Twelfth Meeting of the RBM Partnership
Monitoring and Evaluation Reference Group (MERG)
28 –30 January 2009
Barcelona, Spain

MEETING SUMMARY
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List of Acronyms

AIS	AIDS Indicator Survey
AFRO	Africa Regional Office (WHO)
CDC	Centers for Disease Control
CHW	Community Health Worker
DHS	Demographic and Health Survey
GF	Global Fund (GFATM)
GFATM	Global Fund against HIV/AIDS, TB and Malaria
GIS	Geographic Information System
GMAP	Global Malaria Action Plan
GMP	Global Malaria Programme (WHO)
GMS	Greater Mekong Region
GPS	Global Positioning System
HFS	Health Facility Survey
HH	Household
HMIS	Health Information Management System
HIS	Health Information System
HMN	Health Metrics Network
HWG	Harmonization Working Group
IDSR	Integrated Disease Surveillance Response
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
JHU	Johns Hopkins University
LIAT	Logistics Indicators Assessment Tool
LLIN	Long-Lasting Insecticidal Net
LSAT	Malaria Logistics System Assessment Tool
M&E	Monitoring and Evaluation
MACEPA	Malaria Control and Evaluation Partnership in Africa
MAP	Malaria Atlas Project
MARA	Mapping Malaria Risk in Africa
MAWG	Malaria Advocacy Working Group
MCH	Maternal and Child Health
MDR	Multi-Drug Resistant
MEG	Malaria Elimination Group
MERG	Monitoring and Evaluation Reference Group
MICS	Multiple Indicator Cluster Survey
MIP	Malaria in Pregnancy
MIS	Malaria Indicator Survey
MIT	Malaria Indicator Template
MOH	Ministry of Health
MOP	Malaria Operational Plan
MSH	Strengthening Pharmaceutical Systems Project
NMCP	National Malaria Control Programme
PMI	US President's Malaria Initiative
PRIME cycle	Planning, Resource, Implementation, M&E

RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
SEARO	Regional Office for South-East Asia (WHO)
TOR	Terms of reference
UNICEF	United Nations Children's Fund
WG	Working Group (RBM)
WHO	World Health Organization
WIN	Working Group for Scalable Vector Control
WPRO	Regional Office for the Western Pacific (WHO)

1. Summary of Objectives:

- Provide update on recent work and accomplishments
- Discuss malaria M&E in the context of sustained control and elimination
- Discuss guidance needs for routine monitoring and process-level indicators
- Provide update on plans for data collection and reporting
- Report on MERG Task Force activities
- Discuss MERG business issues

2. Summary of Presentations and Discussions

The 12th meeting of the Roll Back Malaria Partnership's Monitoring and Evaluation Reference Group was held from January 28th-30th at the Grand Hotel Central in Barcelona, Spain.

2.1 Day One-Wednesday, 28 January 2009

After brief introductions, Rick Steketee provided an overview of the outcomes of the previous RBM MERG meeting and objectives for the current meeting (see objectives in section 1).

Objective 1: Discuss malaria M&E in the context of sustained control and elimination

Research agenda and M&E priorities for sustained malaria control and elimination (L. Slutsker)

MalERA (Malaria Eradication Research Agenda), funded by the Bill and Melinda Gates Foundation, started through an interest to support the call for malaria eradication and elimination goal called for in 2007 and to support a systematic research effort to help achieve these goals. An overview of previous eradication efforts was provided, including positive aspects and errors in the planning of these campaigns. A major conclusion of that experience is that R&D should be central to eradication and elimination efforts to identify knowledge gaps and research areas. MalERA was created to develop this research agenda to be conducted over 12-18 months with an end result to put out a white paper that defines the R&D agenda. There are seven consultative groups on various issues (e.g. M&E) carrying out the work of this initiative.

There was a meeting on M&E activities associated with the MalERA initiative that took place prior to the RBM MERG meeting (January 26-27th, 2009). The meeting focused on lessons learned from other diseases and countries/regions, diagnostics, and surveillance (communication and reporting systems, response strategies, mapping, other tools (e.g. serology) and special studies (e.g. drug resistance). Outcomes from the meeting included, reviewing the needs when moving from intensified control to elimination in different endemic settings, establishing research priorities that will provided strategies in these settings for elimination/eradication, and publishing a series of articles that present the results of these groups. They would like MERG input in these discussions. The next steps are to draft & circulate report with a review to circulate widely (engaging MERG network) in order to be consultative, extend discussion to other groups (such as MERG) and interact with other MalERA groups (e.g. systems and diagnostics) and other disease programs (e.g. Oncho, LF). Minutes from the MalERA meeting are available from the Barcelona Centre for International Health Research http://www.cresib.cat/en/page.asp?id=1.

