

MEETING REPORT

Thirty-fourth Annual Hybrid Meeting of the RBM Partnership to End Malaria
Surveillance, Monitoring, and Evaluation Reference Group (SMERG)
22–24 May 2024

Venue

Banyan Tree Hotel, Bangkok, Thailand



Photo: Thai Palace. By SMERG Secretariat.

Acronyms

ANC	antenatal care
APMEN	Asia Pacific Malaria Elimination Network
CHAI	Clinton Health Access Initiative
CHISU	Country Health Information System for Data Use
DHIS2	District Health Information Software, Version 2
DQA	data quality assessment
DVBD	Division of Vector Borne Diseases
EOC	Emergency Operations Center
M&E	monitoring and evaluation
MOU	memorandum of understanding
NMCP	National Malaria Control Program
NMEP	National Malaria Elimination Program
PMI	President's Malaria Initiative
PMM	PMI Measure Malaria
PECADOM	PRISE EN CHARGE A DOMICILE
SME	surveillance, monitoring, and evaluation
SMERG	Surveillance, Monitoring, and Evaluation Reference Group
SOP	standard operating procedure
SP&DQ	Surveillance Practice and Data Quality
WHO	World Health Organization

Introduction

The 34th SMERG Annual Meeting that held from 22 to 24 May 2023, in Bangkok, Thailand, brought together 32 in-person SMERG participants from 12 countries. Moreover, online participants and speakers from various countries had the opportunity to attend through Zoom. The main theme for the meeting was **“Malaria elimination surveillance in Southeast Asia – Documenting successes, challenges and lessons learned, in a context of the need for systems resilience to potential threats, to inform surveillance practice in other countries in the Africa region especially those developing an elimination agenda.”** The subthemes were as follows:

Sub-theme 1: Malaria elimination surveillance (structure, challenges, best practices)

Sub-theme 2: Action report back

Sub-theme 3: Data for evaluation of malaria Interventions

Sub-theme 4: Diversity, quality, and use of data in surveillance for malaria elimination surveillance

Subtheme 5: RBM Partnership/Updates on SMERG business

The meeting was chaired and moderated by Molly Robertson and Medoune Ndiop (SMERG co-chairs), Yazoume Ye (President’s Malaria Initiative [PMI] Measure Malaria [PMM]/ICF), Arnaud Le Menach (Clinton Health Access Initiative [CHAI]), Jui Sha (RFI), Jonathan Cox (Bill & Melinda Gates Foundation [BMGF]), and Prof. Richard Maude (Asia Pacific Malaria Elimination Network [APMEN] Thailand). Rapporteurs who supported some of these sessions were Mohammed Wahjib (National Malaria Control Program [NMCP] Ghana), Derek Kunaka (JSI), and Joy Gakenia Murangiri (NMCP Kenya).

The Deputy Director-General of the Department of Disease Control Ministry of Public Health, Dr. Direk Khampaen, welcomed the participants, presented the opening remarks, and officially declared the 34th SMERG Annual Meeting open. In his speech, the Deputy Director presented the synopsis of malaria in Thailand and applauded the RBM SMERG for choosing Thailand for the meeting.

The meeting kicked-off with two presentations from the Thailand Division of Vector Borne Diseases (DVBD) on the topics, “The fight against malaria in Thailand: Subnational health system and community health worker data for malaria elimination” and “Surveillance for elimination - Experience and results from Thailand,” by Dr. Rungrawee Tipmontree, Chief of Malaria Group, and Dr. Prayuth Sudathip and Ms. Suravadee Kitchakarn, respectively.

Meeting notes

Sub-theme 1: Malaria elimination surveillance (structure, challenges, best practices)

Session 1: Focus on surveillance: Interventions in surveillance for malaria elimination

Presentation: *The fight against malaria in Thailand: Subnational health system and community health worker data for malaria elimination/surveillance for elimination—Experience and results from Thailand*

Dr. Rungrawee Tipmontree and Ms. Suravadee Kitchakarn, DVBD, Thailand

The presenters provided an overview of the National Malaria Elimination Strategy, 2017-2026. The strategy includes monitoring and evaluation activities, accentuating four phases to accelerate malaria elimination, develop appropriate innovative measures and models, establish national and international collaboration, and promote community capacity building. Presenters also elaborated on the utilization of data at the subnational level (provincial level) and on the community health

volunteer data. They also shared on the experience and results from Thailand's surveillance and elimination process. They expounded on the requirements of subnational verification of malaria elimination (documentation), which comprised establishment of a surveillance system, case management, disease prevention and control committee, prevention of re-establishment planning, and integration.

For Rungrawee's presentation, click [here](#). For Prayuth and Suravadee's presentation, click [here](#).

Discussion

Key issues discussed included malaria cases originating mainly from the border, among migrants, which poses a challenge to the migration of refugees across porous borders. Also, 68 percent of cases were males, but there seem to be no specific interventions targeting men and the fact that information is at the village level. Household-level data are therefore lacking. All these are action points that require follow-up. As mentioned in the presentation, one of the requirements of subnational verification of malaria elimination – documentation, is setting up a surveillance system that should include the 1-3-7 intervention by indicators and quality. However, there is a challenge for the effective intervention of foci management and the implementation of the 1-3-7 targets. This could be overcome by intensifying active cases detection and the need for the military to help improve target 7 by the Thai National Malaria Elimination Program (NMEP). About the malaria burden at the border, participants recommended the need for more collaboration with other partners, civil society organization, the World Health Organization (WHO), and other countries by the Thai NMEP.

