GUIDELINES FOR
THREE MILLENNIUM DEVELOPMENTS GOALS FUND
MARC INDICATORS
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ACRONYMS LIST

3MDG  Three Millennium Development Goals Fund
ACT   Artemisinin Based Combination Therapy
AIDS  Acquired Immunodeficiency Syndrome
CBO   Community Based Organisation
CHW   Community Health Worker
FB    Fund Board
FM    Fund Manager
G6PD  Glucose-6-phosphate dehydrogenase
GIS   Geographic Information System
GP    General Practitioner
HF    Health Facility
HH    Household
HIV   Human Immunodeficiency Virus
HMIS  Health Management Information System
INGO  International Non-Governmental Organisation
ITN   Insecticide Treated Net
IRS   Indoor Residual Spraying
KO    Used in the treatment of mosquito nets
LLIN  Long Lasting Insecticide Treated Net
MARC  Myanmar Artemisinin Resistance Containment
M&E   Monitoring and Evaluation
MIMU  Myanmar Information Management Unit
NMCP  National Malaria Control Programme
MoH   Ministry of Health
NSP   National Strategic Plan
RDT   Rapid Diagnostic Test
TB    Tuberculosis
TSG   Technical Strategic Group
VHW   Village Health Worker
WHO   World Health Organization
INTRODUCTION

The overall objective of the Three Millennium Development Goals Fund (3MDG Fund) is to reduce the burden of HIV, TB and malaria in Myanmar. Within the 3MDG operational structure, the Fund Manager (FM) is responsible for monitoring and evaluating:

1) the overall progress of the national programmes and the overall situation in Myanmar for the three diseases;
2) the results, including through gender analysis and social equity analysis, of the 3MDG against its objectives and the priorities established by the Fund Board (FB). As such, it is necessary to have a clear understanding amongst all 3MDG partners what is being measured; and
3) the use of resources given to partners by the 3MDG Fund.

PURPOSE OF THE GUIDELINE

The primary purpose of this document is to provide 3MDG stakeholders with some essential information on the malaria indicators for 3MDG which were derived from the Artemisinin Resistance Containment in Myanmar Strategy (MARC) 2011-2015. Partners are strongly encouraged to integrate the MARC indicators into their ongoing monitoring and evaluation (M&E) activities.

These indicators are designed to help partners assess the current state of their activities, their progress towards achieving their targets, and their contribution towards the national response. This guideline is designed to improve the quality and consistency of data collected at the partner level, which will enhance the accuracy of conclusions drawn when the data are aggregated.
INDICATORS OVERVIEW – COMMONLY ASKED QUESTIONS

Indicators are important for two reasons. First, they can help evaluate the effectiveness of activities. Second, when data from programmes are analyzed collaboratively, the indicators can provide critical information on the effectiveness of the response at national level.

Q1: Where is MARC being implemented?

As of March 2013, 3MDG will support implementation of MARC in Tier 1 and Tier 2.

Q2: Where do I find information on calculating and interpretation MARC indicators for 3MDG MARC grants?

- In this guideline. This guideline includes detailed information for the calculation of each MARC indicator required under the 3MDG grant. This guideline includes numerator and denominator (if applicable) definitions, frequency of reporting, Data source required, a summary interpretation of the indicator, and references for additional resources.

Q3: Are these indicators aligned with the National Strategy?

- Yes. These guidelines include indicators from the Artemisinin Resistance Containment in Myanmar (MARC) 2011-2015 strategy, which are applicable to partners working in MARC areas. These indicators will be used to monitor the 3MDG MARC project and almost all (11 out of 12 indicators) fully align with the national strategy.

Q4: Which indicators do I report on and when?

- Partners are expected to report on indicators as per their grant agreement and log frame. Under no circumstances should a partner try to force inappropriate data into the indicator measurement. There are other opportunities to report achievements not related to the required indicators in the narrative report. If a partner has any questions regarding reporting, they should contact the Fund Manager’s Office before submission of the report. This guideline also provides information on the frequency of reporting.

Q5: How does the MARC Strategy define migrant and mobile populations?

- The MARC Strategy uses the following definitions:

  Migrant: A person who takes up residence or remains in another place for an extended period of time, including seasonal migrants. A migrant moves from one location to another, regardless of duration or distance; experiences inequitable access to public health services resulting from the movement; and is vulnerable to becoming infected
with malaria as a result of the movement. (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Mobile population:** Any person who is constantly moving, such as truck drivers, seafarers, reveling salespersons, “maw sayar”, sex workers etc. (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

Q6: Do I need to disaggregate data by sex and age?

- **Yes.** For the indicators that clearly state in the guideline that sex and age data are required. Apart from indicators 7, 8 and 9, the rest of the indicators must be disaggregated by sex. The challenge for partners is to ensure that data remains disaggregated from the collection point all the way to reporting.

Q7: Do I need to provide village level data?

- 3MDG will use a Geographic Information System (GIS) to see where and when activities are taking place. 3MDG will then be able to map important health information related to MARC and potentially expand data collection with more partners. Partners are to identify where basic health staff and village volunteers are working and the number of cases treated by village for reporting to the National Malaria Control Programme (NMCP). 3MDG will work with the NMCP to compile and map this data.

- **Township level data is required for bed net distribution for all partners.**

Q8: Do I need to count the number of patients treated in mobile clinics?

- Yes. For indicators 1, 2, 3, 4, 5 and 12, the cases treated in mobile clinics **must** be included.

Q9: Do I need to count the number of migrant workers treated?

- Yes. For the indicators 1, 2, 3, 4 and 5, migrant workers treated at any clinic **must** be included.

Q10: How do I collect and compile village based treatment data?

All partners are expected to use the NMCP Malaria Case Register Books.
Village tract and village name should be accordance with the name officially defined by the Ministry of Home Affairs and Myanmar Information Management Unit (MIMU). Visit http://www.themimu.info for more information.

Q11: What are the data sources we should use when collecting information?

- Primary Data sources for partners can include: (i) nationally representative, population-based sample surveys; (ii) specially-designed surveys and questionnaires, including surveys of specific population groups; (iii) patient-tracking systems; (iv) programme monitoring reports; and, (v) routine health information systems. Each indicator has a defined data source. Some names of the tools may be different in your organisation compared to what is listed in this guideline, so please check with 3MDG to ensure your data sources are the right ones.

Q12: Which reporting template should be used to report indicator data?

- 3MDG will provide each partner with an updated MARC reporting template at least one month prior to the reporting deadline. This template will have your targets filled in and is based on your log frame and grant agreement.

