

FOURTH MEETING OF THE RBM PARTNERSHIP
Monitoring and Evaluation Reference Group (MERG)

15 to 16 November 2004 – New York, NY, USA
UNICEF House

MINUTES

I. Welcome and Introductions

Tessa Wardlaw, UNICEF

Tessa Wardlaw welcomed the participants of the Monitoring and Evaluation Reference Group (MERG) for the Roll Back Malaria (RBM) Partnership and introduced Dr. Saad Houry, Director of the Division of Policy and Planning at UNICEF Headquarters, who opened the meeting.

Saad Houry welcomed the group and explained that the Millennium Development Goals (MDGs) have been instrumental in encouraging inter-agency and multi-agency collaboration, of which this meeting of the RBM MERG is further evidence. Houry praised the MERG's achievements, which includes providing input into development of the Africa Malaria Report 2003, facilitating development of data collection tools and methods to fill data gaps in malaria information (such as the Malaria Indicator Survey package), extensive collaboration between the Demographic and Health Surveys (DHS)/ORC Macro and the Multiple Indicator Cluster Surveys (MICS)/UNICEF and in the revision and updates of malaria specific morbidity and mortality estimates.¹ Dr. Houry also mentioned the MERGs work with other partners, such as the Malaria Consortium, and links with other major donors in data collection and analysis. Houry closed by confirming UNICEF's commitment to preventing and treating malaria as an imperative piece in child survival and monitoring and evaluation (M&E) of malaria programs to target interventions.²

II. Review of Objectives and Agenda

Bernard Nahlen, WHO/RBM

Bernard Nahlen welcomed and thanked everyone for participating in the RBM MERG meeting and reminded everyone that meeting minutes from the previous MERG meetings and MERG Task Force meetings are accessible through the RBM partner website <http://rbm.who.int/merg>

Five objectives were identified for the meeting:

1. To report on progress of MERG Task Forces since November 2003.
2. To discuss progress on global and regional reports.
3. To discuss initiatives relevant to RBM monitoring and evaluation.
4. To provide updates on data collection activities and plans.
5. To discuss plans for strengthening links between GFATM/funding sources and coverage assessments.

The objectives were all addressed during the presentations and discussion throughout the two day meeting.

III. Update on September 2004 RBM Board Meeting

Thomas Teuscher, WHO

Thomas Teuscher began by explaining how the external evaluation of the RBM partnership led to the development of the MERG. The RBM Executive Secretary recognizes the importance of this group in documenting the progress of RBM at the global and community levels. Teuscher presented an update from the last Board meeting where the strategic plan of 2005-2015 and the roles of working groups within this partnership were discussed and clarified. The 6th meeting of the RBM Partnership Board:

¹ The Africa Malaria Report 2003 can be found on the RBM website under "Publication": <http://rbm.who.int/merg>

² For more information on the Malaria Consortium visit: <http://www.malariaconsortium.org/>

- brought together all major constituencies in drawing back malaria;
- addressed strategic issues;
- discussed possible country representative replacements next spring, to keep malaria endemic countries as the largest number of constituencies;
- discussed the fact that the Western Pacific and the Americas representatives have not yet been included; however, the Board anticipates their representation soon as it is very important that each group of countries are represented;
- the private sector has become a more active member, which includes companies, research institutions and universities.

The Board meets twice a year and holds monthly teleconferences. One of the major outcomes of the recent meeting was that the global agenda of the RBM Board was outlined in the final adoption of the operating framework, which will assist the Board to move forward in more structured manner. Teuscher stressed that the Board and Partnership Secretariat collaborate on several levels and they would like to present a joint global and country effort through joint work plans—additionally, the Secretariat helps coordinate procurement assistance and support to countries.

The Board meeting also focused on “Constituency Progress Reports” which Teuscher explained are an important part of maintaining ownership among the RBM partner countries. In addition to Benin’s progress report presentation and discussion, a major component of the Board meeting was to finalize the RBM Partnership’s Global Strategic Plan 2005-2015, which includes resources required for meeting the MDGs. The board also created a subcommittee to finalize the draft of the strategic plan, which will be published in December 2004.³

Lastly, Teuscher explained that during a meeting last week regarding working groups, it was noted that the costs for the working groups should be covered under the general budget—the board had difficulties with the working group line-items which could easily reach millions of dollars. Teuscher reported that the board found the working groups costly, and it was suggested that they should be more country focused and provide more guidance to countries.⁴

Assistance from the MERG

The priorities and milestones of 2005 outlined by the Board reflect the importance of the MERG and the guidance the MERG can offer. Teuscher presented the MERG with current issues that the board would like the group to consider and provide guidance on:

- Assist with country reports (how can the MERG provide assistance for this?)
- Implementing country work plans and producing progress reports to show that countries have achieved coverage;
- Assessing how well countries are doing in developing their policies and strategies.