Question and answer session

Question: Are there pharmacies and over-the-counter markets providing antimalaria treatment?

Answer: No over-the-counter markets are allowed to dispense anti-malaria medications.

Question: Is the private sector collaborating on reporting?

Answer: It is required by law for the private sector to report; thus, no challenges with reporting from this sector.

Question: Are there any school malaria interventions? That is, what is being done to address the increase in cases among school children after improved malaria education in schools?

Answer: The following two action points were recommended: (1) increased active detection among school children (mainly in Myanmar), and (2) trained teachers involved in case management.

Question: What lessons can we learn from leadership support for elimination in Thailand?

Answer: (1) Political and high-level commitment, (2) the National Malaria Elimination Committee is under Deputy Prime Minister, and (3) malaria elimination is a law under the Communicable Disease Act implemented at all levels. Lessons learned from entomological surveillance include the following: (1) for all active foci, entomological surveillance is carried out to identify the existence of vectors, and (2) entomological surveillance is also done to identified areas of burden to ascertain if it is a local case by the Thai NMEP.

Question: What preparations are being made toward certification of the 11 provinces, knowing that certification is normally done nationally and not province by province? What are the lessons in this process of certification?

Answer: The criterion for subnational elimination is that the province that has no active case for at least three years will undergo verification and then apply WHO classification to declare a province as malaria free. The verification/assessment will be followed up by the National

Elimination Committee before certification by country; then it will set the province into prevention of re-introductions.

Question: Are there any interventions that address the challenge of having more malaria in males than in females (more than 70 percent)?

Answer: There is no intervention targeting males. This is because men work more in forests and there are no interventions to prevent malaria in these areas in Southeast-Asia. Forests include plantations and orchid farms. The main intervention among this group is active case detection and treatment. Suggested action points include the need to explore effective preventive interventions for forest workers and intensifying social and behavior change among males by the Thai NMEP/South-East Asia.

Session 2: Cross-border surveillance

Introductory presentation: *Cross-border surveillance, experience from Senegal/Gambia*

Momodou Kalleh, NMCP, Gambia, and Latsouck Diouf, NMCP Senegal

Latsouck presented the model for cross-border cooperation in malaria control between Senegal and Gambia as they collaboratively work under the theme, “Together Toward Elimination!” The process of cross-border collaboration began with the signing of a memorandum of understanding (MOU) in 2018, a net distribution campaign (2019), PRISE EN CHARGE A DOMICILE [PECADOM] (2020), sharing of standard operating procedures (SOPs) and collection tools for surveillance and response (2021), and another net distribution campaign (2022). Latsouck highlighted the 11 commitments that help both countries work collaboratively among other strategies. For details of the presentation, click [here](#).

Session 3: Preparing countries for elimination

Introductory presentation: *Preparing country for elimination—Experience from Kenya*

Jane Githuku, PMM/ICF, Kenya, and Joy Gakenia Murangiri, National Malaria Program, Kenya

Talking on the topic “Preparing country for elimination,” Jane presented the Kenya’s experience, elaborating on the five steps taken to set up structures for malaria elimination in the country:

- Step 1 (Strategy): Include elimination objective in the Kenya Malaria Strategy (2019-2023).
- Step 2 (County selection): Select counties for subnational malaria elimination.
- Step 3 (Implementation pathway): Outline key steps and activities required to establish systems for malaria elimination.
- Step 4 (Advocacy): Engage stakeholders, mobilize resources for malaria elimination.
- Step 5 (Readiness assessment): Assess operational and technical gaps in counties targeted for malaria elimination.

For details of the presentation, click [here](#).

Discussion

Cross-border surveillance, experience from Senegal/Gambia. Takeaways and action points include the issue of Interventions targeting males. Latsouck clarified for participants that this intervention targeting males is necessary due to the epidemiology of East Asia, whereby males work in the forest (rubber plantations) and thus are vulnerable to malaria.

Recommended actions: Engage in distribution of insecticide-treated nets (hammock nets) and rapid diagnostic tests.

Participants were also concerned about how to effectively formalize collaboration at the border between Senegal and Gambia. Some challenges discussed include conducting joint activities and developing SOPs and MOU legal frameworks covering especially data sharing as well as long-lasting insecticidal net distribution, intrahousehold spraying, community monitoring, and experience sharing, through 11 commitments.

Recommended actions: Share the MOU with other countries and establish a formal mechanism for follow-up of commitments.

Participants were also interested in discussing cross-border planning, targeting, and mapping strategies, as well as how to synchronize the implementation, evaluation, and dissemination of information. Lessons learned so far include the collaboration of the PMI and Global Fund engagement; harmonized messaging; digitization of a campaign and data through a platform for the long-lasting insecticidal net campaign (through District Health Information Software, version 2 [DHIS2] Tracker—global good); and improved coverage and reduced duplication due to agreed-on indicators from monitoring and evaluation (M&E) specialists.

Recommended actions: Exchange learning, agree on a common platform (technical issue—apolitical), and commodity management across countries.

Deliberating on the surveillance for the PECADOM strategy and monitoring and coordination of the cross-border control plan with support from Catholic Relief Services, participants discussed the challenge of establishing joint sweeps to detect, test, treat, and refer in three target districts and thus recommended the synchronization of funding—same time in both countries by the financial partners.