Please contact the 3MDG office at +95-1-657280-7 for further information and support.
REPORTING FLOW FOR COMPONENT 2 (MALARIA) 2

- Village level case management report
- Township reports
- HQ IP M&E unit
- 3MDG M&E Unit
- 3MDG Fund Board
- FMO
- IP
- Township
- Volunteer
- Village
- HQ
A Public Health Questions Approach to M&E

| Determining Collective Effectiveness | Outcomes and impacts Monitoring | Are Collective efforts being implemented on a large enough scale to impact the epidemic?  
*Survey: Surveillance* |
|--------------------------------------|--------------------------------|------------------------------------------------------------------|
| Monitoring and Evaluating National Programs | Outcomes | Are interventions working/making a difference?  
*Outcome Evaluation Studies* |
|                                      | Outputs | Are we implementing programme as planned?  
*Output Monitoring* |
|                                      | Activities | What are we doing? Are we doing it correctly?  
*Process Monitoring and Evaluation: Quality Assessment* |
| Understanding Potential Responses | Input | What interventions and resources are needed?  
*Needs, Resource, and Response Analysis: Input Monitoring* |
|                                      | | What interventions can work (efficacy and effectiveness)? Are we doing the right things?  
*Special Studies; Operations Research; Formative Research; Research Synthesis* |
|                                      | | What are the contributing factors?  
*Determinants Research; Analytic Epidemiology* |
| Problem Identification | What is the nature and magnitude of the problem?  
*Situational Analysis* |

**The Third One: Monitoring and Evaluation of HIV Programs** John Puvimanasinghe, Wayne Gill and Eduard Beck
QUICK REFERENCE FOR 3MDG MARC INDICATORS

The following indicators will be collected by partners working in MARC areas or implementing malaria projects. The following indicators are from the Artemisinin Resistance Containment (MARC) in Myanmar 2011-2015 Strategy, with the exception for 3MDG MARC Core Indicator 4 which is a 3MDG indicator.

Goal:
1. To prevent or delay the spread of artemisinin resistant Plasmodium falciparum parasites.
2. To reduce transmission, morbidity and mortality of Plasmodium falciparum malaria, with priority to areas threatened by artemisinin resistance

Purpose: Increase access to and availability of Malaria intervention for population & areas not readily covered by the Global Fund

Objective: Improving access to and use of early diagnosis and quality treatment according to the national treatment guidelines

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Treatment indicator</th>
<th>Percentage of confirmed P.f malaria cases treated with ACT plus primaquine according to national guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Treatment indicator</td>
<td>Percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines within 24 hours of onset of symptoms (fever)</td>
</tr>
<tr>
<td>Output</td>
<td>Treatment indicator</td>
<td>Number of people with confirmed P.f malaria treated with recommended ACT plus primaquine.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Disaggregated by sex and age group: &lt;1, 1-4, 5-9, 10-14, and 15 years of age and above)</em></td>
</tr>
<tr>
<td>Output</td>
<td>Treatment indicator</td>
<td>Number of people with confirmed P.v. malaria (by sex and age group) treated with chloroquine [plus primaquine].</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(Disaggregated by sex and age group: &lt;1, 1-4, 5-9, 10-14, and 15 years of age and above)</em></td>
</tr>
<tr>
<td>Output</td>
<td>Indicator</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Output Treatment indicator</td>
<td>Treatment indicator</td>
<td>Number of confirmed falciparum malaria cases receiving DOT</td>
</tr>
<tr>
<td>Output</td>
<td>Diagnosis indicator</td>
<td>Number of RDTs taken and read</td>
</tr>
<tr>
<td>Output</td>
<td>Empowerment of Community Volunteers</td>
<td>Number of volunteers trained and supported</td>
</tr>
<tr>
<td>Output</td>
<td>Insecticide Treated Net (ITN)</td>
<td>Number of LLINs distributed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i) total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ii) migrant/mobile populations</td>
</tr>
<tr>
<td>Output</td>
<td>Insecticide Treated Net (ITN)</td>
<td>Number of mosquito nets treated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i) with regular insecticide treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ii) with long-lasting insecticide treatment (e.g. K-O Tab 123)</td>
</tr>
<tr>
<td>Output</td>
<td>Personal Protection</td>
<td>Number of people given protection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i) other personal protection measures (includes repellents, treated hammock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>nets and other protection other than LLIN/ITN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ii) Indoor Residual Spraying (IRS)</td>
</tr>
<tr>
<td><strong>Objective:</strong> To increase</td>
<td></td>
<td>migrant/mobile populations’ access to and use of malaria diagnosis, treatment</td>
</tr>
<tr>
<td>migrant/mobile populations’</td>
<td></td>
<td>and vector control measures including personal protection</td>
</tr>
<tr>
<td>access to and use of malaria</td>
<td></td>
<td></td>
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<tr>
<td>diagnosis, treatment and vector</td>
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<td>control measures including</td>
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<td>personal protection</td>
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<tr>
<td>Output</td>
<td>Empowerment of Community Volunteers</td>
<td>Number of volunteers trained and support specifically for servicing migrant/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mobile populations</td>
</tr>
<tr>
<td>Output</td>
<td>Diagnosis</td>
<td>Number of people tested for malaria at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i) worksites and (ii) at malaria screening points</td>
</tr>
</tbody>
</table>
1 Percentage of confirmed P.f malaria cases treated with ACT [plus primaquine] according to national guidelines 

(Disaggregated by sex)

**Numerator:** Number of confirmed P.f cases (P.f and mixed infections with P.f) treated with recommended ACT together with Primaquine (for non-pregnant women and above 5 year old cases) and without Primaquine for whom Primaquine is contraindicated: pregnant women and children under 5 year of age.

**Denominator:** Number of confirmed P.f cases (P.f and mixed infections with P.f) confirmed by microscopy or by RDT

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months.

**Interpretation:** Confirmed malaria cases are confirmed by RDT or microscopy.

Mixed infections, with *P. falciparum* present should be reported as “treated for *Plasmodium falciparum* malaria”. Anti-malarial treatment must conform to the national treatment guidelines. The applicable treatment guidelines for 3MDG are the “National Policy for Treatment of Malaria in the Union of Myanmar, Updated 2011”. Please review the National Treatment Guideline for a more comprehensive discussion on the treatment of individuals with G6PD deficiency.

**Additional Information:** 3MDG will request supporting documentation for the numerator and denominator used in the calculation of reported figures in order to verify the reported figures.

Indicator 1 matches with Indicator 3.9 from the NMCP M&E Plan.
2 Percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines within 24 hours of onset of symptoms (fever)  
*(Disaggregated by sex)*

**Numerator:** Number of confirmed malaria cases that have been treated with anti-malarial treatment according to the national malaria treatment guideline **within 24 hours** of the **onset of fever**.

**Denominator:** Total number of confirmed malaria cases (diagnosed with either RDT or microscopy)

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months.