There are currently no guidelines for the country progress reports, but this is something that could be discussed and standardized with countries. Most importantly though, Teuscher explained that the board would like countries to have support in preparing their progress reports and can be confident in the final product. Lastly, the board would like the MERG to assist in finalizing the Global Strategic Plan 2005-2015—the MERG is needed (or a subset of the MERG) to assess milestones in the global strategy and to finalize and support the M&E chapter. A draft of the plan will be ready soon and it will be distributed.

IV. Objective 1: To report on Progress of MERG Task Forces since November 2003

❖ Task Force on Capacity Building
Nathan Bakyaïta, Malaria Consortium

³ The Strategic Plan will be posted to the RBM Partnership website: <http://rbm.who.int/merg>

⁴ RBM Board support to the MERG has been limited to the cost of travel for 4 representatives of malaria-endemic countries to the MERG meetings. The major costs have been borne by MERG partners.

Bakyaita presented findings of the work on the capacity assessments: “Strengthening Capacity for RBM Monitoring and Evaluation in Africa: A Conceptual Framework”. More complete details are provided in the 61-page draft report on the assessment, which is available to the MERG members for review and comments.⁵ Bakyaita explained that Graham Root of the Malaria Consortium could not attend the meeting but that the assessment and presentation were completed with Root and WHO/AFRO. The assessments illustrated several issues that Bakyaita noted for attention and action. In general, the assessments showed that M&E systems for RBM/National Malaria Control Programs (NMCP) at the country level are weak and fragmented; the capacity at the country level is limited and also limited among collaborating partners and non-governmental organizations (NGOs). Bakyaita noted that timely and relevant technical assistance should be provided to malaria programs in M&E. Issues that need to be addressed at the country level to improve M&E capacity includes:

- Use of existing opportunities, resources and structures that are already in place;
- Frame action for M&E within epidemiological and institutional contexts;
- Institutionalize M&E for Malaria control;
- Human Resource development;
- Provide an enabling environment (i.e. working equipment: faxes, computers, copiers);
- Provide partner support: national and sub-national assistance is needed.

The discussion following the presentation highlighted the importance of implementing the report recommendations and for the MERG to turn to existing M&E officers, RBM Focal Points, universities, research institutions and other initiatives (i.e. The US President's Emergency Plan for AIDS Relief--PEPFAR, UNAIDS etc) that National Malaria Control Programs can use for M&E support/guidance. RBM Focal Points are easily found because they are listed on the RBM website, <http://rbm.who.int/merg>, however their role needs to be clearly defined. Bakyaita will look forward to receiving feedback and comments from the MERG and he will finalize the report by end of November 2004.

Following Bakyaita, Maggie Janes, MEASURE Evaluation/ORC Macro presented a brief summary of the HIV/AIDS M&E Technical Assistance (TA) Request and Response System that is being piloted with the PEPFAR countries and teams.⁶ Janes presented the system to the RBM MERG because the system will be expanding to include the Global Fund for AIDS, TB and Malaria (GFATM) and may provide TA services to Malaria and TB in the future. Further follow up and discussions will take place with the MERG on this issue as MEASURE Evaluation collaborates with GFATM and UNAIDS.

❖ Malaria Survey Task Force
Erin Eckert, MEASURE Evaluation Project/ORC Macro
Fred Arnold, DHS/ORC Macro
Allen Hightower, CDC

Erin Eckert explained that *The Guidelines for Core Population Coverage Indicators for Roll Back Malaria: To be obtained from Household Surveys, July 2004* has just been published and more copies will be made available through MEASURE Evaluation. It is also available on the MEASURE Evaluation website and is currently in English but will be translated into other languages.⁷ Please contact Maggie Janes: margaret.r.janes@orcmacro.com if your field office or headquarter office would like copies.

Fred Arnold updated the group on the Malaria Indicator Survey (MIS) Package. The MIS was developed to act as a malaria-specific and leaner survey tool to fill in the gaps of the UNICEF MICS and ORC Macro's DHS at the national level and can even be used at the district level or for program areas—it is a more flexible tool to collect malaria indicators and can be more easily targeted to malarious areas and to the

⁵ The report is included on the CD of presentations from this MERG meeting.

