Uganda.

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

Malaria Prevention: In PY4, HMIS reporting tools allowed for recording of IPTP3 and IPTP4+ (previously this was IPTP3+). 58% of women attending ANC received 4 or more doses of IPTp and 51% received 3 doses of IPTp. MAPD has led in this area since its inception, work to provide TA and support to non-MAPD districts has also resulted in national progress this year.

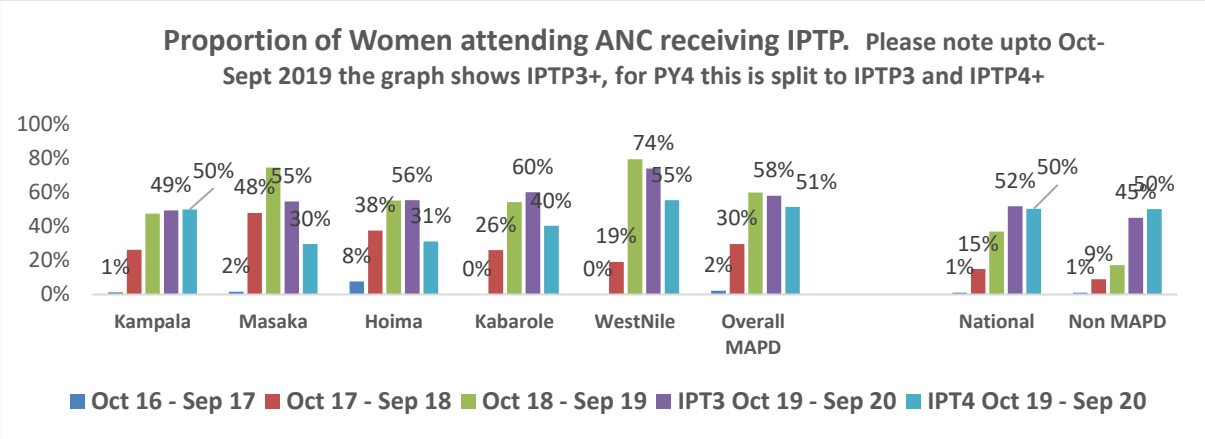


Figure: Proportion of pregnant women attending ANC who have received **three or more** doses of IPTp, *Source: HMIS*

In addition, 78% of women attending ANC from health facilities in the project area received LLINs for protection against malaria.

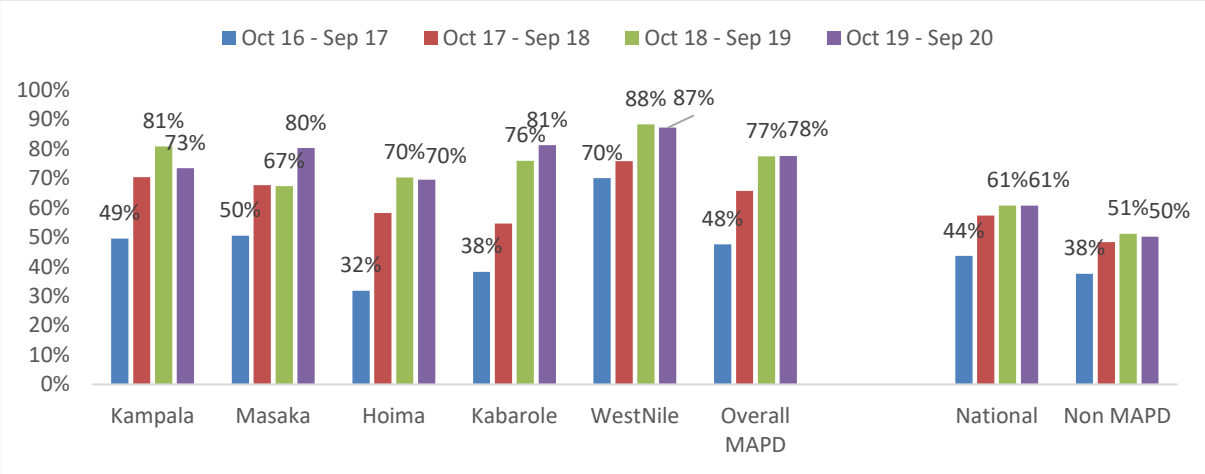


Figure: Proportion of pregnant women attending ANC who have received **LLINs**, *Source: HMIS*

Malaria Case Management: MAPD has contributed to improve malaria case management in its focus districts; which includes improving testing malaria suspects before treatment, and adherence to the test and treat policy. In PY4, 99% of suspected malaria cases visiting health facilities in the MAPD focus area were tested for malaria compared to 89% in non-MAPD areas.

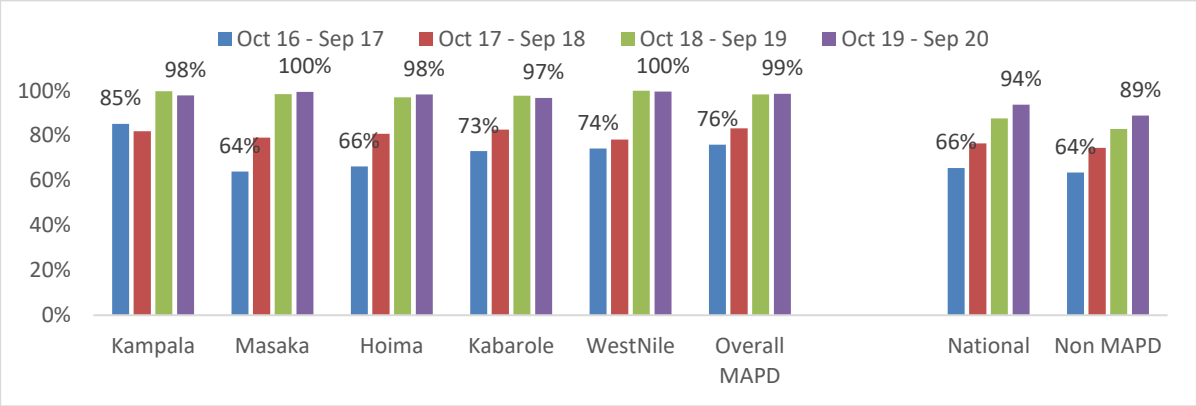


Figure: Proportion of malaria suspected cases tested for malaria before treatment, *Source: HMIS*

In addition, appropriate treatment practices for both positive and negative malaria cases has improved in the project area, as demonstrated by the proportion of malaria negative cases not given antimalarial drugs. This has improved to 98% which is beyond target, and a huge improvement from PY1. MAPD districts, though worse at project start, continue to perform better than non-MAPD districts.

