



Seventh Meeting of the RBM Partnership Monitoring and Evaluation Reference Group (MERG)

6-8 June 2006
Glion, Switzerland

Tuesday, June 6

Welcome and Introductions

Bernard Nahlen, GFATM

Bernard Nahlen convened the 7th meeting of the RBM Partnership MERG. After participants introduced themselves, he reviewed the agenda and objectives of the meeting:

1. To report on progress for major malaria initiatives
2. To review current work and proposed initiatives in data collection, data analysis and burden of disease estimates
3. To discuss priorities and proposed initiatives for capacity building
4. To discuss future leadership of the MERG
5. To evaluate how best to strengthen communication and dissemination activities

A brief summary of discussion and action plans from the 6th meeting in Cairo was also presented.

I. Progress of Major Initiatives

New PMI Countries and Activities—*John Paul Clark, USAID*

John Paul Clark provided an update on the President's Malaria Initiative (PMI) and the effects of the program on the United States government's existing malaria activities. At the time of the presentation, the second year countries that would receive funding from the PMI had not been announced. Please see the corresponding PowerPoint presentation for further details.

Summary:

On June 30, 2005, President Bush announced a new five-year, \$1.2 billion initiative to rapidly scale-up malaria control efforts in high burden countries in Africa. Three countries will be covered in 2006; 7 countries in 2007; 12 countries in 2008; 12 countries in 2009; and 15 countries in 2010.

The goal of the PMI is to reduce malaria-related mortality by 50% in selected countries. This will be achieved by reaching 85% coverage of the most vulnerable groups with proven preventive and therapeutic interventions, including artemisinin-based combination therapies (ACTs), insecticide-treated nets (ITNs), intermittent preventive treatment (IPT) of pregnant women, and indoor residual spraying (IRS).

The PMI initiative will fund commodities, technical support to strengthen national malaria control capabilities and ensure effective program implementation, and monitoring and evaluation. Currently, three country plans have been written and have been endorsed by host country ministries and approved by steering committee. In addition, procurement arrangements have also been put into place, so activities are now underway in the three countries of 2006.

Some strategic issues that still need to be addressed are defining commodity procurement; finding the most effective mix of vector control measures for prevention of malaria at national scale; providing access to effective anti-malarial drugs at national scale; malaria control in fragile states; ensuring continued congressional and public support; and coordination with GFATM, World Bank and others

General discussion:

- Length of PMI: One of the issues discussed was the length of the PMI. Under the current guidelines, the PMI countries will receive 3 years of full funding. In those 3 years, countries have a goal of reducing mortality by 50% and to achieve coverage of the program of 80%.
- Coverage of PMI: The PMI will most likely cover 15 countries.
- Objective of PMI: The objective of the PMI is consistent with the RBM objective of decreasing malaria mortality by 50% by 2010. The umbrella for coordination with other countries is partnership with RBM. A meeting was held in January with RBM's other partners—the Global Fund, the Bill and Melinda Gates Foundation, and The World Bank on how to use funding and which organization's funds are less flexible and more flexible. Two of the key issues discussed at that meeting were procurement and monitoring and evaluation. Coordination among funding partners will limit wastage of resources and duplication of efforts.
- Coordination of PMI with PEPFAR: Some PEPFAR initiatives are funding some of the same things as the PMI. Coordination of the two programs is occurring at country levels and central levels. At the central level, a working group has been developed. A position paper on budgetary issues and capacity building has been created. There is an effort by both initiatives to combine resources at the country level. However, there are also times when the two initiatives are in competition with each other (e.g. human resources) because there has been a tendency in a number of countries to move public sector care to the private sector, so there has been a movement of personnel to the private sector or NGO sector.

Update on the Malaria Booster Program and Country-Level M&E Activities—Joe Valadez, The World Bank

Joe Valadez provided an update on the World Bank's Malaria Booster Program. Please see the corresponding PowerPoint presentation and Excel spreadsheet for further details.