⁶ The President's Emergency Plan for AIDS Relief: <http://www.state.gov/s/gac/rl/or/c11652.htm>

⁷ The MEASURE Evaluation Project: <http://www.cpc.unc.edu/measure/>

malaria transmission season. Arnold explained that the rationale for the MIS is that some indicators that countries need to report on are best measured through household surveys; for example, in compiling the Africa Malaria Report 2003 most of the information came through MICS and DHS questions/data, but some countries have not had either of these surveys or they have them infrequently. The MIS package was also developed to standardize sampling and training interviewers in household surveys. The questions are standard and have all been fielded in previous surveys. However, for countries where Indoor Residual Spraying (IRS) is a major component of control efforts, there may be a need to propose a standard set of questions related to IRS that could be potentially included in standardized household surveys such as the MIS and DHS since there are currently no questions on IRS. Most of the sections of the MIS are complete and the Household Survey Task Force will meet again for two days in the 5-7 January 2005 period to finalize the MIS package. Additional issues to be discussed at the January meeting will include addition of a standardized laboratory component on parasite prevalence, georeferencing as in the DHS, developing consensus around the sampling frames, translating the package, and identifying countries for conducting the MIS surveys, which will also provide an opportunity for potential piloting of additional questions, as needed. Once these things are finalized the MIS will be made available to MERG Task Force members for final review.

Following Fred Arnold and the MIS Package, Allen Hightower of CDC gave an overview of the Personal Digital Assistant (electronic handheld information device/PDA) used for rapid mapping, household surveys and selecting a sample design, which collects data with quality control. Using PDAs may be an option for the MIS. Hightower explained that there are several brands of PDAs that include Global Positioning System (GPS) units and secure data storage systems. Other features for the field include fold out keyboards and protective cases. The PDA for household surveys is a new and helpful next step in data collection because it makes the process easier in the field: no data entry forms, there are quality control features programmed into the system and it produces rapid analysis, which allows preliminary reports to be produced faster. This tool has already been used in a community survey to assess combined measles vaccine/ ITN activities in Zambia with success and will be used in the upcoming national measles/ITN campaign in Togo in December 2005. Some of the problems encountered were charging the devices (although new and stronger batteries are now available) and the logistics—problems that were not anticipated. Overall the PDAs perform very well and can be used with several other features and tools for spatial and statistical analysis (statistical packages like Epi Info 2000 and can be made compatible with Epi Info 6). The precision for use in household surveys is relatively good, and training materials are currently available in English and French. The MERG discussed the possibility of using the PDA with the MIS and doing a cost benefit analysis to see how much time and programming would need to go into using the device versus a paper-based survey.

❖ Mortality Task Force
Richard Steketee, CDC

Rick Steketee discussed “The Child Health Epidemiology Reference Group (CHERG) Estimates of the Africa burden of malaria mortality among children under 5 years of age: A brief update on revising the mortality estimates”. The CHERG revised and lowered the results of an influential study on malaria deaths of children under 5 by 6%; however the refined sensitivity analysis did not reveal different conclusions from the original study. Steketee briefly explained the model used for the estimates and said that the model allows one to extrapolate back to country level estimates, if needed (half of the deaths were in Nigeria, due to the population size). Steketee also noted that the model includes an urban and rural estimation factor. The next steps are to get the estimates for southern Africa from WHO/AFRO, finalize the full report and post it to the internet and work on two manuscripts, one on the results and the other on methodological issues. Also mentioned was the need for these estimates among older age groups within Africa and all age groups in other regions. Steketee also recommended reviewing the notes of the mortality task force on the RBM website, <http://rbm.who.int/merg> from two years ago which give additional background and explain how best to monitor deaths.

❖ Morbidity Task Force

Eline Korenromp RBM/WHO

Carlos Guerra, Oxford University

Deborah Balk, Columbia University

Korenromp discussed “Proposed malaria incidence estimation at country level and feedback from MERG morbidity task force”. She explained the estimation model of morbidity measure used to track progress and she reviewed process through which it was developed. The model uses the MARA-map of climatic suitability for transmission in Africa but it was noted that a similar type of map for regions outside of Africa will need to be developed (which Guerra and Balk will discuss)—so for this estimation all regions outside of Africa were classified by endemicity. The definition of malaria episode used was having an acute fever with malarial parasitemia and the detailed estimation methodology can be reviewed on the RBM website. Korenromp explained that the populations at risk of transmission were not known for some countries so the estimation was not calculated in those cases. Using the estimates, Korenromp showed that the countries with the highest incidence were in AFRO, which had the most cases: Nigeria, DRC, Tanzania, Ethiopia; outside of AFRO, those with the highest number of cases were: India, Indonesia, Pakistan, Myanmar, Viet Nam, Thailand, Bangladesh, Sudan and with the highest incidence rate were: Laos, Honduras, Nicaragua, Yemen, Cambodia, Myanmar. The future updating of incidence estimate will take into account the national population size, national proportion of urban population, Insecticide Treated Nets (ITN), IRS coverage, and populations at risk of malaria transmission. The recommendations from the morbidity task force on the estimation method included: (1) by using these improvements there is minimized need to rely on HIS data, (2) in the meantime, continue using the HIS based estimates, but assess it by HIS evaluation or from independent expert opinion what the actual reporting completeness might be, (3) propose uncertainty ranges on country estimates, summing the estimated uncertainties in all inputs (i.e. approach for CHERG Africa mortality estimation). The MERG also proposed a discussion around parasite prevalence testing in the DHS to compare with the incidence estimates—this might be possible in the DHS, but probably not the MICS. Please see other considerations of the task force from meeting notes on the RBM website.

