



**Informal Consultation to Review the Greater Mekong Sub-Region
Malaria Monitoring and Evaluation Framework**

Meeting report

**9-10 October, 2008
Bangkok, Thailand**

ABBREVIATIONS

ACT	Artemisinin-based Combination Therapy
API	Annual Parasite Incidence
BCC	Behavior Change Communication
CNM	Cambodia National Centre for Parasitology, Entomology and Malaria Control
EDPT	Early diagnosis and prompt treatment
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GMP	WHO Global Malaria Programme
GMS	Greater Mekong Sub-region
IEC	Information Education Communication
ITN	Insecticide-Treated Net
Lao PDR	Lao People's Democratic Republic
LLIN	Long-Lasting Insecticide Net
M&E	Monitoring and Evaluation
MMP	Mekong Malaria Programme
MoH	Ministry of Health
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
PMI	President's Malaria Initiative
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
TMO	Township Medical Officer
TOR	Terms of Reference
SEARO	WHO South-East Asia Regional Office
USAID RDM-A	United States Agency for International Development Regional Development Mission - Asia
USP	United States Pharmacopeia
URC	University Research Co., LLC
VHW	Village Health Worker
WHO	World Health Organization
WPRO	WHO Western Pacific Regional Office

Background

Monitoring, evaluation, and surveillance (M & E) are necessary components of malaria control programs within the Mekong Sub-region. A unified approach towards M & E within the region could highlight important issues and help foster cooperation in achieving regional goals. The Kunming indicators, an effort by countries in the Western Pacific Region to develop common malaria indicators, attempted to analyze, compare, and guide M & E at the regional level. Unfortunately, the Mekong countries faced difficulties in capturing and accurately reporting some of the requested data. Due to this, the WHO Mekong Malaria Programme (MMP) convened the “Informal Consultation to Review the Greater Mekong Sub-Region in Malaria Monitoring and Evaluation Framework” from 9-10 October, 2008 in Bangkok, Thailand to revisit the issue of M & E of malaria programs within the region, and to start the process of developing a new regional malaria M & E framework (or plan for measuring malaria control efforts) .

This meeting assembled representatives from Mekong country malaria control programs, officials from WHO country offices, and other partners working to control malaria within the Mekong region. The goal of the meeting is to begin a discussion of malaria programmatic efforts, existing M & E systems, and the components that are necessary within a regional M & E framework (or plan for measuring malaria control efforts) .

The consultation’s objectives were:

1. To review the regional “Kunming” malaria indicator framework
2. To describe current national malaria surveillance and M & E data collection and reporting systems, and identify key issues and priorities in national malaria surveillance and M & E.
3. To develop a Mekong sub-regional surveillance and M & E framework for the main malaria program areas.
4. To identify requirements for training, technical assistance and M & E tools as well as country focal points and technical members of working group.

These objectives were met through small group discussions and plenary sessions aimed at fostering communication and achieving consensus.

Activities and Findings

The agenda and list of participants for this meeting is attached in Annex 1 and 2.

Day 1 included a critical review of the *Kunming* indicators and presentations from national malaria control programs (NMCP) from Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam. These presentations covered the M&E activities of their country malaria control programmes, including any challenges faced under the current system and suggestions they may have to improve malaria M&E within the region. Meeting attendees were then split into three working groups in order to discuss current key malaria program areas, current surveillance and M&E systems, experiences with the *Kunming* indicators and surveys, and country program M&E priorities. Groups then highlighted the programmatic areas they felt were important for regional malaria control.

On Day 2, the working groups from Day 1 presented and discussed their findings. A plenary session convened to review the group presentations and to reformulate the stated priorities into a framework. Attendees then split into three groups again to consider further details necessary under each section of the framework. In the afternoon, there was a brief discussion of available M&E tools that programs may want to consider implementing, and a plenary discussion of issues that may arise when attempting to implement a new M & E framework.

