



Malaria Surveillance:

Report on Continuous Medical Education of Health Workers

MEASURE Evaluation PIMA

March 2017

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CONTENTS

TABLES	4
ABBREVIATIONS	0
INTRODUCTION	1
Background.....	1
Justification for Malaria Surveillance Mentorship and CME.....	1
Objectives of Malaria Surveillance Mentorship and CME.....	0
METHOD OF CONDUCTING MENTORSHIP AND CME VISITS	0
Review of DQA Findings.....	0
Selection of Health Facilities and Mentors	1
Implementation of Mentorship and CME.....	3
Mentorship Visits.....	0
Facility CME visits.....	1
OUTCOME OF MENTORSHIP AND CME VISITS	2
Gaps Identified and Addressed During the CME and Mentorship Visits	2
Evidence of Good Practice	3
LESSONS	4
APPENDIXES	6
Appendix 1. List of Mentors.....	6
Appendix 2. Action Plan.....	8
Appendix 3. Mentorship Form.....	9

TABLES

Table 1. Summary findings of county malaria DQAs	0
Table 2. List of facilities visited in June and July 2016 and number of health workers trained	2

ABBREVIATIONS

AL	Artemether/Lumefantrine
ANC	antenatal care
CHMT	county health management team
CHRIO	county health records information officer
CMCC	county malaria control coordinator
CME	continuous medical education
DHIS	District Health Information Software
DQA	data quality audit
HIS	health information system
HRIO	health records information officer
IDSR	integrated disease surveillance and response
IPT _p	intermittent preventive treatment for pregnant women
LLIN	long-lasting insecticide-treated net
M&E	monitoring and evaluation
MEval-PIMA	MEASURE Evaluation PIMA
MOH	ministry of health
NMCP	National Malaria Control Programme
OPD	outpatient department
RHDC	rural health and demonstration centre
SCHRIO	subcounty health records information officer
SCHMT	subcounty health management team
SCMCC	subcounty malaria control coordinator
TPR	test positivity rate

INTRODUCTION

Background

Malaria surveillance is the ongoing, systematic collection, analysis, and interpretation of malaria-related data, which is essential for the planning, implementation, and evaluation of malaria control programming. Malaria surveillance is closely integrated with the timely dissemination of these data for evidence-based malaria prevention and control. Objective 4 of Kenya's National Malaria Strategy states that by the year 2018, all of Kenya's 47 counties should have strong and sustainable monitoring and evaluation (M&E) surveillance systems so that key malaria indicators are routinely monitored and evaluated. Two main surveillance systems are in use in Kenya:

1. District health information software (DHIS), which takes its name from DHIS 2, the software that runs it: Daily routine facility data—outpatient and inpatient malaria cases, malaria commodity data, and laboratory data—are consolidated and reported each month to the subcounty health management team that is responsible for the entry of these data in the DHIS.
2. Integrated disease surveillance and response (IDSR) system: Data on clinical malaria cases, laboratory-tested and positive cases, and malaria-related deaths are collected daily at health facilities and reported weekly in the electronic IDSR system.

Health workers in targeted counties received a three-day malaria surveillance training from June to July 2016. The training, which used the surveillance training curriculum of the National Malaria Control Program (NMCP), addressed both data producers and data users and aimed to enhance their understanding of and ability to analyse malaria data and their capacity to identify corrective actions needed to improve malaria programming. Emphasis was placed on data analysis, data interpretation, use of tools to facilitate evidence-informed decision making, and integrating data in decision making processes. The data quality audit (DQA) findings, however, showed that the knowledge gained during the training was not fully translated into practice. The NMCP recognized a need for continuous medical education (CME) and facility mentorship visits as a way to institutionalize the objectives of malaria surveillance.

Justification for Malaria Surveillance Mentorship and CME

Health workers at all levels must have capacity in core competencies to demand and use malaria data in order to build sustainable capacity for effective malaria surveillance. These competencies consist of skills in data analysis, interpretation, synthesis, presentation, and development of data-informed programmatic recommendations and policies.

The key objective of the malaria surveillance training was to equip health workers with these competencies. With support from the Global Fund, the NMCP conducted a malaria DQA whose findings indicated that health workers had not yet fully embraced the malaria surveillance system. To address this gap, MEASURE Evaluation PIMA (MEval-PIMA) in conjunction with the NMCP embarked on a series of facility-based mentorship visits to give health workers hands-on training on malaria surveillance. Health facilities with the greatest challenges were targeted as the first to be visited.