Participants also discussed the development of tools and SOPs for harmonized investigations supported by PATH (share, adapt, validate). Lesson learned from this support from PATH include the use of the workshop format and development of action plans and collaboration frameworks with other countries (Mauritania, Guinea, Guinea Bissau, Mali). Participants therefore recommended the need for shared frameworks and action plans.

Preparing country for elimination—Experience from Kenya. Participants underscored the need to understand the level of imported malaria cases from neighboring counties and the response plan for cases detection through the case-based surveillance system. Participants recommended that the elimination agenda should be elevated beyond the Ministry of Health. That is, it should be higher for inter-ministerial coordination. They also recommended the need to ensure reporting from the private sector and pharmacies to reflect the representativeness of the data reported through DHIS. One of the challenges for malaria elimination in Kenya is low funding, and participants recommended more engagement at the level of the country leadership. The malaria elimination program is contemplating considering malaria transmission risk areas as opposed to administrative units when identifying areas for malaria elimination.

Presentation: Surveillance Practice and Data Quality (SP&DQ) Committee—Session: Updates, discussion, and next steps

Arantxa Roca, PATH

Arantxa presented the update and next steps of the SP&DQ Committee. The committee has been working on the SP&DQ priorities questionnaire and the NMCP tracker. Both links can be assessed here:

- [RBM SMERG SP&DQ Committee 2023 Priorities: Who can contribute what? \(office.com\)](#).

- [RBM SMERG Surveillance Practice & Data Quality Committee: Systematic tracker | National malaria control programme questionnaire V2 \(humanitarianresponse.info\)](#)

For the details of Arantxa's presentation, please click [here](#).

Sub-theme 2: Action report back

Presentations:

1. **Defining key monitoring indicators for targeting of resources and actions – Global Fund indicator revision update**, Erica Berlin, PSI. Presentation [here](#).
2. **Population frameworks and roadmaps**, Sarah Burnett, PATH.
3. **Antenatal care prevalence and intervention monitoring**, Peder Digre, PATH.

Discussion/question and answer session

Population frameworks and roadmaps

Question: What is the importance of using a functional community register?

Answer: If there is a functional community register, it is great, but when closer to elimination, the average age and seasonal migration increases. It becomes challenging to estimate at this point; hence, the need to consider other factors like time and seasonality. The fact that the focus now is on control and less so on elimination. The elimination stage would necessitate the possibility of considering different tools or processes for population estimates than might be needed for a control setting.

Question: Looking at the roadmap presented, the key stakeholder is missing. The statistics bureau is responsible for population estimates, but in defining a roadmap, we do not see them appear anywhere. What is the process of engaging them then?

Answer: I think that they are part of the roadmap. There are several recommendations that would be incorporated when defining a country action plan. The statistics bureau is a stakeholder. The only one limitation was that we were not able to interview anybody from the national statistics offices.

Question: Having precise estimates is going to be a challenge. Can we accept a margin of error that gives us reasonable estimates?

Answer: Yes. Depending on what your use case is, you might have a different estimate or margin of error. So, when you think about an insecticide-treated net campaign, you desire something that is fairly accurate, plus or minus a 10 percent buffer. However, when you are thinking about case incidence, that exact value may not matter as much as the consistency and the trend over time. This is in line with what Peder mentioned about antenatal care (ANC) surveillance and that ability to keep the health facilities in the right stratification bracket. For instance, if you have five stratification categories, how much does changing that population change which category you fall in? To address this, one would have to think about what that margin of error might be that would be acceptable for each use case.

Question: The demographic and health surveillance system are limited to certain geographic areas that have more correct estimates in the defined areas. How could we leverage this?

Answer: I think that is when we should consider what our goal might be with regards to population estimation. It is easy to think about this in terms of campaigns. Routinely, national programs produce reports that show operational coverage. That is, the number of nets to be distributed and what population it is expected to cover divided by the total population. Thus, the true coverage would be the proportion of the total population that has access to nets. The best way to have an estimate is through demographic and health

surveillance systems. So, the goal of improving the population estimate is to arrive at a point of coverage where the level of the demographic health surveillance system is equal to the operational coverage. That is, the demographic health surveillance system estimates in terms of the coverage following an intervention. However, initial program reports tend to have much higher coverage, often because of the use of census estimates or the uneven distribution of nets across an area. So, typically, granular data results might be missing variation. The DHIS may be useful in such instances to get a better estimate of the true coverage and compare that to operational estimates over time.

Antenatal care prevalence and intervention monitoring

Question: What is your reason for using ANC for estimates of prevalence of malaria rather than using the children? Is it an issue of routine versus survey because both are still targeting a sentinel system which has all ages? Instead of the point estimate of a survey, if it is a sentinel site you can disaggregate by every age. What are your views?

Answer: Both ANC attendees and children under five are both good populations to use since they are both still targeting the sentinel system, which has all ages. ANC surveillance seems to work best when paired with a modeling approach. Moreover, considering the trends by age groups, it is possible to model that looking at under-fives or all ages. However, for ANC prevalence, the overall trend, even though the magnitude might not be the same in the community versus the ANC prevalence, the trends were very similar and timely, and generally followed what the community trends depicted. So even if the magnitude is not the same, that is, different between ages, it could still be useful for surveillance purposes.

Question: Several countries are starting community-based ANC; would this improve estimates?

Answer: Yes, it is possible, though what we see in the literature is that currently, ANC attendance at the facility is quite high. I think that would improve estimates if it were community-based ANC. It would, however, also be prone to some of the same challenges that we see in other types of community-based data collection.