Mapping malaria risk with view towards its control and elimination (S. Hay)

Mr. Hay spoke about the Malaria Atlas Project. The main goal is to provide an open-source cartographic information suite to inform malaria control. This includes global endemicity maps and allows maps to estimate populations at risk and burden, new and identical initiative for P. vivax, mapping distribution of vector species distribution databases and maps to guide control and mapping inherited blood disorders. Previous global malaria maps had problems because they were particularly based on expert opinions without the benefit of GIS and were not rigorously documenting assumptions made in map development. Another major issue was that there was no

underlying analysis of uncertainty in terms of making the map. MAP was set up to address these issues. For dissemination, the web release of all maps with paper will take place around March 2009. The 2008 iteration is ongoing (before 2010) and available at http://map1.zoo.ox.ac.uk.

Developing M&E strategies for countries/regions moving toward sustained control and elimination
Mekong regional M&E strategies in the context of elimination (C. Wongsrichanalai)

In the Greater Mekong Region (GMS) there is extensive border transmission in the forest fringe. Extensive cross-border migration (e.g. Burma and Thailand, Burma and China) and malaria control has become more difficult with such population movements. Malaria cases are often occupationally related or found in mobile populations that are hard to reach and follow-up. Eighty percent of malaria cases in some provinces of Cambodia are among men that work in the forest. There is great disparity in control capabilities across countries (e.g. Thailand has extensive control activities even in remote areas while Burma's programs are less extensive and with fewer services in remote areas). This is the epicenter of multi-drug resistant malaria and in 2004 artesunate-mefloquine failures were recorded. These are also the countries with the most experience in ACT use. The area is known for sub-standard drugs and medicines, data that are not comparable across countries and multiple donors with many reporting requirements. 5 of the 6 countries are funded by GFATM.

Some of the problem areas include the population is at risk based on different calculations (e.g. distance to forest; history of transmission; administrative units), administrative units vary by country, and definitions vary over time. Clinical malaria cases are recorded together either confirmed or probable as "treated cases" and are not disaggregated uncomplicated vs. severe (not disaggregated). Grouping by age is difficult to report because cases detected at private sector facilities are not included in the public record. Some facilities perform lots of smears and presumptive Rx but provide poor follow up on slide results. Asymptomatic malaria cases depend on active surveillance. The epidemic is difficult to measure since there is no definition or terminology of epidemic defined. Deaths are also difficult to obtain for some countries and come from various sources. Diagnosis is difficult to distinguish microsopy from RD and treatment definition includes ambiguous units (e.g. no tablets, doses, treatment courses). Finally, prevention is an issue as the net-related indicators are not known (e.g. avg no peoples/net) and this is survey dependent.

There have been many lessons learned. M&E responsibility is not well defined within NMCP. There are not clear M&E frameworks but multiple project based frameworks instead. The indicator definitions are inconsistent and many eradication indicators not related to region, but more Africa malaria-oriented. The data collection tools are also not adapted to the region. However, there are many ways to improve GMS Malaria M&E. Developing a unified malaria M&E framework to serve as a guide with suggested indicators would be a great improvement. This would provide useful information for program management from sub-national to national levels and satisfy needs of funding agencies. Other ways to improve would be to modify the indicators to fit the Asian malaria scenario, create a more effective implementation plan, designate a full-time responsible person/unit and improve M&E resources and infrastructure in the region.

Monitoring drug resistance along the Thai/Cambodia border (E. Christophel)

By 2000, chloroquine resistance developed to render the drug largely ineffective. Mekong sentinel sites were established in 2000 in order to monitor drug resistance trends and to provide evidence for policy change, compare results within and between regions, and establish correlation between drug resistance and AM drug quality and use. The methodology is mainly through in-vivo monitoring

using the standard WHO protocol, each site every 2 years. A regional database was established and a review report and annual updates were produced. There are also publications in journals, information exchange and ACT malaria. Failures have increased for ACT on the Thai/Cambodian border, which has led to intensified and streamline efforts to monitor MDR. There was a Mekong regional meeting in 2007 to agree on what to do: in-vivo monitoring of national P. falciparum 1st and 2nd line treatments; P. falciparum mainly, but get P. vivax baseline. They continue to use existing sentinel sites and no change; adherence to the standard protocol and regional WHO Technical Review Group review; quality assurance of study drugs used in WHO certified lab; training, day to day support through WHO country staff, clinical mid-year external support, national focal points, joint 2 year review and planning sites, regimens); sufficient harmonized funding; lab assessment mission 2008 to do good quality PCR. Between 2000-2007, there was an increase in parasite clearance found in northwest Cambodia, but now there seems to be a downward trend.

