Regional Malaria Civil Society Organization

Consultation Workshop
Cambodia, 4-5th October, 2016

Raks Thai Foundation I Thailand

Contents

Abbreviations

APCASO	Asia Pacific Council of AIDS Services Organizations
APCRG	Asia-Pacific Platform on Communities, Rights, and Gender
BCC	Behavior Communication Chain
CRG	Community, Rights and Gender
CSO	Civil Society Organization
GMS	Greater Mekong Sub-region
ICC	Inter-Country Component
MC	Malaria Consortium
MHDC	Myanmar Health and Development Consortium
MP	Malaria Posts
MMP	Mobile Migrant Populations
MoH	Ministry of Health
HPA	Health Poverty Action
ICC	Inter-Country Component
ICF	intensified case finding
KAP	Key Affected Population
LLHIN	Long Lasting Hammock Insecticidal Nets
LLIN	Long Lasting Insecticidal Nets
MSAT	Mass Screening And Treatment
M & E	Monitoring & Evaluation
MMP	Mobile Migrant Population
PFD	Partners For Development
PR-UNOPS	Principal Recipient- The United Nations Office for Project Services
PSK	Population Services Khmer
RAI	Regional Artemisinin Initiative
RTF	Raks Thai Foundation
RSC	Regional Steering Committee
VMW/VHW	Village Malaria Workers/ Village Health Workers

Introduction

Background

Although significant progress has been made in reducing the burden of malaria in the region in the past 15 years, malaria remains a major killer in the Asia Pacific region. Artemisinin resistant malaria is prevalent in all GMS countries and threatens these gains. The 4th Regional Malaria Civil Society Organization Consultations (CSO) Workshop was held in Phnom Penh, Cambodia on 4 - 5 October 2016. This meeting gave implementing agencies, PR-UNOPS and RAI RSC the chance to come together to reflect on what lessons had been learned to date and to review the process and priorities for CSO in relation to the development of a new global fund concept note (2018-2020).

More than 40 participants from Thailand, Cambodia, Laos PDR, Viet Nam and Myanmar, along with the representatives from APLMA (Asia Pacific Leaders Malaria Alliance), French 5%, RAI RSC, Global Fund secretariat, UNOPS Myanmar and Bill & Melinda Gates Foundation were present at the meeting *(Annex A- list of participants)*. Meeting was funded by the RAI RSC and organized by Raks Thai Foundation with support of Malaria Consortium, Cambodia.

Objectives

- To take stock of success and challenges in the implementation of malaria response by civil society and community-based organizations in the Mekong Sub-region, in particular in the context of RAI.
- To identify key funding gaps and priority investments in view of achieving greater access to malaria and prevention and treatment services by key-at risk populations.
- To formulate recommendations to the RAI Regional Steering Committee (RSC) in preparation for the next regional Concept Note.

Welcome address

Mr. Sun Maysac, CSO Platform Representative for Cambodia and Project Manager of PFD welcomed participants to the meeting and to Phnom Penh. He highlighted the knowledge and expertise shared by participants in serving communities most affected by malaria. He encouraged participants to utilize the opportunity to produce the best outcome from the meeting.

The RSC CSO representative Mr. Louis da Gama extended a warm welcome to all participants. Mr. da Gama explained that the RSC was willing to hear from the CSO Network regarding the work, what else can be done as well as recommendations from each country.

Follow up and Overview of Meeting

Mr. Shree Acharya, Program Officer, Raks Thai Foundation (RTF) and coordinator of regional platform provided an overview to new participants on key issues, challenges and gaps that were reported in previous consultations.

Target groups across all GMS countries were broadly similar and fitted with in Mobile Migrant Population (MMP) definitions. Key effected populations had been identified as:

Ethnic minority groups	Hunters and seasonal agricultural laborers
People working logging, gold mining or plantations	Farmers and forest goers
Border crossers	

There were some constraints and challenges that had been raised prior to the consultations:

Low motivation/support for Village Volunteers, Village Malaria Workers (VMW), and Village Health Workers (VHW)
Need for greater community engagement
Limited Human Resources and Technical knowledge in CSO
Poor access to health care services
Need for more cross border collaboration
Remoteness and marginalization of some communities
Multilingual services needed
LLHIN/LLIN distribution
Failure of patients to complete treatment and poor case follow up
MMP need better services

In all countries most of the challenges and target groups remains the same, therefore, the meeting focused on prioritizing these issues for attention of RSC.

