UNITED NATIONS OFFICE FOR PROJECT SERVICES - MYNAMAR OPERATIONS CENTRE

Regional Artemisinin Containment Initiative Grant (RAI) Monitoring and Evaluation Plan

Addendum to Programme Management and procedural Manual

UNOPS – PR GFATM

2014 - 2016

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Introduction

In August 2013, UNOPS Myanmar (MMOC) was selected by the Regional Steering Committee to become the Regional Principal Recipient (Regional PR) for the Artemisinin Resistance Containment Initiative Grant from the Global Fund in Greater Mekong Sub-region (Cambodia, Laos, Myanmar, Thailand and Vietnam). The implementation of the grant will commence in January 2014.

As the Regional PR, UNOPS has the legal responsibility to The Global Fund to implement the proposal under the oversight of the both the RSC and CCMs. Thus UNOPS is responsible for the quality financial management, timely procurement of supplies and service delivery as well as efficient monitoring and evaluation of grant implementation activities.

This addendum details the Regional PR M&E activities, processes and procedures related to RAI grants implementation in Cambodia, Lao, Myanmar, Thailand and Vietnam. Details of the planned monitoring and Evaluation for PSR processes and activities are provided in respective (National) Monitoring and Evaluation Plans for Malaria and it addendums.

Goal and Objectives of RAI Grant

Countries in the GMS have been successful in reducing malaria over the past 10 years to the extent that Cambodia, Thailand and Viet Nam have all declared malaria elimination as national goals. All of these gains are seriously threatened by the emergence of P. falciparum parasites that exhibit resistance to artemisinin and the partner drugs used in combination with artemisinin.

Goal:

To make an as large as possible contribution to the elimination of falciparum malaria from the GMS, and to prevent the emergence or spread of artemisinin

Objectives:

	Tier 1
1	To interrupt transmission of P. falciparum by universal coverage and usage of insecticide treated bed nets (either long-lasting nets or treated conventional nets) in all targeted areas.
2	To provide universal access to quality diagnosis and treatment for static populations at health facilities (public and private) and through community malaria workers.

3	To provide access to prevention, diagnosis and treatment for mobile and migrant populations.
4	To halt marketing and sale of oral artemisinin monotherapies.
5	To establish and operationalize a rigorous surveillance system linked to a focal response mechanism.
	Tier 2
6	To ensure high levels of usage and coverage of insecticide treated bed nets (either long-lasting nets or treated conventional nets) in all targeted areas.
7	To provide universal access to quality diagnosis and treatment at health facilities (public and private) and through community malaria workers in targeted areas.
8	To halt marketing and sale of oral artemisinin monotherapies.
9	To closely monitor trends in malaria cases, to identify and take action to control outbreaks and to undertake TES in sentinel sites.

RAI's Indicators Framework.

INDICATOR	RAI COMPONENT	Baseline	TARGET		
		2012	**2014**	**2015**	**2016**
Confirmed falciparum malaria cases per 1000 persons per year.	CAMBODIA	3.99	3.19	2.55	2.04
	LAO	29.40	29.10	23.60	15.30
	MYANMAR	8.50	7.50	7.00	7.00
	THAILAND	0.30	0.28	0.25	0.22
	VIETNAM	0.40	0.36	0.03	0.32
	TOTAL		40.43	33.43	24.88
% of administrative units with falciparum incidence <0.1/1,000.	CAMBODIA				
	LAO				
	MYANMAR				
	THAILAND	81%	85%	90%	95%
	VIETNAM	42%	48%	52%	57%
	TOTAL				
% of administrative units with falciparum incidence <1/1,000.	CAMBODIA	16%	33%	38%	49%
	LAO	0%	8%	15%	23%
	MYANMAR	4%	6%	10%	15%
	THAILAND				
	VIETNAM				
	TOTAL				

% of mobile people that used an ITN the last time they slept in transmission areas (disaggregated by category of mobile/migrant person)	CAMBODIA	tbd	tbd	n/a	tbd
	LAO	tbd	tbd	n/a	tbd
	MYANMAR	tbd	tbd	n/a	tbd
	THAILAND	tbd	tbd	n/a	tbd
	VIETNAM	tbd	tbd	n/a	tbd
	TOTAL				
% of mobile population with fever in the last 3 months that accessed parasite-based diagnosis [disaggregated by category of mobile/migrant person]	CAMBODIA	tbd	tbd	n/a	tbd
	LAO	tbd	tbd	n/a	tbd
	MYANMAR	tbd	tbd	n/a	tbd
	THAILAND	tbd	tbd	n/a	tbd
	VIETNAM	tbd	tbd	n/a	tbd
	TOTAL				
# of ITNs/LLINs distributed to at-risk populations	CAMBODIA	0.00	1,018,664	267,064	267,064
	LAO	105,772	62,636	7,400	7,400
	MYANMAR	602,432	1,190,000	536,826	700,000
	THAILAND	n/a	99,300	97,100	95,050
	VIETNAM	0.00	1,602,618	193,014	195,060
	TOTAL		3,973,219	1,101,404	1,264,574
% of pop covered by LLINs T1 &2	CAMBODIA	n/a	42%	42%	42%
	LAO	41%	86%	93%	65%
	MYANMAR	24%	90%	90%	90%
	THAILAND	n/a	87%	86%	69%
	VIETNAM	0%	55%	59%	63%
	TOTAL				
% of estimated suspected Malaria cases received parasitological test	CAMBODIA	100%	100%	100%	100%
	LAO	99.9%	100%	100%	100%
	MYANMAR	78%	92%	97%	100%
	THAILAND	100%	100%	100%	100%
	VIETNAM	0%	86%	91%	95%
	TOTAL				
% of confirmed malaria cases that received first-line antimalarial treatment according to national policy	CAMBODIA	n/a	85%	90%	95%
	LAO	86%	100%	100%	100%
	MYANMAR	100%	100%	100%	100%
	THAILAND	100%	100%	100%	100%
	VIETNAM	99.6%	98%	98%	98%
	TOTAL				
% of p.f casesfully investigated (in low	CAMBODIA	na	50%	70%	90%
	LAO	na	50%	80%	95%