Participants asked about the containment strategy and found that there is an intensified control strategy with a high level of vector control and increasing access to diagnostics and treatment. There is a special strategy for zone 1 to reduce artemisinin drug pressure with the hope that parasites rever to wild type by changing treatment regimen, while at the same time, tackling the private sector issue which is the biggest issue in Cambodia. The government banned all anti-malarial out of the private sector but it is not clear to what extent this regulation is being implemented. Zone 2 will continue with artesunate and mefloquine and will try to get a handle on the private sector. There is also an additional strategy to tackle migration of Burmese to the Thailand/Cambodian border and this migration needs to be monitored. Increased access to these populations is important but there is no strategy developed yet. They plan to start with an assessment and recruit peers or mobile groups to work with migrants. Surveillance will also be a very big issue including mapping parasites and focusing on hot spots and active case detection of villages. The goal is to eliminate malaria from zone 1 and have the rest of country in pre-elimination stage by 2015.

Objective 2: Provide update on recent work and accomplishments

Global Malaria Action Plan (B. Boi-Udom)

The Global Malaria Action Plan (GMAP) is on the RBM website and RBM key. The action plan is for all partners for harmonizing purposes and non-duplications. The focus has been extended to 109 countries, not just Africa. It looks at all types of malaria, not just P. falciparum and P. vivax. The main targets are to scale up and provide 100% coverage by 2015, eliminating malaria in 8-10 countries and focusing on longterm malaria. The 2 main strategies are focusing on the global and regional levels. The global level focus is on control (universal coverage with existing tools), elimination (supporting countries ready for local elimination) and research (developing new tools, inform policy research, and operational research). The regional level focus is as follows:

- Africa: Improve human resource and capacity building, better M&E systems, strong procurement. Want to control in 46 countries
- Americas: 17 in control and 4 in elimination
- Middle East & Eurasia: 3 in control and 14 elimination
- Asia-Pacific: 16 in control and 4 in elimination

MIS workshops (R. Steketee)

Recent workshops took place in Anglophone, Lusaka, Zambia & Francophone, Dakar, Senegal with 20/25 participants in each workshop. Templates, models, guides were assembled by previous

documents used in countries (ie. model for MOU and various templates). All the workshop documents and presentations are available on RBM toolbox website. Participants suggested putting a FAQ together on the website to help clarify how to use these documents. Lessons learned should be documented and available also. There was a suggestion to develop an MOU template that could be signed between partners upfront to allow access to MIS data and datasets online. A suggestion was made to make data available if there are standard data files and a standard dictionary and perhaps host it on the MICS site. There is a user forum tool on the DHS website that might be an idea for this too. However, making it user-friendly may be more complicated if the data is in different formats.

Updated MERG guidelines for core population-based indicators (E. Eckert)

The 2009 guidelines are now available on CD or hard copy. This is a revised version of the document written by Thom Eisele in 2004 and is updated every 2 years as indicators change. The guidelines were written with Africa in mind; however, adaptation can be made for indicators and tools to other regions too. (Page 7 Purpose and Content). The New Major Changes are:

1. page#11 # 3 proportion of households w/at least 1 ITN and/or sprayed by IRS in the last 12 months. All indicators are explained in detail.
2. page #11 #6 Proportion of children under 5 years old with fever in the last 2 weeks who had a finger or heel stick
3. page #14 included 3 impact indicators #9-11- Details are included in document. This is for children only, not pregnant women.

Update on Global Fund Toolkit, MESST, and DQA (M.Lama)

The M&E Toolkit was developed in collaboration with most major partners (two editions developed in 2004 and 2006). The 2008 version is focused on helping countries to develop a robust M&E system and includes an updated set of selected indicators (Top 10) and additional indicators. The toolkit is organized in Part 1: Guidance on Global Fund M&E system, FAQs, Top 10 indicators and Part 2: Focuses on diseases, HIV, TB, Malaria. It provides goals and strategies, monitoring diseases, new developments, and lists of indicators. The malaria component is built on existing indicators with discussion from partners and harmonized with other frameworks, focusing on a balance between country and donor. The description section is organized by interventions: prevention, treatment and impact. The M&E country profiles contain more organized information on M&E systems, providing evidence, advocacy, and long term goals. Currently, 56 Malaria MESST workshops have taken place (77% of GF malaria program countries), 25 (34% country profiles have been done), but there is still a lot of work to do. There have been discrepancies between national and local level data, lack of coordination and inconsistencies (ie. proxy indicator (cases detected) used for indicator treatment in report to GF). The next steps include, planning and collecting data for 09-10 to meet RBM deadline, strengthening M&E systems, collecting high quality data, partner involvement, etc…