Assessment of the regional malaria “Kunming” indicator framework in the WHO WP 1999-2007

E. M. Christophel, M. Mendoza, based on report from P. Graves 2006

The current “Kunming” indicator framework: monitors regional malaria trends and the coverage of control measures; reports and disseminates data; stratifies areas of different risk within and between countries; and contributes to estimates of malaria burden. Updates to the indicator framework are suggested for a number of reasons.

Many of the indicators are consistently and fully reported, such as data on confirmed malaria and malaria deaths, and reporting has generally improved over time in the WPRO region. Confirmed malaria and deaths are the most consistently reported data items. However, some data items are not reported well due to lack of available information in some countries or due to varying interpretations of imprecisely defined indicators such as probable malaria and indicators related to epidemics. Some data items such as severe malaria also were not available.

Additionally, new malaria control tools and some programmatic areas are not covered, and data quality issues have arisen around the following items: “at-risk population”, “probable malaria”, “epidemics” and “treatments given”.

Gaps in the current framework include a lack of rates by gender, age group, and the number of total patients seen in the public health system. Also, no measure of reporting rate from sub-national units exists, but this seemed good in all but one country.

Suggestions to change current data items and indicators include adding those that fill gaps, and dropping or clarifying indicators which are not well-understood or those for which consistent data is not available. Risk stratification of administrative units based on incidence data is strongly desired, and in China, counties rather than provinces should be used as reporting units.

Malaria Control Programme Country Presentations

A brief summary of the progress reports from the second day of the MMP partners' meeting is presented here prior to the country M & E presentations in order to provide context and to compare descriptions of M & E systems with salient program features.

Thailand

Progress Report (October 8 2008)

Ms. Saowanit Vijaykadga, M. Sc., Chief of Malaria Cluster, BVBD Bureau of Vector Borne Disease, Department of Disease Control, Ministry of Public Health, Thailand

Malaria transmission is generally low within the country and the NMCP aims to reduce the malaria morbidity rate to at least 0.40 per 1,000 persons and the malaria mortality rate at least 0.2 per 100,000 persons by 2011. Most cases currently occur along the border, half are non-Thai, and some stratification of risk of transmission exists. Currently, integrated and vertical malaria programs exist, and there is an effort to both integrate malaria control nationally, and to decentralize. Key facets of program concern: vulnerable populations, prompt treatment, bed nets, BCC/IEC, health volunteers and drug resistance.

M&E Report

Dr. Wichai Satimai, Director-Bureau of Vector Borne Disease, Department of Disease Control, Ministry of Public Health, Thailand

The Thai malaria control programme conducts disease surveillance, including active and passive case detection and a monthly report. It also generates bi-annual vector prevention and control measure reports and conducts anti-malarial drug sensitivity monitoring in nine sentinel sites along international borders. Additionally, the Global Fund project, which aims to reduce the malaria burden among the resident population and temporary migrants in endemic areas, conducts monitoring at the central level at a quarterly meeting and bi-weekly at the contractor level. Evaluation of the programme occurs bi-annually by the Malaria Association of Thailand and during years 1 and 4 by an external evaluation team. The flow of data for malaria M & E can be represented within an organizational diagram and clear reporting responsibilities seem to exist. Basic indicators for incidence, mortality, diagnosis and treatment, etc. are available, as well as indicators concerning bed nets, migrants, IEC/BCC and health volunteers.

Cambodia -*Top Samphor Narann, MD, MPH-M&E officer, CNM*

Progress Report (October 8 2008)

Both malaria mortality and morbidity declined in Cambodia between 1997 and 2007. Currently, populations living in forested regions with poor access to public health facilities are especially at risk for contracting malaria. The national malaria program attempts: to provide rapid and accurate diagnosis; give appropriate and acceptable treatment; prevent and control malaria outbreaks; promote effective prevention measures; and increase capacity building to all levels. Under GFATM R6 key program areas include: drug resistance, diagnosis and treatment, program management, M & E, outreach to vulnerable populations, bed net distribution and retreatment, disease mapping and risk stratification, ANC screening and the use of Village Malaria Workers (VMWs).