endemic areas)	MYANMAR	na	16%	32%	50%
	THAILAND	58%	65%	70%	75%
	VIETNAM	0%	50%	70%	95%
	TOTAL				
% of confirmed transmission foci investigated and that received an appropriate response	CAMBODIA	na	tbd	tbd	tbd
	LAO	na	75	75	75
	MYANMAR	na	tbd	tbd	tbd
	THAILAND	na	80%	85%	90%
	VIETNAM				
	TOTAL				
% of confirmed falciparam malaria cased received DOT	CAMBODIA	na	60%	80%	90%
	LAO	0%	17%	48%	80%
	MYANMAR	na	25%	55%	80%
	THAILAND	13%	43%	50%	73%
	VIETNAM	n/a	50%	65%	80%
	TOTAL				
% of private sector outlets stocking oral artemisinin-based monotherapies (special regional survey year 1 & 3).	CAMBODIA	4.2%	tbd	tbd	tbd
	LAO	N/A	10%	5%	0%
	MYANMAR	86%	50%	25%	5%
	THAILAND				
	VIETNAM	tbd	tbd	tbd	tbd
	TOTAL				
% of public sector health facilities without stock-out of key commodities lasting more than one week in the last three months	CAMBODIA	n/a	tbd	tbd	tbd
	LAO	78%	100%	100%	100%
	MYANMAR	90%	95%	95%	95%
	THAILAND	n/a	80%	85%	90%
	VIETNAM	tbd	tbd	tbd	tbd
	TOTAL				

Dat Flow

Please see the annex below for the data flow with thin the countries.

MONITORING AND SUPERVISION OF RAI IMPLEMENTATION

UNOPS- PR is responsible for ensuring that the Co-PRs (Thailand & Vietnam) and the PSR (Lao, PDR) and SRSs (Myanmar) are performing according to their work plans, and that they report to UNOPS - PR on time. The Public Health, Finance,

Procurement and M&E Specialist, will play an important role in coordinating the financial and programmatic monitoring, evaluation, and reporting by RAI countries.

UNOPS - PR will review and verify the performance of RAI Grants implementation through regular monitoring that will be undertaken through a combination of (1) review of reports submitted by the countries and (2) Site visits when applicable.

Updated information such as findings, feedbacks, best practices, lessons learnt from monitoring visits will be shared and given to PSR/SRs as possible. In addition, the identified findings will be recorded and follow-up actions will be agreed with the monitored entities. If in need, the capacity building plan will be based on monitoring findings and results.

REVIEW OF REPORTS

The Co-PRs (Thailand & Vietnam) and the PSR (Lao, PDR) and SRSs (Myanmar) will submit technical and financial reports to UNOPS on a semi-annual basis. It will be the responsibility of the Head of the Performance Management Unit to ensure that these reports are submitted by all countries on a timely basis and that the reports are shared with the Finance Manager and M&E Specialist [see**Error! Reference source not found.**]. Based on the data/results and findings of these reports from the countries, if any significant deviations exist in the programmatic achievements, the deviations must extensively be discussed with each Co-PRs (Thailand & Vietnam) and the PSR (Lao, PDR) and SRSs (Myanmar) and the Programme Director will be informed accordingly. The Programme Director in such cases as necessary will also notify the CCM and RSC. Possible solutions for improvement shall be formulated and assistance requested as and when required. Based on all findings, reports and including field visits and any lessons learnt, a disbursement recommendation will be made to the Programme Director by the Head of the Performance Management at every reporting/disbursement cycle (See later described decision making to this effect). Activities related to a few data quality items may need to be added to the routine program monitoring and supervision visits.

SITE VISITS

Except for Thailand and Vietnam, UNOPS - PR team will also make coordinated visits to selected field sites as per agreed schedules and on risk basis. The aim of these visits is to monitor programme quality and data quality, identify achievements,

challenges and lessons learned, and allow UNOPS and its implementing parners to address bottlenecks and any technical/financial difficulties before they have negative impact on programme implementation. Cross checking with different data sources and spot checking to verify delivery of services and records will also be used.

PR-UNOPS aims to conduct regular monitoring visits to the site visits (to Districts/Provinces/Warehouses/DOT Clincis/Health Centers etc.) where malaria interventions are implemented by PSRs/SRs. The purposes of these visits are to

(1) Make sure that (a) the funded activities are implemented
(2) Assess any adequate system to support implementation properly and oversight

(3) Understand on strengths, threats, challenges/constraints, opportunities and needs in programming, grant implementation, data collection and reporting

(3) Identify the follow-up measures / modifications to implementation arrangements

REVIEWS, SURVEYS, SURVEILLANCE, AND SPECIAL STUDIES

Most reviews, surveys, surveillance and special studies will be conducted under the auspices of the National Programmes with technical inputs from the WHO regional and other partners.