LIST model (T. Eisele)

This is a child survival module, computer-based tool designed to help ministries and partners to prioritize investments and evaluate existing programs. It is a cohort-based model using data from CHERG with links to AIM and FamPlan using the demographic package DemProj. The main inputs are country specific-demographic data, cause of death, intervention coverage, Global-malaria, ITN/IRS, IPTp and antimalarials. Currently, the model is being used for part of the evaluation of the GF and child survival gains in Tanzania. The model is also being used to look at 11 countries with 2 pts of ITN coverage. In addition, there are 12-13 countries that are working to get their own data.

There are future plans to develop a simple version for MOH staff. A demonstration and tool download is available.

Child mortality database (CME Info) (T. Wardlaw)

This methodology is used for interagency child mortality estimation (IGME) by UNICEF, WHO, World Bank, UN Population Division, and others. It uses census and household survey data and there is a lot of variation in surveys and time frames. This tool is available at www.childmortality.org. It allows one to view source data and detailed weights of data point. One can also enter new data using the same approach and can assign different weights for different situations. Countries can manipulate the data with a password, but it is publically available to view data without a password. Access rights are given to child mortality advisors. An administrator at UNICEF cleans the database and opens it up to publish it to the website. There have been several workshops at national levels and interagency where discrepancies have been addressed.

3.2 Day 2 Thursday, 29 January 2009

Objective 3: Discuss guidance needs for routine monitoring and process-level indicators

Update on the status of national M&E plans (N. Bakyaita)

Currently, countries are working on these plans using the standard M&E planning checklist which was developed in Bamako but are at different stages of developing draft plans. Some countries have advanced further while other countries are still in early stages. Some plans are driven by Global Fund signing and countries need support in these activities. M&E Plans are donor-driven rather than a need felt by countries. It is important to coordinate and share information among partners as the partner involvement in the development process may lead to buy-in. Building consensus while developing the plan is an excellent opportunity for limited capacity-building for SME, this plans in tandem with strategic plan (e.g. timeliness and scope). Harmonized indicators around GF M&E toolkit, use of the MESST and attachment A have been helpful to this process. There is an issue of whether funding will be available for implementation. There is an incentive for countries to develop plans but few countries are actually implementing them, so we need to go beyond just the planning stages and ensure that the MEPs are being implemented. There is also a need to build capacity within the NMCPs to implement M&E plans and put M&E plans in public domain so that countries do not have to start from scratch.

Some of the next steps are to share existing plans with countries that have completed the process, using the standardized M&E plan template. Also, make the M&E tools available on the RBM website with clear guidance on how to use the various tools and their linkages. There are also plans for capacity building in all standard M&E aspects including getting more help in sub-regions in a more systematic manner, instead of getting odd phone calls for M&E consultants to support GF M&E plans and signing. The skills that are needed are not necessarily epi skills but M&E skills and routine monitoring skills. Another constructive thing to do is to share the completed plans (e.g. Zambia and Asia plans) and make them available on the RBM/MERG and WHO websites so people have access to these plans. PMI could also work with PEPFAR to could include malaria people in regional workshops for M&E trainings; however, there are substantial M&E resources to support these types of efforts at the country level. Putting together a vision for the types of activities that these resources should support, such as these types of workshops, would be helpful. The goal is to improve on routine malaria surveillance data and logistics management in the African region at the

national level, monthly analyses and bulletin of data by district level; monthly national stock out information for ACT, RSDT and LLIN and quarterly reporting to analyze and report malaria surveillance and health facility logistics information for every country on a quarterly basis. This needs joint provincial supervision to strengthen surveillance, not just from capital cities.