Next steps include meeting with Oxford University to: refine national endemicity distributions, standardize estimates of urban populations and analyze effect of urbanicity in reducing malaria transmission, from review of global parasite prevalence and entomological inoculation rates (EIR) data. By April 2005 there will be a revised set of estimates.

Carlos Guerra presented his team’s work (led by Dr. Simon Hay and Prof. Bob Snow) in determining populations at risk of malaria outside of AFRO, in which the Morbidity Task Force/MERG is interested and have already begun collaboration. The general objective of their work is to develop estimates of populations at risk of malaria down to the first administrative level in non-AFRO countries and also by age group. Their current work will help those working in malaria outside of AFRO to better understand the distribution of populations at risk of malaria across different endemicity levels and will try to explicitly incorporate the influence of urbanization on malaria transmission. Guerra explained that his team will be working on validating the original Lysenko endemicity map with parasite ratio and EIR data outside Africa.^{8,9} Guerra and Deborah Balk are both working in this area and Balk presented her research on “Methodologies to Improve Global Population Estimates in Urban and Rural Areas”. She explained the methodology behind the improvements made in determining urban and rural sites, which would assist those working in Malaria to better determine where populations at risk are and to provide a more accurate and standard definition of urban and rural. Balk explained that using the Global Rural and Urban Mapping Project (GRUMP/GPW3) information, the MERG could possibly improve their understanding of malaria

⁸ Lysenko, A. Y. and I. N. Semashko (1968). *Geography of Malaria: A medico-geographic profile of an ancient disease [in Russian]*. *Medicinskaja Geografija*. A. W. Lebedew. Moscow, Academy of Sciences: 25-146.

⁹ For more information on this methodology, please see Hay, S. I., et al. (2004). "The global distribution and population at risk of malaria: past, present, and future." *The Lancet Infectious Diseases* 4(6): 327-36.

<http://infection.thelancet.com/>

transmission, morbidity and mortality and even look at socio-economic status after reallocating urban and rural estimates. The inputs in population for this methodology are from several sources—Balk and her team are working with the UN population division.¹⁰

❖ Anemia Task Force
Eline Korenromp, RBM/WHO

Korenromp presented “Anemia as a Possible Malaria Burden and Impact Indicator”. The task force made recommendations regarding anemia measurements and malaria during their last meeting. Through research, the task force notes that anemia is to be measured in household surveys as hemoglobin (Hb) level, using the HemoCue test on fingerpick blood in children aged 6-59mo.; surveys should ideally, but not necessarily, be conducted during or immediately after the rainy season, and in any case, at a similar time of the year across subsequent surveys and for timely impact measurement, an interval of 2 years between surveys (range 1-5 years) is optimal. The anemia task force also noted that the key indicator to be reported on is the prevalence of haemoglobin <8g/dl because it is likely to be most specific to malaria and to show the most impressive reduction in prevalence. Reporting mean haemoglobins, standard deviations and the prevalence of Hb<11g/dl could be used for further analyses. Progress has been made integrating anemia testing in surveys, for example, more than 20 countries have already had a DHS with anemia testing. Finally, Korenromp explained that a study is being conducted to review and estimate the burden of malaria-related anemia in African children under five years old and will be completed by February 2005. Other areas that the task force might explore next include alternative measurement options to household surveys, such as (sentinel) clinical surveillance, for example, to measure Hb in pregnant women, using anemia in pregnant women as a supplementary indicator of the burden of malaria in pregnancy and how to interpret trends in anemia in view of confounders. *A side note on anemia testing: The Technical Evaluation Reference Group (TERG) of the GFATM is trying to push the inclusion of impact evaluation into the Monitoring and Evaluation Toolkit for HIV/AIDS, TB and Malaria—for example, if anemia testing is included in a recent DHS in a country, then in two years coverage will have been reached, an MIS could be done and trends could be seen.¹¹

V. Objective 2: To Discuss Progress on Global and Regional Reports

❖ Millennium Development Goals (MDG) Reporting for 2005
❖ Linkage with MDG Country Reporting
Tessa Wardlaw, UNICEF

The Secretary-General’s comprehensive report on the Implementation of the Millennium Declaration is the main report and will be issued in March 2005. Wardlaw explained that there is also a “glossy” MDG Report which is an advocacy document and will complement the Secretary-General’s report and inform the political debate that will take place from mid-March through mid-July 2005. This “glossy” report will be short and include major themes and messages and will be posted on the internet by 30 June 2005 and will contain complete data on all the indicators. The MERG members discussed the confusion between the Millennium Project and the Millennium Report; it was explained that they are two separate projects.¹² Wardlaw also briefly explained the linkage of MDG reporting with the UNDP, which includes country support for country level MDG reporting, as well as training of statisticians who work with government counterparts to do MDG reporting. UNICEF collaborated by presenting on malaria indicators, data collection and analysis and reviewed measurement issues.