**Interpretation:** This indicator provides a proxy measure for project level access to prompt and effective treatment for malaria according to national guidelines. The numerator can be obtained by recording patients taking anti-malarial treatment **within 24 hours** of the **onset of fever**.

The data for the denominator includes males and females of all ages who had fever and diagnosed as confirmed malaria during this reporting period.

**DO NOT** include the cases treated with only ACT, only Primaquine or probable cases. **DO NOT** include referral cases that did not receive malaria treatment before being referred.

The specific drug given and timing of treatment related to the onset of the fever must also be recorded. Anti-malarial treatment must conform to the national treatment guidelines. The
applicable treatment guidelines for 3MDG are the “National Policy for Treatment of Malaria in the Union of Myanmar, Updated 2011”.

**Additional Information:** In an ideal setting, this indicator would be complimented by a representative household sample survey.

In order to align with Roll Back Malaria and Global Fund indicators, fever will be used as the key symptom for calculating this indicator. The limitations of this indicator include recall bias by patients, fever may not have been the result of malaria infection, and there is no way of knowing if treatments were administered correctly. Partners may continue to collect data on other key symptoms; however, 3MDG will only request data on treatment within 24 hours from the onset of fever.

Indicator 2 matches with indicator 2.3 from the NMCP M&E Plan.
Number of people with confirmed P.f malaria (by sex and age group) treated with recommended ACT [plus primaquine].

(Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14, and 15 years of age and above)

Numerator: Number of people with confirmed P.f cases (P.f and mixed infections with P.f) treated with recommended ACT together with primaquine (for non-pregnant women and above 5 year old cases) and without Primaquine for whom Primaquine is contraindicated: pregnant women and children under 5 year of age.

Data source: Malaria Case Register book

Reporting frequency: Every 6 months

Interpretation: Confirmed malaria cases are confirmed by RDT or microscopy.

Mixed infections with P. falciparum present should be reported as “treated for Plasmodium falciparum malaria”.

Anti-malarial treatment must conform to the national treatment guidelines. The applicable guidelines for the 3MDG is the “National Policy for Treatment of Malaria in the Union of Myanmar, Updated 2011”.

This indicator is only for confirmed malaria cases treated with ACT + Primaquine.

DO NOT include the cases treated with only ACT or only Primaquine or probable cases (except for those primaquine is contraindicated: pregnant women and children under 5 year of age).

Additional Information: 3MDG will request supporting documentation for numerator used in the calculation of reported figures. 3MDG will request total treatment figures by township.

Indicator 3 matches with indicator 3.7 from the NMCP M&E Plan.
Number of people with confirmed P.v. malaria (by sex and age group) treated with chloroquine [plus primaquine].

(Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14 and, 15 years of age and above)

**Numerator:** Number of people with confirmed P.v. malaria cases treated with chloroquine plus Primaquine (for non-pregnant women and above 5 year old cases) and without Primaquine for whom Primaquine is contraindicated: pregnant women and children under 5 year of age.

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Interpretation:** Confirmed malaria cases are confirmed by RDT or microscopy. Anti-malarial treatment must conform to the national treatment guidelines. The applicable guidelines for the 3MDG is the “National Policy for Treatment of Malaria in the Union of Myanmar, Updated 2011”. Anti-malarial treatment must conform to the national treatment guidelines.

This indicator is only for the confirmed malaria cases treated with Chloroquine + Primaquine. DO NOT include probable cases or the cases treated with only Chloroquine or only Primaquine (except for those primaquine is contraindicated: pregnant women and children under 5 year of age).

**Additional Information:** 3MDG will request supporting documentation for the numerator used in the calculation of reported figures. **3MDG will request total treatment figures by township.**
Number of RDTs taken and read

*(Disaggregated by sex)*

**Numerator:** Number of RDTs taken and read. Do **not** count invalid RDTs.

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months.

**Interpretation:** The indicator excludes invalid RDTs as per the MARC Strategy and is a reflection of the **number of people tested using RDTs**. Include the number of RDTs tested and read for the general population and also migrant/mobile populations (if the programme serves migrant/mobile populations)

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**Programme Check!** Make sure to cross-check your distribution records for the number of RDTs that were distributed to service providers. Is the number different from the number of people tested? If yes, why? Include this discussion in your narrative report.

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**Additional Information:**

Indicator 5 matches with indicator 3.5 from the NMCP M&E Plan. **3MDG will request total RDT figures by township.**
6 Number of volunteers trained and supported

_(Disaggregated by sex)_

**Numerator:** Number of volunteers trained and supported (excluding volunteers trained exclusively for supporting migrant/mobile populations)

**Data source:** Training records and commodity distribution records (e.g. stationary, health promotion materials etc...)

**Reporting frequency:** Every 6 months. Cumulative annually.

**Interpretation:** Volunteers who have been trained exclusively for support migrant and mobile populations should be excluded in this calculation.

‘Trained’ includes trained/ retrained in prevention and/or treatment and case management. However, retrained numbers should not be included in this indicator.

Volunteers must be trained and supported (supported is defined as given the resources required to perform their duties, which will include stationary, travel allowance, health promotion materials and malaria prevention and detection supplies).

Each partner should stop support to “inactive” volunteers and reallocate their 3MDG resources to support an active volunteer. “Inactive” volunteer is defined as a volunteer who does not submit their report(s) for four continuous months during a six month reporting period.

The below table shows as an example of a counting method used for measuring volunteers trained and supported.

This indicator is related to the 3MDG MARC indicator number 11 (page 23), but volunteers working with migrant and mobile populations are not included in this calculation.

**Example of trained and supported volunteer counting**

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th># Volunteer (T+S) Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>Count</td>
</tr>
<tr>
<td>B (T+S)</td>
<td>B (T+S)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>Don’t count</td>
</tr>
<tr>
<td>C (T)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>Count</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D(T+S)</td>
<td>Count</td>
</tr>
</tbody>
</table>

A,B,C..= Represent name of volunteer  

T= Trained  

S= Supported
**Additional Information:** 3MDG will request supporting documentation for numerator figures used in calculating of reported figures, including volunteer coverage by township. 3MDG Fund requests that partners provide the total number of volunteers trained in their narrative reports.

Indicator 6 matches with indicator 3.11 from the NMCP M&E Plan.

*Only 3MDG trained and supported volunteers should be counted and reported.*
7 Number of LLINs distributed (i) total (ii) migrant/mobile populations

(Township level reporting is required)

**Numerator:** Number of LLINs distributed by township to end-users who are members of a targeted population at risk of malaria (households or individuals)

(i) total number of LLINs (distributed to village population and migrant/mobile populations)

(ii) number of LLINs distributed to migrant/mobile populations (households or individual migrant workers)

**Data source:** LLIN distribution records

**Reporting frequency:** Every 6 months

**Interpretation:** The nets distributed by the organisation to service points, such as clinics, project offices, nets on a truck or cart, are not the same as nets distributed to people at risk and should not be counted.