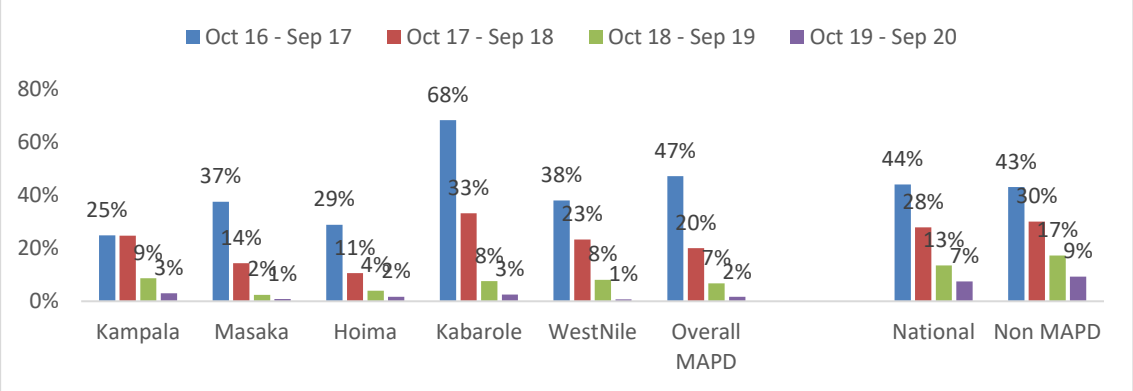


Figure: Proportion of patients at health facilities who received a negative diagnostic test for malaria who

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

COVID-19: The COVID-19 pandemic (first Ugandan case in March 2020) affected project activities as well as health provision and access for the populations, due to GOU lockdowns, economic aspects, supply chain issues, PPE provision, as well as stigma and fear. MAPD made swift adaptations to its approaches to ensure safety of staff, partners, patients and communities and was able to push for continuation of malaria services, and actually improve most of its indicators.

However, some program components had to be delayed due to the GOU lockdown measures and/or PMI guidance to not start new activities. Delays were experienced in HF rehabilitation plans, and the required restructuring of the UCC meant a delay in the linked LIIN durability study.

One challenge to one adaptive approach -**virtual mentorship** is ensuring equity, as phone and internet network can limit access. Also some community health workers found it hard to read SMSs, or engage in the interactive SMS platforms. The project eased these issues through; using phone calls, sending recordings of zoom sessions as well as email content of trainings to correct of internet challenges, and combining these with on-site visits where safe and appropriate.

Floods

This year saw heavy rain, floods and landslides across Uganda posing increased malaria transmission risks. MAPD supported the country in preparedness and planning and transported 64,800 MoH LLINs to 21 flood affected districts (within and beyond those supported by MAPD) and supported actual delivery to 23,111 displaced people in 15 MAPD affected districts. MAPD also supported districts to assess and support case-management services to the displaced (HF, outreaches and iCCM) as well as provide SBC.

Commodity stock-out or inadequate stock: MAPD districts experienced inadequate/stock-out levels of malaria commodities (mRDT and SP) due to NMS delivery delays and LLINs due to insufficient national level stock levels. MAPD supported with redistribution within and between districts as well as ensuring rationale use of test and drugs. There were also challenges within optimal provision of COVID-19 related PPE to district staff and all level HWs. MAPD supported by providing PPE (Malaria Consortium funded) to VHTs and advocating for optimal COVID-19 safety (outside groupings, safe grouping sizes, social distances, mask wearing and buying, adequate handwashing)

ICCM non-malarial commodities: The national stock levels of non-malarial commodities remains a limitation to iCCM. MAPD is working with the MOH's Child Health Division, districts and other key iCCM stakeholders to address this challenge. MAPD advocated for its ICCM districts to be included by MOH and NMS to benefit from the GFF iCCM commodities, and successfully advocated for NMCD to include community level need / quantification for malaria commodities in the NMS health facility procurement plan.

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) Conduct training of district TRPs as additional malaria clinical services mentors 2) Support mentorship of ANC HWs on the malaria service delivery 3) Establish malaria point of service (POS) testing in ANC 4) Support Continuous Quality Improvement of MIP services 5) Support uptake of MIP through provision of commodities for MIP and Directly Observed Treatment (DOT) of SP 6) Conduct MIP grand rounds for RRHs and training institutions	- 34 new TRPs from 31 districts trained as malaria clinical services mentors - 1,914 ANC health workers from 647 HFs mentored in MIP - Malaria POS testing established in ANC for 232 health facilities - CQI projects started in 76 health facilities, cumulatively 435 HFs - 200 water purifiers and 6000 tumblers procured and distributed - 15 tins of SP redistributed - One Grand Round held at Mukono general hospital 78 health workers participated	3.1.1 3.3.1 3.3.2 3.3.2 1.3.1 3.3.1
1.2 initiatives to promote net use and access to LLINs implemented	1) Support NMCD to quantify and develop national plan/Strategy for routine LLINs distribution. 2) Support Districts to quantify & develop comprehensive plan for routine LLIN distribution. 3) Strengthen IVM TWG and other forums 4) Support Districts to conduct facility outreach activities (ANC/EPI LLIN routine distribution 5) Provide LLINs to hard-to-reach and flood affected populations 6) Improve the monitoring of HFs' distribution of LLINs 7) Orientation of teachers in formation of malaria school health clubs to promote net usages. 8) Conduct community and school sensitization of LLIN	- NMCD involved in the quantification and distribution of routine LLINs - DHO supported to quantify LLIN for routine EPI/ANC and coordinate the last mile distribution to health facilities - Continued to support coordination of the IVM TWG - Distributed 746,615 pieces of LLINs to 1400 ANC/EPI clinics in 52 districts. - Supported MoH to transport 64,800 MoH LLINs to 21 flood affected districts - Direct support to distribute 23,111 of the above to IDPs - LLIN stock cards in use, ANC and EPI distributed LLINs recorded - School health clubs formed in 70 schools involving 603 teachers.	3.3.2 3.3.2 3.3.1 1.3.1 1.3.1 3.3.2 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
	use, care and disposal for parents and pupils.	- Sensitization done in 70 schools and to the community through radio talk shows and IPC in schools and communities	3.2.1
IR 2.1 Implementation of iCCM	1) Print and disseminate the updated iCCM guidelines and VHT tools. 2) Orient HWs and VHTs in using new tools in iCCM, including data recording 3) Onsite mentorship of health workers and VHTs accurate and reliable diagnosis of malaria using mRDTs during the roll-out of iCCM 4) Support Parish Supervisors for Home Visits including capacity building 5) Integrated iCCM support supervision into routine mentorship 6) Distribution of VHTs with non-medicine commodities 7) Distribution of PPEs to VHTs and Health Workers 22nd June – 6th July 2020	- Procured and distributed 1,640 medicine boxes and reporting tools for VHT use - 1,123 VHTs supervised and mentored in ICCM digital data reporting and malaria within COVID-19; HMIS registers delivered to VHTs - 2,797 VHTs equipped with 900 mRDTs and mentored on correct use of mRDTs and interpretation of results, and correct use of PPE - 226 VHT supervising HWs mentored on correct use of mRDTs and interpretation of iCCM results. - 92 parish coordinators were trained in new HMIS tools and reporting - ICCM integration was done - 76 health facilities received iCCM commodities which included 1,198 iCCM registers, 1,200 gloves, 1,200 flip charts and 1,200 medicine boxes - 6,199 VHTs supported with MC – MasterCard funded PPE items (facemasks, gloves, eye goggles, bars of soap and jerry cans.	3.2.1 3.2.1 3.3.1 3.2.1 3.3.1 3.3.2 3.1.2 3.2.1
IR 2.2 Diagnostic capacity improved	1) Provide integrated mentorship in diagnostic guidelines, testing technical quality, and reporting 2) Support districts to conduct regular laboratory EQA of malaria diagnostics 3) EQA Initiation and Mentorship in a newly created administrative unit; Kitagwenda	- 201 health workers from 197 health facilities mentored on malaria diagnostics and reporting - Supported DHMTs to implement malaria microscopy, in 107 selected health facilities in 25 districts in West Nile and Kampala regions - Supported routine EQA for malaria at 52 sites - Tracked mRDT stocks on a weekly basis through HMIS 033b - 4/4 HFs targeted and successfully covered for EQA initiation in Kitagwenda district and 7 lab staff were mentored in mRDT & Microscopy testing protocols	3.3.1 3.3.4