Summary:

General discussion:

- Target countries: The Malaria Booster program has identified approximately 19 countries for support up this point in time. In order for the program to be implemented in those countries, there must be involvement with the country at two levels—with country manager at the World Bank and with the country's government itself because undertaking a loan is an important decision and only so much money can be given to a country within a given year.
- Economic Task Force: Economists at the World Bank have been developing this new task force, which is open to anyone who is interested. A scope of work is currently being developed to focus on the cost of malaria to families and households, the cost effectiveness of various interventions, and impact evaluations of diverse strategies. The task force has met and has developed a 3-page concept paper. The group has also had discussions with a fiscal analysis group at University College in London.
- The current budget of the booster program is \$407 million, which includes the countries that have been approved and are in the pipeline. An additional 19 or 20 countries may be added to the program, so the total amount of money in the booster program will exceed \$407 million. The World Bank's commitment to the program is through 2010.
- Targets of the Booster Program: The World Bank's internal target have been consistent with the Abuja targets, so currently, the program is looking at 60% of under-5 children sleeping under an ITN and 80% of houses with ITNs, for example. The target for mortality reduction is the same as that of the PMI. The World Bank is focusing on indicators that can be measured on an annual basis and can be used for managing programs—outcome indicators and processes—rather than inputs since the World Bank has a financial unit that is dedicated to managing that particular component.

Update on The Global Fund Activities—Bernard Nahlen, *The Global Fund*

Bernard Nahlen provided an update on the recent activities of The Global Fund. Please see the corresponding PowerPoint presentation for further details.

Summary:

The Global Fund is an independent public-private partnership with a mandate to raise and disburse new funds in a transparent manner to achieve sustained impact on HIV/AIDS, TB, and malaria. Coverage of proven interventions is measured by assessing the number of people reached, service delivery points, and people trained to deliver a service.

Measurement tools and indicators have been developed for all levels, including impact, system effects, grant performance, and operational performance. The top malaria-related indicators for Global Fund reporting are as follows: number of ITNs distributed to people at risk (or where appropriate, number of houses receiving indoor residual spraying according to national policy); number of people with uncomplicated or severe malaria receiving anti-malarial treatment as per national guidelines; death rates associated with malaria (all cause under-5 mortality in highly endemic areas); and incidence of clinical malaria cases (estimated and/or reported).

After 5 rounds of proposals, 81 countries the Global Fund has covered 81 countries. Sixty four percent of all international funding in 2004 was provided by the Global Fund. Seventy four

percent of Global Fund grants from Rounds 1-5 have been awarded to sub-Saharan Africa. South Asia, the Middle East, and North Africa have received the next highest percentage (11%).

General discussion:

- Disbursement of funds: The Global Fund disburses funds based on the reporting of the top ten indicators (see presentation). Currently, 81 countries are covered, with 97 components. Money is committed for 5 years, but the target disbursement is for the first 2 years. At the end of the second year, countries are evaluated to see if they are on track to receive the additional 3 years of funding.
- Round 6: Round 6 of funding is soon approaching. There is currently a perception that malaria grants are not of the same quality as in previous rounds. The hope is that the countries applying for Round 6 funding now have experience in putting proposals together, and that WHO, CDC, and other technical partners can assist countries in getting their proposals together.
- Grant performance: The figures on ITNs presented in the PowerPoint presentation show the number of ITNs that have actually been distributed, not just those that have been approved for purchase.
- Continuity of funding: The PMI's operational plan has changed every year. In order to have continuity in the face of a shifting resource base, USAID is encouraging PMI countries to apply for Round 6 funding so they have a diversified funding base.

Quick Impact Initiative—*Hailay Desta Teklehaimanot, Quick Impact Initiative for Malaria*

Hailay Desta Teklehaimanot presented an update of the Quick Impact Initiative. Please see his PowerPoint presentation for further details.

Summary:

The Quick Impact Initiative is part of the UN Millennium Project. The purpose of the initiative is to play a role in connecting immediate and high-impact Quick Wins to long-term strategies for meeting the Millennium Development Goals. As part of the MDG, malaria endemic countries are expected to scale-up their malaria control programs to achieve a quick malaria impact by 2008.

The goals of the Quick Impact Initiative are to have: 100% of children under five years of age protected by long-lasting insecticide-treated nets; 80% of people living at risk of malaria protected by locally appropriate vector control interventions; and 100% of children under five years of age treated with effective anti-malarial drugs within one day of onset of illness.

The 4 indicators selected to measure progress towards the MDG/Malaria goal and targets are: malaria prevalence rate; malaria-related death rates in <5s and other population groups; and proportion of children <5 and other population groups who receive appropriate clinical treatment for malaria.

However, a number of barriers to scaling-up implementation have been identified, including lack of coordinated input to malaria control, inadequate financial resources, lack of effective

commodity management systems, and ineffective monitoring and evaluation systems, just to name a few.

The initial 10 countries targeted by this initiative are: Senegal, Ghana, Mali, Nigeria, Ethiopia, Uganda, Kenya, Malawi, Rwanda, and Tanzania.