The key indicators are:

- # of suspected malaria cases
- # of malaria cases tested with RDT or microscopy
- # of confirmed malaria cases
- Total # of all cause cases
- # malaria cases
- # of confirmed malaria cases
- # of malaria deaths
- # of all cause admissions
- # of all cause deaths
- # of first ANC attendances
- # of preg women who received 2 or more doses of drug during ANC visit
- # of health facilities reporting stock outs of ACT
- # of health facilities reporting stock outs of RDT continuous for 1 week in last month
- # patients treated with ACS at health facility
- # of ITN sold or distributed
- # of LLINs sold or distributed
- # of structures targeted for IRS during previous cycle
- # of structures sprayed during previous cycle
- # of people protected by IRS

Currently, data is collected at the district level and reported to the national level, which produces a bulletin on a monthly basis. On a quarterly basis, a compiled bulletin is assembled across countries and put on the WHO website. Data collection tools linked to GMP database have been developed for this purpose. There is a web-tool created to complete reporting of this information. As for implementation, 2 countries per IST, based on their readiness, start with a few countries while mobilizing local resources from interested partners for other countries. Human resources and training of national SME focal points and data managers for all countries by IST are needed to start the bulletin and reporting in 6 countries by March 2009.

WHO work on routine monitoring (M. Otten)

Some practical examples of how this has worked and analyses done on the data were presented by K. Gausi on how this can be used to inform programs. A short list of routine indicators (e.g. 20 indicators) can be included in HIS systems. WHO/AFRO proposed to put together a national malaria bulletin every month containing logistics information and national surveillance that are built on these surveillance data, which contain national and district level information. There is a need to emphasize the use of data from HIS systems and routine monitoring issues, as well as reporting completeness. Trends could be misinterpreted if there are also changes in reporting completeness over time. OPT attendance and health system expansion needs to also be taken into account in interpreting these data. You do not want to look at absolute numbers for these reasons, but want to make sure that you are analyzing these data correctly. A question came up about rating the quality of HIS systems in countries. There are several groups that are taking up this issue, such as the RHINO (Routine Health Information Network), which looks at ways to improve routine information network, although not

disease specific. HMN is also active in this area and we should follow up with this group to look at some of these issues and bring in these other partners to understand their processes.

P*MI activities in routine monitoring activities (R. Salgado)*

The objective of this tool is to verify general availability of commodities, monitor the supply chain management of PMI malaria commodities and contribute to the establishment of an effective supply chain monitoring system. PMI hopes gathering this information will trigger actions from health facilities, medical stores; expiry date of antimalarials; commodities leakage; what is ordered and purchased and match with inventories. The tools that were available for monitoring were the Malaria Logistics System Assessment Tool (LSAT), Logistics Indicators Assessment Tool (LIAT), USAID/Deliver Project, and Strengthening Pharmaceutical Systems Project (MSH). Approximately 20 facilities in Tanzania were selected with up to 5 warehouses linked to the health facilities, including mainly facilities with 3 or more patients per day. There was an analysis plan developed based on the indicators with detailed information on what is included in addition to a set of standard tables to be produced. The next steps include testing in Tanzania (currently ongoing) and implementation of program in all 15 PMI countries by end 2009. The resources will be made available through MOPs (Malaria Operational Plans) for each country and each country will get money in these plans to do this. A follow up action plan is needed based on the information generated. So far there are results from 3 facility visits in Tanzania. These visits were conducted in 3 hours and could be done in one day. There was significant use of SP despite presence of ACT in the facilities. Health workers used SP mainly for women and in cases where a diagnostic test is negative (SP used for negative; ACT used for positive cases). Stock outs were present but health workers compensated by cutting up dosages. There were several complaints that MSDs deliver drugs close to expiry dates. About half of malaria cases received an antibiotic in addition to the anti-malarial.

Monitoring LLIN deliveries to countries (H.Koenker)

The net mapping project that tracks LLIN deliveries from manufacturers to countries is used to determine the number of new currently available LLIN in countries, age of nets, and project future need based on universal coverage. The fundamental difference between manufacturer delivery data and implementer distribution data was double counting and looking at different types of nets; therefore the manufacturer data was most reliable across countries in Africa. Many assumptions were made including, the manufacturer sales data was the best, only main manufacturers were used, and all nets delivered were distributed by programs. Other assumptions on population and universal coverage were defined as 1 LLIN per 2 people. Currently in 2009, the project is tracking LLINs produced and delivered by quarter, tracking tendering press to see how we are progressing with major donors and NMCPs toward universal coverage. A recommendation is to continue the project, capturing quarterly manufacturer data and including other interventions such as IRS into the calculations, while also identifying mechanisms to collect in-country distribution data and summarize quarterly information for possible actions.