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
	4) Integrated support supervision & mentorships for lab staff and other health workers in targeted health facilities on microscopy and mRDT	-2803 staff mentored on diagnosis	3.3.1 3.3.1
	5) Conducted WHO Malaria Microscopy Certification Assessment	- 12 Microscopists where certified, 4 lab staff attained the level 1 certification, 5 attained level 2, 2 attained level 3 and 1 attained 4. This adds up to 48 WHO certified malaria microscopist trained/assessed by MAPD project.	
	6) Support DHMTs to implement EQA 7) 23/52 districts are currently participating in EQA <100 health facilities are collecting EQA slides	- 23/52 districts are currently participating in EQA <100 health facilities are collecting EQA slides	3.2.1
		- 29 lab staff underwent proficiency testing in Masaka, Rwenzori and Hoima regions. The average PT score 76%.	3.3.4
	8) Collaboration with Baylor Uganda to initiate EQA I supported labs in Rwenzori Region	- Provided technical assistance to Baylor-Uganda in lab EQA in three districts in Rwenzori region - 11 lab staff mentored on mRDT/Microscopy and EQA protocol and supporting tools given (EQA log books, Slide boxes)	3.1.2 3.1.2
	9) To assess the level of awareness and preparedness for our health workers in the context of Malaria and COVID-19 pandemic.	- During the COVID-19 pandemic, MAPD supported DHT teams to assess the level of preparedness during the COVID-19	
	10) Assess and verify the reported malaria upsurges and stock status for malaria commodities and supplies.	- Supported all districts to assess	3.2.1
	11) Provided technical Assistance (TA) support in form of WHO ECAMM training. In addition to providing equipment and EQA tools for roll out EQA in their region.	- 4 implementing partners; RHITES-Acholi, SURMA, IDI/ and Mildmay projects - 9 microscopes to be used in the training of laboratory staff and EQA tools for roll out EQA in their region. -	3.1.1 3.3.1
IR 2.3: Service providers' capacity for management of uncomplicated malaria cases improved	1) Provide job aids to for malaria management to health facilities	- Distribution of 499 IMM Job aides to health facilities in 13 districts	1.3.1
	2) Orient district malaria mentors in MMGT	- 11 DHT members were trained as malaria management mentors in 5 MAPD districts	3.2.1

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) Support mentorship of health workers on malaria case management	- 1,914 health workers mentored in 647 health facilities on-site -28,858 health workers mentored of-site - Data was extracted weekly shared to the team which helped to inform decision making concentrating on HFs doing poorly as regards the core MAPD indicators.	3.3.1
	4) Training of Malaria Clinical Mentors	- Supported NMCD to train 13 to roll-out malaria clinical services	3.3.1
	5) Identify hot areas for intervention response and take appropriate action	- Supported DHMT, VHTs, LC1s and Key Influencers in hot spot response in 13 districts. - Conducted sensitization meetings in 394 villages using 665 health workers from 78 health facilities reaching 2,064 persons in 705 homes - Tested 6,849 individuals during the outreaches and 2,496 (36%) confirmed positive using mRDT	3.1.1 3.3.1
	6) Conduct clinical audits for malaria cases at selected HFs (HCIV and hospitals	- 364 health workers from 37 health facilities were mentored during clinical audits - 39 health workers from 12 health facilities mentored during mortality audits	
IR 2.4: Service providers' capacity for management of severe malaria cases improved	1) Improve HWs performance in management of severe malaria through health facility based mentorship	- Conducted a grand round where 78 (59F, 19M) hospital staff were mentored in severe malaria management in Mukono district	1.3.1, 3.3.1
	2) Build capacity of RRH & general hospital staff in severe malaria management & mortality audit	- 202 health workers from 125 hospitals and HC IVs were trained as mentors for high volume sites with focus on management of severe malaria modules	1.3.1, 3.3.1
	3) Support onsite mentorships/audits at HCIV and Hospital levels	- Conducted support supervision and onsite mentorship to monitoring continuity of malaria services during COVID-19	3.3.1
	4) Conduct monthly supportive supervision meetings at Hospitals and HC IVs	- 364 health workers from 37 health facilities were mentored during clinical audits. 39 health workers from 12 health facilities mentored during mortality audits - Conducted monthly support supervision to all supported hospitals and HC IVs	3.3.1, 3.3.5 3.3.2
	5) Monitor availability and use of injectable artesunate in refugee settlement HFs	- Supported redistribution of 1400 vails of artesunate to hotspot HFs in Rwamwanja (800 vails) and Bujubuli (600 vails)	