DATA QUALITY ASSURANCE MECHANISMS AND RELATED SUPPORTIVE SUPERVISION

The UNOPS- PR DQA system will be used to verify the quality of reported data, as well as provide periodic information on the underlying data management and reporting systems for, at a minimum, program level output indicators. The purpose of the DQA is to have an overall indication of the accuracy of data and re-in force good data practices among staff.

The DQA Manual clearly identifies and articulates the roles and responsibilities of the key stakeholders, data flow and the methodological approach to carrying out the DQA. It includes the need for selective checking of data errors or other problem,

including a full data audit (please refer to DQA Manual for details attached in Annex 7).

The DQA System is seen within the framework of the national M&E system and its resources along with the leadership of the Technical Support Groups. It's aligned with and used to inform the national M&E system, the national Strategic Plans and national Operational plans.

All RAI countries, with exception of Thailand and Vietnam are expected to undergo a DQA at least once a year.

At a minimum, one month of data should be checked so that reports can be compared with source data. Indicator quality checks will be decided based on:

1. Critical data items (those for the most important indicators or those where errors are large scale or common) can be checked more frequently
2. Several different indicators can be identified and one randomly selected for use for each different facility or for use across facilities for the month

This will consist of five levels of activity:

- Minimizing routine sources of data errors through supporting SR implementation. Underlying the data quality checks are the reporting forms at both the service delivery sites and intermediate aggregate levels. It is therefore critical that all personnel involved in the recording, reviewing, and management of data have a thorough understanding of how all data collection tools and reports that aggregate these data are to be completed. The UNOPS team with the SRs and technical partners will develop instructions for all reporting forms and ensure that all relevant personnel are trained in the completion of the forms – both through initial training and yearly refresher training.

- Field validation of report data against source data by UNOPS PR staff. Spot checks will also be carried out at facility level and at beneficiary level. The DQA check is different to routine monitoring (see section below). The DQA will be an ongoing process throughout the period of the programme.

- Cross-checking databases using logic to find errors and identify improbable relations between data items. UNOPS staff will routinely conduct crosschecks using SR data and PR databases. The cross-checks will be conducted at a minimum of every three months (and preferably monthly) on SR data corresponding with the reporting period. Where problems are identified, the crosschecks will move to the SR level and ultimately the facility level to identify the level of error and needed corrections.

- Adequately storing data to prevent loss, ensure availability of information for validating reports and for evaluation, and to limit access to protect confidentiality and integrity of the data.

- Providing feedback on DQA checks. Regular feedback on M&E findings, including the DQA will be provided to SRs. Furthermore, UNOPS policy is that in cases of a 10% or larger difference in individual items for quantitative data checks, formal steps will be initiated for more in-depth checking and making corrections.

1.1. EVALUATIONS

The Evaluation of the RAI grant is guided by the grant performance framework, ERAR, national Malaria M&E plan.

UNOPS also recognizes that the GFATM has the discretion to conduct an independent evaluation of the programme that will focus on results, transparency and substantive accountability.

1.2. CAPACITY BUILDING AND PROGRAMME LEARNING

UNOPS places a strong emphasis on programme learning as a way to constantly improve its operations and accountability. At a global level, UNOPS has "communities of practice" and learning from the Myanmar programme will be shared through these forums.

At a local level, UNOPS will organize an Annual Meeting for SR partners. This will be linked with the timeframe for the Annual report. The Annual Meetings will be an opportunity to share and review best practice and lessons learnt among SRs. The content of the meeting will either include a general review or will focus on a specific theme or topic for more detailed exploration. The agenda will be developed in consultation with SRs and M-CCM to ensure that it is useful to their priorities.

2. Monitoring and Verification Plan

Intrinsically tied to disbursement decisions as an ongoing management tool for mitigating risk, prior and post disbursements, are a series of risk mitigation measures. The frequency and scope of the monitoring procedures and methodology to be applied to a particular SR shall be determined by the degree of potential risk identified through continuous programmatic assessment and capacity building being undertaken by the PR. This approach will assist in matching appropriate methodologies that are relevant for the SR and in prioritizing which SRs require more detailed monitoring. Based on this approach some SRs maybe monitored more frequently than the others because of their higher risk level.

Please note that the risk-based monitoring plan outlined in this document focuses on programmatic areas. It should be read together with the Financial Management Policies and Procedures Manual which provides information on SR and SSRs Financial oversight processes and Procurement and Logistics processes, including risk-based monitoring plans.

The PR will undertake standard programmatic monitoring and verification processes for all SRs. These measures and tools include:

A. Reports:
   - Quarterly Technical and Expenditure Reports
   - Desk Validation / Review at country level

B. Field Monitoring Visits, including:
   - Project Progress M&E Visits
   - Review of M&E Processes
   - Review of supporting Documents

C. Review meetings focussing on overall programme performance.
D. Data Quality Assurance
E. Annual Review Meeting including Quality of Implementation/Lessons Learnt.

These mitigation tools for SR programmatic monitoring will be used for all SRs and selected SSRs. Further details on each of these activities have been included in the sections above.