Objectives of Malaria Surveillance Mentorship and CME

The mentorship and CME visits had the following objectives:

1. To strengthen healthcare workers' capacity to conduct routine malaria surveillance
2. To improve malaria data quality at targeted health facilities
3. To improve the use of malaria data at the facility level

METHOD OF CONDUCTING MENTORSHIP AND CME VISITS

The county health management team (CHMT) and the subcounty health management team (SCHMT) conducted mentorship and CME visits, with technical and financial support from MEval-PIMA. The approach consisted of the following steps:

1. Review of DQA findings to identify challenges at the facilities
2. Identification of facilities and mentors requiring support
3. Capacity-building through on-site or off-site mentorship and CME

Review of DQA Findings

The Global Fund supported malaria DQAs targeting 20 facilities in each of the eight lake malaria-endemic counties. Table 1 summarizes the main findings of this activity. Weak surveillance systems—which included those defined by poor data quality; incomplete, inaccurate, and low reporting rates; poor documentation in the primary registers; and a lack of evidence of use of data for decision making—were selected for additional mentorship and CME. The DQA results were used as a sampling frame to select facilities with weak malaria surveillance systems. Key findings of the DQA are summarized according to five functional areas of DQA in Table 1.

Table 1. Summary findings of county malaria DQAs

Functional Area		Summary
I	M&E structures, functions, and capabilities	<ul style="list-style-type: none"> • Most facilities, especially high-volume facilities, employ informal staff as data clerks. • Customer care department staff are responsible for data entry in the outpatient department (OPD) using primary ministry of health (MOH) reporting tools. • In most facilities, no data verification is done before submitting data to the next reporting level. • Most key M&E and data management staff have not received the required training on data management processes and tools.
II	Indicator definitions and reporting guidelines	<ul style="list-style-type: none"> • The health information system (HIS) department has provided operational indicator definitions that meet relevant standards, but these are not followed systematically across service points. • The NMCP has clearly documented what must be reported, to whom, how, and when reporting is required on the instructions pages of primary data collection and reporting tools.

III	Data collection and reporting forms and tools	<ul style="list-style-type: none"> • Although the national HIS department has issued standard data collection and reporting tools to most counties, the tools have not been disseminated to the facilities, especially private and faith-based facilities. • Some counties had not disseminated the new reporting tools to the facilities, so the facilities were using old or improvised registers, because no clear instructions on what to do with the old ones had been given. • Some data elements were missing from the new registers (e.g., MOH 511 did not have a column for reporting long-lasting insecticide-treated nets [LLINs]). As a result, most facilities opted to use the patient pack register rather than the officially recognized one. • Where the Artemether/Lumefantrine (AL) monthly summary tools are unavailable, the facilities use photocopied tools. • Some data elements are left blank in the source documents in most facilities, especially in the labs and OPDs. Despite entering the required data elements in the AL dispenser book, the pharmacy department did not indicate this in the monthly summaries. • Most of the facilities visited have made efforts to comply with national data confidentiality guidelines.
IV	Data management processes	<ul style="list-style-type: none"> • There is no mechanism to cross-check the consistency between summary and primary documents. • Patient data was maintained according to international confidentiality guidelines. Registers are kept under lock and key and accessible only to authorized personnel. • Some facilities, notably those using manual systems, double count patients. Patients who lose their patient booklets or forget their OPD numbers are reregistered as new clients. • There are no clearly defined procedures to identify and reconcile discrepancies in reports or to periodically verify against source data.
V	Links with the national reporting system	<ul style="list-style-type: none"> • The facilities submit hard copies of summary reports to the subcounty health records information officer (HRIO) and the subcounty pharmaceutical facilitator to key into DHIS 2 by the 15th of the following month. • High-volume facilities with HRIOs enter data at the facility level and submit hard copies of the data to the subcounty for record keeping.

Based on the DQA findings, each CHMT instituted different measures to address challenges identified through mentorship and CME visits.