Presentations - day 1

Regional Artemisinin Initiative Regional Steering Committee (RAI RSC) meeting and activity update

Ms. Amelie Joubert, RSC Secretariat

RAI is the first regional initiative of the Global Fund. Commencing in 2014, it allocated US$100m for all 5 GMS countries, US$85m to the Country Component and US$15m to the Inter-Country Component (ICC). The country components intensify malaria control interventions in areas of resistance (Tier 1&2), while the ICC targets border areas and MMPs. Through these investments we have seen success in four key areas

1. Continued reduction of malaria caseload in GMS
2. Expansion of coverage / range of malaria interventions through national programs
3. Expanding the reach of services for high-risk populations
4. Trialing of new malaria elimination strategies

Currently, CSO (across all GMS countries) are receiving 33% of available RAI funds. It was proposed, by the group and agreed that CSO share of available funding under the next grant should increase to 50% of available funds.

Country	Received to date	Total 2014-2017 (USD) NFM + RAI	GF share of malaria program financing
Cambodia	$120 M (2003-)	**$45 M**	65%
Lao PDR	$54 M (2003-)	**$17.5 M**	80%
Myanmar	$60 M (2005-)	**$66 M**	69%
Thailand	$59 M (2004-)	**$45 M**	80%
Viet Nam	$50 M (2004-)	**$22 M**	72%
RAI Inter-country		**$15 M**	-
Total (USD)	**$343 M**	**$210.5 M**	

Figure 1 Global Fund Malaria financing in the GMS

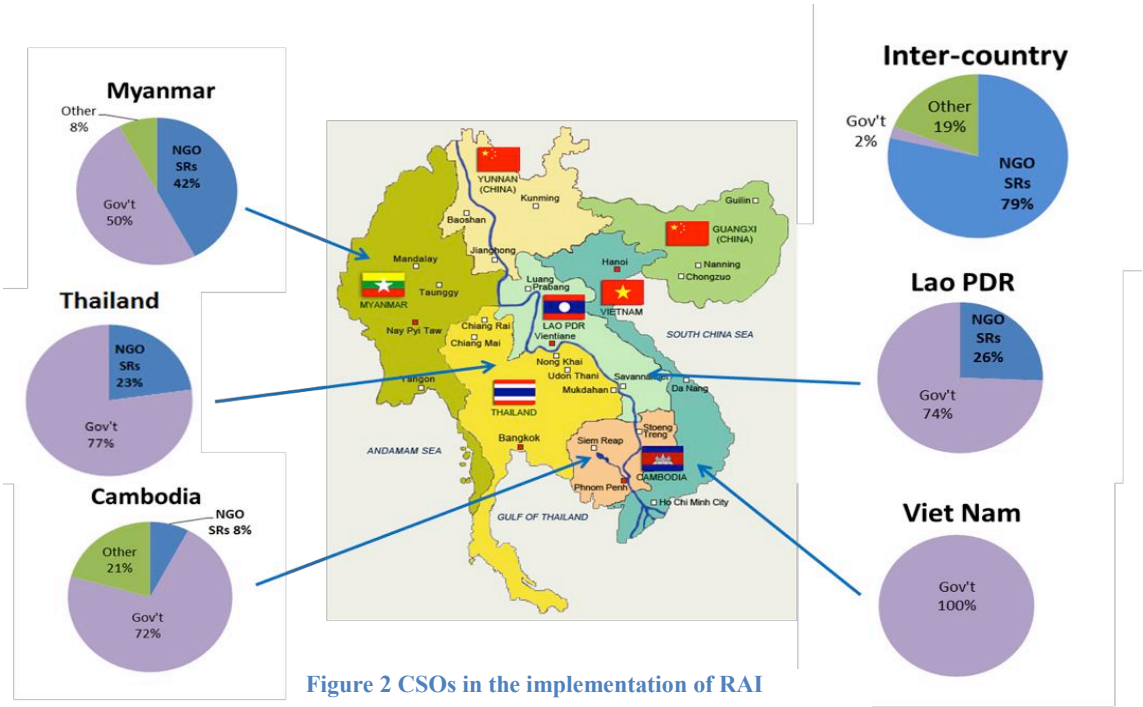

Figure 2 CSOs in the implementation of RAI

The current timelines for the next grant cycle were shared. Although dates could not be confirmed until the RSC retreat and meeting (10-11 October 2016). Ms. Joubert confirmed that:

- RAI - current grant to end December 2016 (1 year extension Jan-Dec 2017)
- Country Level consultations to start in November and December
- Concept Note submission April/May 2017
- Next grant to commence January 2018.
- It's expected that the next grant will merge all funding models into one.