❖ Abuja Progress Report
Khoti Gausi, ICP/AFRO/WHO

¹⁰ For more information, please visit: <http://sedac.ciesin.columbia.edu/plue/gpw/index.html?main.html&2>

¹¹ The GFATM M&E Toolkit: http://www.theglobalfund.org/en/about/policies_guidelines/default.asp

¹² For information on the Millennium Project, please visit: <http://www.unmillenniumproject.org/html/about.shtm>.

“AFRO and Inter Country Malaria Programme (ICP MAL) for Southern Africa Reports on Progress on Implementation of the Abuja Declaration Plan of Action” was presented by Khoti Gausi.¹³ The main objective of the report is to assess how far country programs have moved towards implementing the elements of the Abuja plan of action.¹⁴ Countries were surveyed and self reported their progress—36 out of 49 countries responded. Gausi explained that the report also includes some information from DHS, MICS and other reports. Areas reviewed include: organization and management of the health system, percentage of government expenditure on health, disease management, provision of anti-malarial drugs and malaria control related materials, malaria drug and treatment policies, disease prevention and the Abuja targets. Gausi also included some information on human resources, research and GFATM. The report will be coming out in about a month. There was some concern raised among the MERG members that the data in this report might be problematic and that this report and the Global Malaria Report (discussed below) should include consistent information—if they do not correspond, it could make the validity of this report weak. WHO is in the process of reviewing the Abuja and the Global Malaria Reports for consistency where similar data are being presented. Recommendations for future reports included having additional country information to validate the self-reported information from countries.

❖ Draft of the Global Malaria Report
John Miller, RBM/WHO

John Miller gave an update of the draft Global Malaria Report and the information collected, including the challenges in putting together the report and the encouraging information that is being received from countries. The major goal of the report is to show progress in countries. Miller also briefed the group on regional tabulations by section of the report, which included antimalarial drug efficacy, services delivered and resource tracking. The date for country feedback and submission of information in the report is the end of November 2004, which can not be extended further if the report is to be ready by early 2005. The hard-copy version of the report will include progress reports on the selected high malaria burden countries; the on-line version will include all country profiles (those countries who did not submit information will have a blank country profile). Updating the figures and finalizing the draft report will take place in December 2004; the report will be circulated for review and feedback in January 2005 and then will be published in February 2005.

VII. Objective 3: To Discuss Initiatives Relevant to RBM Monitoring and Evaluation

❖ Malaria in Pregnancy (MIP) Piloting Assessment Update
Bernhard Nahlen, RBM/WHO

Bernard Nahlen updated the group on MIP group and their efforts to do assessments to capture information on process indicators, for instance, on stock outs and for outcome indicators and impact indicators. These assessments took place in Kenya, Uganda and Nigeria. Nahlen explained that a country’s Health Management Information System (HMIS) was useful in measuring training provided, drug stock outs and intermittent preventive treatment (IPT). However, other indicators, such as ITN use are best measured by household surveys. For the impact indicators on reduction in maternal anemia and low Birth weight (LBW), special studies will be required, since it is not possible to obtain reliable data on from the routine HMIS, which does not include standardized, good quality data on maternal anemia and LBW. Since most pregnant women in malaria-endemic areas deliver at home where birth weights cannot be measured, UNICEF and WHO presently use a method to estimate LBW incidence which combines household survey data with LBW measurement in a subset of deliveries where the newborn has been weighed. An emphasis on collection more measurements of birth weight among women delivering at home in malaria-endemic areas. Is needed to improve on these estimates and will likely require special studies. A report has been drafted and will be posted to the RBM website when final.

¹³ The Abuja Report also includes Sudan which is not a part of WHO Africa Regional Office (AFRO).