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 2.5: Quality of malaria services improved	1) QI through CQI	CQI projects started in 76 health facilities	3.3.2
IR 3.1 capacity of the DHMTs to effectively manage and sustain malaria activities in the focus areas built.	1) Support DHT & HF-based Performance review meetings in districts performing below PY4 targets on each indicator 2) Support District planning 3) District capacity for 'hot spots' improved 4) Develop capacity of district mentors to use malaria mentorship guide and tool kit (MMGT) 5) Support MMGT-based mentorship of HWs to strengthen ANC 6) Provide feedback to the DHMT and health facility staff on key malaria surveillance indicators	- Held performance review meetings with all MAPD districts, - mentorship and support supervision in selected health facilities, supporting health facility staff wherever they had data gaps and challenges. - Engaged DHTs in all districts to ensure continuity of malaria activities and develop malaria specific messages in COVID context. The districts were provided with the guidelines of continuity of malaria services in the context of COVID-19 - Participated in DHMT/COVID taskforce meetings attended to ensure prioritization of malaria services within COVID 19 - Trained 11 DHT members as malaria management mentors in 5 districts Done through quarterly performance review meetings	3.3.5 3.1.2, 3.3.5 3.1.1, 3.1.2 3.1.1, 3.1.2 3.3.5 3.3.5
IR 3.2: Improved efficiency in delivery of malaria services in focus areas	1) Implement performance based in-kind grants through Sub grant agreements with DHMTs 2) Carry out renovation works at identified HFs.	- Supported the delivery of 52 in-kind grants complete set of Desktop computer given to 52 districts - Six (6) districts received additional filing cabinets to improve on their filing capacity. - 2 MiFi, 1 manual BP unit mercury adult cuff, 3 digital thermometers and 2 Stethoscopes where given to 4 HFs - In addition, Mukono district received a filing cabin - Wabusana HC III in Luwero District was targeted for construction works, evaluation of bids is ongoing	3.3.4 3.3.4
IR 3.3: Capacity of NMCD to effectively manage and sustain national malaria activities built	1) NMCD staff to participate in the semi-annual regional meetings. 2) Organize malaria grand rounds – Regional Referral Hospitals (RRH) 3) Support the NMCD to conduct and coordinate	- Supported NMCD to organise the scientific colloquium - 78 health workers in 1 hospital and training institutions oriented on malaria policies, through grand rounds	3.3.5 3.3.1 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
	national malaria TWG meetings online	- MAPD supported and coordinated MIP (10 sessions), iCCM, MCH, SBCC, IVM, SME-OR, MIS TWGs	
IR 4.1: Health facilities capacity for quality services delivery development	1) Collaborative Quality improvement (CQI) through activities supported	Collaborative QI implemented in 76 health facilities – noticed improvement in malaria indicators	1.3.1, 3.3.1
IR 4.2.2 SBCC	1) Hold advocacy and Interpersonal communications activations in 13 districts	- Done in 13 districts	3.3.1
	2) Community dialogues and Household visits in targeted communities	- 1,371 community dialogues conducted reaching 16,366 individuals sensitized on malaria prevention and correct use of LLINs - 8,235 household visits were conducted with 15,624 individuals reached.	1.3.2, 3.2.1
	3) Support Radio talk-shows	- 3 districts were supported to conduct regular talk-shows informing communities about key malaria messages for prevention, control & treatment.	
	4) Support formation of VHCs	- Established 15 Village health clubs in 8 districts.	
	5) Supported formation of new and supervision of pre-existing school health clubs	- 70 schools were visited reaching 603 and oriented on school health malaria program and formed school health clubs	1.3.2
	6) IPC activations in high TPR burdened health facilities and communities in all districts by Pentagon	- 126 health facilities reached during IPC activities	
	7) Support health workers to document success stories	- 7 success story was documented - 3 Facebook stories were documented	3.3.1 1.3.2, 2.2.1, 3.2.1
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. 1) Support the provision of gender and youth sensitive MIP services	- Disseminated MAPD gender analysis results to stakeholders at national and regional level, - Reviewed project strategies, tools and activities and provided gender and youth integration input. - Piloted and followed-up the provision of gender and youth sensitive MIP services at Busaana HC III in Kayunga district and shared a report with the stakeholders - Designed relevant SMS messages for VHTs during COVID 19	3.2.1 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
	2) Design and share SMS messages to VHTs and Health workers about MIP and gender interventions in the context of COVID-19		
4.4.1 Routine Monitoring & Evaluation	1) Mentorship of health workers in new HMIS tools	- MAPD supported the roll out of the revised HMIS tools; mentoring HWs in their use, including proper summarization of data on registers and reporting forms, and reporting DHIS2. - 306 public facilities and over 550 health workers reached. - Mentorships conducted in completing and using revised HMIS tools including weekly, monthly and quarterly reporting from the VHTs into DHIS2	3.3.5
	2) Mentorship of health workers to effectively analyze and use HMIS data	- MAPD identified info needs by users and producers and strengthened core competencies and skills through mentorships to DHTs and HF records personnel. - Through onsite and virtual mentorships, the project mentored 493 health workers in various districts in the project area. - DHMTs and health facilities were supported to conduct quarterly data analyses and reviews. In addition, health facilities developed and monitored malaria surveillance channels for early detection of upsurges - MAPD supported production and dissemination of various malaria information products including malaria weekly status reports at both national and district levels	3.3.5
	3) Performance review meetings	- the team conducted mentorship and support supervision in selected health facilities, supporting health facility staff wherever they had data gaps and challenges	3.3.5
	4) Improve data quality and establish data quality control mechanisms	- 45 poor preforming health facilities reached through onsite mentorships before COVID-19, and virtual mentorships after COVID-19. - Notably regular analysis and use of routine data for performance measurement. Planning and decision making enabled health facilities and DHMTs identify areas with poor quality data/errors for correction before subsequent performance reviews. The project supported	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
		biostatisticians and health facilities to work with the Division of Health information/MoH to rectify these in DHIS2	
	5) Data verification	The team conducted data verification in all upsurge HFs/districts.	
	6) Conduct regular HMIS data support supervision	Support supervisions were conducted to review, HMIS data and OPD register data.	
	7) Ensure availability of tools and commodities	MAPD conducted gap analysis and shared with key stakeholders. MAPD distributed 1000 weekly, 1000 monthly, 2500 VHT reporting tools.	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	TES Study results shared widely. PY5 TES study scope finalized. LLIN Durability permission and protocols approved. Will commence in PY5 with the UCC	3.3.5

IR 1.1: High quality, accessible programs for prevention of MIP implemented.
The performance of IPTp3 and IPTp4+indicators in the project is at 58% and 51% respectively. The performance of the IPTp3 indicator was influenced by health worker practices to minimize missed opportunities, early ANC attendance, 4th and 8th ANC contacts, and availability of Sulfadoxine-Pyremethamine (SP) in health facilities as well as reporting. Now all MAPD districts having a reporting rate of above 50% and 88% of them (46 districts) have one of above 85%! This is a big achievement. MAPD also supported districts and HWs to use the new MIP related HMIS tools which allow for recording IPT3, and IPTP4+. MAPD rolled out innovative HW virtual mentorship to ensure continuing improvement in knowledge, attitude, skills and practice. A total of 1,914 health workers from 647 health facilities received onsite and virtual mentorship in ANC and in MiP respectively.

The SP stock-out rate reduced from 15% to 12% as a result of MAPDs influence on SP being provided budget free by NMS, improved HF forecasting and district redistribution. MAPD also distributed 200 water purifiers and 6,000 tumblers to 1400 health facilities for DOTS provision. 67 MIP focused CQI projects were implemented in 22 districts. Through technical support to the NMCD, MiP and related issues have continued to improve with involvement of the MOH RHD and other stakeholders focusing on malaria as one of the major causes of poor fetal and maternal outcomes. MAPD supported monthly MiP TWG meetings. MAPD contributed to the development and dissemination of the new WHO/MoH MiP Policy Guidelines, and ensured a MIP emphasis within the updated RMNCH guidelines. MAPD also improved MIP services within private facilities through capacity building of private midwives with domiciliary services.

IR 2.1 Initiatives to promote net use and access to LLINs implemented. The project delivered **746,615** LLINs for routine ANC/EPI HF distribution. Though national stocks caused some delays/disruption to HF provision for half the project year, those receiving a LLIN at ANC1 remained the same as last year (78% vs 77%). MAPD also supported the MOH to transport 64,800 MoH LLINs to 21 flood affected districts and supported actual delivery to 23,111 in MAPD affected districts (15). MAPD has also provided TA and supervision to the UCC, and has prepared all aspects of the linked LLIN durability study. The project team continuously quantified LLINs needed and monitored the quantities in the health facilities and utilization by the communities during mentorship and outreaches respectively. MAPD has strengthened the LLIN supply chain system with increased district involvement in the quantification, distribution and monitoring of use, including support to PNFPs.
Though LLINs national level stock outs hampered MAPDs ability to ensure optimal LLIN ANC coverage, its work in improving protection through IPTP3+ has provided those women coming to the HF with malaria protection.

IR 2.1 Implementation of iCCM. MAPD supported the MOH Child Health Division (CHD), NMCD, and 13 districts to implement iCCM, while strengthening iCCM systems. Supervisory capacity was built within HWs and Parish Coordinators to support VHT home visits (focus on environmental compliance, quality of care and data reporting). The project supported linkages between districts-HFs and community health provision, and now districts include iCCM commodities within their procurement plans as well as support commodity redistribution from HFs to community. MAPD also procured and distributed 1,640 VHTs iCCM medicine boxes to support proper equipping of VHTs. New health clubs were also formed to support iCCM delivery. Some districts have already taken impressive ownership of the ICCM program through self-funding review meetings, initiating easier approaches for data collection, and driving iCCM importance to their HFs through top-level district level involvement and oversight. The MAPD promoted approach of "doughnut iCCM" has been accepted and included in the new Uganda Malaria Reduction and Elimination Strategic Plan 2020-2025, which enables Uganda to better implement ICCM within its commodity constraints thus improving equitable access to care.
MAPD through the support of Malaria Consortium (with MasterCard Foundation) supported VHTs with PPE and training, so to ensure safe provision of malaria care within the COVID-19 pandemic. A total of 6,085 VHTs and their supervising health workers were mentored on correct use of mRDT and interpretation of results; on the correct use of PPE while they perform their work in the communities. They were also mentored on digital data reporting and COVID-19 infection prevention and control.