Selection of Health Facilities and Mentors

The facilities were selected based on the following factors:

- Facilities identified during the DQA visits and data review meetings as having significant data quality issues
- Facilities that had not received prior malaria surveillance training
- Facilities with low reporting rates in DHIS 2

- Facilities that had not received malaria-specific supervisory support from the SCHMT or CHMT for a long time

Fifty-two facilities from five counties were visited, and 352 healthcare workers were mentored (Table 2).

Table 2. List of facilities visited in June and July 2016 and number of health workers trained

	Name of County or Facility	No. of Health Workers Trained			Mentorship CME Dates
		Male	Female	Total	
A)	Kisumu County				
1	Railways Dispensary	2	4	6	21 June 2016
2	Nyalenda Dispensary	2	2	4	21 June 2016
3	Rabuor Health Centre	4	3	7	22 June 2016
4	Nyangande Dispensary	6	3	9	22 June 2016
5	Bodi Dispensary	5	6	11	23 June 2016
6	Got Nyabondo Dispensary	4	0	4	24 June 2016
7	Kodiaga Prisons	0	3	3	24 June 2016
8	Nyahera Subcounty Hospital	2	3	5	24 June 2016
9	Kombewa Subcounty Hospital	23	16	39	16 July 2016
10	Ober Kamoth	8	9	17	29 July 2016
11	Ahero County Hospital	19	15	34	28 July 2016
12	Muhoroni County Hospital	17	28	45	27 July 2016
B)	Homa Bay County				
1	Nyamasi Dispensary	1	1	2	21 June 2016
2	Kindu Adventist	2	1	3	23 June 2016
3	Aga Khan Dispensary	3	1	4	24 June 2016
4	Ndhiwa Subcounty Hospital	5	4	9	20 June 2016
5	Rangwe SDA	2	0	2	22 June 2016
6	Magwa Health Centre	6	3	9	21 June 2016
7	God Ber Dispensary	1	1	2	18 July 2016
8	Kasewe Dispensary	0	1	1	19 July 2016
9	Othoro Level 4 Dispensary	2	2	4	19 July 2016
10	Ombek Dispensary	2	0	2	20 July 2016
11	Wire Dispensary	0	2	2	20 July 2016
12	Nyambola Dispensary	1	2	3	21 July 2016
13	Nyangiela Dispensary	2	1	3	21 July 2016
C)	Migori County				
1	Migori County Referral Hospital	0	5	5	20 June 2016
2	Midoti Health Centre	1	5	6	22 June 2016
3	Ogwedhi Health Centre	2	3	5	23 June 2016
4	Suna Rabuor	2	0	2	24 June 2016
5	Bonde Dispensary	1	3	4	18 July 2016
6	Wath Onger Dispensary	3	3	6	18 July 2016
7	Othoch Rakuom Dispensary	4	5	9	19 July 2016

8	Muhuru Health Centre	5	4	9	19 July 2016
9	Iwanda Health Centre	6	4	10	20 July 2016
10	St. Camilus Mission Hospital	6	5	11	20 July 2016
11	Kambato Dispensary	5	1	6	21 July 2016
12	Macalder Mission Dispensary	1	2	3	21 July 2016
D)	Siaya County				
1	Masogo Dispensary	1	2	3	12 July 2016
2	Malango Health Centre	1	1	2	12 July 2016
3	Abidha Health Centre	1	3	4	13 July 2016
4	Saradidi Dispensary	1	2	3	13 July 2016
5	Rambula Health Centre	1	1	2	14 July 2016
6	Ligega Helath Centre	0	4	4	14 July 2016
7	Tingwangi Health Centre	0	3	3	15 July 2016
E)	Kakamega County				
1	Lunganyiro Dispensary	1	3	4	14 July 2016
2	Mumias Model Health Centre	1	3	4	14 July 2016
3	Mulwanda Dispensary	0	1	1	14 July 2016
4	Butere County Hospital	1	3	4	14 July 2016
5	Iguha County Hospital	0	4	4	19 July 2016
6	Chief Mulimu Dispensary	1	0	1	19 July 2016
7	Emusanda Health Centre	1	3	4	19 July 2016
8	Makunga RHDC	3	0	3	19 July 2016
	Total	168	184	352	

The mentors were selected from the CHMTs and SCHMTs according to the following criteria:

- Experience in malaria surveillance and malaria programming
- Trained in malaria surveillance
- Demonstrated ability to transfer knowledge and skills
- Availability and commitment to visit two facilities per day

Appendix 1 lists the mentors the counties selected.