M&E Report

The National Malaria M&E System in Cambodia works with other departments in the Ministry of Health and other research and M&E institutions to advocate for evidence-based approaches to malaria programmes. The system maintains a national malaria M & E task-force which helps formulate, implement, and oversee the malaria M & E system including data dissemination and quality assurance. The M & E system has a framework with identified data sources, and data flow can be illustrated within an organizational chart of the national malaria control program. The M&E system faces a number of problems implementing international indicators, including: the lack of standardized or harmonized definitions in proposed malaria indicators and indicator frameworks; lack of key impact indicators disaggregated by age-groups and geographic coverage; and limits on the ability of the programme to generate indicators requested by other international organizations including the Global Fund. The Cambodian M&E programme suggests that WHO should facilitate the standardization of common indicators and terminologies and that a malaria patient card should be used to collect data for items not collected by routine HIS. The national program is utilizing Village Malaria Workers (VMW) to address the needs of vulnerable populations, but the M & E of their activities has not been incorporated into the HIS yet. The NMCP has compiled an extensive list describing experience with national and international malaria indicators.

China

Progress Report (October 8 2008)

Malaria is currently confined to endemic areas in 21 provinces, with 10 of these representing 96% of reported cases. In general, malaria burden has decreased from 1991 to 2007, but there has been a slight increase since 2001. Increased scale-up efforts resulted in a 22% decrease in burden from 2006 to 2007. The Global Fund program operates in Yunnan, and the MoH conducts a joint program with Myanmar on the border of the two countries. Malaria control within ethnic minorities and mobile populations are a key concern in China. Currently the malaria program utilizes five major strategies for malaria control including: case detection, health education, vector control, surveillance, and case management.

M&E Report

The China CDC initiated a disease reporting system in 2004, and by 2005 had set up 64 malaria surveillance sites in 19 endemic provinces. In addition, malaria is a reportable disease in China; there is malaria control staff at each administrative level of the CDC; and a daily reporting system has been implemented for incidence and mortality data. Global Fund outcome/impact indicators are also collected regularly with success, and this is attributed to the presence of an effective GFATM specific M & E plan. There has been difficulty with some measurements such as “population at-risk” and indicators dealing with “epidemics” due to lack of clear definitions. Additionally, it has been difficult to collect data for process indicators such as number of bed nets treated because support and a regular, integrated reporting system do not exist. Delivering care to migrants are important to malaria control in China, and the China CDC would like to suggest distinguishing migrants within border counties or a township, migrants in border counties from inland counties or provinces, and migrants from neighboring countries.

Lao PDR

Progress Report (October 8 2008)

Malaria has declined in Lao and is no longer among the 10 reportable diseases of the MoH. New policies, strategies and intervention tools need to be revised along with this reduction in malaria incidence. The program goals are to reduce morbidity and mortality by 80%, and to expand net coverage and early detection and treatment. Malaria endemic areas should be re-stratified as soon as possible and efforts, funding, and tools should focus on high malaria endemic foci in the south of Laos. The NMCP also studies drug resistance in 5 sentinel sites, and the country’s malaria vectors and insecticide resistance in 16 sites.

M&E Report

The Laos National Malaria Control Program has received four grants from GFATM, and the NMCP M & E plan for 2008-20012 was updated focusing on M & E infrastructure, data collection and recording, and data use and dissemination. The GFATM recipients report data on incidence, mortality, net coverage, training, case management, outreach to minorities, timely reporting and drug quality/resistance. Challenges to carrying out M&E in Laos include: limited human resources and significant turnover, incompleteness and inaccuracy of reports, and some confusion regarding reporting requirements.

Myanmar

Progress Report (October 8 2008)

Malaria burden has decreased from 1990 to 2006; in 2006, the malaria morbidity rate was around 10 per 1,000 persons and the mortality rate was around 3 per 100,000 persons. High risk groups are migrant workers in rural areas, forest workers, upland farmers, and ethnic minorities. Malaria transmission is especially high in forested areas. Efforts to stratify risk and focus efforts are underway. Currently, approximately 75% of malaria cases were due to *P. falciparum*. Resistance of this parasite species to chloroquine and sulfadoxine-pyrimethamine is high and widespread. Current malaria interventions include: bed nets, vector control, community planning, cross-sectoral collaboration, case management, BCC, training, supervision, drug resistance/quality surveillance, and access for vulnerable populations.