General discussion:

- Technical Assistance: Nine or 10 countries will be applying for funds for Round 6. At the end of the week, people from the project will be traveling to some of the countries to help with their grant applications. The project works closely with WHO.
- Identification of countries for TA and funding: Countries were identified based on the UN Millennium Project. Funding for the project comes from the UN.
- Targets: One of the targets of the Quick Impact Initiative is to have 100% of children under five years of age protected by a long-lasting insecticide-treated bednet. Concerns were raised about how feasible this target is to reach, especially given a limited amount of time. One of the dangers of setting targets too high is that even significant increases in coverage may be seen as a failure. Most countries are setting the Abuja target of 60%.

II. Current Work and Proposed Initiatives in Data Collection, Data Analysis, and Burden of Disease Estimation

Update on DHS and MICS Surveys—Fred Arnold, ORC Macro and Tessa Wardlaw, UNICEF

Fred Arnold and Tessa Wardlaw presented an update on the DHS and MICS surveys.

Summary:

The indicators collected in the MICS 2005-2006 Malaria Module are: household availability of insecticide-treated nets; under-5s sleeping under insecticide-treated nets; and under 5s sleeping under mosquito nets; malaria treatment; intermittent preventive treatment; and source and cost of ITNs and antimalarials.

General discussion:

- Angola: The Angola survey was originally supposed to be a DHS, but the survey could not be undertaken due to concerns with elections in 2007. The government was wary of having any negative information on their programs made public before the election.
- Key issues for data analysis: Concerns were raised about the comparability between countries over time and how to determine which indicators to use. Time trends with data cannot be used if the indicator did not exist in earlier surveys.

Update on IRS Indicator Development—Joe Keating, Tulane University

Joe Keating provided an update on IRS Indicator Development. Please see the corresponding PowerPoint presentation for further details.

Summary:

The development of standardized indicators for measuring IRS indicators at a program level has been complicated by a number of challenges. For example, different reporting systems, data collection protocols, and data presentation formats are currently in use across countries, making it difficult for comparisons to be made by country or region. Different types of insecticides are being used, which is a function of their formulation, the ecology of the area, and the susceptibility and behavior of the vector.

Coverage indicators should measure the reach of the program, the types/amounts of insecticide use, and the evidence of insecticide persistence.

General discussion:

- Suggested indicators:
 1. Proportion of households sprayed in last 12 months
 2. Proportion of population protected over last 12 months
 3. Amount of insecticide sprayed per household
 4. Persistence of residual activity
- Coverage indicator 2: Humidity and temperature are the biggest determinants of the persistence of an insecticide. Regardless of the type of insecticide, metal and mud walls will not be able to absorb it well.
- Coverage indicator 3: This indicator is an input/process indicator, and is also presented as a coverage indicator in this presentation. It gives the amount of DDT used per house, which can help to determine whether the sprayer is using an adequate amount of spray per household. This indicator helps to inform programs on how much insecticide needs to be used and how long it lasts. If equipment is 100% functional and is standardized, the rate of application can also be standardized easily. However, if spray levels are too high, spraying could cause adverse health effects; if spray levels are too low, vector resistance can arise.
- Coverage indicator 4: There is not much in the literature on the length of time an insecticide will stay active on a surface. This question will lend insight on how often to spray and on the types of surfaces on which the spray will have a greater impact. However, laboratory capacity will be necessary to answer this question. Bioassay and susceptibility tests are currently being used to determine this indicator. Resistance tests do not necessarily have to be done in the field.
- DDT and security: If DDT is only used for wall spraying, the risk of environmental contamination is extremely low. However, supply chains can be leaky. Since this chemical can be used as a pesticide, the supply chain has to be extremely secure and monitored so that DDT does not end up in the water table. USAID is currently undertaking a regional environmental impact assessment on this issue for the Africa region.
- Next steps: The indicator for ITN coverage is relatively straightforward to calculate because it is possible to ask how many bednets are in the house. However, guidelines need to be developed to help countries report consistently, especially regarding the denominators of the coverage indicators.

Update on Angola MIS—*Fred Arnold, ORC Macro*

Fred Arnold provided an update on the upcoming Angola MIS. Angola is one of the first three countries selected by the U. S. President's Malaria Initiative (PMI) for early intervention. The survey is currently in the planning stages, but fieldwork will be conducted in October-November 2006. Please see the corresponding PowerPoint presentation for further details.