¹⁴ The Abuja Plan of Action, visit the RBM website: <http://rbm.who.int/>

❖ Child Survival Indicator Selection Meeting June 17-18, 2004 Update
Tessa Wardlaw, UNICEF

Wardlaw explained the objectives of the meeting were to reach interagency consensus on a minimal set of key indicators for monitoring progress toward the child survival related goals. The focus of the meeting was to identify a short list of child survival coverage and impact indicators that could be measured through household surveys for A World Fit for Children and the MDGs. Two lists of indicators (high priority and secondary) were proposed, all of which can be measured using the DHS and MICS. Malaria is an important component of child survival so there are three indicators related to malaria in the high priority list: household availability of ITNs, ITN use (under fives) and anti-malarial treatment (under fives). Wardlaw explained that meetings have been held between staff from the MICS and DHS survey programmes to harmonize the questionnaires. Efforts are on-going to harmonize with other household survey programs, including the CDC-supported Reproductive Health Surveys and with the World Bank's Living Standards Measurement Surveys (LSMS), as well as others.¹⁵

❖ Malaria Consortium M&E and West Africa Network for Monitoring Antimalarial Treatment (WANMAT)

Walter Kazadi, Malaria Consortium/Gates Malaria Partnership

Walter Kazadi spoke on "Strengthening Systems for Monitoring Anti-Malarial Treatment in West Africa: Example of WANMAT II". The purpose of WANMAT II is to contribute to a better understanding of the epidemiology of Anti-Malarial Drug Resistance in West Africa and to use the information collected to develop/ implement rational anti-malarial drug policies (AMDP) and improve malaria case management. Kazadi gave the status of the country team visits (five countries visited out of the nine) and what was observed/discussed with the WANMAT country teams. Kazadi shared information on the country systems reviewed for antimalarial drug efficacy monitoring—there were several sentinel sites identified, but staff and infrastructure need to be strengthened, there is inadequate funding to run the sites, drug efficacy studies were conducted but not in a systematic manner and there is no standard quality assurance/quality control. Countries have adapted the standardized WHO in vivo protocol in different ways.¹⁶ Kazadi discussed some of the challenges and next steps to be taken by WANMAT II, which include providing enhanced support to improve the quality of evidence and policy development through a subset of sentinel sites, support the AMDP change process, including M&E of new policies and run a Resource Center. Lastly, Kazadi explained that the Malaria Consortium West Africa Office has been providing support to Ghana in the M&E of GFATM activities, and that this has proven very instrumental in the disbursement rates from GFATM. He also mentioned that they are willing to replicate the same experience in other WANMAT II countries and would be glad to share their experiences with the MERG and other partners.

❖ Training Courses for M&E—defining a Malaria Module

Erin Eckert, MEASURE Evaluation

Eckert presented some of MEASURE Evaluation's past and present training programs in M&E and proposed a discussion around how MEASURE Evaluation could assist the RBM MERG in providing a module on M&E of Malaria programs for national and/or sub-national trainings. The MERG agreed that the Capacity Building Task Force's report on the capacity assessments is a good place to start the discussion—how can the MERG target these gaps in malaria-specific or ongoing malaria activities in training? Eckert and the MERG will plan to follow up very soon with the Capacity Building Task Force to carry this forward.

¹⁵ The World Bank's Living Standards Measurement Study (LSMS) household survey information:
<http://www.worldbank.org/lsm/>

¹⁶ For more information on the WHO in vivo protocol visit: <http://mosquito.who.int/malariacontrol> click on "Diagnosis and Treatment", then click on "Resistance".

❖ Climate Information for Measurement of Malaria Incidence for MDGs

Madeleine Thomson, International Research Institute for Climate Prediction (IRI), The Earth Institute at Columbia University

Madeleine Thomson presented work on climate issues and malaria transmission undertaken within the framework of the IRI WHO/PAHO Collaborating Centre for climate sensitive diseases. Thomson explained that measuring climate may be important in determining the impact of programs in areas where climatic factors (e.g. rainfall and temperature) determine a large proportion of interannual variability in incidence. In some areas rainfall can also be forecasted to attempt to predict where malaria transmission will likely be high or low in a particular year. Thomson reviewed several country examples of the intersection of rainfall and malaria transmission and pointed out that important information can be learned from using climate data when assessing the outcomes and impacts of malaria programs. For example, trends in Eritrea show that there has been a general decrease in malaria—is this due to less rainfall or more progress in control or both? Because of the weaknesses of the climate observing systems in most countries Thomson proposed that it is usually appropriate to use more than one source of data (station data, satellite data). Further, she proposed that one could distinguish the impact of climate and interventions on outcomes using multiple regression techniques and that use of such data and methods could contribute greatly to the MERG. Lastly, seasonal forecasts may be useful for malaria control resource allocation in specific geographic areas, which could bring different national institutions together to work on a plan of action. Thomson stressed to the MERG that measuring the success of malaria interventions through analysis of recent trends in malaria (morbidity, mortality, birth weight etc) indicators without taking into account climate variability will result in over-optimistic interpretation of results in some countries (i.e. those in drought) and over-pessimistic interpretation of results in some countries (i.e. those wetter since the baseline year). Thus in areas where malaria transmission is highly climate dependant, climate information may help to both measure the achievement of malaria targets and achieve the malaria targets.¹⁷ Thomson's last point focused on the capacity building/training issues for using climate data, which can bring different national institutions together to work on malaria resource allocation, prevention and treatment issues.