Question: What is the ANC service uptake in the service areas? Does this consider the models to predict?

Answer: I am not sure about this question but will investigate that.

Question: Would community-based intermittent preventive treatment affect the outcomes?

Answer: Yes. I do believe that would probably affect the outcomes if there had been treatment administered prior to the first ANC visit. Ideally, women who had received treatment should be excluded.

Question: Why do you use the community register instead of population estimates?

Answer: In Pakistan, for instance, where female volunteers collect data on number of births and deaths in the community on a continuous basis, this could also be considered as a population estimate, though more direct methods could be used. The key is to ensure that this vital statistics registry should have checks in place to validate the completeness and accuracy of the data on an ongoing basis.

Sub-theme 3: Data for monitoring and evaluation of interventions

Presentations:

1. **Data repositories and data systems challenges and best practices from Nigeria**, Chukwu Okoronkwo, NMEP Nigeria. Presentation [here](#).
2. **Harnessing surveillance data to improve active detection in Thailand**, Jui Shah, RTI. Presentation [here](#).
3. **Data quality assessments for interventions: MACEPA, preliminary results from Zambia**, Smita Das, MACEPA/PATH. Presentation [here](#).
4. **Data quality assessment using malaria routine data quality assessment tool—Kenya**, Jane Githuku, PMM/ICF,. Presentation [here](#).
5. **Routine data quality assessment using the malaria routine data quality assessment mobile application – Adaptability for elimination setting**, David Boon, JSI. Presentation [here](#).

Discussion/question and answer session

Data repositories and data systems challenges and best practices from Nigeria

Question: How are the data repositories used in the supervision process? Do the supervisors use data from the repository or feed information into the repository?

Answer: The Ugandan repository appears to be a bit more advanced as they just finalized what is known as the malaria module that brings together under one instance all the malaria-related data consisting of all the indicators. Nigeria is also working to achieve this. In addition, Nigeria has repositories that can be downloaded, and it is also working on automating the generation of the bulletins.

Question: Does the data repository allow for research data usage and what is the process?

Answer: Nigeria has a malaria operational research agenda. So, the operational research agenda is in the repository. This allows people to understand the key questions that it could address. Presently, they are trying to create a space to fit in a template to which research findings could be uploaded, and how this could be translated into policy briefs. In terms of the supervision process, Nigeria uses repositories to identify and analyze data from facilities with data quality issues and correct them before the window closes. Since there is a team working at the committee level, the data repository is used to compare the data. The data are consistent with what is being reported on the DHIS2 platform.

Data quality assessments (DQA)—all presentations related to DQA

Question: On the comparison of incidence based on what had been reported versus what is documented in the registers, I think the more important question is whether there are issues with administering correctly and consistently malaria tests. How was this factored in the analysis?

Answer: Evaluating quality of care is not part of these routine DQAs in Zambia. There are other supervision visits that look at this issue.

Question: Had there been an effort to see how comprehensive the documentation on the registers is? Are all fever and malaria cases really being captured?

Answer: They can only assess whether fever and malaria cases recorded in registers are being captured. It is a different kind of evaluation to determine whether cases seen at the facility are recorded into the registers. Evaluating quality of care is not part of a normal DQA but is recommended since it is contributory to data quality improvement and thus, a limitation.

Question: Looking at the initial DQA, the follow-up, and the DHIS data, there seem to be huge outliers, which may pose potential problems within the case-reported data or within some of the

reactive data. Is there a possibility of pairing and has that been done in any of the cases? That is, pairing to target the DQA spots where there are red flags?

In addition, the Zambian DQA supervision seem quite extreme, as it is a two- to three-day process at each facility every couple of years (seven years), while in other places like Mozambique, it has been incorporated into the routine supervision. Also, elsewhere, a very much more lightweight version of a DQA might be carried out multiple times per year. So, what is your take about the relative pros and cons of one approach over another? Is there a sort of happy medium where we can get good quality DQA done on a more frequent basis?

Answer: There are two standard ways to look at data quality. One is conducting these health facility data quality checks, looking at source documents and comparing them to what has been reported. The other is to do an analysis on the aggregate data in the health management information system, and we have tools for both methods. The analysis of aggregate data in health management information system is low-hanging fruit. We have tools that facilitate and automate that. And we can do that every month for every district and every health program. These types of DQA supervisions are costless. However, conducting DQA at the facility level is much more demanding and costly. So, a health facility assessment on a representative sample of sites may be conducted every couple of years prior to strategic planning. This approach is sufficient for most sites that are deemed not high priority for elimination. For those districts (sites) targeted for elimination, where we really want to see high-quality data, we conduct more frequent data quality checks. We can prioritize sites that are showing problems of data quality and go there more often and maybe the places that are reporting good quality data we could go to less often, but we have a lot of tools at our disposal, and we should be making use of all of them.

Question: How do you target the data quality visits?

Answer: We approach this differently as we want the data quality audits to be scientific and representative of what is happening in a particular county. We therefore conduct random selection of health facilities to visit so that the aggregate score that we calculate is representative of the data quality for that county. What we target is what we call mentorship visits, which are meant to address the data quality issues that are identified. The DQA results are used to identify hospitals and health facilities that have issues, data quality issues, and target them for mentorship, for data quality improvement efforts. We also use the WHO quality tool that is embedded in DHIS to flag outliers or hospitals, or health facilities reporting inconsistent data and target them for mentorship. But for the DQA, we keep it as scientific as possible so that we can have an accurate estimate of the data quality in a particular site.