M&E Report

The WHO country office executes the Three Diseases Fund (3DF) in Myanmar for malaria prevention and control. Three different programme components are carried out separately by WHO, the Myanmar Council of Churches and the Myanmar Medical Association. Challenges to M&E program implementation include the need for: regular supportive supervision, monitoring, data collection and timely reporting, technical support, financial support, logistics management, scheduling and quality of trainings, and participation and commitment of Township Medical officers (TMOs). The program currently measures investments in BCC, bed nets, case management, and training.

Vietnam- Dr. Nguyen Manh Hung-Director of Vietnam NMCP

Progress Report (October 8 2008)

Between 1991 and 2007 malaria morbidity, mortality and API declined in Vietnam. The round 3 Global Fund project (2005 - 2009) is attempting to reduce malaria in the remaining 23 highly endemic provinces. Challenges to the program include: environmental changes; the fact that 30.7% of the total population lives in the endemic areas; coverage and quality of control activities in the malaria endemic areas is limited; and illegal migrant populations stay in the forests.

M&E Report

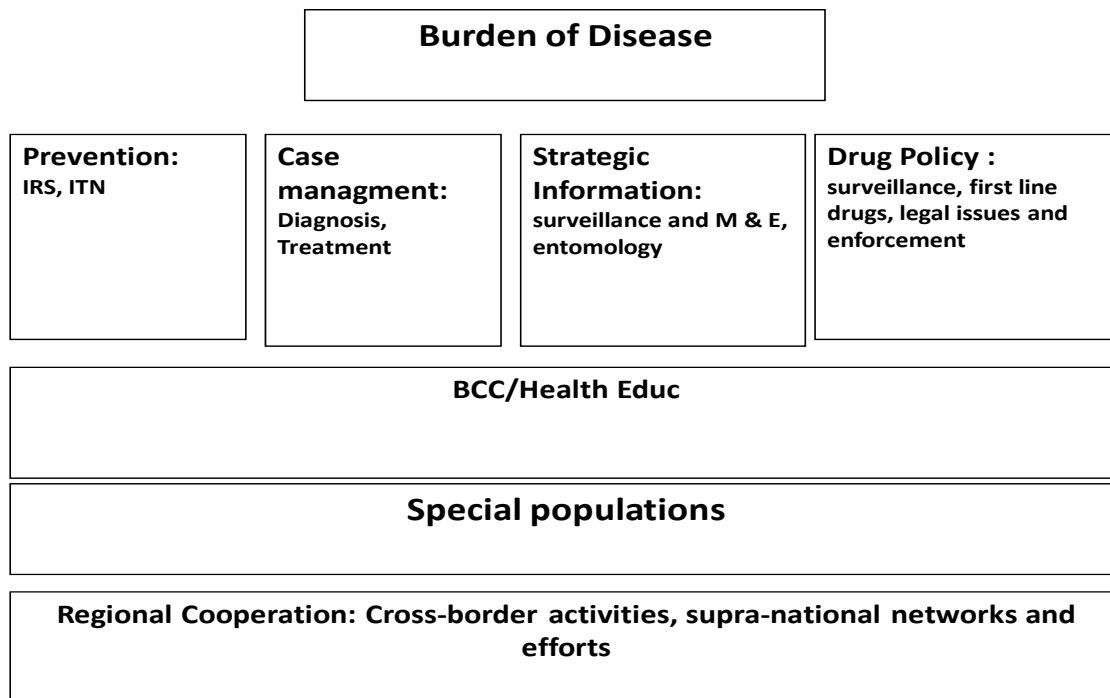
The National Malaria Control Programme finds issues with the case definitions of “probable” and “suspected malaria cases” in the Kunming indicators which do not allow for easy reporting of this indicator. The program suggests the need for risk stratification as the indicator for “average number of persons per net” only needs to be collected in areas where vector control measures are applied or in malaria endemic areas; this information needs to be collected by surveys and is time consuming and costly. Additionally, the population at risk needs to be better defined. The NMCP has developed organizational charts showing data flow for malaria M & E. The program currently collects indicators on disease burden, net coverage, and BCC messages learned. Disease burden indicators are stratified by age and by pregnant women.