IR 2.2 Diagnostic capacity improved The project maintained and sustained successes in improving malaria diagnostics and testing rates remained at 99%. This has been achieved through integrated onsite and online support supervision mentorships on mRDT and microscopy testing, and external quality assurance of malaria microscopy. 12 microscopists received WHO malaria microscopy certification - 4 attained level 1 certification, 5 attained level 2, 2 attained level 3 and 1 attained 4. MAPD also supported 23/52 districts to participate in EQA and slide discordance is at 2.6%. from 3.8% (YR.3), 5% (PY2) and 12.2% (Yr.1.) as compared to the national target of <15%. Malaria testing has been successfully championed within Uganda during the project as demonstrated by districts self-funding EQA activities, and 2 districts self-funding ECAMM training participation (at a tune of over $500), as well as other IPs and non-MAPD districts receiving TA from MAPD.

IR 2.3 and 2.4 Service providers' capacity for management of uncomplicated and severe malaria cases improved. Over the project period the provision of quality malaria care has increased dramatically as proven by sustained HF indicator-based improvements (testing rates, proportion of negatives treated, reporting rates, malaria-related mortality metrics. In PY4 giving an antimalarial to negative malaria patients reduced from 7% in PY3 to 2% in PY4 (target is 5%).

Capacity building through onsite and virtual integrated mentorship has continued to ensure quality health worker provision of malaria case-management. In light of COVID-19, off-site support mechanism was developed. This phone, and computer based technology (toll-free phone line, including SMS, interactive SMS, IVR messaging, phone calls and zoom) was developed to cover all aspects of malaria support including supply chain management and youth & gender. 28,858 health workers were reached. MAPD also supported capacity building of new district mentors to roll-out malaria clinical services. TRPs supported provision of integrated onsite mentorship in malaria case management with districts taking on increased levels of ownership and responsibility for this. Capacity for severe malaria management has also been built. 202 health workers from 125 hospital and HC IVs were trained as severe malaria management mentors, and the "Rapid assessment of severe malaria management in regional referral and private hospitals in Uganda' drafted. HWs were mentored in clinical and/or mortality audits with HF follow-up conducted to correct areas of risk. MAPD continued to support redistribution of artesunate from RRH to lower level high volume HFs experiencing regular stock-outs particularly the refugee settlement HFs of Rwamwanja HC III and Bujubuli HC III. MAPD also supported district malaria response teams to carry out investigation and responses to localized malaria upsurges through date verification, line-listing, data verification, EQA, targeted mentorships, restocking of malaria commodities, HF audits and community action. The main challenges faced during the year include persistently high positivity rates in most of the MAPD districts and seasonal malaria upsurges related to heavy rainfall and floods affecting all MAPD supported regions.

IR 3.1 Capacity of the DHMTs to effectively manage and sustain malaria activities in the focus areas built. PY4s focus was to improve district capacity to collect, analyze, and manage health information. MAPD provided 52 in-kind grants, each district received a desktop computer, with some additionally receiving MiFis and filing cabinets. Monitoring of the use of the items is ongoing through our integrated support supervision visits at regional level.

The LDPG policy was adopted by all USAID IPs within MAPDs PY4. The project team disseminated this to district leaders and worked with them to identify funds and or opportunities for integration and GoU buy-in. MAPD supported health sector performance review meetings in all supported districts.

IR 3.2 Improving efficacy in delivery of malaria services. In PY4, Wabusana HC III in Luwero District was targeted for rehabilitation work, however due to COVID-19 activities were postponed. All preliminary work is completed and a pre-bid meeting held with 15 companies in September. Work is on track for PY5. All timelines have been shared and agreed upon with USAID.

IR 3.3 Capacity of NMCD to effectively manage and sustain national malaria activities built. MAPD contributed to; the NMCD Mid-Term Review (MTR), the UMRESP development, the Continuation of Essential Services (including malaria) during the COVID-19 guidelines, as well as all malaria TWGs and the malaria within COVID-19 stakeholder meetings. Resource mobilization has also been supported through TA for Global Fund grant writing, improved stock forecasting, and advocacy for prioritization and national support to malaria commodity provision. MAPD strengthened commodity stability through quantifications, and successfully advocating for; ICCM malaria commodity stock management improvements, the addition of artesunate as a MoH tracer medicine (so it will be tracked within the DHIS system) and the revision of the NMS EMHS kit quantity for AL and RDTs, in response to malaria upsurges.

The NMCDs engagement with the private sector has also been developed though key partnership meetings and development of key frameworks e.g. NMCD Private Sector Strategy, launch of the private sector Uganda Malaria Free (UMF) fund board of directors, integrated regulatory and quality systems tool for standardized licensure, quality assurance and accreditation of private facilities; as part of the national insurance scheme. MAPD also supported private provider training in case management in Karamoja region, and presented updates for malaria private sector engagement in the Public-Private Partnership TWG meeting.

MAPD has also developed the countries capacity for entomological surveillance through TA to MOH/VCD to establish the Anopheles mosquito observatory, and training of staff from 24 districts with support from Mulago School of Medical Entomology and Parasitology.

MAPD has supported linkages between NMCD staff and districts through malaria performance reviews, grand rounds and disseminations (including new MIP guidelines, MoH quality of care standards during integrated mentorships and Continuation of Essential Services within COVID-19) as well as through support supervision, and. *See Partnership section for more info*

IR 4 Cross-Cutting:

SBC. MAPD built capacity of DHMT, HF staff, community and HHs for improved behavior around malaria, including within COVID-19 pandemic. MAPD promoted district involvement through participatory district engagement and planning meetings, HF based actions, schools (pre-COVID-19), radio engagements, community dialogues (pre-COVID-19), and household visits. MAPD linked district, HF and community data and engagements through all the above. Rural community sensitizations within two themes "Keep your Child's Dream Alive" and "Prevention of Malaria in Pregnancy" were also rolled out, and SBC monitoring and use tools improved and districts and community capacity built on in its use.

Due to the COVID-19 outbreak, the project adapted its approach to ensure promotion of malaria care, while also ensuring malaria care was not lost due to COVID-19. In this light MAPD adapted its approaches from grouped to HH or individual, with these being supported with radio and drive through vans. VHT capacity for SBC was also built. MAPD also managed to get malaria messages integrated in the GoU approved COVID-19 messaging which highlighted the importance of maintaining malaria behaviors.