She further mentioned the composition of RSC (17 members), in which 2 members in non-government sector includes community based and civil society organization.

RAI significant achievements between2013-2015.

•Reduction of malaria case load

•Expansion of coverage

•Expanding the reach to target population

•Trailing of new malaria elimination strategies

Agenda of Consultation

- Upcoming RAI RSC meeting during 10-11 October and RSC activity update
- Status of implementation of the RAI by PR-UNOPS
- Status of implementation of the RAI by PR-UNOPS -MC Cambodia
- MC Cambodia strategic priorities for the future (Next round of RAI) • Integration of TB, HIV and Malaria in global fund grant
- Strategic priorities for the future (Next round of RAI) • Integration of TB, HIV and Malaria in global fund
- Malaria platform working group meeting

Status of implementation of the RAI, PR-UNOPS

On behalf of PR-UNOPS Dr. Attila Molnar and Dr. Eisa Hamid gave presentations.

Dr. Molnar reflected on malaria programing and its direction for the program. Noting the progress that has been made to date, Dr. Molnar felt it was clear that elimination of malaria from the GMS is well on its way. To help us achieve this goal he said energies needed to focus on ensuring everyone has access to services and early detection and treatment. For fringe and remote communities UNOPS have seen that Malaria Posts (MP) can play a key role in providing these key services. MP's are an important tool for elimination, and he encouraged the network to consider what other services they can provide so they remain relevant and trusted services in the communities they serve.

"We value CSO partnerships because they are deliver"

Dr. Atilla Molnar, PR-UNOPS

"The last mile will be walked in the bushes and CSO are best positioned to walk that last mile"

Across the region it's been observed that CSO and Public Sector work together in different ways and important matter is partnership does still exists. The public sector will remain central in managing epidemics and National Malaria Managers will remain a critical element to all our efforts. It is important for CSOs and the public sector to continue their partnerships. Whilst there have been challenges in these partnerships we have seen significant developments, in Vietnam have shown some action in the field after a period of negotiations and in Myanmar the government has opted to allocate some of its own funding to CSO. These are positive signs and we should be encouraged by this.

On matters of governance, Dr. Molnar noted it was important issue in all countries they worked, but there would always be a tension. The role of the RSC is to help coordinate and address the issues. RAI activities have only been operating for 2 ½ years and it has displayed the impact in partnerships, policies and practices. This would be a boast while developing the next Concept Note. The process will be bottom up and PR-UNOPS will encourage Ministry of Health (MoH) to bring the CSO into the system. PR-UNOPS is keen to see the role of the CSO grow and valued their partnership because of the services they provide.

CSO were encouraged to do what they do best MP's, working with volunteers, providing services and collaborating with the government.

Dr. Eisa Hamid gave an update on the achievements of RAI since it began. RAI a $100 million program has reached an estimated population of 42,073,276.

Progress updates were given on the RAI Indicators.

Indicator	Achievement
Confirmed Falciparum malaria cases per 1000 persons/year (Tier 1 & 2 areas)	P. falciparum malaria incidence rates have decreased in all countries (period 2012-2016). (Insert graph)
1. % of administrative units with falciparum incidence <1/1000 persons (T1 & T2 areas)	This is to be reported in 2017, but the trend is showing increasing territories with low malaria. Over 60% of the targeted administrative units in Tier 1 and 2 reported a Falciparum Malaria incidence of <1/1000 person per year. The results indicate that growing numbers of administrative units are moving toward malaria elimination. Thailand and Vietnam also set targets for % of administrative units with falciparum malaria incidence <0.1/1,000 and showed good progress as well. Cambodia was affected but the increased number of cases in 2015. Thus the number of ODs with malaria rates less 1/1000 has increased in 2015 compared with that of 2014.
Number of ITNs/LLINs distributed to at risk population through mass campaigns	3.56 million LLIN distributed
Proportion of population at risk potentially covered by long lasting insecticidal nets distributed	Reporting not due yet, but updates show nearly 100% of target areas covered
% of suspected malaria cases received parasitological test	All countries achieved their target per the indicator definition, however no country reached their numerical targets
% of confirmed malaria cases that received first-line antimalarial treatment according to national policy	Three countries (Cambodia, Lao, and Vietnam) met or almost met their targets. Thailand achieved less than 68% that was mainly due to reporting issues where patients referred to hospitals were not reported hence their data were not included. In Myanmar the low performance is more on recording and reporting rather than the quality of case management. Improvements can be seen in NMCP in the sense that more confirmed cases were provided treatments according to treatment