Mapping ITN distribution in Zambia (J.Miller)

Since 2003, ITN distribution is coordinated and monitored by the NMCP. Information reported is on dates of distribution, quantities, type of net, and program of ITN distribution to district level. Initially, the ITN distribution process was through commercial vouchers, market, ANC and numerous small scale programs but since 2005 it is mostly through large free mass distribution and MIP. There has also been a large increase in the number of nets distributed in Zambia between 2003 and 2008

with a focus on getting 3 ITNs per household for an 80%level (and now 100%level) and targeting non-IRS districts. There is an issue of the degradation of nets if they only last for 3 years, and how to track these nets and replace them. There is a great deal of nets planned for the system and maintaining the flow of nets to different districts is important. We have also spent a lot of time trying to determine IRS activity and ITN needs based on this activity. There is very little understanding of the life of the nets (3-5 years) and there is little evidence for these debates.

There is a large GF proposal for Zambia focusing on the home management of malaria, including 14 districts trained on home management and CHWs and lots of work among partners (CHW activity logs – standard procedures for this). Previously CHW was ad hoc but now there is a need to boost the system and support CHW work force. There are questions being posed about the larger role of CHWs in the health sector with passive case detection CHWs seeing 2 positive RDTs per quarter in Livingstone and how the process of testing and treating for malaria fits into the scope of what they should be doing overall in the health sector. The next steps are active case detection (extending HMM training with additional surveillance, pushing the idea of elimination, targeting hot spots in a few districts or whole districts, systematic house to house visitation for test and treat by CHWs, asking questions about what diagnostic support in addition to RDTs may be required in follow up visitations, developing standard log books for routine reporting and supporting mini-MIS on PDAs with GPS to delineate coverage and identify hotspots. So far, women's questionnaire dropped but few fever prevalence added to HH QRE. Another option is using PDAs to support an algorithm for testing (e.g. using target groups for testing instead of going after everyone).

ACT Watch (AntiMalarial Market Survey)(K. O'Connell)

This is a 5 year multi-country study that started in 2008 to provide evidence on availability, price, quality, and user of anti malarials and to understand the market structure of anti malarials. (More info on www.actwatch.info). Research studies include

1. outlet survey that is conducted every 6 months to understand price and affordability of anti-malarials in private and informal sectors
2. supply chain research to determine the price and availability of antimalarials across the supply chain
3. antimalarial drug quality on what is the quality and purity of ACTs
4. household survey – what are the levels and trends in the use of effective and ineffective anti-malarials – what determines the use?

There are standard study designs and templates to standardize across countries. Currently, we are working closely with partners and research teams to adapt methods and get ethical approval, as well as pilot testing and training. We are measuring AMFm indicators, RBM indicators, drug quality of ACTs, maps of the supply chain from distributors to point of sale (mark ups and market structure). We are moving forward with outlet and household surveys in a number of countries; supply chain research is conducted at same time as outlet surveys; and collecting data for drug quality study in some countries. The preliminary baseline survey outlet/household survey results will be available in March 2009. Measuring affordability is based on AMFm guidelines of minimum wage of government worker and how much people are willing to pay for anti-malarial drugs in addition to other ways to measure affordability.

Objective 4: Provide update on plans for data collection and reporting

Update on MICS surveys (T. Wardlaw)

UNICEF is increasing MICS frequency from 5 yrs to 3 yrs and looking at countries for next round MICS4. Pilot testing begins in Kenya Jan-Feb 09 with new regional coordinators in place and more TA available in country. The schedule is:
2008-2009 planning, revised core questionnaire and began country selection
2009-pretest of questionnaire
2009-2010-complete surveys

The new areas of measurement are:
Malaria-diagnostics and IRS, HH protected by ITN/IRS
Diarrhea-zinc, rotavirus, PCV vaccine
Neonatal care,
Water/sanitation
Child development-questions being tested

Update on DHS surveys (F. Arnold)

Currently, 75 surveys were done in 2003-2009 and 32 surveys are underway or planned thru 2009. There are several different types, 73 DHS, 9 AIS, 4 MIS, 2 MIS/AIS, 10 SPA, 9 specialized surveys. The malaria content in the surveys include, prevalence and treatment of fever in children, ownership and use of ITNs, intermittent preventative treatment during pregnancy, indoor residual spraying (some countries, but not all, will increase in future), anemia testing, malaria testing (a few surveys), verbal autopsies (Ghana, Rwanda, Uganda, Madagascar), aavailability, expiration and stockouts of malaria drugs, availability of malaria services, counseling and treatment for malaria in relevant SPA surveys.