Summary:

The Angola MIS will collect information on estimated malaria prevalence among children under 5 and pregnant women; prevalence of anemia in children under 5 years and women 15-49; household ownership of ITNs and use by children under 5 years and pregnant women; coverage and timing of IRS in selected areas; use of IPT for malaria among pregnant women; child mortality and probable causes of death.

For the Angola MIS, Capillary blood will be drawn and tested for anemia with the HemoCue system. The RDT that will be used for malaria is Paracheck. Microscopy will be used in a subset of about 300 children. Respondents will receive immediate feedback on the results of the RDT. If positive, respondents will be given basic health education messages as well as a full course of Coartem.

Mortality Task Force Report—Tessa Wardlaw, UNICEF

Tessa Wardlaw provided an update on the Mortality Task Force. The objectives of the task force meeting were to review the need for assessing the impact of malaria control efforts on mortality; to evaluate options for assessing mortality impact; to make recommendations on how best to assess the impact of malaria control efforts on mortality; and to develop a consensus on the process for harmonizing/coordinating efforts to monitor trends in malaria-related mortality. Please see the corresponding PowerPoint presentation for further details.

Summary:

For all high burden African countries, the task force recommends: monitoring of coverage of key malaria control interventions; to using a model-based approach to predict the mortality impact of malaria; to undertake additional analysis if complementary information on monitoring trends is available; and to coordinate with partners to keep assessments consistent.

The next steps for the Mortality Task Force are to produce guidance papers with MERG recommendations, develop a user-friendly software package for countries to produce model-based estimates of the mortality impact of malaria control activities, and to develop a plan for disseminating and training in software packages.

Proposed Software Package for Malaria Mortality Estimates—Emily White Johansson, UNICEF

Emily White Johansson provided an update on the proposed software to assess the mortality impact of malaria control efforts. The model was developed to assess the impact of child

survival interventions (including malaria) on under-five mortality. The original purpose of the model was to show which key child survival interventions had the greatest impact on mortality. Please see the corresponding PowerPoint presentation for further details.

MERG Recommendations for Evaluating the Impact of Malaria Control Efforts on Mortality in Africa—*Carla Winston*

Carla Winston provided an update on the draft MERG paper for evaluating the impact of malaria control efforts on mortality in Africa. Please see the corresponding PowerPoint presentation for further details.

General discussion:

- Timeline: The issue of a timeline is really important. Coverage will increase over the years that the mortality intervention increases. The first coverage survey will occur after scale-up and the second coverage survey assesses whether the intervention coverage has or has not increased. Mortality looks at the baseline prior to scale-up. Coverage is used to assess if it is realistic to assume that the mortality decrease that you see in a follow-up mortality survey is plausibly associated with the intervention coverage scale-up. Mortality impacts are likely to be underestimated because of the timeline unless earlier coverage estimates are used (e.g. 2007 instead of 2010).
- Validation of the model: There are plans to validate the model as part of the scaled-up ACSD efforts¹. Regional level mortality estimates can be obtained from the MICS and DHS. In Malawi, for example, there are two DHS surveys that show the reduction in all-cause child mortality associated with increasing coverage. A wealth of data will be available in the next 6-9 months. A group should be pulled together to use MICS and DHS data to do some secondary analysis to inform some of these issues as more programs roll-out.
- Further research: Larger samples in malaria affected countries in high burden areas could be examined, and mortality can be examined seasonally if the sample size is large enough. Also, in countries in which there are altitude and climatic differences, mortality changes in malarious areas versus non-malarious areas can be examined.
- The MERG is working on a companion piece to give the perspective of the MERG on mortality measurement.

Wednesday, June 7

I. Update on RBM Partnership

Update on RBM Partnership Board Meeting—*Tom Teuscher, Roll Back Malaria*

¹ Accelerated Child Survival and Development (ACSD) is a child-survival initiative that started in 2001 by UNICEF in four countries in the West and Central Region of Africa (Mali, Benin, Senegal and Ghana). The thrust of the accelerated approach is the reduction of mortality and malnutrition in children under five years of age in areas with very high mortality rates, through scaling up of cost-effective child survival interventions.

Supporting harmonization at the global level is essential. The MERG is an example of a mechanism that generates consensus around key issues such as objective setting, intervention strategies, program design, implementation planning, and monitoring and evaluation.