VIII. Objective 4: To Provide an Update on Data Collection Activities and Plans

❖ Regional and Sub-Regional Level: MICS Update and Household Survey Schedule Update

Trevor Croft, UNICEF

John Miller, RBM/WHO

Trevor Croft explained that the next round of MICS will be conducted in 2005 and preparations are in progress. One of the most challenging issues at present is that the questionnaire has become too long and complex and this could compromise the quality of all the data collected. Effort will be made over the next several weeks to reduce the questionnaire size and complexity. Within this context, there is a possibility that the bednet roster may be cut. However, the key malaria indicators would be measured but the questions may be shortened or moved under other sections of the questionnaire. Croft explained that he doesn't want to cut the bednet roster, but will have to see what happens in the discussions. The question about adding anemia testing and an anemia module to the MICS was considered, however, as mentioned previously, it would be very complex, and he did not think that the MICS could handle it. Croft reminded the MERG that the DHS and MICS are very different, and that DHS has the resources to provide anemia testing (technical assistance, funding and training) and the MICS does not.

The scheduling of the next round of MICS is in process right now and John Miller presented the Household Survey Update, which can be found on the RBM website. Miller explained that some of the DHS AIDS Indicator Surveys (AIS) and the MICS are missing from the list. Tessa Wardlaw and Trevor Croft explained that by December 2004 there should be list of countries updated for the next round of the

¹⁷ For more information on the International Research Institute and their work, please visit: <http://iri.columbia.edu>

MICS. The MICS should start for most countries in the middle of 2005, but some will start closer to 2006.

❖ Status of PSI Coverage Surveys

Hibist Astatke, Population Services International (PSI)

Hibist Astatke discussed “Monitoring and evaluating PSI ITN programs using a performance framework for social marketing” and gave an overview of the framework, survey methods, scaled questions on ITNs and how PSI’s surveys are used to improve programs. Usually the PSI surveys are topic specific, however, sometimes topic areas (reproductive health, HIV/AIDS, condoms etc.) are combined into one survey. PSI uses tracking surveys yearly to see the use/availability of the product (i.e. ITNs) and RBM recommended questions are used in the surveys. Astatke explained that PSI uses scaled questions to determine how effective the use of ITNs are and to show the different levels of acceptance by producing a range score. PSI uses national, regional, risk group, under fives and women representative surveys and the regions are divided into urban and rural.¹⁸

❖ Sample Vital Registration with Verbal Autopsy (SAVVY) Update

Philip Setel, MEASURE Evaluation

Philip Setel presented a methodology which can produce mortality rates in countries where a vital registration system is absent. SAVVY is a sample demographic surveillance system built around vital events monitoring with active mortality reporting and cause of death through verbal autopsy. The purpose of SAVVY is to improve the capacity to monitor and measure vital events and generate reliable, consistent, representative and internationally comparable cause-specific mortality statistics. Setel explained that SAVVY is composed of demographic surveillance system, a mortality surveillance system and nested surveys. He shared his experience in Tanzania, where SAVVY is being implemented. The methodology is being supported by the US Emergency Plan for AIDS Relief which has funded the further development of SAVVY tools and promotion in other countries. Validation studies have been completed on verbal autopsy and on SAVVY, which showed positive results. Setel is also working with the Health Metrics Network (HMN) and WHO to promote the method. The MERG is interested in what SAVVY can provide and the Mortality Task Force will follow up to discuss a set of countries where collaboration might be feasible— Setel noted that feasible countries might include Tanzania, Uganda, Zambia, Vietnam, Indonesia and Thailand.

IX. Objective 5: To Discuss Plans for Strengthening Links between GFATM/funding Sources and Coverage Estimates

❖ GFATM disbursements to date for malaria, GFATM Linkage and malaria M&E and Liberia example: malaria M&E needs and GFATM resources

John Miller, RBM/WHO

Tessa Wardlaw, UNICEF

Bernard Nahlen, RBM/WHO

Miller began by explaining that the GFATM website has all of the disbursement information up-to-date, for public review and showed an example from Nigeria.¹⁹ He explained that the issue around poor reporting and M&E by GFATM Principal Recipients (PR) is due to the lack of guidance in the first couple of rounds of funding regarding M&E. In the last few months, with the release and publicity of the Monitoring and Evaluation Toolkit for HIV/AIDS, TB and Malaria, GFATM are trying to notify PRs and Country Coordinating Mechanisms (CCM) that 10% of their funding should be allocated to M&E. Bernard Nahlen gave an example from Liberia, where WHO and the Ministry of Health (MOH) were scrambling to

¹⁸ Population Services International M&E/research, please visit: <http://www.psi.org/research/>