Although this indicator is among one of the service delivery indicators closest to predicting net ownership and usage within households, it should not be equated with indicators that are measured through household surveys.

This simple measurement represents a six month distribution towards a target and will be aggregated by the 3MDG across reporting periods to measure partner progress. Data should be reported as a total, with disaggregation for migrant and mobile population data.

**Migrant:** A person who takes up residence or remains in another place for an extended period of time, including seasonal migrants. A migrant moves from one location to another, regardless of duration or distance; experiences inequitable access to public health services resulting from the movement; and is vulnerable to becoming infected with malaria as a result of the movement (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Mobile population:** Any person who is constantly moving, such as truck drivers, seafarers, reveling salespersons, “maw sayar”, sex workers etc. (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Additional Information:** 3MDG will request supporting documentation for the numerator used in the calculation of reported figures. 3MDG will request total number of LLINs distributed by township. Indicator 7 matches with indicator 3.1a and 3.1c from the NMCP M&E Plan.

Only 3MDG funded LLINs are to be reported. All partners must report the number of LLINs distributed by township.
Percentage of households (HH) in target areas with at least 1 LLIN/ITN per 2 persons in Tier 1 and 2 in MARC areas

**Numerator:** Number of households surveyed that have at least one LLIN/ITN per 2 persons in the household

**Denominator:** Total number of households surveyed

**Data source:** National or State/Regional level represented Household Survey lead by NMCP

**Reporting frequency:** Every 3-5 years

**Interpretation:** The numerator for this indicator is obtained by asking household respondents if there is any mosquito net in the house that can be used while sleeping, and from determining for each net whether it is a factory treated net that does not require any treatment (an LLIN) or a net that has been soaked with insecticide within the past 12 months.

This indicator provides a measure of ITN/LLIN penetration. When compared with access and coverage indicators, it provides information about equity (whether ownership is widespread in the population or is concentrated in a few households). It requires data collection at the household level using a household questionnaire. It is also important that surveys be conducted with sufficient sample size and designed to allow comparisons among regions and urban and rural strata. The numerator of this indicator is obtained by asking household respondents how many mosquito nets they have in the house per person and by determining whether the net has been treated not more than a year before the survey or with impregnated insecticide in net fibres which make it an LLIN. This indicator provides a proxy measure for household use of ITNs/LLINs in the project area or national level among those at risk for malaria. The reported figure represents a point in time estimate and as such will be representative of coverage of ITNs/LLINs at the end of any reporting period; thus, no aggregation by 3MDG will be made across reporting periods.

Indicator 8 matches with indicator 2.1a from the NMCP M&E Plan.
**Number of mosquito nets treated with insecticide**

**Numerator:** Number of community owned nets treated/retreated within the reporting period

i) with regular insecticide treatment (e.g. K-O Tab or tablets lasting up to 12 months)

ii) with long-lasting insecticide treatment (e.g. K-O Tab 123)

**Data source:** Net treatment reports

**Reporting frequency:** Every 6 months

**Interpretation:** Data should be disaggregated by nets treated with regular insecticide treatment, which includes KO tablets or other tablets lasting up to 12 months, and by nets treated/retreated with long-lasting insecticide treatment lasting up to three years.

Indicator 9 matches with indicator 3.2 from the NMCP M&E Plan.

**Only 3MDG funded ITNs are to be counted and reported.**
Number of people given protection i) other personal protection measures (includes repellents, treated hammock nets and other protection other than LLIN/ITN) ii) Indoor Residual Spraying (IRS)

**Numerator:** Number of people given protection through

i) other personal protection measures (examples include repellents, treated clothing and treated hammock nets)

ii) Indoor Residual Spraying-IRS (only as part of an IRS campaign and to exclude spraying that was conducted by a member of the household)

**Data source:**

i) Distribution records of other personal protection items are used for other personal protection measurement.

ii) IRS Report is used for Indoor Residual Spraying

iii) Household Survey is used for both personal protection items and IRS

**Reporting frequency:** Every 6 months

**Interpretation:** This indicator is a proxy measure for personal protection measures and IRS coverage.

Protected through other personal protection measures includes insecticide treated cloth (like a long-sleeve treated shirt or repellents). The intention of the indicator is to capture the extent to which other personal protection measure are used in the project and is not a measure of the proportion of the population continually protected.

IRS can be conducted either as part of the national strategy for malaria control or undertaken by a NMCP, an NGO, a CBO or private company. It is important to capture IRS that has occurred only as part of an IRS campaign and to exclude spraying that was conducted by a member of the household. There is an assumption that a crowding index will be applied to population estimates. The estimated number of people per household, the crowding index applied and the number of households reached should be included in the narrative report. Ideally, this information should be complimented with a national household survey.

Indicator 10 matches with indicator 3.3 from the NMCP M&E Plan.

**Only 3MDG funded personal protection measures are to be counted and reported.**
Number of volunteers trained and supported specifically for servicing migrant/mobile populations  
*(Disaggregated by sex)*

**Numerator:** Number of volunteers trained and supported specifically for servicing migrant and mobile populations

**Data source:** Training records and commodity distribution records (e.g. stationary, health promotion materials etc...)

**Reporting frequency:** Every 6 months, cumulative annually.

**Interpretation:** ‘Trained’ includes trained/retrained in prevention and/or treatment and case management. However, retrained numbers should not be included in this indicator.

Volunteers must be trained and supported (supported is defined as given the resources required to perform their duties, which will include stationary, travel allowance, health promotion materials and malaria prevention and detection supplies).

Each partner should stop support to “inactive” volunteers and reallocate their 3MDG resources to support an active volunteer. “Inactive” volunteer is defined as a volunteer who does not submit their report(s) for four continuous months during a six month reporting period. The table on page 17 is an example of the counting method.

**Migrant:** A person who takes up residence or remains in another place for an extended period of time, including seasonal migrants. A migrant moves from one location to another, regardless of duration or distance; experiences inequitable access to public health services resulting from the movement; and is vulnerable to becoming infected with malaria as a result of the movement (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Mobile population:** Any person who is constantly moving, such as truck drivers, seafarers, reveling salespersons, “maw sayar”, sex workers etc. (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Additional Information:** 3MDG may request supporting documentation for numerator figures used in calculating of reported figures, which should include location data of where the volunteer works. One volunteer may work in many locations. **3MDG Fund requests that partners provide the total number of volunteers trained in their narrative reports.**

Indicator 11 is match with indicator 3.12 from the NMCP M&E Plan.