Gender and Youth MAPD launched the Afya Connect virtual communication campaign in Yumbe district for use by the MAPD team to remain connected with the stakeholders and beneficiaries of Vijano Leo (Youth Today), a community-based malaria youth activity. Malaria champions in the district and VHTs/LCs in the respective villages of the most affected villages were trained on how to use the platform and eventually conduct malaria related preventive activity within COVID-19 pandemic era. Selected VHTs and malaria youth champions were orientated on the home visit reporting form before conducting home visit in malaria burdened homes and villages in Yumbe town council. VHTs and Malaria champions who conducted home visits and community sensitizations

M&E Surveillance and Learning. To ensure availability of tools and commodities, the project procured HMIS 105 and HMIS 033B for the health facility monthly and weekly reporting respectively. As a sustainability strategy, MAPD supported district review meetings, where action plans were developed and followed up by the respective districts. MAPD conducted HW mentorship on; new HMIS tools, regular support supervision, data verification and mTRAC particularly in performing poorly HFs, those reporting malaria deaths and/or discrepancies in data reported. A total of 1600 health facilities were supervised, with HWs and HMIS records officers mentored.

MAPD has built the capacity of the district officials and health workers to collect and documented malaria success stories. The team developed 3 Facebook stories and 7 success stories.

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 interventions. During this period, MAPD has continued to strengthen collaboration with NMCD/NMCD, other IPs and the academia.

Continuation of Essential Malaria Services (within COVID-19) MAPD supported collaboration and provided TA to NMCD to develop and ensure technical guidance for malaria services within COVID-19 through TWGs, MOH meetings, Malaria Partnership meetings and provision of evidence MAPD supported districts in terms of guideline dissemination, data analysis, stock management, mentorship and supervision as well as community SBC. And supported information flow between districts and the center.
Malaria District Review Meetings: MAPD used district and regional performance review meetings to link NMCD, districts and implementing partners. This involved sharing work plans, performance results and lessons learnt during implementation. Action plans were collectively developed based on identified gaps and follow up made by the districts.

Malaria Supply Chain Management: MAPD worked with MOH, UHSC and districts to improve malaria commodities supply chain during PY4. MAPD has worked with district MMS and had transition meetings for the SPARS and medicines management interventions in Kalangala district with Rakai Health Services Project (RHSP).

Lab collaboration with Baylor-Uganda (Sustainability Approach): MAPD provided technical assistance to Baylor-Uganda in the Rwenzori region to initiaite malaria EQA scheme in 3 Facility Hubs that are earmarked for accreditation to ISO:15189:2012 in Kasese (Kagando Hospital) and Kyegegwa (Bujubuli HC III and Mukondo HC III) respectively.
Lab support to RHITES-Acholi, SURMA and IDI/Mildmay: MAPD provided technical assistance (TA) in form of training to these projects. In addition, MAPD provided 9 microscopes to SURMA project and used in the training of laboratory staff and EQA tools for roll-out EQA in their region.
Lab collaboration with WHO and AMREF to strengthen EQA systems*:* MAPD working with WHO and AMREF to oversee the national standards set by the Uganda National Health Laboratory Services using the WHO AFRO SLIPTA approach, MAPD conducted a Malaria Microscopy Certification Courses for 12/12 laboratory personnel from the selected districts (***some supported by districts themselves)***

SBC collaboration: MAPD supported the distribution of GF-supported NMCD IEC materials (1,300 Apron, 6300 wash lines, 10,000 ABS boards and 1,800 posters through different partners (TASO, KADO, PACE, CHAI, UHF, NDAI, ABT Associates, SURMA, MAPS and Living Goods).

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, as well as the dissemination of MAPDs Therapeutic Efficacy Study results.

Community Involvement and Feedback MAPD generates community dialogues/household visits 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. In addition, MAPD has responded to malaria upsurges and seasonal floods and supported affected districts through community interventions.

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

Learning and Adaptation

During year 4 implementation, the project has observed and learned several lessons that have enabled it to improve its intervention planning and delivery to sustain and improve impact. Lessons have been learned through regular data analysis, project reviews, adaptation of innovation and collaborating with other stakeholders to respond to district and community needs. Detailed below are lessons that have been learned and how they have been applied to influence decisions and increase efficiency in intervention implementation

LLIN distribution. With the view that LLINs are key malaria commodities, the project has observed that engagement of stores personnel and DMMS in LLIN quantification and distribution will ensure that there is a consistent supply of LLINs at health facilities. In addition working on the supply and delivery of LLINs in district stores to coincide with delivery of essential medicine kits, will enable the districts to leverage on delivery essential medicine kits to deliver LLINs to health facilities

Activity integration. The project has observed that integration of activities that reinforce the role of supplies provision for DHMTs such as commodities distribution with support supervision roles such as mentorships and audits motivated participation from the DHMT members. The district health team members were more available to participate in such supplies integrated activities than activities that only had supervision roles especially in times when there was no monetary allowance given to the DHMT. With this observation, the project with continue to have such activity integrations with in COVID-19 prevention guideline

Importance of quality malaria data. The project has observed that the involvement of Health facility based staff in community response to malaria helps them to understand the importance of data and the need for its quality (accuracy and completeness). Follow up of household members in the community to conduct SBC and interpersonal communication is informed by data from OPD registers (case line listing).

Intensive engagement with health center IIs. HC II are the initial contact with the health system other than community health workers since they are at each parish. Data on has shown that HCIIs account for about 70% of the facilities in the project area and they therefore see the highest proportion of malaria cases. The project therefore intensified malaria prevention, diagnosis and treatment efforts at these facilities including health worker mentorships and performance review meetings and data use.

Learning and innovation in the context of COVID-19: In March this year, Uganda instituted a lockdown following reporting of the COVID-19 index case. Within the lock down period, MAPD supported the Ministry of Health to develop guidelines for continuation of essential services which included malaria prevention, diagnosis and treatment at both health facilities and the community.

Learning from the COVID-19 situation, the project revised IPTp in pregnancy guidelines to ensure safety of mothers from COVID-19 when attending ANC including flow for IPTp DOTS: pregnant women bring their own cups, client washes hands thoroughly with soap and water or use an alcohol-based hand rub, health worker leaves packet of three SP tablets on the table and ask pregnant woman to pick it up, or when using a large container of SP, use a clean spoon to dispense tablets into the woman's hand

Furthermore, MAPD utilized various technologies to ensure continuity of malaria prevention and control services including use of data to demonstrate importance of maintaining malaria care, conducting off-site mentorships using zoom, use of m-TRAC SMS to mobilize health facilities for mentorships, malaria commodity stock tracking/redistribution and sending reminders to health facilities to report HMIS data. These technologies have enabled the project deliver interventions in a timely and cost effective manner and will continue to be used in the project in the next year.

2.4 Inclusive Development

The project built on the strong foundation for effective gender and youth programming formed in previous years through gender and youth focused interventions at HF and district level. All activities were informed by the project's gender and youth mainstreaming tools that were developed drawing on the learning from the MAPD gender and youth analyses, gender and youth mainstreaming best practices, as well as MAPD implementation experiences. In PY4, MAPD supported a gender focused program in Kayunga District and a Youth focused participatory program in Yumbe District. Both bring community members, HWs and District staff together to plan, implement, monitor and adapt programs. MAPD has also developed guides to facilitate inclusive dialogues to explore and correct gender and youth-related barriers to early and continuous ANC, LLIN use, early diagnosis and treatment for malaria as well as joint decision-making in the household on health care and other household resources.

In response to COVID-19, MAPD developed a virtual communication campaign, "Afya Connect" utilized to facilitate and promote connection with and between service providers, community members and other stakeholders in all MAPD areas of operation. The campaign included components such as phone calls, online mentorship and discussions (using WhatsApp groups created by service providers), a phone-based Short Message System (SMS), Interactive Voice Recording (IVR) and teleconferencing.