¹⁹ For GFATM disbursement information: http://www.theglobalfund.org/en/funds_raised/commitments/

put money aside for a survey, but then became aware that the GFATM PRs had money for M&E which could be used for a survey. Liberia will likely be the first country to use the MIS survey. The use of Global Funds in this way was not publicized or made well-known previously to those working on M&E at the country level. Our role as members of the RBM MERG, UNICEF, WHO and other partner headquarters is to make sure that an announcement gets out to the field/PRs/CCMs that as much as 10% of Global Funds should be allocated to a sound M&E plan, which will include surveys. Finally, Nahlen emphasized that the country capacity needs require urgent attention, and that there should be a link between proper use of GFATM resources for M&E to strengthen capacity to meet the goals of the projects and GFATM reporting.

X. Summary and Next Steps

Bernard Nahlen, RBM/WHO

Before closing the meeting, Bernard Nahlen asked John Paul Clark of USAID to discuss briefly the issue of choosing another global indicator since the drug stockout indicator for the global level was dropped after discussions at the 3rd MERG meeting in Geneva last May. Clark reported that he had some ideas but wanted others to work with him on this. He also mentioned that the MERG should collaborate/learn from other initiatives that are looking for alternative indicators to drug stockouts (US President's Emergency Plan for AIDS Relief etc.). Also an issue that Clark wanted to discuss was methods to measure the proposed indicators; he mentioned several options that need further discussion and thought. These options include the ORC Macro/DHS Service Provision Assessment (SPA) survey, which he will follow up with Fred Arnold; the Health Metrics Network (HMN) with Philip Setel and Service Availability Mapping (SAM), which he will follow up with Rich Steketee, CDC.²⁰ This team will meet and report back to the MERG. All of the objectives of the meeting were met and Bernard Nahlen summarized the next steps for the MERG and its task forces and expressed thanks on behalf of the MERG to UNICEF for hosting the meeting before closure.

Next Steps:

The RBM Board

- RBM Partnership Board to clarify expectations and types of support which will be available for the MERG.
- MERG to provide support to finalize the M&E chapter of the RBM Global Strategic Plan.

Task Forces

- Finalize the country assessment report from the Capacity Building Task Force:
 - Please review and send comments to Graham Root Rootg@ug.afro.who.int and Nathan Bakayita nbakayita@yahoo.com by end of November 2004.
 - Report will be finalized by the end of November 2004.
 - Will hold a meeting to discuss how to operationalize the report—January/Feb. 2005?
- The Household Survey Task Force will meet to finalize the MIS package in Washington, DC 5-6 January 2005.
 - “Lean” Malaria Module to be discussed/followed up.
- Further discussion and finalization of the Morbidity Estimation Method
 - Follow up on work related to populations at risk, urban/rural standardization etc.
- Mortality Estimates
 - Update for the Global Burden of Disease based on CHERG work for children under five and other risk groups.

Reports

- Reporting:
 - Abuja Report will be ready within the next few months.

²⁰ The Service Provision Assessment (SPA) is a facility survey:

http://www.measuredhs.com/aboutsurveys/other_surveys.cfm, the Health Metrics Network (HMN):

<http://www.who.int/healthmetrics/about/en/>, the Service Availability Mapping (SAM):

<http://www.who.int/mediacentre/news/releases/2004/pr75/en/> and additional SAM documents will be made available to the RBM MERG.

- The Global Malaria Report 2004 will be ready to be published in February 2005.
- The MDG Report will be out 1 May 2005.

Other Initiatives

- Non-governmental/research institution support to M&E activities at the country level
 - Malaria Consortium to share M&E tool being used in Ghana (and elsewhere) related to GFATM support to PRs.
 - MEASURE Evaluation to further develop a malaria component of the the M&E training and will follow up with Task Force on Capacity Building.
 - PSI will continue to share methods and data/results from ITN surveys.
 - Further discussion on how SAVVY and Columbia Earth Institute (CEISIN and IRI) tools relate to RBM M&E (and in specific task forces). *Since this MERG meeting in November, IRI has been in discussions with those working on the WHO Global Atlas for infectious disease in the incorporation of routine climate information into the Global Atlas database.*²¹

GFATM

- Links to GFATM M&E
 - WHO/UNICEF to follow up with Bernhard Schwartlander to discuss assuring quality of country-level M&E plans and how GFATM resources can assist to accelerate development of improved M&E systems
- Follow up with SAM/SPA/IMCI/Health Metrics on indicators and measurement tools.

Next Meeting: Bernard Nahlen reported that WHO Regional Office for Eastern Mediterranean (EMRO) has offered to host the meeting in Cairo, Egypt 4-5 May 2005. Nahlen will follow up with the EMRO and inform MERG members.

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²¹ For more information on the WHO Global Atlas, please visit: <http://globalatlas.who.int/>

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