**Only 3MDG trained and supported volunteers should be counted and reported.**
12 Number of people tested for malaria i) at worksites ii) at malaria screening points

[Disaggregated by sex and by worksite or malaria screening point (names of sites are not required)]

**Numerator:** Number of people having been tested for malaria at worksites and at malaria screening points by microscopy or RDT

i) at worksites

ii) at malaria screening points

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Interpretation:** Worksite is defined as a fixed place of work outside the home. Persons working at changing sites, for example, in plantations, should be recorded at the location of their current worksite rather than the address of their employer’s place of business, if appearance at this site will be required for at least one week. (Organisation for Economic Co-operation and Development).

Malaria screening point is defined as a point arranged by partners at strategic locations where by migrant/mobile people can access malaria testing and treatment e.g. border checkpoints, train stations, bus stations, prisons, camps etc...

**Migrant:** A person who takes up residence or remains in another place for an extended period of time, including seasonal migrants. A migrant moves from one location to another, regardless of duration or distance; experiences inequitable access to public health services resulting from the movement; and is vulnerable to becoming infected with malaria as a result of the movement (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Mobile population:** Any person who is constantly moving, such as truck drivers, seafarers, reveling salespersons, “maw sayar”, sex workers etc. (Guidelines on the prevention and control of malaria for migrants in Myanmar, Ministry of Health and IOM, 2012).

**Additional Information:** This indicator will be collected by organisations working with mobile and migrant populations only.

Indicator 12 matches with indicator 3.6 from the NMCP M&E Plan.
Number of confirmed falciparum malaria cases receiving DOT (Disaggregated by sex)

**Numerator:** Number of confirmed P.f and mixed malaria cases who received DOT by VHWs.

**Data source:** Malaria Case Register book

**Reporting frequency:** Every 6 months

**Interpretation:** DOT is defined as Direct Observed Treatment for first and third day of malaria treatment for P.f and mixed cases.

**Additional Information:** This definition is agreed by NMCP and RAI partners. This indicator will be revised according to NMCP M&E plan.
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# 3MDG AEI Indicators and Definitions for C2 Partners

## Outcome Indicator

<table>
<thead>
<tr>
<th>Proportion of community members reporting receiving services of ‘good’ quality or better.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
</tr>
<tr>
<td>Numerator</td>
</tr>
<tr>
<td>Denominator</td>
</tr>
<tr>
<td>Data Sources</td>
</tr>
<tr>
<td>Reporting Frequency</td>
</tr>
</tbody>
</table>

### What it measures:
Community member’s perception of the quality of 3MDG-supported health services.

Community members are defined as people living within the 3MDG supported project areas. They are main users of the feedback mechanisms. In 2015 a survey will not be conducted to collect this data, therefore, the number of documented feedback will be the proxy for community members (denominator). This is due to ensuring confidentiality and building trust in the feedback mechanisms during the start-up phase. The numerator will be the number of documented feedback that report services of ‘good’ quality or better.

Good is defined as any positive experience/satisfaction related to the perception of quality of service received by the community member. For the purpose of this initiative, the focus is on
the users’ perception of quality which includes but is not limited to the following elements: location and condition of facilities, availability of appropriate drug supplies and equipment, appropriately skilled health workers, good interpersonal relationships, appropriate and timely services, and a well-functioning referral system.

Quality of healthcare is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge\(^1\).

3MDG supported health services are defined as health services which are 1) directly delivered by 3MDG’s implementing partners and/or their sub-grantees; or 2) delivered in health facilities which are technically and/or financially supported by 3MDG, its implementing partners and/or their sub-grantees. In the future, 3MDG will develop systems to measure community satisfaction of 3MDG supported services in a more robust manner. In 2015, the focus will be on establishing feedback mechanisms and ensuring access and understanding of the use of feedback by all partners in 3MDG programme areas.

\(^1\) Institute of Medicine, [www.iom.edu](http://www.iom.edu) [accessed on August 11, 2014].
### Output Indicator

#### 5.1 Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI & CS)

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of staff from MoH, IPs, local NGOs and CBOs at central, regional and township level receiving AEI&amp;-CS related trainings conducted by IP and 3MDG resource persons disaggregated by sex and age.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff from MoH, IPs, local NGOs and CBOs (at central, regional and township level), trained in AEI &amp; CS in a calendar year (disaggregated by sex and age).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP training records.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six monthly and Annually</td>
</tr>
</tbody>
</table>

**What it measures:** The number of staff from MOH, IPs, local NGOs and CBOs at central, regional and township level receiving AEI & CS related training conducted.

*Trained* is defined as attendance at an AEI&CS-related training or workshop. Trainings are disaggregated into the following categories (i) Basic training, (ii) refresher training and (iii) Training of Trainers and to avoid double counting, all data will be captured using standardized tools. For AEI training, specific attendance sheets capturing above information have to be used.

Only those staff that attend the entire training, refresher training or training of trainers will be counted as trained. Training/workshop reports should include documentation of overall satisfaction of training/workshop given, including lessons learnt for improving upon training/workshop methods.
Training is defined as an organized activity aimed at imparting information and/or instruction to improve the recipient's performance or to help him or her attain a required level of knowledge or skill.

Workshop is defined as a class or seminar in which the participants work individually and/or in groups to solve actual work-related tasks to gain hands-on experience.

Age is defined 15-24 (youth), 25-59 (adult), 60 and over as senior/pensioner. These categories are defined using the most recent information from the 2014 census and existing pension laws. These definitions are subject to change.
### Output Indicator

#### 5.2.1 Number and percentage of community members aware of mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th>Percentage of community members in focus group discussion sessions who are aware of formal mechanism(s) to provide feedback in 3MDG-supported areas at the time of measurement. (disaggregated by sex and age).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of community members from the focus group discussion who report being aware of formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age).</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age).</td>
</tr>
<tr>
<td><strong>Data Sources</strong></td>
<td>AEI &amp; CS Assessment Tool</td>
</tr>
<tr>
<td><strong>Reporting Frequency</strong></td>
<td>Annually</td>
</tr>
</tbody>
</table>

**What it measures:** The extent to which community members are aware of the feedback mechanism(s) of implementing partners funded by 3MDG.

Community members are defined as people living within the 3MDG supported project areas. They are main users of the feedback mechanisms.

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members’ perspectives. These mechanisms give the implementing partners information to adjust their programs and projects to best meet
individual and community needs. Examples include suggestions boxes, focus group discussions, community meetings, directly in-person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

**Feedback** refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP’s work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.

**AEI & CS Assessments** are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner’s management team, staff, communities, partners and other key external stakeholders, and is led by an external organisation or the implementing partner itself.

**Sampled:** As part of the AEI & CS assessment process, community members will be chosen to participate in focus group discussions concerning their experiences and perceptions about an implementing partner’s AEI & CS practices.

**Limitation:** Data collection will be done at Focus Group Discussion Session and this may not reflect all community levels.