Question: I noticed that the sample size of facilities doubled in the timeframe, and I am just wondering if you could explain, maybe I missed it in your presentation, how the sampling was done. I wonder if that factors into this conversation about frequency and resources.

Answer: So basically in 2015, the DQAs were done mainly in southern province. Around 2017 is when we see that doubling; that is when the districts from the western province were incorporated into the selected DQA sites. So, more facilities were added. But then over time, both districts increased, which explains why you see that huge increase.

Question: How institutionalized are the DQAs at health facility level? I understand the data quality audits are usually top down, but at the facility level, how institutionalized is the process as an assessment? And who is ordering the process? A lot of times, turnover and the training, the tips that may be linked to the owner of the processor may have an impact on the process. For the people who have conducted a lot of these DQAs, are you tracking staff continuity of the health facility?

Answer: Yes. This is part of our next steps for the analysis, Derek responded. Anecdotally, in Zambia specifically, there is staff turnover at the district level, and it has an impact on how DQAs are conducted. In Zambia, ownership of the DQAs is at the district level. The district health officers are responsible for ensuring the data quality at the health facility, addressing discrepancies, and providing mentorship as needed, as well as creating action plans. The institutionalization process in Nigeria that is being put in place is called the Model Health Facility Concept. Nigeria considers coverage seriously as they conduct data quality improvements by ensuring that selected health facilities are representative of all the zones. When a particular facility is selected as a model, all the required mentorship, support, and quality of care is provided, so that health facility becomes a mentor to others.

Reacting to the question on institutionalization and turnover, Jane cited the example of Kenya, whereby action plans are developed in conjunction with the team at the health facilities that are responsible for implementing them. They are also involved in the data review meetings because these are conducted out of the health facility but include the health facility staff. With regards to tracking staff turnover, which greatly affects the data quality, Kenya takes tracking and turnover of mentors seriously. Jane underscored the importance of tracking turnover of the mentors and stated that their involvement in the DQAs have seen a 20 percent turnover over one year.

Sub-theme 4: Diversity, quality, and use of data in malaria elimination surveillance

Session 1

Presentations:

1. **Setting up sustainable surveillance and response mechanisms: Experience in Laos**, Bram Piot, PSI. Presentation [here](#).
2. **Assessment of malaria surveillance in elimination settings – Using the WHO surveillance assessment toolkit**, Arnaud Le Menach, CHAI. Presentation [here](#).
3. **Role of community health workers in malaria elimination settings**, Aung Myint Thu (Wayne), Program Coordinator, Malaria Department, Shoklo Malaria Research Unit. Presentation [here](#).
4. **Global Malaria Dashboard (RBM Dashboard)**, Marsha Deda. Presentation [here](#).

Discussion/question and answer session

Role of community health workers in malaria elimination settings

Question: How is data shared between the cross-border regions? Is there a system in place to manage the quality-of-care issues or the data quality issues?

Answer: In the past, data were shared typically at a higher level, but currently, there is engagement at both local and national levels and more collaborative work even at the level of cross-border supplements.

Assessment of malaria surveillance in elimination

Question: What are your thoughts with regards to transition to an Emergency Operations Center (EOC) system in a country with both control and elimination zones? How do you coordinate setting up those two systems? In addition, what happens if we ever have the unfortunate situation of outbreaks in certain areas that are bigger than the resources that the EOC has? At what point do you start to think about having a more malaria-specific response as is the case in a control zone?

Answer: During the transition, since many districts have not seen a single area case in a long time, this allows for the national program to focus their efforts more on the burden

reduction areas as the district malaria teams are being phased out into the generic disease control and communicable disease control units at the provincial and district levels. The challenge is how to implement a malaria surveillance system and how to report malaria in those elimination areas into the overall notifiable disease system, as this is not all under the EOC. The EOC is there to help coordinate and monitor compliance with protocols and standards.

As for the capacity to respond to large outbreaks, the role of the EOC is much more in terms of coordinating outbreak response, and it does not matter whether it is a large malaria outbreak or dengue or COVID-19; it just suffices for the district to mobilize required resources. We also utilize the public response teams' concept of surge capacity, whereby we have trained core staff as well as other trained staff from other divisions within or outside the Ministry of Health who are able to mobilize resources when there are larger-scale emergencies.

Sub-theme 5: RBM Partnership

Session 1

Presentations:

1. **Health Community Committee: Report and plan for 2023**, Richard Maude, APMEN. Presentation [here](#).
2. **SP&DQ Committee: Report and plan for 2023**, Hannah Edwards and Julianna Smith, Malaria Consortium. Presentation [here](#).

Session 2

Breakout session—Brainstorm with other RBM working groups

The brainstorming session seemed to be the hallmark of all the presentations, discussions, and the question-and-answer sessions, as members reflected on all the action points raised during the discussions. Emphasizing the importance of the session, Yazoume Ye underscored the fact that the brainstorming session was an opportunity for participants to reflect on the need for a data control system that is more effective and beneficial for service. The concern was on ensuring the data quality and establishing a matrix to measure the quality of service. Also, there was/is the concern of understanding who should own the process. That is, are the Ministry of Health and the NMCP in the country part of this process? How do we measure the updates that have been put in place by some of these countries? All the participants representing all the RBM working groups therefore brainstormed on critical issues that the SMERG as a surveillance, monitoring, and evaluation community needs to address. The [Malaria in Pregnancy working group also sent their suggestions](#) on what the working group expects from the SMERG.