Implementation of Mentorship and CME

The following key areas of focus were selected based on gaps identified:

- Proper documentation and reporting using the new MOH registers
- Surveillance and importance of malaria surveillance at the facility
- Malaria management per the malaria clinical guidelines (test, treat, and track)
- Malaria diagnosis using malaria rapid diagnostic test kits and microscopy
- Good malaria commodity management practices, including record keeping

Mentorship and CME visits targeted the following departments:

- Outpatient department (OPD)
- Health records
- Pharmacy
- Laboratory

Mentorship Visits

County malaria control coordinators (CMCCs) and subcounty malaria control coordinators engaged in joint activity planning and communicated with targeted facilities. Two facilities per day were targeted for mentorship visits and one facility per day for CME visits. Mentors briefed those in charge of each facility on the purpose of the visit, and then the team toured the facility to understand patient flow and how malaria control services are offered in the different departments. The team observed how the healthcare workers documented data in source documents. Each team member visited his or her area of focus: the outpatient, laboratory, or pharmacy department. They observed data entry in registers and discussed malaria data collection, analysis, and presentation. Mentors asked questions and demonstrated correct data collection procedures. At the end of the visit, the team held feedback meetings with facility staff and developed an action plan, as shown in Appendix 2. The mentees filled out a checklist on the areas focused on during the visit—to provide documentation and a reference for future visits—using the mentorship form shown in Appendix 3. Mentees conducted a presentation on malaria surveillance during the debriefing session, depending on the number of staff at the facility and the number of staff who were not training participants.



Feedback meeting at Mulwanda Health Centre, in Khwisero Subcounty. Photo: Dr. Faustina Sakari, malaria control coordinator, Kakamega County

Facility CME visits

Facility CMEs targeted health workers who were not trained during the malaria surveillance training. The CMEs were organized and conducted per the routine facility CMEs. This was to ensure that normal service delivery at the facility is not interfered with. The county and subcounty malaria control coordinator made a presentation at the facility.



Kakamega CMCC facilitating a CME session at Makunga Rural Health and Demonstration Centre. Photo: Dr. Faustina Sakari, malaria control coordinator, Kakamega County

The following issues were discussed during the CME sessions:

- 1. Malaria surveillance data collection tools:** Tools discussed were OPD registers (MOH 204 A and B); patient booklets and cards; AL daily activity registers; AL monthly summary tools; lab registers and reporting tools (MOH 240, MOH 706, and MOH 643); antenatal care (ANC); child welfare clinic registers (MOH 405, MOH 511, and MOH 105); and monthly MOH summary reporting tools.
- 2. Reporting on malaria surveillance data:** The teams discussed key malaria indicators, their numerators and denominators, how to generate them from the registers, and how to compute percentages. The following indicators were discussed:
 - Outpatient confirmed malaria cases <5 years and >5 years
 - Outpatient malaria test positivity rate (TPR)
 - Inpatient malaria cases
 - Inpatient malaria deaths
 - Treatment—percentage of confirmed clients on AL
 - LLINs distributed to those under five years of age and pregnant women
 - Intermittent preventive treatment for pregnant women (IPTp)—IPTp-1 and IPTp-2
- 3. Data quality issues:** Healthcare workers were asked to identify data quality issues in their registers and discuss them with the team.

4. **Data analysis, interpretation, and use:** Interpretation of malaria surveillance indicators was discussed. The participants were shown how to calculate simple proportions and present them on bar graphs and line graphs.
5. **Data flow:** The participants were taken through data flow processes from the facility to the subcounty and on to DHIS 2. The rationale for timely reporting was explained.