The next RBM Partnership Board meeting will be at the end of July in New York. Minutes from the last board meeting are available at:

http://www.rollbackmalaria.org/partnership/board/meetings/docs/9th_RBM_Board_Meeting_Communique.pdf

II. Progress of Major Initiatives (Continued)

Update on Zambia MIS—Rick Steketee, PATH

Rick Steketee presented an update on the Zambia Malaria Indicator Survey. Please see the corresponding PowerPoint presentation for further details.

General discussion:

- Training methodology: One lesson learned from the Zambia MIS is that too many people were being trained at one time. The MPH program at the University of Zambia wanted to involve their students in the survey, so they requested that 25 people from the program also be trained. The training included a walk through of the survey's principles. On the first day of training, the group reviewed a hard-copy of the questionnaire. On the second day, the group split into smaller teams of 6-8 people per team. Nearly everyone had their own PDA to practice with, so the participants were never trained off of the hard-copy. Built in programming checks allowed for quality control.
- Translation of the survey: Visual basic allows you to translate the questionnaires into French or Portuguese. During the training, the trainees practiced translating the survey into various local languages. Teams reported on whether or not they had any problems. In the cases where translation was necessary, the survey was administered by a community health worker or a nurse from that particular province or district.
- Parasite Prevalence Survey Component
 - Coartem: The national policy in Zambia is to treat malaria in children with Coartem. Anyone who was found to be positive for malaria from the rapid diagnostic test and had a fever in the last 7 days was given a 3-day dose of Coartem by a nurse.
 - Discordance in testing: A child who tested negative by Paracheck but who is slide positive was not followed up for delivery of treatment if asymptomatic at the time the blood sample was taken. Had the child been febrile at the time of testing, the child would have been referred to a clinic. A child who is febrile but Paracheck negative will be referred to a health center.
- PDAs: The use of PDAs for surveys in Africa has been spotty. The effective use of the PDA depends on the background of the interviewer and how the PDA was purchased. No PDAs were lost or damaged in this survey. They are kept in waterproof, airtight

cases. GPS devices are built into the PDAs and games and other extra functions are removed so there is not a lot of incentive to steal the device since it cannot function well outside of the survey.

- Team composition: Everyone who finished the training was prepared to go out into the field and collect data. Data collection was done in teams of four. The team leader was generally a female nurse; there were 3 females and 1 male on each team.
- Budget: The rough budget shown in the presentation does not include technical assistance.

RBM Capacity Building Task Force Summary—*Erin Eckert, MEASURE Evaluation*

Erin Eckert summarized the recent meeting of the Capacity Building Task Force. Please see the attached PowerPoint presentation for further details.

General discussion:

- Objectives: The objectives of the Task Force were to review issues in capacity building for malaria M&E; to set priorities for RBM MERG in terms of capacity building; to outline an agenda for action to develop capacity in countries and regions; and to identify partners to provide technical and financial support for capacity building for malaria M&E
- Issues: Some of the issues in capacity building are: to ensure sustainability, buy-in is needed at all levels, especially at the senior level; capacity building needs adequate time, resources, and commitment; capacity building is a continuous process and should be planned from the beginning; individual and institutional capacity should always be linked; and capacity building can take many forms, including training, mentoring, on-the-job training, short-courses, web-based/distance learning, listservs and e-discussion forums.

Performance Monitoring for Malaria Control Program Implementation—*Rick Steketee, PATH*

Rick Steketee summarized the draft MERG paper, “Performance Monitoring for Malaria Control Program Implementation: Guidelines for Standard Indicators.”

General discussion:

- Challenge: One of the challenges of creating this document was to not produce even more indicators. One of the objectives of the paper was to help countries understand that they do not need as many indicators as the HIV community.
- Classification of indicators: There is an impression that the Global Fund has its own indicators, but the reality is that they use the RBM-recommended indicators. The Global Fund’s indicators are the country’s indicators that the country uses when setting up its grant application.
- Rational set of indicators: This paper is part of the process for RBM to provide guidance to countries on how to stay focused on a limited set of indicators. It will help identify a logical set of indicators related to outcomes, not all of which will be measured since some will only be useful for diagnostic purposes, for example.

- Measurement strategies: It will be critical to have a set of guidelines for measurement strategies. The next step is to look at capacity building strategies
- Next steps: Because Round 6 is coming up, there is an opportunity for countries to rationalize all of their monitoring indicators and align them. There have been discussions with the Global Fund on their willingness to do this as part of the harmonization process. John Miller's experience with the recent process can be put into a document as potential guidance to other countries. It would be very useful to have clarity on indicators (both lower level and core indicators), so having standardized language is important. This framework can be adapted to different countries and has to match Global Fund applications. It will give a country a template from which it can work.