The expected outcomes include the specific action or product that needs to be addressed by the SMERG; what should be done (developing a manual, make a proposal); who do you think should be the primary driver (a subgroup or a person responsible for the action); and the timeline for the action to be conducted. The results that constituted the action points would be used for the Menti-poll that would help to rank the action items according to priority. The following templates summarize the takeaway points from the three breakout groups.

Group 1: Sammy Kvartunas, Julianna Smith, Monica de Cola, Marsha Deda, Patricia Nchamukong., Shea Henson, Mariam Mohammad, Jane Githuku

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
Surveillance, monitoring, and evaluation (SME) support—typically tagged behind other funding or projects without specific SME support, which minimizes its focus	<p>Advocacy among funders for funding strictly for surveillance or SME—pushing the need for funding based on the cost effectiveness of having the surveillance systems and data available</p> <p>SMERG advocating for the funding and tracking SME funding</p>	SMERG Secretariat		1 year
<p>Private sector not integrating into the surveillance systems. Suboptimal reporting by the private sector.</p> <p>The private sector is designed for profit-making—want to be sure we are complementing the two sectors for the community’s needs.</p>	<p>SMERG lobbying countries for reporting guidelines, especially from the private sector reporting. The burden of malaria patients ultimately falls to the public sector system so it will be important to emphasis the need for the reporting by both sectors to reduce this burden.</p> <p>Engaging the private sector to encourage reporting, with emphasis on the importance of the reporting.</p> <p>SMERG can encourage countries through different channels—African Leaders Malaria Alliance forum as a platform for encouraging and enforcing reporting.</p> <p>Consistent training between the public and private sectors.</p> <p>Public health acts at country levels for the private sector.</p> <p>Capturing data from the private sector—SMERG giving guidance to countries on how data can be captured at the outpatient level, not as part of the commodity system.</p>	NMCPs	SMERG Secretariat	1 year

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
<p>How to capture learning and action items from the various assessments and DQA tools—lack of guidance to countries on what is expected of them for the surveillance systems</p> <p>How countries can track where they are in different transmission zones</p> <p>Lack of funding for data quality improvement actions—linked to the need for increased funding for SME</p>	<p>Decision-making tool for tracking different actions based on the tools available—from the DQA, the populated actions need to be tracked and any effects on the quality of the data.</p> <p>A feedback mechanism following the DQA to the facilities for tracking improvements. SMERG could develop this sort of framework for countries.</p>	RBM	SMERG	
<p>Cost-benefit case for investing in malaria in elimination settings where the burden is low. The incentive is low for medium and low transmission areas since funding decreases as the transmission decreases in certain areas.</p>	<p>Need to show the cost-effectiveness of moving toward elimination</p> <p>Defining cost-effectiveness in an elimination setting and the contributing factors</p>			
<p>Some countries are less experienced in the elimination settings.</p>	<p>Peer learning with countries that have more experience in elimination settings with those that are newer—cross-region learnings between countries</p>	SP&DQ		

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
Case-based surveillance— lack of resources for countries in identifying how/when to use case- based surveillance	<p>Linkages between countries and WHO and providing a toolkit for countries wanting to utilize case-based surveillance</p> <p>A repository of resources (e.g., Thailand’s examples for surveillance are not widely know and other countries do not have access to these examples)</p> <p>Linked to the need for cost-effectiveness advocacy Institutionalization of DQAs among the facilities—not as an audit but a review of their own data that the facilities do on their own</p>			

Group 2: Arnaud Le Menac,

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
Surveillance assessment is helpful but lacks benchmarks of where surveillance system sits within maturity system (e.g., country X had achieved components A, B, and C but needs more to be done on D).	Formulate surveillance maturity scale/framework of where the surveillance system sits and what needs to be done to achieve the optimal one (e.g., operationalization of surveillance guidelines).	Committee/ working group and then identifying key folks or organization leveraging existing funding (or channeling funding to organization/ individuals) NB: similar approach may apply to 2, 3 and 4?		
DQA methods, approach, and outputs is heterogeneous across multiple countries.	Document what has been done across multiple countries and develop <u>brief</u> best practices (e.g., flow chart, visuals, decision tree) about what the standards should be (e.g., frequency, level, sampled facilities, done during supervision or more representative sample...).			
Population denominator (and other geography information) are difficult to access, assess quality.	Continue sharing information around key challenges, help prioritization of these challenges (e.g., work on governance, and in parallel landscape with existing sources), formulate practical and brief guidance/tools (and capacity) on how to evaluate the quality of denominator/ geographical datasets.	PATH seems to have started some work there, and could build from that to include other partners to draft of the upcoming plan.		