OUTCOME OF MENTORSHIP AND CME VISITS

Gaps Identified and Addressed During the CME and Mentorship Visits

1. **Limited understanding of malaria surveillance:** The healthcare workers had limited knowledge about malaria indicator definitions, how to calculate and interpret indicators, and how to package and present the indicators in a format that different audiences can easily understand. Presentations on the malaria indicators and malaria surveillance were done to help health workers better understand malaria surveillance. The importance of timely and accurate reporting in DHIS 2 was stressed during the mentorship. Those without user rights were asked to get in touch with their respective HRIOs to view data and report their monthly data directly in the system.
2. **Most facilities do not analyse data:** Few facilities had wall charts on malaria surveillance indicators in most departments. The health workers were encouraged to monitor malaria indicators. Examples of how to plot the indicators manually and electronically were given. Health workers were asked to use available resources (e.g., flip charts to plot their graphs as they try to lobby for resources to buy computers that would enable them to generate the graphs electronically). These graphs are to be used during the routine facility data review forums to discuss malaria trends at the facilities. The graphs will also encourage health workers to use the same data to make decisions whenever necessary.
3. **Use of standard registers:** Most facilities were improvising lab registers using counter books, and not all standard data elements were captured in the books. Nets issued to babies under one year of age were recorded in a Population Services Kenya booklet, instead of MOH 511, in most facilities. Standard laboratory registers were not available in most facilities. The county promised to disseminate the tools to the facilities where available, and facilities were encouraged to request tools from the county, as needed. MEval-PIMA was tasked to follow up on issues regarding the registers at the quarterly national surveillance monitoring evaluation and operation research technical working group meeting.
4. **Standard laboratory practices:** The majority of laboratories still report on microscopy slides as “MPS” (Malaria Parasite Seen) and do not report on the malaria species and developmental stages observed. Medical laboratory technologists do not store malaria slides for quality assurance. Mentorship of the laboratory staff emphasized proper documentation in line with standard practices and involvement in the national quality assurance system.
5. **Poor documentation:** Facilities do not follow standard operating procedures on how to complete the registers. Not all data elements are captured; page summaries were not provided; and data entries were incorrect in registers and summary tools. For example, in pharmacy reporting, AL dispensed was recorded as total number of patients on AL per weight band. The health workers were taken through the instructions in the registers on how to fill out the different columns in the registers correctly. They were also mentored on the importance of providing page summaries in

the registers, because this was the major reason for huge discrepancies between the data in the primary data tool and the monthly summary reporting tool.

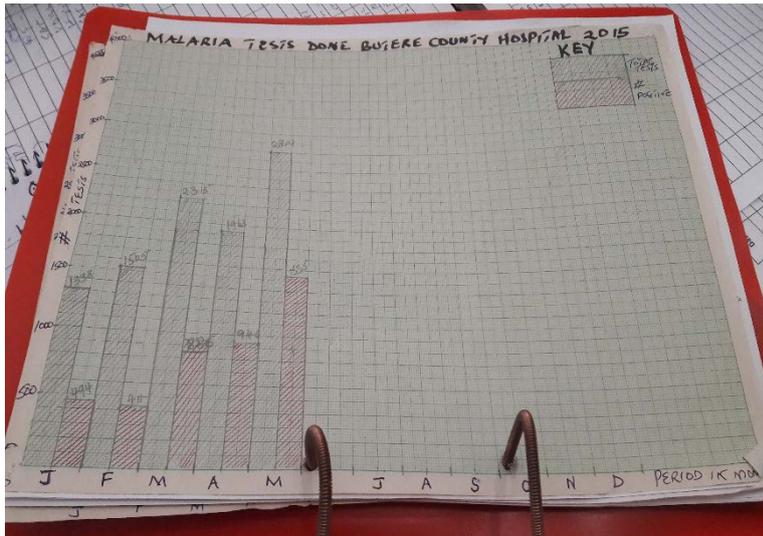
6. **Access to DHIS 2 was still an issue with some of the HRIOs at the facility level.** The county health records information officer (CHRIO) was tasked with ensuring that all facility HRIOs were provided with access rights for DHIS 2 and make following up with the division of Health Information System for assistance in case they face any challenges. The misconception that only the health records department was to use data was corrected during the mentorship and CME visits. All health workers were encouraged to make a habit of interacting with their data routinely to make evidence-informed decisions. At minimum, every health worker should be able to view the data reported in DHIS 2.