However, as risk levels increase, these mitigation tools will be used more frequently with some SRs. Based on the risk analysis outlined in the sections above, specific programmatic oversight actions are planned for different SRs. These specific actions are detailed in Annex 6 for each individual SR, however the general principles are shown in Table 3 below.

Table 3: SR Programmatic Oversight Grid System

Verification and Monitoring Tools	Myanmar	Lao	Cambodia	Thailand	Vietnam
A. Reporting and Desk Review and Validation of Technical and Expenditure Reports.	Every 6 months	Every 6 months	Every 6 months	Every 6 months	Every 6 months
B. Field Monitoring Visits ▪	Every 3-6 months	Every 3 months	Every 3-6 months	NA	NA
C. PR- SR meetings focussing on overall programme performance.	Quarterly	Quarterly	Quarterly	NA	NA
D. Capacity Building	Ongoing	Ongoing	Ongoing	If required	If required
E. Data Quality Assurance	At least every 12 months	At least every 12 months	At least every 12 months	At least every 12 months	At least every 12 months
F. Annual Review Meeting	Once per year	Once per year	Once per year	Once per year	Once per year

As with the risk analysis, the resulting oversight plan will be reviewed at least every 6 months and revised if necessary based on updated information gathered during actual field monitoring visits, through DQA, during conduct of capacity building activities and through review meetings.

ANNEXES- TOOLS AND TEMPLATES

Annex D- Programmatic Progress Update

RAI Annex D_20140226.xlsx

Annex E- Financial Reporting Template

RAI Annex E _20140226.xlsx

RDQA Multi-Indicator Tool

RDQA Multi-Indicator_Nov 2

ANNEX A- INDICATOR REFERENCE SHEET (IMPACT INDICATORS)

Indicator Reference Sheets should be filled in for each indicator that is part of the M&E plan and of the Performance Framework. The Indicator Reference Sheet below shows an example to provide guidance on information to be included in each cell.

Indicator	**Confirmed falciparum malaria cases (microscopy or RDT) per 1000 mid-year population. [Results disaggregated by source and tier].**
Rationale/Purpose	This indicator measures annual confirmed *Plasmodium falciparum* (P.f.) and mixed malaria cases per 1,000 mid-year population reported in public health facilities and by community level. Two different laboratory tests are reported through public health facilities: microscopy and rapid diagnostic test (RDT); whereas, only RDTs are used at community level. for the ICC, PCR diagnosed cases are also

	included.
Numerator	Total number of P.f. and mixed malaria cases (diagnosed through microscopy or RDT) from the public health facilities and community level. Mixed cases are included.
Denominator	Mid-year population estimated from the population census.
Data collection frequency	Monthly
Measurement Tool	Health Information System (HIS)
Method of measurement	Health facility reports and community reports
Indicator	**% of Administrative Units with falciparum incidence <1/1,000 in Tier 1 & Tier 2**
Rationale/Purpose	The aim is to eliminate P.f. malaria Artemisinin resistant from low endemic areas, where pre-elimination status (P.f. falciparum incidence <1/1,000) has already been achieved. National level data will be reported by public health facilities and by the community level.
Numerator	Number of Administrative Units with falciparum incidence <1 per 1,000 people. Mixed cases are included.
Denominator	Total number of Administrative Units in malaria endemic areas – 45 ODs
Data collection frequency	Monthly
Measurement Tool	Malaria Information System (MIS)
Method of measurement	Malaria information reports and the community level reports
Indicator	**% of indigenous cases among investigated case (applies only to low endemic areas… to be defined). [Results disaggregated by tier].**
Rationale/Purpose	The aim is to eliminate P.f. malaria Artemisinin resistant, where pre-elimination status has already been achieved. An indigenous case is any case contracted locally, without any strong evidence of a direct link to an imported case. The definition of indigenous

	will apply to geographic location e.g. province, district or village levels.
Numerator	Number of indigenous P.f. and mixed malaria cases among investigated cases.
Denominator	Total number of P.f. and mixed cases investigated.
Data collection frequency	TBD
Measurement Tool	Malaria Information System (MIS)
Method of measurement	Malaria information reports

ANNEX A- INDICATOR REFERENCE SHEET (OUTCOME INDICATORS)

Indicator Reference Sheets should be filled in for each indicator that is part of the M&E plan and of the Performance Framework. The Indicator Reference Sheet below shows an example to provide guidance on information to be included in each cell.

Indicator	% of mobile people that used an ITN the last time they slept in transmission areas (disaggregated by category of mobile/migrant person) (special regional survey year 1 & 3).
Rationale/Purpose	This indicator measures the level of ITN use among at mobile /migrant population
Numerator	Number of mobile people that used an ITN the last time they slept in the transmission areas.
Denominator	Total number of mobile people surveyed
Data collection frequency	Every 2 , depending on the availability of funding
Measurement Tool	A special module within Malaria Survey (CMS) or a special survey on Mobile Migrant Populations.
Method of measurement	
Indicator	**# of ITNs distributed to at-risk populations.**
Rationale/Purpose	This indicator will cover only distribution of Long Lasting Insecticide-treated Nets (LLINs) and Long Lasting Insecticide-treated Hammocknets (LLIHNs) to the additional population at risk (living in malaria endemic area). LLINs will be distributed to the static population; whereas, LLIHNs will be distributed to the mobile people.
Numerator	Number of insecticide-treated nets distributed to individuals at risk.
Denominator	None
Data collection frequency	periodically
Measurement Tool	ITN distribution reports
Method of measurement	LLIN/LLIHN distribution lists