In order to promote the institutionalization of gender and youth mainstreaming, the project provided technical input on gender and youth mainstreaming in key MOH documents and activities including the MAAM implementation guidelines, Malaria Program Review (MPR), the UMRESP 2021-2025 and interim Guidance for Sustained Delivery of Essential Health Services in the context of COVID-19 in Uganda. Additionally, gender and youth issues were integrated into various MAPD documents including guides, concepts and reports using the gender and youth mainstreaming tools. As a result, MAPD has better activity implementation guides and is targeting populations vulnerable to exclusion better. The MAPD Gender and Youth team also designed a MAAM Malaria Smart Homes Model for inclusion in MAAM Guidelines and for the consideration by the Global Fund Proposal writing team. It was based on a number of resources and experiences including the gender- and youth-responsive community dialogues on malaria which addresses exclusion. The MOH accepted the model, improved it and shared it with various stakeholders for comments. When the model is fully adopted and funded, MAPD will seek opportunities to participate in its implementation in PY5.

The project also drafted malaria learning aids for the Social Behavior Change (SBC) school activities. The aides comprise of illustrated short stories, games and Do It Yourself (DIY) activities that will be used in schools and other learning centers to conduct sessions around changing behavior on malaria prevention and case management. The malaria learning aids will be used during the school health activities when schools reopen to improve inclusion of adolescents in malaria responses. An art-based school engagement malaria game – "Spin the Wheel" was also developed This is a practical game that addresses various constraints that hinder women, men, boys and girls to have access to malaria information on prevention and timely malaria treatment. The game will be used during school health and village health club activities when schools re-open and village meetings are allowed.

2.5 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**
R2 2.1.	SMS/Phone calls and zoom to provide mentorship to health workers in the wake of COVID-19	Improved knowledge among the frontline health workers	A total of 28,858 Health workers reached (phone call/SMS plus zoom)
R4.2	Afya Connect". Which uses phone calls, online mentorship and discussions (using WhatsApp groups created by service providers), a phone-based Short Message System (SMS), Interactive Voice Recording (IVR) and teleconferencing.	improved connection with and between service providers, community members and stakeholders in all MAPD areas of operation	

2.6 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 TRANSPARENCY AND ACCOUNTABILITY, LESS THAN 300 WORDS.

During the year, MC trained its staff and sub-contractors on the safe guarding policy, USAID's counter trafficking in persons, and MC Security Policy. All these policies are on display in all the MAPD offices.
During the period under review, MAPD continued to sensitize its staff and subcontractors on reporting and preventing fraud. MAPD shared the USAID guidelines and displayed these guidelines in all the regional offices and the main office in Kampala.

Project staff and contractors are well informed and aware of the consequence of not adhering to the guidelines and procedures to follow if fraud occurs.

3. LEADERSHIP DEVELOPMENT

Leadership development activity	Planned outcome in the year	Indications/examples of outcomes
Activity 1 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.	Improved community likage and responsibility for malaria	Increased accountability and quality service demand Increased service responsiveness

Youth participation and gender issues promoted.		
Activity 5 Staff Development Provided leadership coaching as well as Management and safety within COVID-19 sessions	Improved Management ((including remote management) and safety within conducting operations	

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 any conditions.

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.

It has also compiled COVID-19 contingency work-plans and budget and monthly reports.

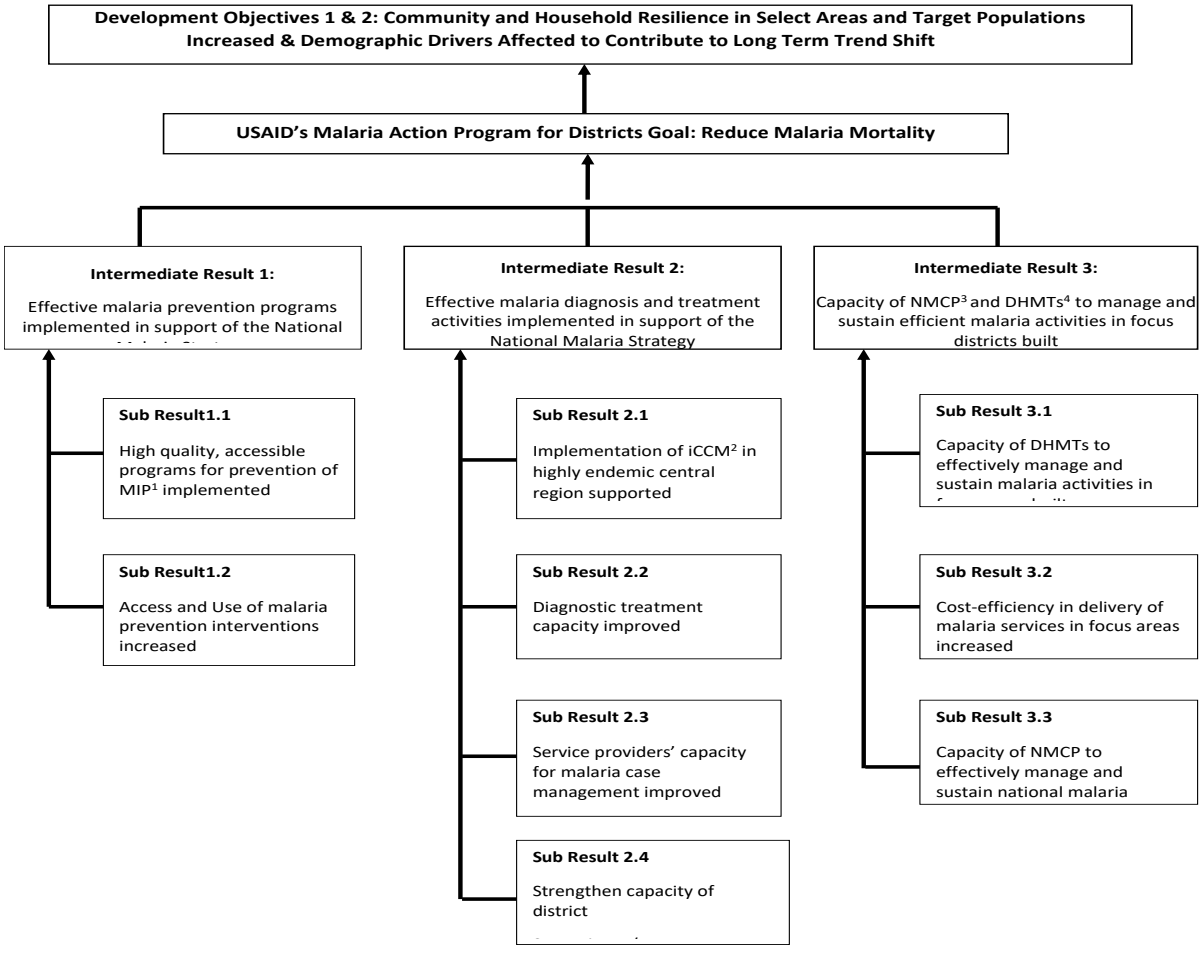
6. ACTIVITY MEL PLAN UPDATE

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? NO

INSERT BRIEF NARRATIVE ON AMELP UPDATES, LESS THAN 500 WORDS.
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.[1]

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	$35,787,288	
d. Total estimated cost share (if applicable)	NOT APPLICABLE	
e. Total estimated leverage (if applicable)	NOT APPLICABLE	
f. Total Expenditure billed to USAID/Uganda	$32,482,741	
g. Expenditure incurred but not yet billed	$1,351,810.02	
f. Total Accrued Expenditure (both billed and not yet billed); sum of lines f and g	$33,834,551.02	

	Actual spend for four quarters			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quarterly expenditure rate by funding source	$1,054,009	$2,014,675	$1,441,682	2,763,607.02

During the period under review, GoU in their 2019/2020 budget announced an increase in taxes/services fees on fuel; this in turn increased the cost of travel and transportation.
The project explored means of minimizing costs, engaging some service providers on fixed term framework agreements for costs such as accommodation and other recurring expenses to lock in prices for periods of longer periods in 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.
In the third and fourth quarter, due to COVID, the project submitted a revised contingency plan, which saw an increase in online transactions ad this resulted in an increase in banking fees and charges. Measures for affordable mobile electronic banking cushioned the banking fees on usual bank transfers.