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
Guidelines can be a bit generic around surveillance, and countries struggle to apply them.	Operationalization of surveillance guidelines (e.g., specifics can be identified but will include visualization flow of information, how to do case investigation, what data to collect, definition of indicators like mobile migrants, or standardize classification of imported vs local). This could be done by documenting what countries do through a set of visual aids as a starting point, draft brief lessons/guidance from there.			
Role of SMERG is unclear (information sharing platform, operationalization of guidelines,) and for whom is this (e.g., value for partners, programs).	<p>Revise (or clarify) TOR, with the opportunity to rethink vision, role of co-chairs and Secretariat, administration, communication, audience, funding mechanisms to support some of the actions, relationship with key organizations such as WHO, APMEN, RBM Secretariat, etc.</p> <p>Approach may vary but could include a member survey, communicate on role and vision, more routine facilitation of the network, website improvement, leveraging less formal structure, etc. ...</p>	Co-chairs and Secretariat and with all members		

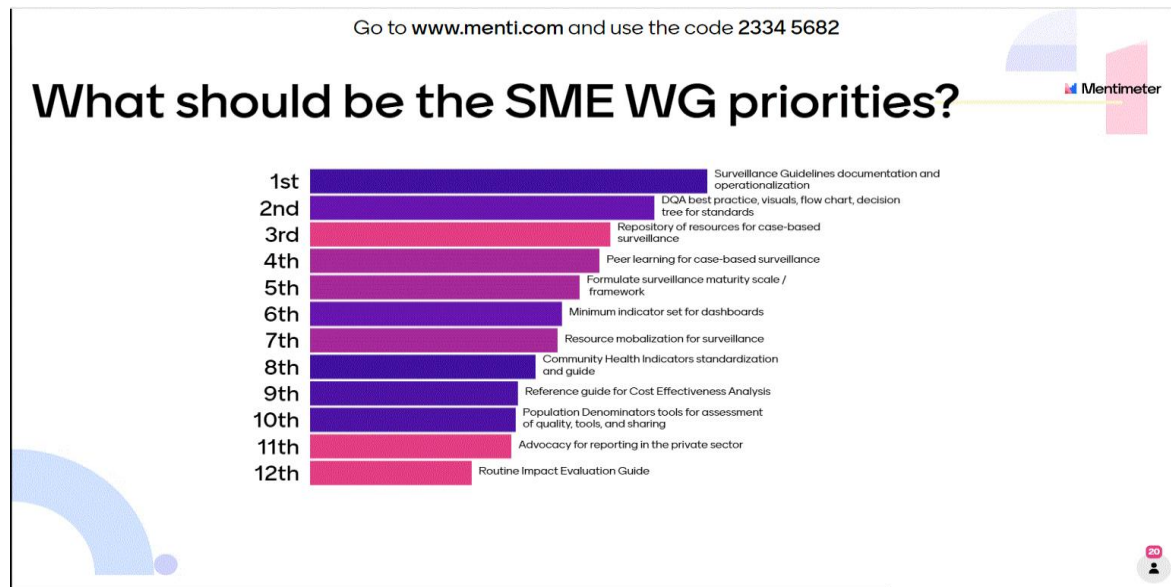
Group 3: Yazoume Ye, Latsouck Diouf,

Issue	Action	Primary driver (person/group)	Needed support (person/group)	Timeline
Limitations in operationalizing surveillance as an intervention in countries	Develop a support and guidance document on how to set up/transform surveillance as an intervention			
	Synthesize the different data quality assessment tools			
	Define the minimum package of data quality elements (DQA for malaria) to guide countries for informed decision-making			
	Set up an advocacy group for the mobilization of resources to support countries in the development of surveillance			
Inadequate use and harmonization of dashboards (diversity and disparity)	Define a minimum package of indicators for the development of dashboards for data visualization and decision-making			
	Use the DHIS2 platform for setting up dashboards			
Other issues	Develop a cost and efficiency analysis document			
	Develop a reference document of indicators at the health facility and community levels			

Menti-poll results

All the suggestions in the templates above were synthesized and entered in a Mentimeter, which was later shared with participants to rank the action items according to priority. The figure that follows shows the result of the Menti-poll ranked according to the prioritization of the action items, with the first being the most prioritized and the last the least prioritized.

Figure showing results of the Menti-poll



Sub-theme 5: Updates on SMERG Business

SMERG Strategy Document/revision of the Terms of Reference of SMERG: Process and timeline

Molly Robertson, SMERG co-chair, Global Fund

In this final session, SMERG co-chair, Molly Robertson, updated participants on the need to revise the SMERG Terms of Reference. This revision is crucial, following the restructuring of the RBM Secretariat that governs all the working groups, including the SMERG. The SMERG will be producing the SMERG Strategy Document that will guide the operationalization of SMERG activities. The timeframe will be three years. This document will:

- Define SMERG main priority areas and steps to address them for the next three years.
- Serves as a roadmap for the SMERG, in addition to the Terms of Reference.
- Serve as an advocacy document for funding.
- Measure SMERG achievements and define what success looks like.

Process and timeline:

- Co-chairs produce a draft, which is shared to members for inputs by end of June 2023.
- Final draft is discussed and validated at the meeting in October 2023 (American Society of Tropical Medicine and Hygiene).

Molly also underscored the importance of an Annual Action Plan. This action plan will:

- Define specific activities to implement during the year.
- Include clear benchmarks and deliverables.
- Provide costs for implementing activities.
- Derive from action points agreed upon during SMERG meetings.

Process and timeline:

- Co-chairs, with support from the Secretariat, will produce a draft based on action points from the meetings.
- Share the draft with members for input.
- Engage for funding—partners are encouraged to contribute.
- The development process should take more than three months.