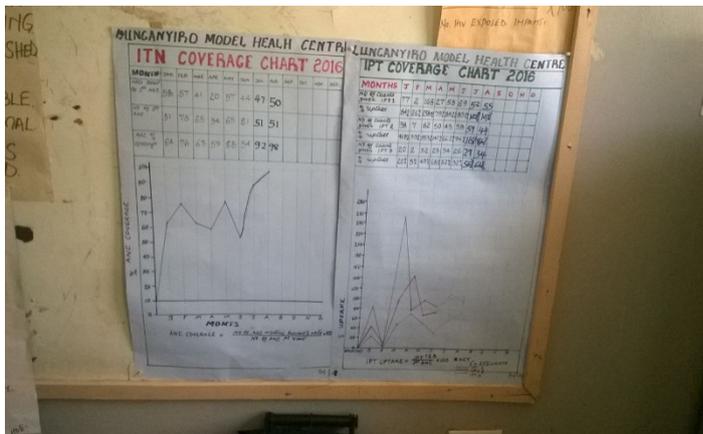
Demonstration of proper data entry at Sondu Subcounty Hospital's outpatient department. Photo: Lilyana Dayo, malaria control coordinator, Kisumu County

Evidence of Good Practice

Some of the health workers were implementing the skills gained during the surveillance training sessions, such as the analysis of data through the use of charts and graphs to track the indicators of interest at a facility using simple manual tools. Two examples are below:



Graph showing the number of malaria tests done by the number of people who tested positive at Butere County Hospital. Photo: Dr. Faustina Sakari, malaria control coordinator, Kakamega County.



Coverage of interventions against malaria in pregnancy at the Maternal and Child Health Department of Lunganyiro Model Health Centre. Photo: Dr. Faustina Sakari, malaria control coordinator, Kakamega County.

LESSONS

Following are some of the lessons learned from implementation of the mentorship and CME visits at the facility level:

1. The short malaria surveillance training duration provided a limited opportunity to apply the new skills learned. After the training, county teams were supported to conduct mentorship visits, during which they applied the skills practically in a facility to set up, customize malaria surveillance graphs and demonstrated the use of these skills in a facility and documented learning and findings for future reference.
2. There is need for continuous training, through CME and mentorship of healthcare workers on malaria surveillance, in order to reach a critical mass that will ensure change at the facility level. This should be the collective responsibility of all malaria implementing partners and stakeholders in the region, because the number of health workers yet to be reached is substantial. Regular updates and

refresher trainings should be given to those already sensitized, to foster a culture of data use in decision making.

3. The data demand and use capacity of SCHMTs needs to be ensured so that they can support the CHMTs to implement activities at the facility level. This capacity should trickle down to the facility health management team, because they are the data producers, and they should be able to make sense of the data before transmitting it to the next level. If good, reliable data can be generated right from the source, then those relying on the data at higher levels of management can start using the data to inform accurate and timely decisions. These data users should insist on having data before making any decision, and that will lead to efficient and effective use of scarce resources.
4. A variety of members with different skills on CHMTs and SCHMTs ensures a balanced composition of mentors who can address issues they identify at a facility when they are implementing mentorship activities. This is important, because different cadres have specific strengths and expertise in their fields of specialization. Having a mix of these cadres during the mentorship exercise will make health management teams more effective in addressing some of the gaps that present challenges to health workers at their facilities.
5. Data analysis and sharing should be encouraged at the subcounty and facility level to build the practice of data use at all levels. This practice should be adhered to, change attitudes, and promote good data use among health workers. The health managers should play a key role in encouraging data use and be good stewards of data themselves. This will create a demand for accurate and timely data from the data producers. A specific day of the week should be set aside by all facilities to look critically at and interrogate their data before they summarize and send it to the next level. The health managers at the SCHMT should demand data reports and use them to allocate resources during the annual work planning processes.

