Case management indicator review

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Photo: PSI/Impact Malaria

OVERVIEW

- Summary of the issues
- Indicator review methods
- Finding
- Considerations for improvement

CURRENT MEASUREMENT ISSUES

Facility level data:

- Developed from early days when diagnostics were not readily available
- Emphasis on epidemiologic data, not performance management data;
- Suffer from perception of poor quality
- Lack of standardization, little linkage with other supporting data (LMIS, lab, etc.)

Survey data:

- Most reliable and robust data source for some questions
- Biomarker measurement: malaria/anemia
- Self-reported data on for CM questions;
- Data only available every 3-5 years so not actionable for performance management

Quality of Care data:

- increased data collection, used locally for program mgmt

Photo: PSI/Impact Malaria

METHODS

- Desk reviews of existing guidance on indicators for description, definition, calculation
- Key informant interviews with NMCPs, donors, implementing partners
- Focus groups on key topics
- Field visit in Madagascar and Tanzania

NB: Much of this information comes from a project supporting the Global Fund to review its indicators and measurement issues.

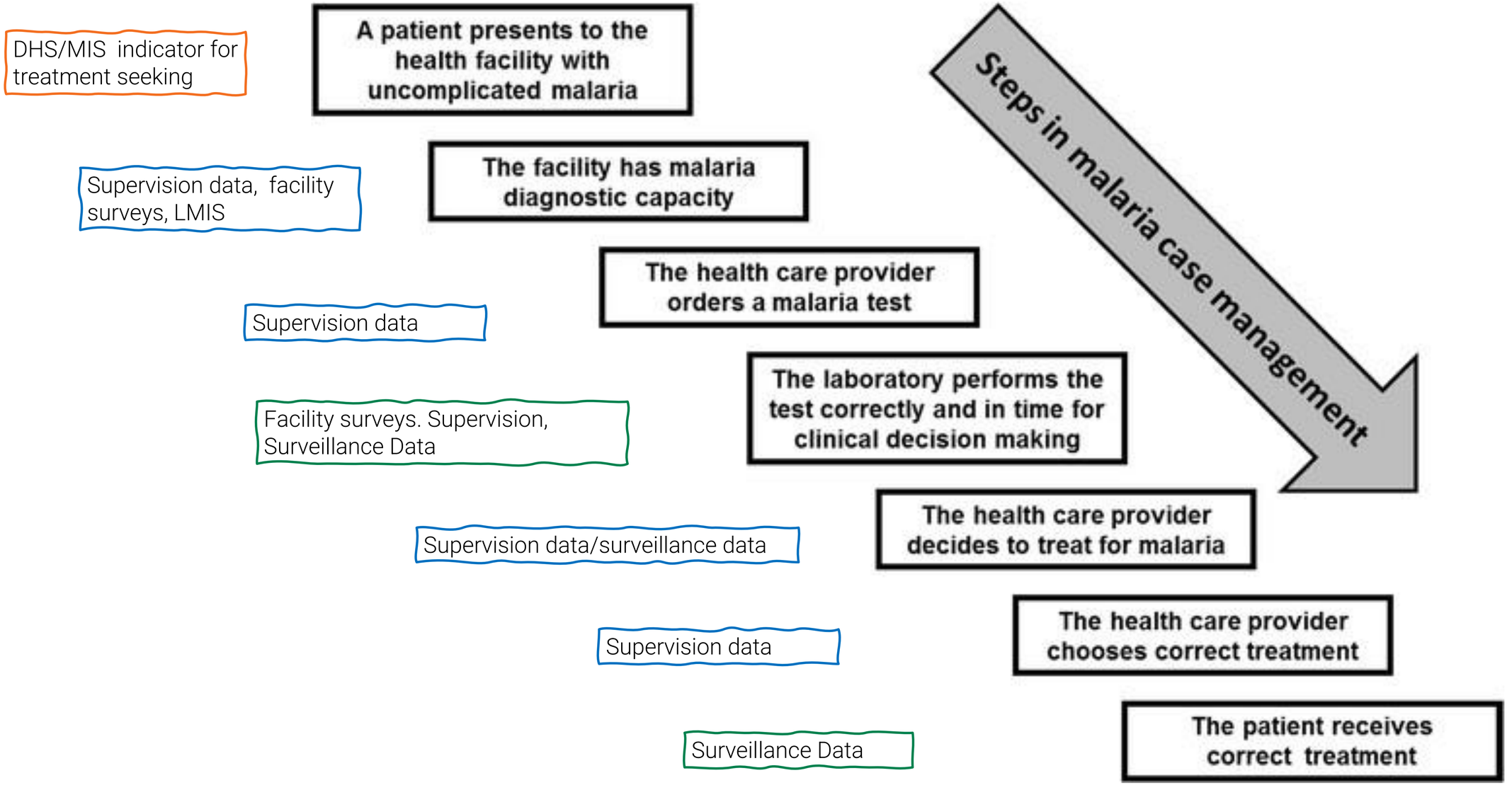
Proposed indicator revisions for Global Fund fall into 4 categories