Update on MIS surveys (M. Choi)

The MIS in Senegal, Angola, and Zambia were completed in 2006. In 2007, Mozambique was completed and a draft is available. Kenya is awaiting completion. Rwanda was completed by RSPH and does not have a public report. Tanzania has a preliminary report available. In 2008, Ethiopia's final report was made available thru MOH. The Liberia fieldwork is supposed to be completed in Feb 09, while the Senegal field work will be completed in Jan 09. Zambia, Zimbabwe, Eritrea are planned for 2009 and Ethiopia has a possible MIS planned for late 09. Uganda has a combined AIS and MIS to be fielded in April/May 2009. Madagascar MOH is collecting parasitemia data in early 09. Southern Sudan is tentatively scheduled for Oct 09. Namibia and Comoros are pending. Participants asked if there are countries where there is a gap with no DHS/MICs. Normally, 2-3 years is the plan for MICS but there can be additions if necessary. In effort to have no countries left out, it was suggested that we post survey plans quarterly to the RBM MERG website.

Intervention progress summary report (E. White Johansson)

The report gives an overview of global malaria context, prevention, treatment, malaria control in pregnancy, mortality impact (LIST model). It is a printed publication that can be put on the RBM website.

World Malaria Report 2008, including new morbidity estimates (R. Cibulskis)

This report includes data from 109 endemic countries. The data are centered on 2006 with some 07 and 08 updates. The report features new estimates of malaria burden by country and measures of progress towards RBM 2010 and MDG 2015. The estimates are in line with previous reports, but some cases were different outside of Africa. Two methods were used. The method for Africa used a crude map dividing Africa into high and low risk, adjusted for urban and rural areas and ITN/IRS coverage, and looked at different age groups. The method outside of Africa found estimates were too high previously. The endemicity base map that was developed in 60s was not representative of today and adjustment attempts were crude. Therefore, we focused on used cases reported, adjusting for lack of case confirmation, missing HMIS, and public vs. private sector. The public sector was an adjusted estimate while the private sector and untreated used DHS/MICS data. Outside of Africa the areas for improvement are to have better estimates for high priority countries, confirmed and probable cases, health facility reporting, and utilization of facilities. Within Africa, we can improve endemicity maps and incidence estimates.

Update on World Malaria Report 2009 plans (M. Otten)

An annual progress report is needed for malaria community, similar to other diseases. This will be financing by GF and others, using 2008 LLIN, ACT, RDT, IRS, IPTpw data. Within Africa, there will be better maps, coverage of interventions, trends in malaria cases and deaths and trends in drug resistance. Outside of Africa, the focus is on elimination.

3.3 Day 3 Friday, 30 January 2009

Objective 5: Report on MERG Task Force activities

Update on MERG Task Force activities

The Survey and Indicator Guidance TF produced the core indicator guidelines after meeting in July to discuss indicators. The need was to define universal coverage. MERG provided guidance on measurement issues related to universal coverage and recommendations for how to define universal coverage. There is a need to revisit the issue of including universal coverage in updated core indicator guidelines since it is now included as an indicator for secondary analyses but this is a major goal in the GMAP.

There has been no action with the Dissemination TF.

The Morbidity TF held a meeting in Boston and another meeting following the Barcelona MERG

The Mortality TF further developed the LIST model and need to review the new mortality data.

There has been no action with the Capacity Building TF.

MERG support for other RBM task forces and activities

HWG M&E support for Global Fund applications (R. Steketee)

The GF applications are the countries responsibility. Even though partners can provide support, the contract is between GF and the country. There are 2 main issues in signing, (1) bonified reviewed procurement and distribution plan and, (2) M&E national costed plan and to undertake the MESST.

HWG looks to MERG to find possible consultants in order to review their M&E plans. This might be an issue for TF support. Right now the problem is that Rick gets the phone call asking for names of consultants to support this signing effort. Countries end up with a plan but there is no follow up, which ends up being a problem for WHO/AFRO who actively support these efforts. This is also a problem outside Africa with consultants.

Also, an issue was raised that the MESST tool was under time pressure and is actually destructive to partner collaboration since these workshops were conducted without notifying partners. GF has not been asking for a GF specific M&E plan, but there is time pressure for grant signing which makes partner collaboration difficult. Perhaps MERG can learn from SE Asia, which is doing this in a timely manner and helping to develop the plans in advance of GF signing. There needs to be a more systematic effort in terms of capacity building to support developing a national M&E plan efforts.