[1] 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.

This year saw MAPD have a full SMT with the appointment of the Senior Malaria Technical Advisor role.

Management of staff was ensured during COVID-19, with phone and computer based support, both in terms of project management and for COVID-19 updates, safety and guidance.

Key procurements for next period include sub-contracts for one construction firm to conduct HF rehabilitation at one site.

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 21) 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

- Provide technical resource persons with the revised MIP training manuals
- Support Directly Observed Treatment (DOT) of SP
- Embed MIP TWG within ANC TWG
- Transition meetings with NMCD, RHD, ANC/MIP IPs, Rakai Health Services Project (RHSP) for MIP commodity support

LLINS

- Support routine distribution of LLINs through ANC/EPI clinics
- Support UCC
- Conduct first stage of LLIN Durability Study
- Transition meetings with NMCD, and Districts (who are already taking lead on LLIN delivery)

Case Management

- Implementation of iCCM in hard-to-reach and highly endemic districts supported
- ICCM Transition meetings with
- Offsite/onsite final mentorship
- Conduct WHO Malaria Microscopy Certification Assessment
- Finalize district mentorship and supervision plans
- Concretize capacity for severe malaria audits
- Conduct TES study
- Transition meetings with NMCD, Districts, HF-in charges, and all partners (including PMI/USAID ICCM project, SBCA project, and others)

Capacity Development

- Further NMCD Transition and Partnership Meetings
- Transition meetings (2 per district)
- Provide districts with toolkits
- District malaria plans (post MAPD) including HF capacity building plans.
- Support NMCD to conduct and coordinate national malaria TWG meetings
- Support annual Scientific Research Colloquium under the UMRC
- Infrastructure development of targeted HFs

10. ANNEXES

10.1 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.

10.2 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: The use of data to identify key households to support. Tumuramye's Story on the fight against malaria.

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.

Tumuramye's Story on the fight against malaria

Summary: *Malaria and poverty are connected; the impact of malaria is not only felt in terms of the human suffering and death, but also by the significant economic burden to households and the economy. Mr. Tumuramye tells his story of how malaria has made him numerous jobs to earn an income and be able to treat malaria in his home. Tumuramye, a 35-years old father to 5 children and expecting his 6th, has borrowed money from relatives, friends and in-laws to treat his family for malaria.*

Background: Malaria is one of the most common diseases which poses an enormous public health problem in Uganda. It accounts for 25-40 percent of outpatient visits at health facilities, 15-20 percent of all hospital admissions, and 9-14 percent of all hospital deaths (UDHS 2016). In Uganda, malaria is not just a disease commonly associated with poverty, but it is also a cause of poverty and a major hindrance to economic development. A single episode of malaria is estimated to cost, on average, Ugx 30,000 ($8) per person. This is more than many people can afford. In communities, such as Mwitanzige in Kakumiro district, where health facilities are few, access to health services becomes a big challenge. However, with the help of MAPD, trained key influencers reach the most affected households to support them to ptoect themselves better from malaria. One way this is done is through the "zooming in approach" where households which have had malaria are selected for support. The approach is data-driven and helps to reach the most affected communities, households and individual. Together with the family, the key influencer draws action plans and a monthly follow up plan is agreed upon. Through the zooming-in approach, Tumuramye's household was identified and visited by the key influencer to support them identify malaria issues affecting them.

Tumuramye narrates how he has had to borrow money to treat malaria. "For the past one year, it has been so bad that every month he had 2 or 3 children suffering from malaria at Kisiita Health Center III. *"By the time the key influencer visited me, I had taken 4 children 6, 8, 10 and 12 years old and all had tested positive for malaria within the week."* He recalls.

During his routine activities at the health facility, Julius Ngabirano the key influencer noticed that Mr. Tumuramye's household had 4 children registered in the OPD register that had tested positive for malaria in the same week. This prompted Julius to make a visit to Tumuramye's house. At the time of the home visit, Julius Ngabirano observed that the household did not have any bed nets. During his interaction with Tumuramye, he noted that a lot of money had been spent on treating the children. *"I would ask myself, are we under spiritual attack or the disease just loves to visit this home? I have to spend Ugx 15,000 on transport for each trip. Sometimes the boda boda feels sorry for me and subsidizes to Ugx 8,000. I also need money for other things like a meal and medicines that you find out of stock at the health center. I have borrowed money from my friends and relatives. I have to dig, weed and do all sorts of work to pay back the borrowed money."* says Mr. Tumuramye.

Way forward: Julius gave a talk to the family and emphasized the importance of the LLIN to prevent malaria. He also highlighted the dangers of malaria including death, affecting the mental state of the children besides abortion of the unborn child. He encouraged them to invest in LLINs, sleep undert hem proprelry every night and to close doors and windows in the evening. At the time of the follow-up visit in August 2020, Mr. Tumuramye had bought 2 bed nets from the earnings of the casual labour. He also benefitted from the universal net distribution campaign where he got 2 additional nets "I*t's been two months of freedom from episodes of malaria, and I have not gone back to the health center."* says a beaming Mr. Tumuramye.

Next Steps: Home visits are key especially to households that suffer malaria episodes frequently. Julius, the Key Influencer will continue to support the family to ensure the nets are well cared of and that the net culture is strengthened. Mr. Tumuramye is willing to share his experience and life-changing story with his family and friends. He is scheduled to be hosted on a community a radio talk show supported by MAPD to share his story and influence other community members.

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

INSERT PULL OUT QUOTE.

……..…*"I would ask myself, are we under spiritual attack or the disease just loves to visit this home? I have to spend Ugx 15,000 on transport for each trip. Sometimes the boda boda feels sorry for me and subsidizes to Ugx 8,000. I also need money for other things like a meal and medicines that you find out of stock at the health center. I have borrowed money from my friends and relatives. I have to dig, weed and do all sorts of work to pay back the borrowed money"* ……says Mr. Tumuramye.

……..*"It's been two months of freedom from episodes of malaria, and I have not gone back to the health center"* ……says a beaming Mr. Tumuramye.

*** 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 malaria preventing a key PMI area within its MOPs. This example is from Mwitanzige village in Kasiita HC III, Kakumiro 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.

Harriet Abesiga
h.abesiga@malariaconsortium.org
Tel: 0782840240

10.3 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[2] in Current Quarter, referencing the Schedule of Works:		
NA		
Narrative Description of Work Scheduled for Next Quarter, referencing the Schedule of Works:		
Bid evaluation and rehabilitation of one HF commences		

[2] 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.