APPENDIXES

Appendix 1. List of Mentors

	Name of mentor	Sex	Cadre/title
A)	Kisumu County		
1	Ogollah Hellen A.	F	County laboratory coordinator
2	Lilyana Dayo	F	County malaria control coordinator
3	Judy Rotich	F	Subcounty malaria control coordinator
4	Ngiti Shem	M	County health records information officer
5	Christopher Nyagol	M	Subcounty health records information officer
6	Mary Obiero	F	Subcounty laboratory coordinator
7	Isabel Akinyi	F	Subcounty pharmaceutical facilitator
8	Oscar Munambo	M	Subcounty malaria control coordinator
9	Odhiambo Aketch	M	Subcounty malaria control coordinator
10	Onyango Dickens	M	County director of health
11	Michael Otieno	M	Subcounty health records information officer
B)	Homa Bay County		
1	Charity Mugambi	F	Subcounty malaria control coordinator
2	Schollar Ogolla	F	Subcounty health records information officer
3	Judith A. Oyuga	F	Sub County pharmaceutical facilitator
4	John Odhuno	M	Subcounty health records information officer
5	Waringa Vincent	M	County director of health
6	Mathias Ochieng	M	Subcounty laboratory coordinator
7	Lucas Okumu	M	Subcounty laboratory coordinator
8	Bernard O. Nyaberi	M	Subcounty health records information officer
9	Daniel Okuku	M	Subcounty malaria control coordinator
10	John Dolla	M	Subcounty malaria control coordinator
11	Stephen Okum	M	Subcounty malaria control coordinator
12	Gichana Emily	F	Subcounty laboratory coordinator
13	Clara Ahenda	F	County malaria control coordinator
C)	Migori County		
1	Jecinter Odira	F	Subcounty health records information officer
2	Fredrick Keya	M	Subcounty laboratory coordinator
3	Chester Kolek	M	Subcounty pharmaceutical facilitator
4	Florence Ngere	F	County malaria control coordinator
5	Simeon Okuthe	M	Subcounty malaria control coordinator
6	Lilian Ayoyo	F	Subcounty malaria control coordinator
D)	Siaya County		
1	Peter Omoth	M	County malaria control coordinator
2	Charles Oduor	M	County laboratory coordinator
3	Dickson Owino	M	Subcounty health records information officer

4	Patrick Omondi	M	Subcounty malaria control coordinator
5	Omondi Elisha	M	Subcounty malaria control coordinator
6	Joseph Oyare	M	Subcounty pharmaceutical facilitator
7	Fredrick Osanya	M	Subcounty malaria control coordinator
8	Carey Obuya	M	Subcounty malaria control coordinator
E)	Kakamega County		
1	Faustinah Sakari	F	County malaria control coordinator
2	Stella Viteti Shivogo	F	County health records information officer
3	Violet Tabasia	F	Subcounty pharmaceutical facilitator
4	Tom Nyongesa	M	Subcounty malaria control coordinator
5	Rose Idanyuku Karevera	F	County clinical officer
6	Emisiko James	M	County laboratory coordinator
7	Frederick Chabulia	M	Subcounty health records information officer

Appendix 2. Action Plan

An example of an action plan from the Kakamega mentorship report

Action Plan for Malaria Surveillance					
Weaknesses /Gaps	Proposed Solution	How It Will Be Addressed	Person Responsible	By When	Potential Partner
Not all staff were trained on malaria surveillance	Trainings on malaria surveillance	Through CME trainings and mentorship	CMCC, CHRIO	Quarterly /biannually	MEASURE Evaluation
Poor data quality	Proper documentation, follow SOPs, page and monthly summaries	CME mentorship supervision trainings	SCHRIO	Daily/monthly	URC, Malaria Care, APHIAplus Western, NMCP
Improvised lab registers	Avail lab registers	Avail lab registers; improvised registers to capture all data elements	CHRIO	End of June 2016	
Sub-counties and facilities not analyzing data	Data analysis at the subcounty and facility levels	Subcounty and facilities to do monthly data analysis and plot malaria surveillance graphs	SCHRIO, SCMCC, facility in charges	Monthly	
Facilities not having wall charts/graphs on malaria surveillance indicators	Avail wall charts for plotting surveillance indicators	Avail standardized charts for plotting malaria surveillance indicators	CMCC	Annually	MEASURE Evaluation

Key: APHIAplus: AIDS, Population, and Health Integrated Assistance Plus; CMCC: county malaria control coordinator; CME: continuous medical education; NMCP: National Malaria Control Program; SCHRIO: subcounty health records information officer; SCMCC: subcounty malaria control coordinator; URC: University Research Company

Appendix 3. Mentorship Form



Pima Mentorship form

County: _____ Output: _____ Facility/Program name: _____

MFL code: _____ Sub County _____ Quarter _____

Mentors' details

Date (dd/mm/yyyy)	Name of Mentor	Gender	Cadre	Title	Phone number	Organization (Program/County/Facility)	Signature

Mentee Details

Date (dd/mm/yyyy)	Name of Mentee	Gender	Cadre	Phone number	Topic	Specific Learning Objectives	Expected Knowledge / Skills to be gained	Specific area (s) covered	Progress of Mentee Comments /Next steps	Signature

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