Election of SMERG co-chairs

Yazoume Ye, PMM/ICF

Yazoume updated participants on the SMERG co-chair election process and procedure, as outlined in the SMERG Terms of Reference. He stated that two co-chairs will be elected from the SMERG membership, and one of these must be from a malaria endemic country. The co-chairs will serve a three-year term and are limited to two consecutive terms. However, there is no limit on the number of nonconsecutive terms a co-chair may serve. Co-chair Medoune Ndiop has served for two consecutive terms and thus is not eligible for the next SMERG co-chair election. Although Molly has been co-chair since 2020, due to the COVID-19 pandemic disruption, she has only served one term and thus is eligible for the next election. It was proposed and agreed upon that between July and September 2023, there will be an election to replace Medoune, and the installation of the new co-chair will be in October 2023 during the American Society of Tropical Medicine and Hygiene meeting. For continuity, the election to replace or re-elect Molly will run from October 2023 to February 2024, and the elected co-chair will be installed during the 35th SMERG Annual Meeting in May 2024, in a venue yet to be decided upon by SMERG members. The new SMERG Secretariat with the collaboration of the co-chairs will reach out to the members with further information on the election. For details on the presentation, click [here](#).

New secretariat support structure and management of PMI contribution—Transition of support to Country Health Information System for Data Use (CHISU)

Yazoume Ye, PMM/ICF

Yazoume briefed participants on the [function of the SMERG Secretariat](#) that has been supported over the years by PMM, through PMI funding, led the university of North Carolina at Chapel Hill, with ICF, JSI, and Tulane University. The SMERG Secretariat is in its transition phase, as CHISU will take over because PMM support will end by 30 June, 2023. The SMERG will officially hand over documents to CHISU on 30 June. The SMERG co-chairs thank Yazoume, who has faithfully provided oversight to the MERG (now SMERG) Secretariat since its inception more than 10 years ago. They symbolically bade him farewell but requested that he stay connected and available to support the SMERG and the new Secretariat. The co-chairs further thank Patricia Mbah Nchamukong for coordinating the activities of the SMERG Secretariat over three years and for the excellent organization of the 34th SMERG Annual Meeting in Bangkok, Thailand. Derek Kunaka (JSI), on behalf of CHISU, expressed their gratitude to Yazoume and the SMERG co-chairs for organizing the very successful meeting. He further thanked all the participants and expressed CHISU's willingness to continue with the activities of the SMERG.

The SMERG co-chairs announced that a poll will be sent out to members for their suggestions for the date and venue of the next annual meeting that will be held in May 2024. The co-chairs thanked all the participants, online participants, the Ministry of Health, and DVBD Thailand for all the support and for attending the 34th SMERG Annual Meeting. The meeting was finally declared closed by the co-chairs.

Appendix

List of Participants—34th SMERG Annual Meeting, Bangkok, Thailand

Name	Email	Organization	Position	Country
Co-chairs				
Medoune Ndiop	medoune.ndiop@pnip.sn	NMCP Senegal	Co-chair SMERG	Senegal
Molly Robertson	molly.robertson@theglobalfund.org	Global Fund	Sr Specialist, Malaria	Switzerland
Secretariat				
Yazoume Ye	yazoume.Ye@icf.com	PMM/ICF	Vice President, Malaria Surveillance and Research	USA
Patricia Mbah Nchamukong	patricia.nchamukong@icf.com	PMM/ICF	Coordinator and Communication Specialist	USA
Participants				
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Timothy Finn	timothy.finn@ucsf.edu	UCSF Malaria Elimination Initiative	Sr Research Manager	Laos
Bram Piot	bpiot@psi.org	PSI	Project Director	Laos
Jonathan Cox	jonathan.cox@gatesfoundation.org	BMGF	Senior Program	US
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Massaya Sirimattayanant	massaya@tropmedres.ac	MORU / APMEN	Coordinator APMEN SRWG	Thailand
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Jui Shah	juishah@rti.org	RTI International	Chief of Party	Thailand

Name	Email	Organization	Position	Country
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Mariam Said Mohamed	mirosaid4@gmail.com	Malaria Control & Elimination Ministry of Health	Malaria Surveillance, Monitoring and Evaluation Focal Point	Somalia
Dr Direk Khampaen		Department of Disease Control, MOPH	Deputy Director-General,	Thailand

Photos: 34th SMERG Meeting, Bangkok, Thailand

Opening of the 34th SMERG Meeting



SMERG Participants and the DVBD Team



Dr. Direk Khampaen,
Deputy Director-General,
Department of Disease Control,
MOPH Thailand



Dr. Rungrawee Tipmontree,
Chief of Malaria Group, DVBD,
Thailand



Suravadee Kitchakarn,
DVBD Thailand



Arnaud Le Menach, CHAI



Bram Piot, PSI



Prof. Richard Maude, APMEN Thailand



Group discussion



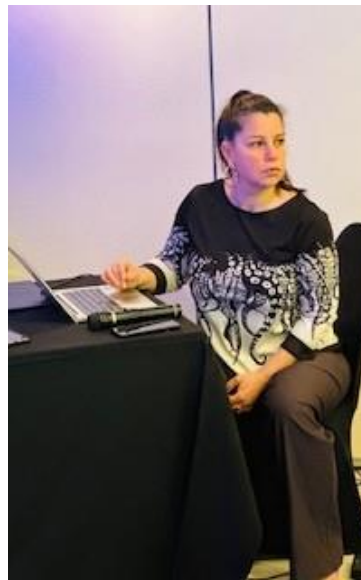
Mohammed Wahjib, NMCP Ghana



Patricia Mbah Nchamukong, PMI/ICF



Medoune Ndiop, co-chair, NMCP Senegal



Molly Robertson, co-chair, Global Fund



Yazoume Ye, PMM/ICF—SMERG Secretariat

[For videos, click here.](#)