Indicator	**# & % of population at risk potentially covered by ITNs distributed. [Results disaggregated by tier].**
Rationale/Purpose	This indicator measures the level of the population at risk, where distribution of LLINs was done. Not survey-based reporting but rather based on number of ITNs distributed.
Numerator	Number of persons potentially covered by ITN from number of insecticide-treated nets distributed.
Denominator	Total number of population at risk based on tier 1 and 2
Data collection frequency	Monthly
Measurement Tool	ITN distribution reports
Method of measurement	LLIN/LLIHN distribution lists

Indicator	% of suspected malaria cases that receive a parasitological test (Numerator and denominator presented in results). [Results disaggregated by tier].
Rationale/Purpose	This indicator aims to measure access to diagnosis test (i.e. microscope or rapid diagnosis test) by patients with clinical signs of malaria (i.e. fever cases). The data is reported through the following: • By the public health facilities, using number of blood smears and rapid diagnostic tests (RDTs) used nationwide; and • By the community level (VMWs), using the number of RDTs used under SSF malaria and RAI covered areas. Similar to output/coverage indicator #1 of SSF malaria grant, which covers the private sector.
Numerator	Number of people tested for malaria (public health facilities & VMWs).
Denominator	Number of people tested for malaria (public health facilities & VMWs).
Data collection frequency	Monthly
Measurement Tool	CNM's MIS
Method of measurement	Health facility reports and malaria registers used by VMWs
Interpretation	This indicator reports on tested people through public health facilities and VMWs.
Other relevant information	Page 236 of the Global Fund's M&E Toolkit, Malaria, 4th edition

Indicator	DISCUSSION UNDER WAY WITH THE GLOBAL FUND AND CNM ON HOW TO REPORT ON THIS INDICATOR IN LIGHT OF THE ABSENT LINK BETWEEN DATA ON DIAGNOSED CASES (IN LAB REGISTER) AND TREATED CASES (OPD REGISTER) % of confirmed malaria cases that received first-line antimalarial treatment according to national policy (numerator and denominator presented in results). [Results disaggregated by tier].
Rationale/Purpose	Prompt treatment with an effective antimalarial drug regimen is a key component of the technical strategy for controlling and preventing malaria. National data is reported by the public health facilities and by the community level (VMWs). Malaria confirmed cases (all species) who received the first –line treatment are reported through the OPD/IDP registers as treated cases; whereas, confirmed cases are reported through the laboratory register as malaria positive tested patients (all species). There is no link between the two records. Because of this, more than 100% results can be expected as is also seen with the baseline results. Identical to the combination of output/coverage indicator #2 and 3 of the SSF malaria grant.
Numerator	Number of malaria confirmed cases (all species) by microscopy or RDT who received the first-line antimalarial treatment according to national treatment guidelines.
Denominator	Total number of malaria confirmed cases by microscopy or RDT.
Data collection frequency	Monthly
Measurement Tool	HIS and CNM's MIS
Method of measurement	Health facility reports and malaria information reports
Interpretation	This indicator reports on number of malaria ACT treated patients over the number of positive tested patients.
Other relevant information	Page 238 of the Global Fund's M&E Toolkit, Malaria, 4th edition

Indicator	% of confirmed cases in low endemic areas fully investigated. [Results disaggregated by tier].
Rationale/Purpose	The aim of the field investigation is to determine whether an infection was acquired locally and therefore whether there is ongoing local malaria transmission. All reported P.f. or mixed malaria cases should be investigated to allow the case classification by origin of infection • Autochthonous: a case locally-acquired by mosquito-borne transmission, i.e. an indigenous or introduced case (also called 'locally transmitted'). • Imported: a case the origin of which can be traced to a known malarious area outside the country in which the case was diagnosed. • Indigenous: any case contracted locally (i.e. within village boundaries), without strong evidence of a direct link to an imported case. • Induced: a case the origin of which can be traced to a blood transfusion or other form of parenteral inoculation but not to normal transmission by a mosquito. • Introduced: a case contracted locally, with strong epidemiological evidence linking it directly to a known imported case (first generation from an imported case, i.e. the mosquito was infected from a case classified as imported). It includes administration of a standardized questionnaire to a person in whom a malaria infection is diagnosed. It should include administration of a standardized questionnaire to a person in whom a malaria infection is diagnosed. Results will be reported only for RAI (1 OD in Y1 and total of 2 ODs in Y2 and Y3). NB: contextual information - 7-10 ODs are expected to be covered through SSF by 2015. This is a new activity. Targets set considering resourcing at OD level and RAI budgets.
Numerator	Number of P.f or mixed malaria patients fully investigated.
Denominator	Total number of confirmed P.f. and mixed malaria patients in low endemic areas in ODs where the intervention is conducted under RAI.
Data collection frequency	TBD
Measurement Tool	TBD
Method of measurement	TBD
Interpretation	-

Other relevant information	Page 26 of WHO Disease Surveillance for Malaria Elimination Page 237 of the Global Fund's M&E Toolkit, Malaria, 4th edition