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3 Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.
Output Indicator

5.2.2 Number and percentage of community members that use mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)

Definition
\[
\text{Percentage of community members in focus group discussions that use formal mechanism(s) to provide feedback in 3MDG-supported areas at the time of measurement (disaggregated by sex and age).}
\]

Numerator
\[
\text{Number of community members from the focus group discussion who use formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age).}
\]

Denominator
\[
\text{Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age).}
\]

Data Sources
\[
\text{AEI & CS Assessment Tool}
\]

Reporting Frequency
\[
\text{Annually}
\]

What it measures: The extent to which community members that uses the feedback mechanism(s) of implementing partners funded by 3MDG. This indicator will only be collected from 2016 as systems and process will be developed in 2015 to address data collection.

Community members are defined as people living within the 3MDG supported project areas. They are main users of the feedback mechanisms.

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members’ perspectives. These mechanisms give the implementing partners information to adjust their programs and projects to best meet
guideline for 3mdg marc indicators

individual and community needs. Examples include suggestions boxes, focus group discussions, community meetings, directly in-person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

Feedback refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP’s work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.

AEI & CS Assessments are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner's management team, staff, communities, partners and other key external stakeholders, and is led an external organisation or the implementing partner itself.

Sampled: As part of the AEI & CS assessment process, community members will be chosen to participate in focus group discussions concerning their experiences and perceptions about an implementing partner’s AEI & CS practice.

Limitation: Data collection will be done at Focus Group Discussion Session and this may not reflect all community levels.

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5 Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.
Output Indicator

5.2.3 Number and percentage of feedback that were addressed by the IP in the reporting period based on the IP’s procedure (disaggregated by type of feedback)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Number and percentage of feedback addressed in the reporting period based on the IP’s procedure, disaggregated by type of feedback (as defined in the procedure).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Number of feedback received by implementing partners that were addressed in the reporting period based on the IP’s procedure.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of feedback received by implementing partners through formal mechanisms to provide feedback in the reporting period.</td>
</tr>
<tr>
<td>Data Sources</td>
<td>IP reports and Feedback and Response Mechanism Records</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Six Monthly</td>
</tr>
</tbody>
</table>

**What it measures:** the extent to which feedback received by the IP through formal mechanisms is addressed by the IP based on a procedure that follows good practice.

Feedback refers to opinions, concerns, suggestions and advice of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspect in the IP’s work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.⁶

Mechanisms to provide feedback are defined as the formal method(s) that implementing partners utilise to collect feedback from the communities in which they work to better understand their programs and projects from community members’ perspectives. These mechanisms give

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⁶ Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.
the implementing partners information to adjust their programs and projects to best meet individual and community needs. 7 Examples include suggestions boxes, focus group discussions, community meetings, directly in-person at the organisation, through health staff, workshops, providing ready to post envelopes etc.

**Addressed** means that the IP has fully followed the procedure (see below) and decided that no further action can or will be taken in relation to the feedback.

**Procedure** refers to a specified series of actions **defined by the IP** based on the context and taking into account good practice, through which the IP processes feedback and ensures that feedback is reviewed and acted upon. The procedure clarifies the purpose and limitations of feedback, how feedback can be raised, types of feedback and steps to be taken in order to decide if the feedback requires any action and/or a response to the feedback provider, the response timeframe for communicating with the feedback provider, etc.

**Types of feedback** 8 are categorized as Suggestion, (+) Positive Feedback, Concern, (-) Negative Feedback, Question and Others.

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8 Categories are adapted from 3DF Community Feedback Mechanism Report Template
Output Indicator

5.3 Number and Percentage of implementing partners with improvement in their Accountability, Equity and Inclusion (AEI) and Conflict Sensitivity (CS) systems and practices

| Definition | Percentage of implementing partners with improvement in their AEI & CS systems and practices in a calendar year, as measured through an AEI & CS assessment. |
| Numerator | Number of implementing partners with improvement in their AEI & CS systems and practices in a calendar year, measured through an AEI & CS assessment |
| Denominator | Number of new or existing implementing partners contracted by 3MDG who had implemented AEI & CS assessment in the previous year |
| Data Sources | AEI & CS Assessment Tool |
| Reporting Frequency | Annually |

**What it measures:** The proportion of implementing partners that have taken practical steps and improved their organizational AEI & CS systems and practices.

Implementing partners are defined as organizations that have received grants from 3MDG to design, implement or deliver MNCH, HIV, TB or Malaria-related project, programs or services under Components 1 or 2 of the 3MDG program.

Improvement is defined as any increase in total score (percentage) on the AEI & CS Assessment Tool.

AEI & CS systems are comprised of the following elements:

1. Dedicated and capacitated staff with clear roles and responsibilities
2. Funding for development and implementation of AEI & CS systems and practices
3. Organizational policies and strategic plans for addressing AEI & CS needs/issues
4. Specific operating **procedures** or guidelines around AEI & CS issues or practices e.g. client complaints, stakeholder participation in service delivery

5. **Tools** that support AEI & CS policy and procedure operationalization

6. **Information systems** that support addressing AEI & CS needs, feedback, learning and performance improvement

**Practice** is defined as the actual application of AEI & CS concepts, theories and systems.

**AEI & CS Assessments** are defined as the process of assessing an organisation's AEI & CS-related policies, systems and practices using the AEI & CS Assessment Tool. The process entails interviews with the implementing partner's management team, staff, communities, partners and other key external stakeholders, and is led by an external organisation or the implementing partner itself.
### Output Indicator

#### 5.4 Number and proportion of women representatives attending the National Annual Review Meetings/Workshops

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th>Proportion of women representatives attending annual National Annual Review Meetings/Workshops</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of women representatives who attend National Annual Review Meetings/Workshops</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of representatives who attend National Annual Review Meetings/Workshops</td>
</tr>
<tr>
<td><strong>Data sources</strong></td>
<td>National Annual Review Meetings/Workshops’ participant record &amp; report</td>
</tr>
<tr>
<td><strong>Reporting frequency</strong></td>
<td>Annually</td>
</tr>
</tbody>
</table>

**What it measures:** This indicator assesses the representation of women in the National Annual Review Meetings/Workshops, which is organized by the Ministry of Health HIV, TB and Malaria programmes to review progress in disease control and to offer guidance on future HIV, TB and Malaria control directions and efforts so that they have an opportunity to influence the needs in accordance with specific disease situation or prevalence.

This indicator information will be collected for Component 2 HIV/TB/Malaria Programme.

Representatives are defined as persons chosen (through appointment, election or self-selection) to act and speak on behalf of a wider group at the National Annual Review Meetings/Workshops for HIV/TB/Malaria.