CATEGORY	NUMBER OF INDICATORS	EXAMPLE
Wording Change	28	**Malaria I-15:** Number of locally acquired malaria cases Suggested change: Number of locally acquired malaria cases (pre-elimination and elimination settings)
Data Collection Improvement	15	**Malaria O-2:** Proportion of the population with access to an ITN within their household Suggested Improvement: Consider more frequent data collection through LQAS or mobile phone surveys
Remove from Framework	14	**Malaria I-2:** Confirmed malaria cases (microscopy or RDT): rate per 1000 persons Reason: Direct overlap with Malaria I-10: Annual parasite incidence confirmed malaria cases (microscopy or RDT): rate per 1000 persons/year (elimination settings
No Change	10	**Malaria I-4:** Malaria test positivity rate

Indicators from existing sources could fill gaps in the Modular Framework

Example Gaps in Modular Framework	Examples of Potential Indicators from Existing Sources
 **Vector Control:** No indicators for entomological data	• Resistance status* (by chemical type and subnational area) (Entomological Surveillance Planning Tool (ESPT) guide for routine entomological surveillance for decision making)
 **Case Management:** Insufficient outcome indicators to measure quality of care; existing supervision data underutilized	• Proportion of supervised health workers demonstrating competency in uncomplicated malaria case management (Supervision Data)
 **Specific Prevention Interventions:** Indicators needed for newer interventions, including malaria vaccines and Perennial Malaria Chemoprevention	• Number and % of children in the target age group who received the full number of malaria vaccine doses (Routine EPI)

MONITORING THE TREATMENT CASCADE



CONSIDERATIONS – ROUTINE DATA

☑Use **FEVER** instead of 'suspected case'
Advantages: fever is a measurable clinical sign, more objective measure

☑Collect **AGE Group** for indicators
Either 5 year brackets, or <5, 5-10, >10
Advantage: allows better tracking of burden by age group

☑Disaggregate by **GENDER/PREGNANCY STATUS**
Advantage: better understanding of burden and trends in subgroups,

Caveat: All of this requires changes to standard DHIS2 data collection, a major undertaking.

Photo: PSI/Impact Malaria

CONSIDERATIONS – DATA SOURCES

☑Integrate **CHW data** more completely into routine DHIS2
Advantage: capturing cases treated outside a health facility

☑Increase **PRIVATE SECTOR** reporting into routine DHIS2 reporting
Advantage: capture cases treated in the private sector, more visibility into private sector practices.

☑Encourage linkages between **LAB, PHARMACY, SUPPLY CHAIN** data systems to better understand outcomes
Advantage: 360º view of strengths and weaknesses of service delivery