Indicator	% of confirmed transmission foci that received an appropriate response
Rationale/Purpose	Focus is defined as, a circumscribed locality situated in a currently or formerly malarious area with the continuous or intermittent epidemiological factors necessary for malaria transmission. Once a case of locally acquired malaria has been detected, a focus investigation is carried out to describe the areas where malaria occurred and delineate the population at risk. The focus investigation identifies the main features of the location, including the populations at greatest risk, the vectors responsible for transmission, where they are located and when transmission occurs. On the basis of the investigation, the focus can be classified into one of six types: • Endemic: Transmission is occurring and is not effectively controlled; if malaria control interventions are being implemented, the effect has not yet been sufficient to reduce transmission to low levels. • Residual active: Transmission is occurring in an area that has had transmission within the past 2 years (or past two transmission seasons); it is effectively controlled, with major reductions in malariological indicators after interventions. • New active: Transmission is occurring in an area that has had transmission for less than 2 years or has never had local transmission. New active foci can be further subdivided into first degree, in which only the first generation of transmission has taken place (i.e. only introduced cases are present) and second degree, in which second- or later-generation malaria and indigenous cases are present. • New potential: Isolated imported, induced or relapsing cases are occurring during the transmission season in a receptive area that had no transmission in the past 2 years or more. If there is no evidence of renewed local transmission after 1 year, these areas would cease to be new potential foci and would become 'cleared up'. • Residual non-active: There is no local transmission in an area with a history of local transmission within the past 2 years. Relapses or delayed primary infections with P. vivax or a recrudescence (treatment failure) of an infection acquired before transmission ceased may occur. • Cleared-up: No local transmission has been recorded during the past 2 years in an area with a history of malaria and conditions that are suitable for transmission. Appropriate response includes screening and focal insecticide residual spraying (IRS) of households around the index case. A response plan is prepared according to the results of the field and focus investigation, including the entomological evaluation. This is a new activity. Targets will be set based on 2014 results as a baseline.

Numerator	Number of confirmed transmission foci where an appropriate response was taken following a P.f. and mixed malaria patient investigation.
Denominator	Total number of confirmed transmission foci in ODs identified through P.f. and mixed malaria case investigation.
Data collection frequency	TBD
Measurement Tool	TBD
Method of measurement	TBD
Interpretation	-
Other relevant information	Page 26 of WHO Disease Surveillance for Malaria Elimination Page 250 of the Global Fund's M&E Toolkit, Malaria, 4th edition

Indicator	# of targeted communities with community-based diagnostic and treatment services.
Rationale/Purpose	This indicator aims at providing access to malaria diagnosis and treatment through the training of VMWs in villages in high endemic areas. It includes VMW villages covered by RAI and VMW/MMW villages covered under SSF malaria grant.
Numerator	Number of villages covered by Village Malaria Workers (VMWs) scheme in high incidence areas (>10/1000) in tier 1 & 2. Cumulative over the program term.
Denominator	None
Data collection frequency	TBD
Measurement Tool	CNM's MIS
Method of measurement	Malaria information reports
Interpretation	-
Other relevant information	-