Working Group Presentations:

Current Key Malaria Program Intervention Priority Areas

Participants split into three groups and discussed the programmatic areas that are important for malaria control within the region. Groups then identified the key areas that should be measured within a regional malaria framework. The separate groups identified several different key priority areas: diagnosis and treatment, prevention, surveillance, health education, special groups, health systems, IEC/BCC, vector control, case management, and M & E. A plenary session was then convened to evaluate the identified programmatic areas, and to distill them into a preliminary framework. Through discussion, some components were consolidated or eliminated and the framework below was produced.

Framework based on Group Discussion



Impact:

Burden of disease – measure of disease incidence, prevalence, morbidity, and mortality

Distinct programmatic areas:

Prevention - measure of bed and hammock net distribution, IRS activities

Case management – measure of diagnosis and treatment, RDTs, microscopy, ACTs

Strategic information – measure of sentinel surveillance, surveys, health information, strategic planning, data use, and entomology

Drug policy – measure of drug resistance/quality surveillance, policy regarding first line drugs, legal issues and enforcement

Cross-cutting areas:

BCC/Health education – measure of BCC/IEC for correct use of bed nets, rational drug use, integration of malaria messages into general BCC, production and harmonization in different languages

Special populations – measure of activities/outreach targeting migrants, minorities, geographically at risk

Regional Cooperation – measure of cross border collaboration, regional networks for malaria control

Working Group Presentations:

What needs to be measured within the new framework

Participants split into three groups to discuss components of the new framework and to start determining what should be measured.

Burden of disease should be determined by measuring the populations at risk, and creating a more clear definition of malaria cases. Instead of the probable and suspected definitions currently used, the region should consider using “confirmed,” and “unconfirmed but treated malaria cases.” Measures of uncomplicated and severe malaria are also necessary.

Prevention should measure net distribution, net retreatment, and IRS activities.

Case management should measure the identification of true cases of malaria and the appropriate treatment of malaria. Also need to monitor the availability of proper supplies, the use of ACTs, RDTs, health service utilization and health seeking behavior.

BCC/Health education need measures of standardization and harmonization, clear policies, strategies, and M & E of behavior change.

Special populations should measure activities aimed at migrants, minorities, forest dwellers, inaccessible regions, border communities, pregnant women and children. Also need to assess whether outreach and BCC are done in appropriate languages.

Regional cooperation should be monitored by aligning policies, measuring effective monitoring of mobile communities, coordinating investigation of outbreaks along the border, and building functional cross-border networks with adequate resources.

Groups did not have adequate time to discuss **strategic information** and **drug policy**.

Available M & E tools

In order to inform NMCPs within the region of specific M & E tools that are available, and to allow programs to start considering barriers to implementation that may need to be overcome, the tools available for M & E of malaria were briefly described:

- M & E System Strengthening Tool (MESST) - a self assessment of the M & E system that helps countries identify areas of improvement and formulate national M & E plans. (http://www.theglobalfund.org/en/performance/monitoring_evaluation/)
- Routine Data Quality Assessment (RDQA)- improves data quality by assessing collection, compilation, and reporting at all levels of the M & E system. (<http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/RDQA%20Guidelines-Draft%207.30.08.pdf>)
- M & E toolkit – useful for developing and improving a unified M & E system within a country. (http://www.theglobalfund.org/en/performance/monitoring_evaluation/)
- GMP Indicator and Measurement Guide- describes suggested standardized indicators for routine data. (<http://www.who.int/malaria/monitoringandevaluation.html>)
- Malaria Indicator Survey (MIS) – a household-level survey for malaria specific data. (<http://www.rbm.who.int/merg.html#MIS>)