	guidelines during this period compared to the same period (Jan - Jun) in 2015
% of confirmed cases in low endemic areas fully investigated	The overall % achieved progress against the planned targets. Thailand maintained 100% target achievement as in previous period. Good progresses in Myanmar and Vietnam. There was not targets for Laos and Cambodia did report on cases investigation
% of confirmed transmission foci that received an appropriate response within 7 days	A new indicator included to measure the timely response to foci. The overall % achieved in GMS countries was less than the planned targets but Vietnam and Myanmar met their targets. No targets were set for Thailand and Laos
% of public health facilities reporting no stock out of malaria commodities during the reporting period	The indicator is reported on annual basis in Vietnam and Thailand. For this reporting period's data from was available in Myanmar and Laos. Cambodia has not roll out the automated reporting system. Data on stock level are collected during supervision visit

CSO activities under RAI are under Vector Control, Case Management, (Behavior Communication Chain) BCC, Surveillance, Coordination and Cross-border collaboration, and M&E/research modules.

- Vector control: distribution of net to identified forest-goers
- Case management: VHVs/ MPs including intensified case finding (ICF) among target communities, forest-goers and new migrants. Case follow-ups by VMWs and MMWs on day 28 to assess for parasite clearance.
- BCC: Development and distribution of BCC/IEC materials to target populations and to individuals crossing the border. Community campaigning sessions and activities to deliver BCC messages which are developed by applying principles of positive deviance approaches.
- Surveillance: Active surveillance and mapping: identification of hotspots of transmission and parasite dispersion along international borders through border surveillance posts. Development and first-phase implementation of a mobile phone application and outbreak alert system to be used by PPs and VMWs in selected border regions to notify cases in real-time and alert to conduct outbreak investigations
- Coordination and Cross-border collaboration: Participation in cross-border collaboration meeting to share data and information on activities, and plan for joint activities such as cross-border referrals and joint outbreak investigations
- M&E, Research: OR, MDA, MMP Survey, ACT Watch, oAMT replacement, Regular monitoring and supervisions to the project areas
- Artemisinin resistance and impact in GMS

Tom Peto, PhD, Mahidol Oxford Research Unit (MORU)

Artemisinin resistance presents an immediate and real threat to the progress that is being made to eliminate malaria from GMS. The presentation covered 5 key issues:

1. History of antimalarial drug resistance
2. Artemisinin and partner drug resistance
3. Importance of eliminating falciparum, whilst we can still treat it
4. Containment and elimination strategies
5. Likely impact in GMS of Artemisinin resistance

CSO have a role to play in addressing the threats posted by Artemisinin resistance. Dr. Peto's presentation highlighted a number of areas where CSO are already active that should be prioritized to accelerate malaria elimination. Containment strategies including Community based case management; Vector Control and Quality routine data and surveillance areas are key interventions to treating symptomatic cases and areas, many of the Regional Platform Members are actively working in. The challenge that CSO and others face is how to deal with asymptomatic cases, which are likely to be many more than we thought; causing disease and contributing to transmission and resistance.