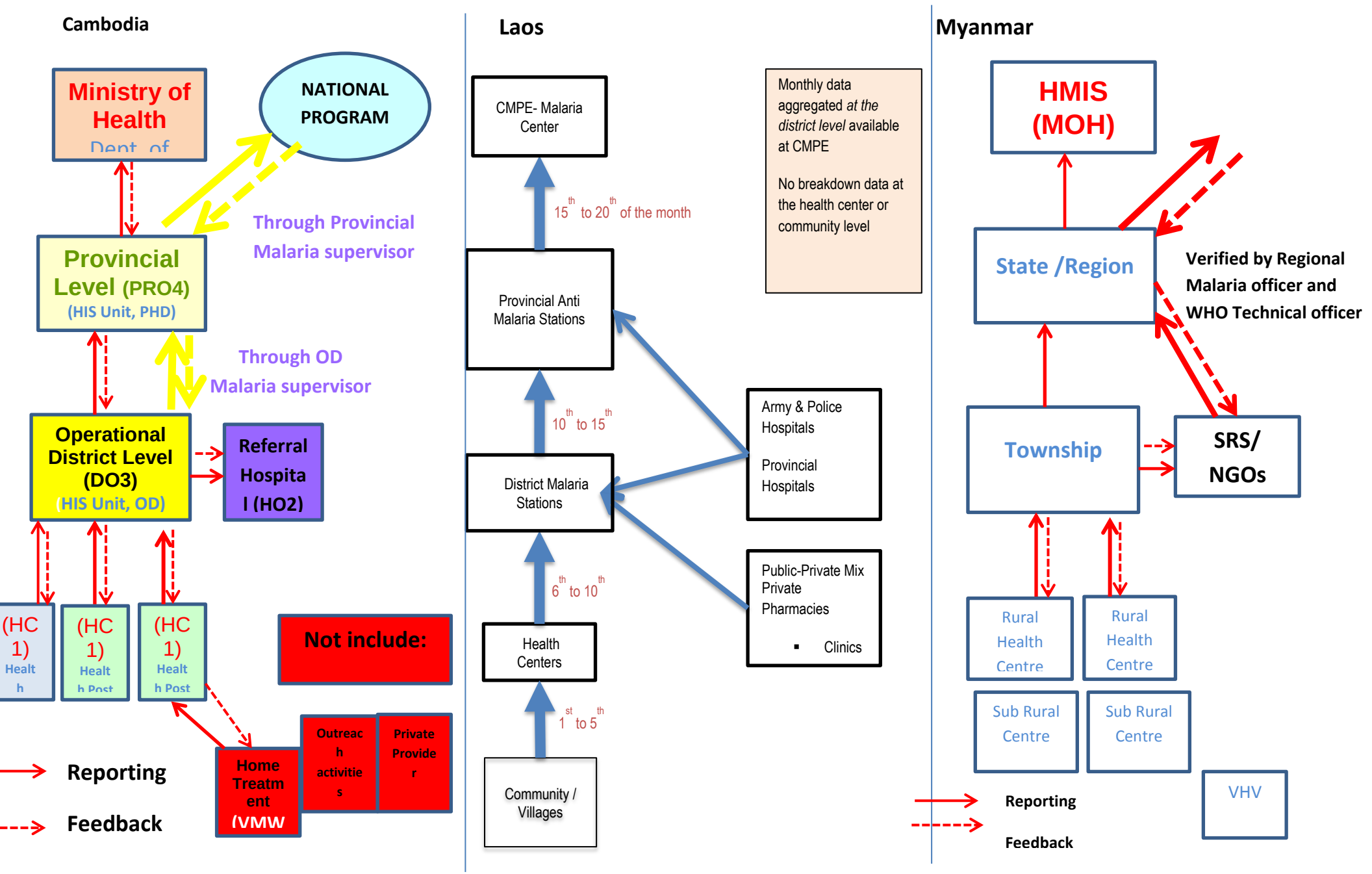
Indicator	% of confirmed falciparum malaria cased received DOT (disaggregated by tier).
Rationale/Purpose	This indicator aims at monitoring compliance to treatment by P.f. and mixed artemisinin resistant cases. Patients have to take their full course of treatment in front of VMWs - directly observed treatment (DOT). The data will be reported by the community level (VMWs) for both SSF malaria grant and RAI grants are included.
Numerator	Number of confirmed P.f and mixed malaria cases who received DOT by VMWs.
Denominator	Total number of confirmed P.f. and mixed malaria cases reported by VMWs.
Data collection frequency	Monthly
Measurement Tool	CNM's MIS
Method of measurement	Malaria information reports
Interpretation	-
Other relevant information	Top 10 indicator

Indicator	% of mobile population with fever in the last 3 months that accessed parasite-based diagnosis
Rationale/Purpose	This indicator measures access to malaria diagnosis by the mobile people, as defined under the outcome indicator. Data expected to be collected through a survey. Data is currently collected and available only for villagers who go to the forest for a short-term.
Numerator	Number of mobile population with fever in the last 3 months who accessed parasite-based diagnosis (microscopy or RDT).
Denominator	Total number of mobile population with fever in the last 3 months.
Data collection frequency	Every 2 or 3 years, depending on the availability of funding
Measurement Tool	A special module within Cambodia Malaria Survey (CMS) or a special survey on Mobile Migrant Populations. NB: This will be discussed with in-country partners and an update provided.
Method of measurement	-
Interpretation	-
Other relevant information	Similar to page 236 of the Global Fund's M&E Toolkit, Malaria, 4th edition

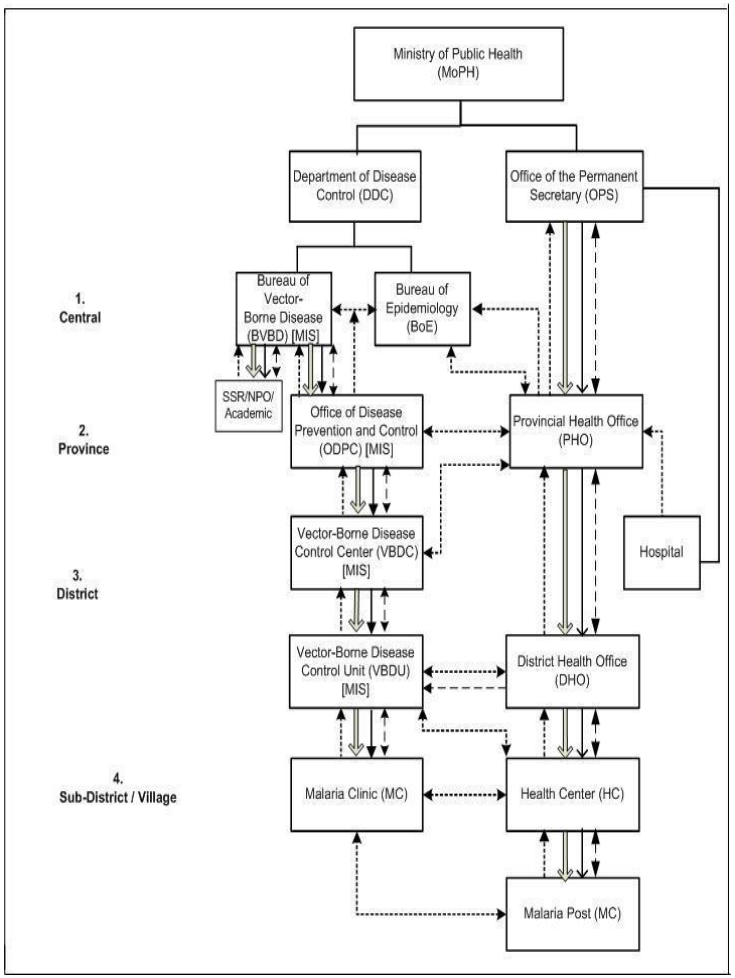
Indicator	% of private sector outlets stocking oral artemisinin-based monotherapies
Rationale/Purpose	This indicator will contribute to halt drug pressure for selection of artemisinin resistant malaria parasites by improving access to appropriate treatment and preventing use of monotherapies and substandard drugs in private sector. This indicator will be collected through surveys at private sector outlets covered by ACT Watch conducted by PSI and CMS. It is to be discussed further with CNM what will be the primary data source for this survey – ACT Watch or CMS. CMS 2013 is currently underway. The data collection for ACT Watch 2013 has just been completed with the results due to be reported in Q1 2014. Identical to outcome indicator #1 of the SSF malaria grant.
Numerator	Number of private sector outlets stocking oral artemisinin-based monotherapies (ACT).
Denominator	Total number of private sector outlets surveyed.
Data collection frequency	Every 2 or 3 years, depending on the availability of funding
Measurement Tool	Cambodia Malaria Survey and ACT Watch survey (conducted by PSI). Primary source on which reporting will be based is under discussion.
Method of measurement	Drug outlet survey
Interpretation	
Other relevant information	-