- Net Tracking Tool - assesses retention and utilization of nets. (<http://www.malariaconsortium.org/pages/developingasustainableitnmarket.html>)
- Malaria Patient Card - tool to collect standardized case management data on patients visiting clinics for malaria treatment (See Annex 4).
- Community Level Program Information Reporting (CLPIR) - toolkit for creating systems to collect data at the community level for HIV/AIDS, but could be adapted for malaria. (http://rhinonet.org/Docs/Membership/Forums/Community-Based_HIS/clpir_intro.pdf)
- Drug Quality Assessment Tools available through USP: assessment of medicine regulatory authority, indicators and sampling guidelines for Medicine Quality Monitoring (MQM), sampling protocol for accepting new shipments of medicines, rapid assessment of drug quality assessment and quality control within a pharmaceutical supply and distribution system. (<http://www.usp.org/worldwide/dqi/resources/assessmentMaterials.html>)
- GMP database - management tool for program planning, decision making and monitoring progress. (<http://www.who.int/malaria/monitoringandevaluation.html>)

Plenary discussion on implementation

Discussions of barriers to implementation that may need to be addressed occurred throughout the meeting. This summary reflects those comments as well as the discussion during the plenary session.

Systemic barriers to implementing useful new M & E systems frequently exist. Within the Mekong region, data collection and management varies from country to country: some countries utilize their HMIS system for malaria M & E, while other countries have multiple systems. Other obstacles to M&E presented include: a fragmented M&E plan; limited information and difficulty in collecting information on migrant/mobile population; confusing indicators without standardized definitions; and poor data quality.

Programs generally need: national M & E plans rather than project based plans and resources to strengthen M & E infrastructure such as reporting structures, human resources, and necessary equipment. Also, clear definitions including the identification of appropriate denominators are necessary. Useful data must also be gathered from entomological and drug sensitivity/quality surveys and special studies.

The participants identified three technical questions that needed to be answered for effective malaria control within the region: measuring the population at risk, the adaptation or creation of effective surveys within the region, and the need for stratification of risk.

Any new M & E system must also satisfy the needs of country programs. In order to be effective the new system must satisfy a program's management needs, and the requirements of international organizations.

Conclusions and Recommendations

From discussions and presentations, it is clear that many factors affect malaria control within the Mekong region, and that these factors frequently cross borders. The prior attempt to implement a regional malaria M & E system, the Kunming indicators, met with difficulty but these experiences will help guide the current process.

After group discussions, the participants identified eight potential components of an M & E framework for malaria. In order to measure impact, disease burden must be measured. The meeting identified four distinct programmatic areas: prevention, case management, strategic information, and drug policy. The participants also recognized three cross-cutting components of malaria control: BCC/health education, special populations, and regional cooperation. In small groups, discussions began to identify desired activities and qualities within regional malaria control. Conversations will continue to further develop the framework and indicators to reflect the needs of the region.

WHO MMP, NMCPs, USAID, MEASURE and other partners will work collaboratively to develop a regional malaria framework. Due to the diversity of programs, the framework will take the form of a guide with suggested indicators for the region. Country programs can then use the guide to select which components and indicators are applicable to their program. The ultimate goal is to develop an implementable framework that provides programs with useful information for program management and satisfies the needs of international organizations. Efforts will also be made to try and reduce reporting burden which can be significant. The framework will examine current M & E requirements and will try to integrate them in order to streamline reporting.

From the meeting, three components of the framework stand out:

1. Determining indicators for routine data sources such as HMIS systems – this will largely involve identifying the existing data systems within different countries and adapting them to assure comparability, as well as defining new indicators that countries may want to consider collecting.
2. Determining indicators for non-routine data sources such as surveys and sentinel site surveillance – this will be based on the region's needs, any existing guidelines, expert opinion, and current practices.
3. Answering specific key technical M & E issues such as defining the population at risk, adopting existing malaria survey tools to the Mekong region, and determining if risk stratification by geographic area may be appropriate.