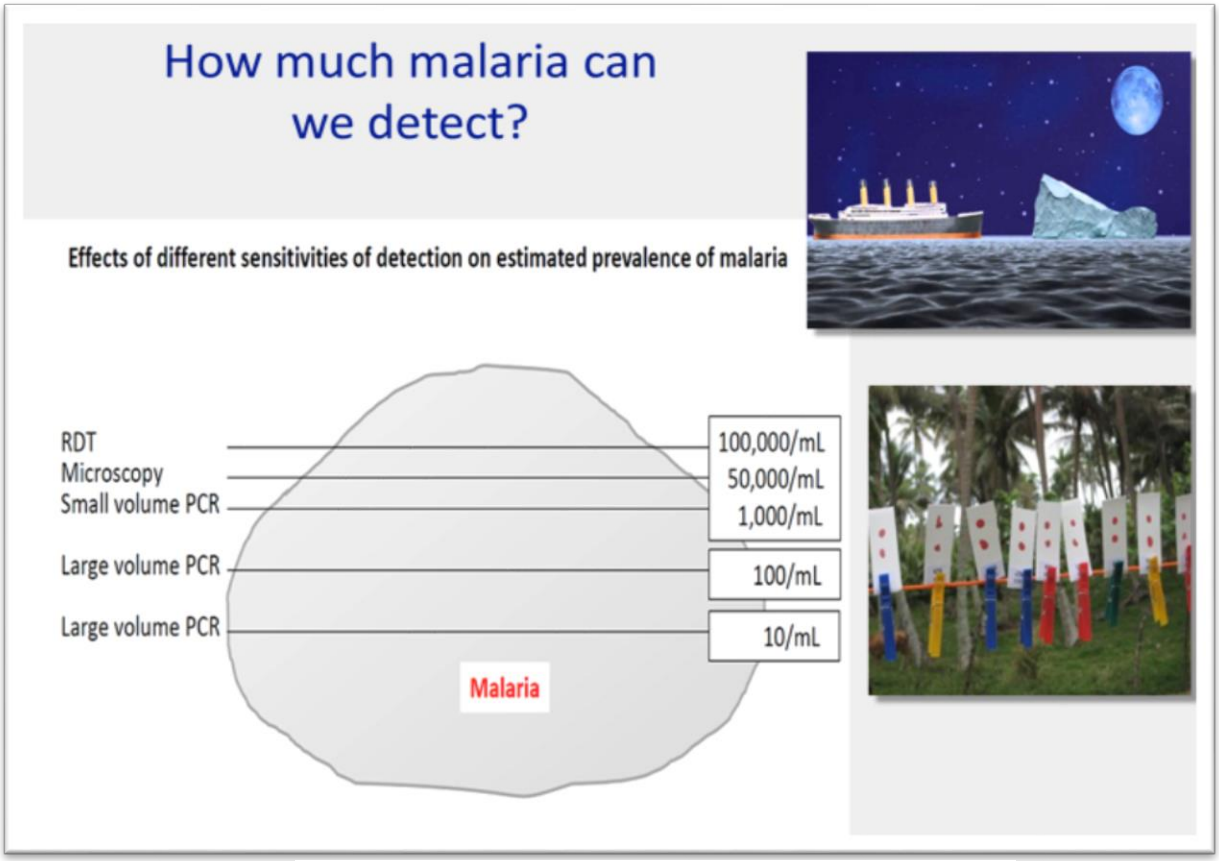

Figure 3 Malaria detection

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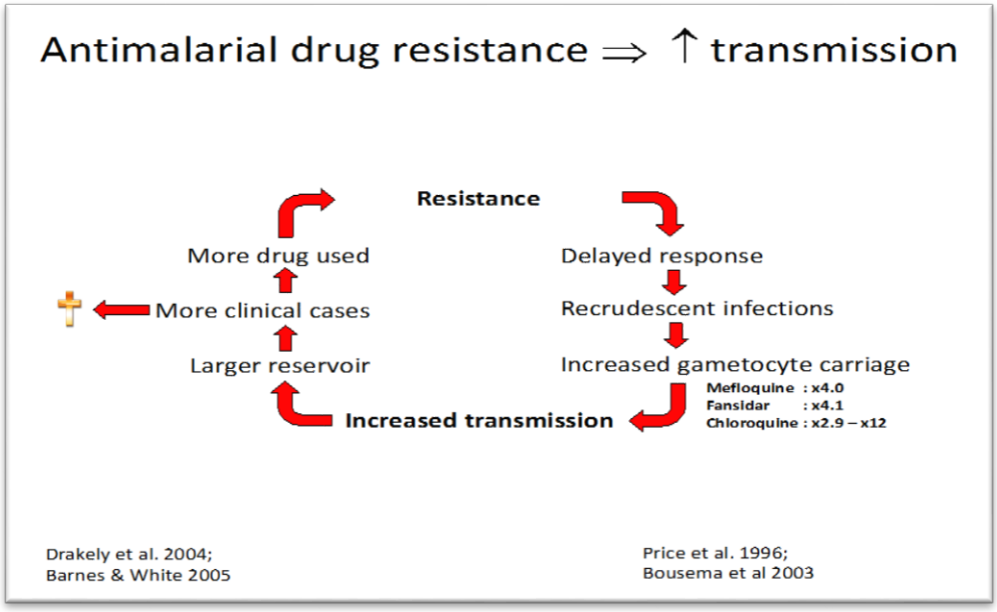

Figure 4 History of antimalarial resistance

He further explained the delayed response, has increased the transmission leading to more clinical cases and the resistance. Dr. Peto proposed CSO and other actors should consider additional tools to accelerate elimination including, MSAT using novel diagnostics, target MDA, Reactive Case detection, Vaccination and Chemoprophylaxis for high risk group.