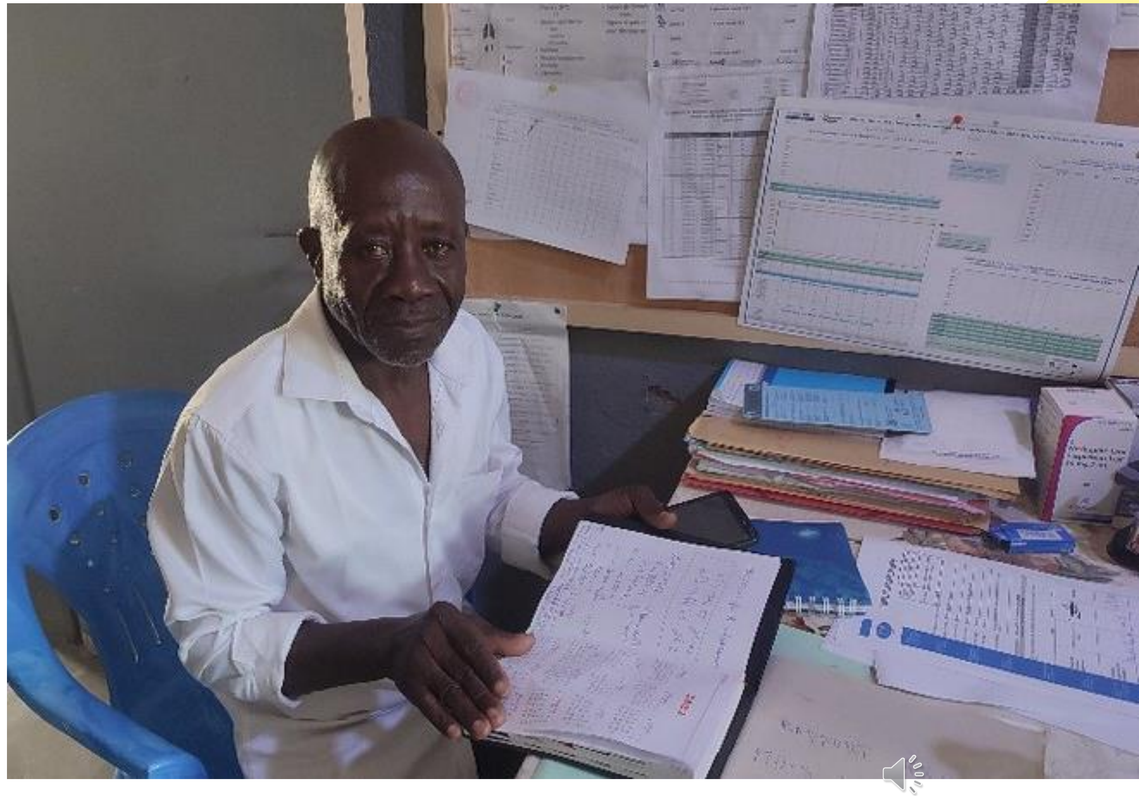
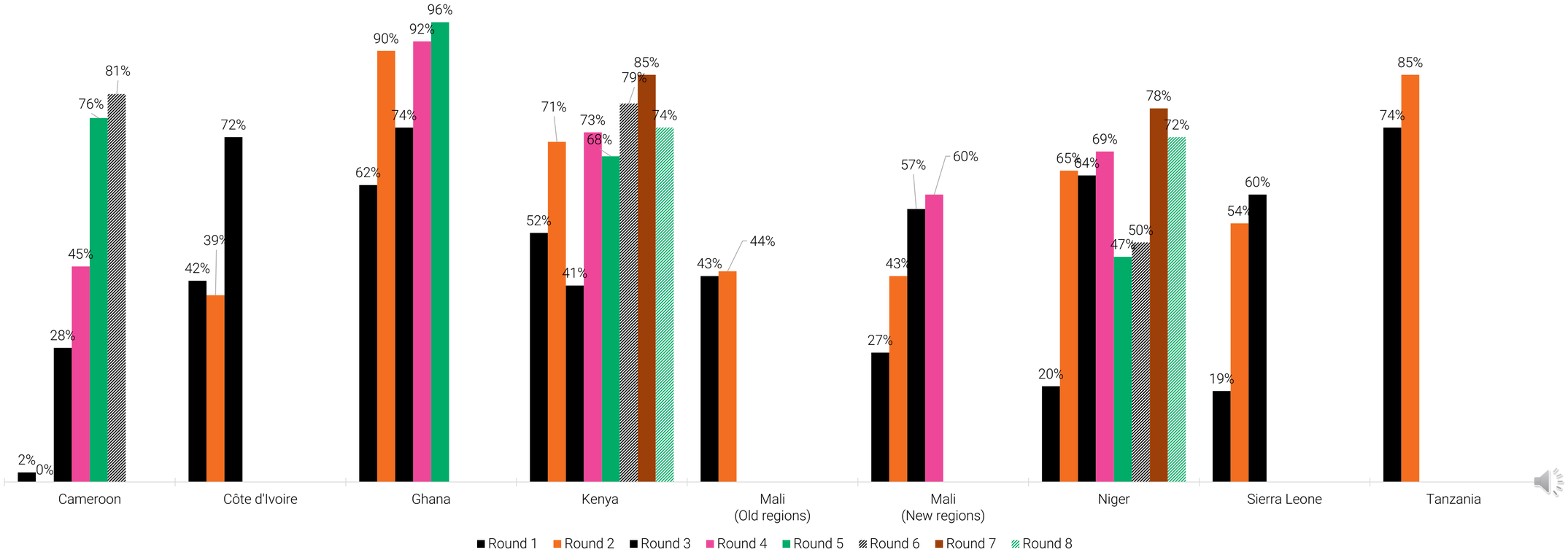


Photo: PSI/Impact Malaria

CONSIDERATIONS – QUALITY OF CARE

☑Collect and use **Quality of Care** data routinely.
Advantage: understanding the process to achieve coverage and impact

Percentage of providers competent in MIP treatment protocols from baseline to most recent supervision



Source: OTSS+/ISS data

MONITORING VS IMPACT

Monitoring

Purpose: performance improvement, management

Frequency: monthly, quarterly

Data Source: routine data, surveillance, supervision, campaign data

Primary Users: local health officials (district, health facility)

Impact

Purpose: evaluation, strategy, progress towards national goals

Frequency: annually, every 3-5 years

Data Source: surveillance, surveys

Primary Users: national health authorities, donors, int'l NGOs

It is important to consider the PURPOSE and USE of the indicators that countries are asked to collect.

FUTURE NEEDS

- Tracking subnational vaccine rollout
    - Campaigns? Health facility based?
- Monitoring multiple first line drugs
    - In elimination areas or areas where resistance has been identified
- Transition to case-based routine system for elimination

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