Health Metrics Network—*Bob Pond, Health Metrics Network*

Bob Pond summarized gave a presentation on the Health Metrics Network. Please see the corresponding PowerPoint presentation for further details.

General discussion:

- Recipients of funding: In two or three cases, a Central Statistics Office or other entity has received a grant from HMN, but the overwhelming majority of grants have been given to HMIS units of MOHs.
- Country visits: The first contact with a country was organized through regional offices, which helped the HMN organize inter-country workshops. Then, a series of 4 country workshops was organized that focused mainly on sub-Saharan Africa.
- Collaboration: One of the challenges in the malaria community is the number of funders. The HMN does not fund projects, but rather attends meetings to sell the notion that coordination between groups will create efficiency and will allow people to think longer-term about M&E. There is recognition by countries that a strategic plan for coming up with a list of indicators has to be developed so that program units do not develop their own M&E approaches separately. At the country level, this requires the engagement of local representatives of various initiatives—of bilaterals or the World Bank or other organizations. This has proven to be challenging since many offices at the country level have not been oriented to the procedures yet, so getting them to see the development of broad strategic processes has been difficult.
- Data warehouses: Data warehouses have been disappointing. It will be difficult to create one for malaria, where funding is very splintered. This may be part of the reason that it is difficult to attract donors who will provide earmarked funding for this particular activity. Managers at the district level have to be able to access statistics in a database. In the absence of that, managers are finding that they have to make ad hoc requests to different organizations to get the data they need.

Technical Support Unit for the MERG—*Erin Eckert, MEASURE Evaluation*

Erin Eckert gave a presentation on the Technical Support Unit for the MERG. There is a need for a mechanism to operationalize the guidance and recommendations of the RBM MERG at both the global and country levels. The proposal is to link the RBM-MERG technical guidance

with a Technical Support Unit (TSU) to support multi-country M&E capacity development for the specific outcomes of achieving quality and consistency in M&E from participating countries. This partnership will be done with key technical persons and groups. Additional financial support will be leveraged for this critical need.

The goal of the TSU is to operationalize the recommendations of the RBM MERG to strengthen monitoring and evaluation of malaria programs. The operational objectives focus on both global initiatives and national program strengthening:

- At the country level, to strengthen monitoring and evaluation capacity at the sub-regional and country program level;
- At the global level, to coordinate and conduct analytic activities in support of RBM MERG's global mandate

Please see the corresponding PowerPoint presentation for further details.

General discussion:

- Topics: Some of the topics that might be interesting to include in the analytic piece are: the discussion of countries like Malawi and looking at all-cause mortality and malaria intervention and examining the trends, and the disaggregation of mortality information by geographic area and seasonality using existing datasets.
- Products: The concept of having this unit be product-driven will be useful since having actual products allows you to see the outcomes of your work. The more product-oriented the MERG is, the easier it is to show that work is being done by the group. It would also be easier to obtain funds if products are created.
- Funding gap: The funding gap has been discussed at the World Bank. There has been an attempt to add together money that has been committed to a country over the short and long term and compare this to the amount of money that a country needs to reach its targets. Using that information over time would be helpful in assessing if the country's projected funding gap is accurate. If targets are reached faster or slower, then this will have an implication on the amount of money needed to reach those targets.
- Impact of trainings: There is an indicator in the current framework on how many people are trained. A question was raised on how contributions will be evaluated when there is a lot of money for training activities. MICS workshops begin in September, so there will be an opportunity to be more proactive about identifying institutions that need to participate in these workshops and to think through the types of questions that can be posed for further analysis of data. A few people should be brought together to think through these issues.
- Further analysis: A full-time point person has been identified to coordinate and help with further analysis. There is a need for analysis at both the global level and country level.
- RBM database: RBM has developed a database for information on nets and ACTs. The database should be made public in a couple of weeks.

Technical Issues: The MIT & LQAS—*Joe Valadez, The World Bank*

Joe Valadez gave a presentation on the MIT and LQAS. Please see the attached PowerPoint presentation for further details.