All three components will be addressed in partnership with local partners including the WHO and officials from national malaria control programs. Regarding the first component, efforts will be made to gather the relevant information remotely, but trips to specific countries may be necessary to gather field input on the proposed framework. For the third component, MEASURE will engage global technical experts in malaria to start the process of answering these questions.

The framework will continue to evolve as discussions with stakeholders continue. In the near term, MEASURE will continue to communicate with NMCP officials within the region, WHO, and USAID to gather information on existing M & E systems within the Mekong region.

The following timeline was proposed for developing the framework.

1. Oct 2008 Hold M & E framework meeting with goals of:
 - a. Formulating an M & E framework based on key issues identified by countries.
 - b. Identify members of core working group that will develop framework details such as specific indicators and/or planned M & E strengthening activities.
 - c. Identifying potential obstacles that need to be addressed in order to implement the M & E framework.
2. Take-home work to be completed during the 2 months following the meeting:
 - a. Adapt the proposed framework to better reflect ideas proposed during the meeting and distribute this for comment (November 08).
 - b. Create a list of proposed indicators for M & E framework and plan a follow-up meeting of core working group (December 08).
 - c. Country representatives, WHO, USAID and other partners discuss proposed M & E framework with stakeholders within the region to examine feasibility, completeness, and any other concerns that may need to be addressed (January 09).
3. Convene meeting of core working group consisting of NMCP officials, WHO, USAID, MEASURE, and other partners to finalize indicator list and reach a consensus (February 09).
4. Distribute proposed indicator list to countries and partners, and solicit feedback regarding them (March 09).
 - a. Arrange country visits, or convene another core working group meeting to finalize the indicator set if necessary (April 09).
5. WHO, USAID, and MEASURE talk to partners and country representatives to identify specific country visits to collect input from the field and/or provide specific TA (January – June 09).
6. Finalize indicator based on feedback and write a guidance document for the Greater Mekong Subregion M & E Framework (May -June 09).
7. Distribute guidance document and solicit feedback (July - August 09).
8. Organize meeting to introduce completed Greater Mekong Subregion M & E Framework to countries. (September 09).

9. If sufficient funds available, develop curriculum for training and implementing of framework with NMCP officials, and conduct trainings within countries (October 09).

DRAFT

ANNEX 1



Informal Consultation to Review the Greater Mekong Sub-Region Malaria Monitoring and Evaluation Framework

9-10 October 2008
Millennium Hilton Bangkok Hotel
Bangkok, Thailand

MEETING AGENDA

October 9, 2008 (DAY 1): Learning from Experience

- 08:30 Registration of participants
- 09:00 Opening remarks
- WHO
 - USAID
 - MEASURE
- 09:15 Introduction of participants (MMP)
- 09:20 Nomination of chairperson, co-chair person, and rapporteur for Day 1
- 09:25 Meeting rationale / Objectives and expected outcomes (MEASURE)
5. To review the regional "Kunming" malaria indicator framework
 6. To describe current national malaria surveillance and M & E data collection and reporting systems, and identify key issues and priorities in national malaria surveillance and M & E.
 7. To develop a Mekong sub-regional surveillance and M & E framework for the main malaria programme areas.
 8. To identify requirements for training, technical assistance and M & E tools as well as country focal points and technical members of working group.
- 09:45 "Kunming Indicators", a critical review (WHO/WPRO)
- 10:05 Group Photo & Coffee Break