Indicator	% of public sector health facilities or private sector sites without stock-outs of RDTs lasting more than one week in the last three months
Rationale/Purpose	The objective of this indicator is to measure the availability of RDTs in health facilities in public sector and at community level (VMWs). Ensuring adequate and continued supply with no reported stock-outs of ACT and RDTs is essential for the delivery of effective diagnosis and treatment of malaria cases. Reporting will be based on the existing system (at present – supervision reports; in the future - sms-based reporting system budgeted in RAI.). The numerator and denominator definitions below are based on the existing system of measurement through supervisions. Identical to the output/coverage indicator #7 of the SSF malaria grant which covers 331 HCs. Under RAI, this indicator will cover additional 484 HCs.
Numerator	Total number of quarterly health facility supervision reports with no reported stock-outs of RDTs during the reporting period. This will be a sum of the reports of the 2 quarters of the 6-month reporting period.
Denominator	Total number of quarterly health facility supervision reports received by CNM during the reporting period. This will be a sum of the reports of the 2 quarters of the 6-month reporting period.
Data collection frequency	Quarterly
Measurement Tool	Initially, health facility supervision reports. Subsequently - SMS-based reporting system. The numerator and denominator above are defined based on the existing system.
Method of measurement	
Interpretation	-
Other relevant information	Similar to page 239 of the Global Fund's M&E Toolkit, Malaria, 4th edition

Indicator	% of public sector health facilities or private sector sites without stock-outs of ACTs lasting more than one week in the last three months
Rationale/Purpose	The objective of this indicator is to measure the availability of ACT in health facilities in public sector and at community level (VMWs). Ensuring adequate and continued supply with no reported stock-outs of ACT is essential for the delivery of effective diagnosis and treatment of malaria cases. Reporting will be based on the existing system (at present – supervision reports; in the future - sms-based reporting system budgeted in RAI.). The numerator and denominator definitions below are based on the existing system of measurement through supervisions. Identical to the output/coverage indicator #6 of the SSF malaria grant which covers 331 HCs. Under RAI, this indicator will cover additional 484 HCs..
Numerator	Total number of quarterly health facility supervision reports with no reported stock-outs of ACTs during the reporting period. This will be a sum of the reports of the 2 quarters of the 6-month reporting period
Denominator	Total number of quarterly health facility supervision reports received by CNM during the reporting period. This will be a sum of the reports of the 2 quarters of the 6-month reporting period.
Data collection frequency	Quarterly
Measurement Tool	Initially, health facility supervision reports. Subsequently - SMS-based reporting system. The numerator and denominator above are defined based on the existing system.
Method of measurement	-
Interpretation	-
Other relevant information	Similar to page 239 of the Global Fund's M&E Toolkit, Malaria, 4th edition


Cambodia
Ministry of Health
Dept of
NATIONAL PROGRAM
Through Provincial Malaria supervisor
Provincial Level (PRO4)
(HIS Unit, PHD)
Through OD Malaria supervisor
Operational District Level (DO3)
(HIS Unit, OD)
Referral Hospital (HO2)
(HC 1) Health
(HC 1) Health Post
(HC 1) Health Post
Not include:
Home Treatment (VMW
Outreach activities
Private Provider
Reporting
Feedback
Laos
CMPE- Malaria Center
15th to 20th of the month
Provincial Anti Malaria Stations
10th to 15th
District Malaria Stations
6th to 10th
Health Centers
1st to 5th
Community / Villages
Monthly data aggregated at the district level available at CMPE
No breakdown data at the health center or community level
Army & Police Hospitals
Provincial Hospitals
Public-Private Mix Private Pharmacies
Clinics
Myanmar
HMIS (MOH)
State /Region
Verified by Regional Malaria officer and WHO Technical officer
Township
SRS/ NGOs
Rural Health Centre
Rural Health Centre
Sub Rural Centre
Sub Rural Centre
VHV
Reporting
Feedback

Thailand



Vietnam