General discussion:

- Database working group: Joe Valadez spoke about organizing working groups with members from UNICEF, USAID, CDC, the Global Fund, and DHS to unite different available databases into one tool which reports program information and finance information together. He proposed the creation of two working groups. Members of the database group should also be part of the data architect group.
- TOR and Workplan: There should be a terms of reference for the working group so that it can institutionally make decisions on how to best facilitate work into completion and over what timeframe. This is important because of shifting staff. A workplan should also be developed by the group. This should be the first order of business. PMI will have to discuss this with CDC and Matt Lynch will be the key person involved. Joe Valadez will organize the meeting and the Global Fund and UNICEF will each have to identify an individual to join the group.
- RBM database and MIT database: The RBM database has been used to populate the MIT tables. The MIT should be able to support the RBM database. Joe Valadez will speak to Ryan Williams and Maru's team at WHO to use whatever resources are available to bring the data together. The MIT is not replacing the RBM database, but is supporting it.

Working Together: Strengthening of Country M&E Systems Through RBM and The Global Fund Support—*Sonia Diaz Monsalve, The Global Fund*

Sonia Diaz Monsalve presented information on malaria grants and performance-based funding. Performance-based funding ensures that investments are made where impact on the three diseases can be achieved, provides incentives to focus on results and timely implementation, and helps to identify effective efforts for early replication and scale-up. Please see the attached PowerPoint presentation specific details.

General discussion:

- Toolkit: The second version of the M&E toolkit came out in 2006.

Models of Technical Assistance for M&E—*Kate McIntyre, Tulane University*

Kate McIntyre gave a presentation on models of technical assistance on M&E.

General discussion:

- Accreditation: One suggestion is to require consultants who provide technical assistance on malaria to go through an accreditation process (as is done for TA for TB). A program would initially require some investment, but it would be a way to control poor quality technical assistance.

- Combining TA: It will not be feasible to combine TA for HIV, malaria, and TB since it will be difficult to find consultants who are aware of all of the indicators for all three diseases.
- Finding TA: When people at the regional or country level look for TA, they often go to people they know first. Pushing down TA to a lower level is linked with better dissemination and communication of the work that the MERG does. Consultants need to know that the indicators exist, so getting MERG products out there will help create consistency in TA. Current patterns of demand for TA need to be examined so that products can reach these consultants.
- MERG “stamp” of approval: An idea that was discussed is having a MERG “stamp” of approval on products as well as consultants. The MERG would have to create a course to prepare consultants and identify people to work as consultants. A draft training curriculum could be created. UNAIDS has done this with PEPFAR, so the same type of activity could be done for malaria.

Update on M&E and DQA Initiatives—*Ronald Tran Ba-Huy, The Global Fund*

Ronald Tran Ba-Huy presented an update on M&E and the DQA initiatives. Please see the attached PowerPoint presentation for further details.

General discussion:

- RBM support for M&E Checklist: The RBM would like to be associated with the initiative to publish an M&E checklist in the Fall of 2006. The RBM logo should appear on the publication.
- Focal point: The RBM MERG is willing to designate a technical focal point that could be contacted regarding the development of the DQA tool.
- TERG: The TERG will be meeting next week. They last recommended that there should be a stakeholder workshop. This will be a great way to raise the awareness of the complex issues involved in setting up an M&E program.

Future Leadership of the MERG

There will be a RBM board meeting in July. The role of collaborative mechanisms and the original TOR will be reviewed. The TOR should be reviewed not just for leadership but also for this potential operational arm. In fact, the TOR should be reviewed as needed based on new developments. Operational and funding issues will also have to be reviewed.

The MERG invites WHO to continue to have a strong presence in the work of the group. During the time that the RBM Partnership is undergoing significant change, the MERG members requested that no change be made to the leadership for the next year. Thus, it was requested that the current chairs remain in place for a year and the TOR should be revised as needed for discussion at the next MERG meeting.

Thursday, June 8

I. Progress of Major Initiatives (Continued)

Update on the Malaria Consortium—*Helen Counihan, Malaria Consortium*

- **Background:** The Malaria Consortium is an NGO that provides technical assistance on interventions for prevention, case management, and diagnosis of malaria. The organization's headquarters is in London but its biggest office is located in Kampala.
- **Funding:** The Malaria Consortium is being driven by funding now that the organization does not primarily rely on DFID for money. There are worries that the organization will need help with M&E, so it would be great if the group was given the resources to participate in M&E decision-making. The organization is now seen as a business now rather than a technical arm of DFID.
- **DFID:** There has not been a consistent presence of DFID at the meetings. It is a good time to get in touch with them to invite them to the meetings.
- **Partnership:** The Malaria Consortium should consider registering with the World Bank as a preferred vendor so that it will be easier for the Bank to work with the NGO. The PMI is considering giving the group some funding to do some formative evaluations. CDC is also a willing partner.