Attending is defined as having been recorded as present on the National Annual Review Meetings/Workshop’s attendance sheet for the duration of the workshop.
Output indicator

5.5 Number and proportion of women involved in Peer/Self-help groups and community volunteer groups in project areas (cumulative figure)

<table>
<thead>
<tr>
<th>Definition</th>
<th>Number of women who are involved in Peer-based/Self-help group-formed activities or community based volunteer activities in project areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Number of women who are involved in Peer/Self-help groups or volunteer based activities in project areas.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of people who are involved in Peer/Self-help groups or volunteer based activities in project areas.</td>
</tr>
<tr>
<td>Data sources</td>
<td>Outreach worker record/ volunteer training record</td>
</tr>
<tr>
<td>Reporting frequency</td>
<td>Six monthly</td>
</tr>
</tbody>
</table>

**What it measures:** This indicator measures the involvement of women in the Peer (excluding staff) /Self-help groups and community volunteers in HIV Harm Reduction, Tuberculosis and Malaria projects. Increased active participation by women may strengthen effective communication such as same sex discussions, to meet the service needs of women beneficiaries.

1. **Self-help groups** also called mutual help or mutual aid groups are composed of peers who share a similar mental, emotional, or physical problem or who are interested in a focal issue, such as education or parenting[^9].
2. **Peer/Self-help group** are the groups in which participants support each other in recovering or maintaining recovery from drug dependence or disease in HIV[^10].

**Note:** women’s involvement in volunteer groups is already captured in the existing 3MDG indicators for MDR TB and Malaria. HIV Harm Reduction and TB ACF partners will be requested to report this indicator.


[^10]: WHO, UNODC, UNAIDS Technical Guide: For countries to set Targets For Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users, 2012 Revision
# Accountability, Equity and Social Inclusion Glossary of Terms

| Responsibility | • Practice good governance and accountability  
|               | • Keep commitments to the people who use health services  
|               | • Listen (and respond to) the voices of people  
|               | • Empower and inform users of the health system |

| Fairness (Equity) | • Being fair and just to all people who use the health system.  
|                   | • Recognising that people are different and need different support to ensure their rights are recognised. |

| Gender Equity | • Being fair to women and men.  
|              | • Taking specific actions to address historical and social discrimination and disadvantages in Myanmar that prevent women and men from otherwise operating as equals. |

| Health Equity | • All people have the opportunity to have the highest level of health.  
|              | • Understanding the different barriers to health that people face and working to address them.  
|              | • All people can access quality health care regardless of their socio-economic position, including age, disability, gender or other circumstances.  
|              | • Ensuring that health policies and services respond to the specific needs of different groups of people. |

| Inclusion | • Involves all people in decisions that affect their health.  
|          | • Understanding diverse experiences and preferences, and enabling people from many different circumstances (e.g. cultural, linguistic and geographic) to participate in health care planning.  
|          | • Mutual respect, tolerance and making all people feel valued.  
|          | • Ensuring that all voices are considered in decision-making processes. |

| Empowerment | • People – both men women and men – taking control over their lives.  
|            | • People setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance.  
|            | • Supporting efforts by communities to carry out collective actions.  
|            | • Building confident and informed users of the health system.  
|            | • Creating ownership. |

| Conflict Sensitivity | • Capacity of an organisation to understand the context in which it operates, how its activities influence that context and vice-versa, and to act upon that understanding to maximise positive impacts and avoid negative ones (“do no harm”). |
# ANNEX 1: AT GLANCE SHEET FOR 3MDG COMPONENT

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>How to count and calculate (Numerator)</th>
<th>Denominator</th>
<th>Source</th>
<th>Reporting Frequency</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Percentage of confirmed P.f malaria cases treated with ACT plus primaquine according to national guidelines</td>
<td>Number of confirmed P.f cases (P.f and mixed infections with P.f) treated with recommended ACT together with Primaquine (for non-pregnant women and above 5 year old cases) and without Primaquine for whom Primaquine is contraindicated: pregnant women and children under 5 year of age.</td>
<td>Number of confirmed P.f cases confirmed by microscopy or by RDT</td>
<td>Malaria Case Register book</td>
<td>Every six month</td>
<td><em>Not</em> to include the cases treated with only ACT or only Primaquine or probable cases (except for those primaquine is contraindicated: pregnant women and children under 5 year of age).</td>
</tr>
<tr>
<td>2.</td>
<td>Percentage of confirmed malaria cases treated in accordance with national malaria treatment guidelines within 24 hours of onset of symptoms (fever)</td>
<td>Number of confirmed malaria cases treated with anti-malarial treatment according to the national malaria treatment guideline</td>
<td>Number of confirmed malaria cases confirmed by microscopy or</td>
<td>Malaria Case Register book</td>
<td>Every six month</td>
<td><em>Disaggregated by sex</em></td>
</tr>
<tr>
<td>No.</td>
<td>Indicator</td>
<td>How to count and calculate (Numerator)</td>
<td>Denominator</td>
<td>Source</td>
<td>Reporting Frequency</td>
<td>Note</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------</td>
<td>---------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 3.  | Number of people with confirmed *P.f* malaria treated with recommended ACT (plus primaquine).                                           | Number of people with confirmed *P.f* cases (*P.f* and mixed infections with *P.f*) treated with recommended ACT together with primaquine (for non-pregnant women and above 5 year old cases) and without Primaquine for whom Primaquine is contraindicated: pregnant women and children under 5 year of age. | NA          | Malaria Case Register book | Every six month     | Disaggregated by sex and age group: <1, 1-4, 5-9, 10-14, and 15 years of age and above  
DO NOT include the cases treated with only ACT or only Primaquine or probable cases (except for those primaquine is contraindicated: pregnant women and children under 5 year of age). |
<p>| 4.  | Number of people with confirmed <em>P.v.</em> malaria (by sex and age group) treated with chloroquine [plus primaquine].                     | Number of people with <strong>confirmed</strong> <em>P.v.</em> malaria cases treated with chloroquine plus Primaquine (for non- | NA          | Malaria Case Register book | Every six month     | Disaggregated by sex and age group: &lt;1, 1-4, 5-9, 10-14, and 15 years of |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>How to count and calculate (Numerator)</th>
<th>Denominator</th>
<th>Source</th>
<th>Reporting Frequency</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Number of confirmed falciparum malaria cases receiving DOT</td>
<td>Number of confirmed P.f and mixed malaria cases who received DOT by VHWs</td>
<td>NA</td>
<td>Malaria Case Register book</td>
<td>Every six month</td>
<td>Disaggregated by sex&lt;br&gt;DOT is defined as Direct Observed Treatment for first and third day of malaria treatment for P.f and mixed cases.</td>
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</tbody>
</table>