RBM M&E Toolkit (R. Steketee)

The tools development work established to find and review existing program tools, develop new tools or refine existing tools, and test, revise, update/adapt and share tools. Now there is a full set of tools available for program improvement for country malaria control. With rapid changes and the growing number of partners and links, this approach has evolved to address issues such as spectrum from scale up to sustained control to elimination and science and program guidance. There is a small group working within RBM Partnership to share the work for this RBM Toolkit. They have jointly adapted the PRIME cycle (Planning, Resource, Implementation, M&E) addition policies and strategies and advocacy to define main tools in the toolbox. The Task Force is now engaging sub-regional networks and partners, working on a prototype format and populating the toolbox with various tools on a password protected website. The M&E portion of toolbox includes M&E plans and budgets (includes MESST, RBM framework for monitoring progress, evaluating outcomes and impact, M&E toolkit), M&E survey based tools (includes MIS), routine health information systems (includes HMIS assessment (HMN) tool), reporting and quality assurance (includes Data quality audit tool). The aim is to have a one stop shop for all of these tools. In the future, this toolbox could become background documents for a distance learning course, particularly for training consultants or general M&E training.

AMFm M&E Technical Advisory Group (M. Lama)

In April 2008 the GF Board met to discuss their need for an M&E experts group to advise how this initiative should be monitored and evaluated and advise the GF team on issues related to the pilot phase as well as if AMFm is on track to achieve its Phase 1 objectives. They are currently examining lessons learned from countries and whether it is possible to further roll out the initiative. The one-year pilot phase is almost complete and they want to discuss lessons learned prior to rolling out the initiative in other countries.

Objective 6: Discuss MERG business issues

Discuss MERG business issues
RBM Partnership Board Meeting *(R. Steketee/B.Nahlen)*

The meeting was held in New Delhi in November 2008 where there was a brief opportunity to put something up in front of the board in order to raise the issue of M&E. They recognized the existing RBM MERG work and RBM needs and agreed on the following principles for scaling up:

- build on existing mechanisms
- strengthen systems for reporting of information at all levels
- mandating RBM MERG to work with partners to define the scope and terms of work, locations and mechanisms for implementing enhanced M&E
- requesting RBM MERG to engage partners to help support this work with staffing or financial assistance

There is approval to come back to the Board with more detailed ideas for how to do this work, specifically, building on existing systems, strengthening country and regional capacity, and clarifying the scope of RBM partnership supported work in M&E.

RBM needs to determine reporting needs and expectations for 2010 goals, including measurement, report outlines, timing of reports and country engagement and responsibilities. There have been a lot of discussions around how we will monitor the 2010 goals and MERG has looked in to this issue in depth. The GF Evaluation used the LIST model in its 5-year evaluation and we will probably need to do similar work with modeling. We also need a general report for the public that shows an estimate in a plausible manner on the achievement of RBM goals.

3. Outcomes/Action Points of the Meeting

Task Force and Items	Next Steps	Responsible	Timeframe
Survey Indicator Guidance Task Force • Coordination of HH survey Activity (UNICEF) • FAQ • Website • Improve data collection for antimalarial treatment (e.g. pill boards) • Adaptation of questionnaire to changes in RBM indicators • Further analysis of cost and source of supplies data from MICS • Incorporation of HH expenditures • MIS application outside of Africa • Revision of MIS package • VA lessons learned • MIS/AIS combination surveys – lessons learned	Convene a meeting – individual items from list will be assigned to various task force members	UNICEF and Macro	March 2009
Capacity Building Task Force • Further analysis of survey data for evidence based programming • Curriculum training • Gather training materials from other groups, including ACTMalaria • Include something on HR needs • Develop strategy to build in-country capacity	Convene meeting	TBD – but Macro agrees to host first meeting	Spring 2009 (before next MERG)
Dissemination Task Force • Scheduling for reporting for 2010 targets • Assist with the promotion and dissemination of the new 'Toolbox' on the RBM website • Develop 1-page info sheet on universal coverage indicator • Other (get notes from Hannah)	Convene meeting Generate interest from other RBM partners in helping	JHU/VOICES	Spring 2009 (before next MERG)
Mortality Task Force • Document VA experience (in conjunction with survey TF) • Data quality assessment on U5MR data • Application of LIST model (impact assessment based on coverage) • Review MERG guidance note and update as necessary • Assist with GBD estimates	Meeting in conjunction with Survey TF	UNICEF	March 2009
Morbidity Task Force • Per Richard C. meeting Friday afternoon (TBD)	TBD	WHO	TBD

Surveillance and Routine Reporting Task Force • Diagnostics (as needed for surveillance and M&E purposes) • Resistance monitoring as part of M&E system	Form group Convene meeting	WHO/CDC	Spring 2009 (prior to next MERG meeting)