II. Communication and Dissemination Activities

Improved Communication and Dissemination Strategies—*Emily White Johansson*

Emily White Johansson made a presentation on the needs for an improved communication and dissemination strategy.

- **Versions:** Different versions of products should be created for different audiences. Some of the audiences might include: technical specialists and advisors within partners (global level technical specialists and country level specialists); country programs (e.g. national malaria control program, MHCH programs, HMIS, IDSR, central statistics offices); academics in malaria; and NGOs.
- **Support:** There is a technical M&E group in Uganda that is supported by the National Malaria Program. However, they do not meet very often and are not efficient. One suggestion is to provide support to the national program to invigorate their meetings.
- **Goals:** At the global level, the group should push to have one M&E system; at the country level, TA should be provided.
- **Response:** The MERG has to be responsive to the needs of its audience. If the target audience at the global level still needs guidance, the MERG has to figure out a way to respond to the need, whether it is by the whole MERG or by a specialized agency that partners with the MERG. The MERG not only is responsible for disseminating information, but also has to respond to the needs of others. In some cases, it may be necessary to demand a response from the audience.
- **Harmonization of dissemination:** One organization may want to send materials out to their country offices itself. Another organization may want the MERG to do it. There

are different routes of dissemination for different organizations, so the route has to be harmonized.

- Routes of dissemination: Some of the routes for dissemination are the listserv, the WHO mailing list, and the list of African public health training courses. Multiple products can be pushed at one time but has to be done so strategically with the target audience in mind.
- Meetings: It would be ideal to have country M&E officers from different countries meet annually and have the MERG also be an active participant in the meeting.

Update on Current Communication/Dissemination Strategies—*Reena Sethi, ORC Macro*

Reena Sethi provided an update on the malaria M&E listserv and the RBM MERG website. Please see the attached PowerPoint presentation for further details.

- Listserv: The Malaria M&E listserv is functioning once again. To subscribe, send an email to reena.sethi@orcmacro.com and type in “subscribe” as subject. Messages will initially be delivered once per week.
- RBM MERG website: The website is currently being reorganized with the help of RBM.

III. Summary of Meeting

Bernard Nahlen summarized the key points of the meeting and further actions:

- UNICEF has agreed to produce the next version of the companion piece to the PMI document giving the MERG’s view of mortality measurement.
- Validation of models: The CHERG will be meeting soon and will update the Lancet model. Once the model is finalized and validated, John Stover can develop the software to go along with that model. UNICEF should chair another meeting of the Mortality Task Force in September since it will take some time to update the model and develop the software. By the time this occurs, the “Options” paper will have made further progress within the PMI.
- Bernard Nahlen spoke with David Bell of WPRO, who has spoken with SEARO about an upcoming meeting in September. The point of the meeting is to bring people together who are involved in mapping initiatives. Maru Aregawa of WHO/GMP will follow up with headquarters and WHOPRO to find out what the plans are.
- Any comments on the M&E framework should be given to Rick Steketee, who will give them to John Miller. John should look at the M&E checklist to make sure that it does not conflict with his framework.
- The operational arm of the MERG has a long list of tasks that can be done, and MEASURE might be able to fund some of the work. The World Bank should also be able to provide some funding. The approach should be to discuss what is needed and come up with a scope of work (with John Miller).
- Carla Winston will follow up with AFRO on some of the new documents they have produced on integrated disease monitoring and on the validation of the new forms they have proposed.
- The Guidelines for Core Indicators is being printed.

- A preliminary report on the Zambia MIS should be ready by the end of June. The Household Task Force meeting should have a conference call at the end of July to discuss procedures, lessons learned, and costing from the Zambia MIS.
- Two IRS coverage indicators (households sprayed and people protected) will be drafted by Kate McIntyre. An entomologist should also be involved in this process. The IRS indicators will not replace program level indicators.
- The MERG's role is to provide guidance on core indicators for reporting program-level indicators, but the group has no intention of going indicator by indicator for lower-level indicators. Smaller indicators should be discussed at the country level.
- The time and place for the meeting of the Economic Impact Task Force will be worked out by the World Bank.
- There should be further discussion on who will put together the World Malaria Report 2007. In the past, WHO and UNICEF have worked on it together, with the World Bank sharing some financial data.
- The TOR for the MERG needs to be reviewed.
- The next general meeting of the MERG will potentially be held in Zambia in late November/early December.