Note: DO NOT include probable cases or the cases treated with only Chloroquine or only Primaquine (except for those primaquine is contraindicated: pregnant women and children under 5 year of age).
<table>
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<tbody>
<tr>
<td>6.</td>
<td>Number of RDTs taken and read</td>
<td>Number of RDTs taken and read. Exclude: invalid RDTs and this indicator is used the number of people tested using RDTs. Include: the number of RDTs tested and read for the general population and also migrant/mobile populations (if the programme serves migrant/mobile populations)</td>
<td>NA</td>
<td>Malaria Case Register book</td>
<td>Every six month</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>7.</td>
<td>Number of volunteers trained and supported</td>
<td>Number of volunteers trained and supported (excluding volunteers trained exclusively for supporting migrant/mobile populations)</td>
<td>NA</td>
<td>Training records and commodity distribution records</td>
<td>Every six month, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>No.</td>
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</table>
| 8.  | Number of LLINs distributed | (i) total number of LLINs (distributed to village population and migrant/mobile populations)  
(ii) number of LLINs distributed to migrant/mobile populations (households or individual migrant workers) | NA | LLIN distribution records | Every six month | Only 3MDG funded LLINs are to be reported. All partners must report the number of LLINs distributed by township. |
| 9.  | Number of mosquito nets treated | (i) total number of community owned nets treated/retreated within the reporting period  
(ii) regular insecticide treatment (e.g. K-O Tab or tablets lasting) | NA | Net treatment reports | Every six month | Disaggregated by sex |
<table>
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<td></td>
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<td>up to 12 months)</td>
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<td></td>
<td></td>
<td>Long-lasting insecticide treatment (e.g. K-O Tab 123)</td>
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<tr>
<td>10.</td>
<td>Number of people given protection i) other personal protection measures</td>
<td>Number of people given protection through i) other personal protection measures (includes repellents, treated hammock nets and other protection other than LLIN/ITN) ii) Indoor Residual Spraying (IRS)</td>
<td>NA</td>
<td>i)</td>
<td>Every six month</td>
<td>Only 3MDG funded personal protection measures are to be counted and reported.</td>
</tr>
<tr>
<td></td>
<td>(includes repellents, treated hammock nets and other protection other than LLIN/ITN) ii) Indoor Residual Spraying (IRS)</td>
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<tr>
<td>11</td>
<td>Number of volunteers trained and support specifically for servicing migrant/mobile populations</td>
<td>Number of volunteers trained and support specifically for servicing migrant/mobile populations</td>
<td>NA</td>
<td>Training records and commodity distribution records</td>
<td>Every six month, Cumulative</td>
<td>Annually</td>
</tr>
</tbody>
</table>
| 12  | Number of people having been tested for malaria at worksites and at malaria screening points by microscopy or RDT | Number of people having been tested for malaria at worksites and at malaria screening points by microscopy or RDT
   |                                                                 |                                                                                                        | NA          | Malaria Case Register book                  | Every six month     | Disaggregated by sex and by worksite or malaria screening point (names of sites are not required) |
## Component 2 AEI indicators

<table>
<thead>
<tr>
<th>No.</th>
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<tbody>
<tr>
<td></td>
<td>Outcome</td>
<td>Proportion of community members reporting receiving services of ‘good’ quality or better</td>
<td>Number of community members reporting ‘good’ quality of 3MDG-supported health services.</td>
<td>IP reports and Feedback and Response Mechanism Records</td>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Number of staff from Ministry of Health (MoH), Implementing Partners (IPs), local Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) (at central, regional and township level), trained in Accountability, Equity, Inclusion and Conflict Sensitivity (AEI &amp; CS)</td>
<td>Number of staff from MoH, IPs, local NGOs and CBOs (at central, regional and township level), trained in AEI &amp; CS in a calendar year (disaggregated by sex and age).</td>
<td>NA</td>
<td>IP training records</td>
<td>Six monthly and Annually</td>
<td>Disaggregated by sex and age</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Number and percentage of community members aware of mechanism(s) to provide feedback in the focus group discussion who report being aware of formal</td>
<td>Number of community members from the focus group discussion who report being aware of formal</td>
<td>Total number of community members from the focus group discussion in 3MDG- AEI &amp; CS Assessment Tool</td>
<td>Annually</td>
<td></td>
<td>Disaggregated by sex and age</td>
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<tr>
<td>5.2.2</td>
<td>Number and percentage of community members that use mechanism(s) to provide feedback in 3MDG-supported areas (disaggregated by sex and age)</td>
<td>Number of community members from the focus group discussion who use formal mechanism(s) to provide feedback in 3MDG-supported areas at time of measurement (disaggregated by sex and age).</td>
<td>Total number of community members from the focus group discussion in 3MDG-supported areas (disaggregated by sex and age).</td>
<td>AEI &amp; CS Assessment Tool</td>
<td>Annually</td>
<td>Disaggregated by sex and age</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Number and percentage of feedback that were addressed by the IP in the reporting period based on the IP’s procedure (disaggregated by type of feedback)</td>
<td>Number of feedback received by implementing partners that were addressed in the reporting period based on the IP’s procedure.</td>
<td>Total number of feedback received by implementing partners through formal mechanisms to provide feedback in the reporting period.</td>
<td>IP reports and Feedback and Response Mechanism Records</td>
<td>Six Monthly</td>
<td>Disaggregated by type of feedback</td>
</tr>
<tr>
<td>5.3</td>
<td>Number and Percentage of implementing partners with</td>
<td>Number of implementing partners with improvement in their AEI &amp; CS systems</td>
<td>Number of new or existing implementing partners contracted</td>
<td>AEI &amp; CS Assessment Tool</td>
<td>Annually</td>
<td>Disaggregated by sex and age</td>
</tr>
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<tr>
<td></td>
<td>improvement in their Accountability, Equity and Inclusion (AEI) and Conflict Sensitivity (CS) systems and practices</td>
<td>and practices in a calendar year, measured through an AEI &amp; CS assessment</td>
<td>by 3MDG who had implemented AEI &amp; CS assessment in the previous year</td>
<td></td>
<td></td>
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<tr>
<td>5.4</td>
<td>Number and proportion of women representatives attending the National Annual Review Meetings/Workshops</td>
<td>Number of women representatives who attend National Annual Review Meetings/Workshops</td>
<td>Total number of representatives who attend National Annual Review Meetings/Workshops</td>
<td>National Annual Review Meetings/Workshops’ participant record &amp; report</td>
<td>Annually</td>
<td>3MDG will follow up national programmes for reporting figure</td>
</tr>
<tr>
<td>5.5</td>
<td>Number and proportion of women involved in Peer/Self-help groups and community volunteer groups in project areas (cumulative figure)</td>
<td>Number of women who are involved in Peer/Self-help groups or volunteer based activities in project areas.</td>
<td>Total number of people who are involved in Peer/Self-help groups or volunteer based activities in project areas.</td>
<td>Outreach worker record/ volunteer training record</td>
<td>Six Monthly</td>
<td>Please provide target as % only. (Do not present absolute figure)</td>
</tr>
</tbody>
</table>