- 10.30 Country presentations (15 minutes + 5' clarification)
- Thailand
 - Cambodia
 - China
- 12:30 Lunch Break (Yuan Restaurant, 2nd Floor)
- 13.30 Country presentations (Continued)
- Lao PDR
 - Myanmar
 - Viet Nam
- 15.00 Coffee Break
- 15:30 Working group 1:
- We split into 3-4 parallel discussion groups who will nominate a note-taker. Each group will then discuss working Group TOR:*
- *Describing current key malaria programme intervention priority areas*
 - *Current malaria surveillance and M & E data collection and reporting systems*
 - *Experiences with Kunming Indicators and surveys*
 - *Current issues and obstacles*
 - *Your programme M & E priorities*
- Group will think about the issues from the following perspective:*
1. *What is their country and region's experience with M & E for the specific topic and are there any special concerns that need to be considered?*
 2. *How was this key issue addressed by the Kunming indicators? Does an indicator exist? Was it useful? What changes do you suggest to the Kunming indicator(s)? Are there any components of this key issue that were not addressed by the Kunming indicators, and if so, what needs to be generally measured?*
 3. *Do you need to do any surveys or surveillance to measure aspects of the identified key issue?*
 4. *Are there existing HMIS , GMP, or GFATM indicators that you use to measure this key specific issue? Any issues with these indicators? Do these indicators correspond with any of the Kunming indicators?*
 5. *Does the key issue vary across countries, and if so, do any specific concerns need to be addressed? Are there any cross-border concerns?*
 6. *Any specific tools or TA needs that may be useful?*
 7. *Any other specific concerns regarding M & E of the key issue?*
- 17:00 Preparation of presentation of working group results in plenary
- 18:00 Closure of Day 1

October 10, 2008 (DAY 2):

9:00 *Nomination of chairperson, co-chair and rapporteur*

9:05 *Group Presentations (10 minutes each)*

9:30 *Plenary to formulate framework based on group discussions*

10:15 *Coffee break*

10:30- 12:00 *Reconvene Groups*

TOR: 1-3 Indicators to place in sections assigned to each section of framework

Lunch

13:00 *Group presentations 20 mins each (+ 10 discussion of each group's presentation)*

14:30 *Available M & E Tools*

14:45 *Plenary Discussion :*

TOR: Framework Implementation

A: Barriers to implementation

B: Specific TA needs

16:15 *Plenary: Identify contacts, plan timeline*

17:15 *Closure*

ANNEX 2



Informal Consultation to Review the Greater Mekong Sub-Region Malaria Monitoring and Evaluation Framework

9-10 October 2008
Millennium Hilton Bangkok Hotel
Bangkok, Thailand

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ANNEX 3

SUGGESTED MODIFICATIONS TO KUNMING INDICATORS

- Drop 'at-risk' population for now
- Add 'total patients (outpatients, inpatients, and deaths) seen at health facilities
- Divide confirmed cases into slide and RDT
- Drop 'probable cases' ?
- Use 'severe cases' and 'deaths' without dividing into probable/confirmed
- Drop epidemic items for now
- Drop doses of drugs distributed
- Drop average persons per net
- Report LLIN/ITN separately as well as number of ITN retreated
- Report number of houses sprayed rather than population covered (as data item)
- Add incidence of clinical/suspected cases
- Drop incidence of probable malaria
- Add incidence of severe malaria instead of proportion of cases which are severe
- Drop API (clinical and asymptomatic combined)
- Drop case fatality rate of Pf malaria
- Drop number of treatment doses
- Drop indicators based on at-risk population denominator
- Use total population of administrative units as denominator for prevention activities

ANNEX 4

MALARIA PATIENT CARD

Province / Region..... District Date / /

Health unit OPD No.....

Name

Age Sex..... Pregnant NO Uncertain
 YES 1st 2nd or 3rd trimester

1. Clinical assessment for malaria _____

Duration of fever (days before visit) 1 2 > 2
Ask and check for signs of severe malaria (tick ✓): If other signs of uncomplicated malaria:
 Multiple convulsions
 Impaired consciousness or lethargy If other signs of severe disease:
 Vomiting everything
 Unable to walk or to sit unassisted

2. Laboratory examination _____

• Laboratory examination: YES NO
• Blood smear: positive negative
• RDT: positive negative
• *Malaria species*:
 falciparum vivax mixed infection others not identified

3. Diagnosis CLINICAL CONFIRMED _____

Uncomplicated malaria Re-treatment Severe malaria

4. Treatment prescribed _____

.....
.....

5. Treatment dispensed _____

YES NO Amount

6. Action taken _____

Sent home Referred Admitted