There were certain problems noted about the asymptomatic reservoir, such as:

a) How big is it? Bigger than we thought
b) Does it cause disease? Probably
c) Does it contribute to transmission? Almost certainly
d) Does it contribute to the resistant parasite pool? Yes
e) How to get rid of it?

RAI ICC work update/sharing by implementers

John Holveck, Country Director, Health Poverty Action Laos PDR

HPA RAI, NFM and ICC target areas are located in Champasack, Sekong and Attapeu Provinces (population 335,153). Mr. Holveck noted that this area has received a lot of attention and support from donors but what is urgently needed is coordination at the field level and for people to take time to understand the complexities of working in this region. Given the complexities of working in these provinces HPA's achievements in their D.O.T program (100% completion) are impressive and did raise the question, is this something we should be focusing on more in other projects?

HPA Activities in Lao PDR

NFM	RAI	RAI-ICC2
Train VMW/ Village Health Volunteers on routine data collection, reporting and provide telephone top up support.	Training and incentives for DOT supervisors	Mapping, tracking, testing, treating and evaluating behaviors of MMPs in target villages.
Training of Trainers (ToT) for the Lao Women's Union at the District and Provincial levels and joint IEC/BCC activities	Incentives for PPM staff for identification and referral of patients to DOT supervisors	Training on EDAT for MP staff
IEC/BCC activities on malaria prevention and health seeking behavior.	Supervision and monitoring of DOT supervisors by health staff	Training on EDAT for military health staff
Community and school-based activities, including Malaria Peer Educators Health Promotion activities, school theatre groups	Training and incentives for DOTs in 15 target districts	Sign/map boards
Village clean-up day every month to be led by LWU representatives and annual village health day that includes health edutainment	Health education campaign	Pilot survival kits for forest goers and military
'Race to Zero' campaign during World Malaria Day	Intensified case detection	Quarterly review meetings with MPs at District level
Workshops with managers/directors of companies	malaria screening at border points and 3 international bus stations for international migrant workers	Conduct workshop at 6 monthly intervals to review progress and make mid-course corrections and lessons for scaling up
Establish mobile and internet-based data management and information system at District and HC levels.	MMP Survey I and MMP Survey II	
Monitoring and supervision of low performing villages	Recognition and awards to top performing Village Malaria Volunteers	
Annual reviews and reflections with stakeholders		

However, he concluded with certain issues for challenges such as overloaded staff, delayed reports, limited skills & capacities of staff, evaluation, information along with lack of cooperation and lack of flexibility.

Kylie Mannion, RAI-ICC Regional Programme Manager, Malaria Consortium

Malaria Consortium (MC) was granted the RAI-ICC project for both Thailand and Cambodia. The project Trans-border malaria: Fine-scale mapping of high-risk populations and targeting of hotspots with appropriate and novel intervention packages involves MC Thailand, MC Cambodia, Raks Thai Foundation and Population Services Khmer (PSK).

Figure 7 Active Surveillance

The project that began field activity in April 2016 is being conducted in two phases.

Phase 1 Active Surveillance and Mapping identified populations, workplaces and areas along the borders that are vulnerable to malaria. The mapping and surveillance activities brought together data from Provincial Health Departments, Health Centers, Village and Community mapping exercises and MC operated border checkpoints.

Phase 2, Targeted interventions began in the second half of 2016. Based on Phase I outcomes teams are providing a range of services to communities living and working along the borders of Ubon Ratchathani, Preah Vihear, Stung Treng and Ratanakiri.

Figure 8 MMW training in the community

Services and outreach offered:
1. Campaigning and Sensitization events
2. ICF - Intensified Case Finding
3. LLHIN distribution
4. Active Case Detection
5. Mobile Malaria Posts
6. Real time case reporting – Private Providers
7. Additional training and support to MMW and VMW
8. Distribution of IEC materials

Project Strengths
- Connections and relationships with hard to reach populations
- Mobility and Adaptability
- Learn by doing approach
- We complement and add to the national programs

Looking Forward
- We need to provide services to people where they are – plantations, farms, unofficial checkpoints, forests etc.
- Our programs must be willing to adapt to changes in mobile populations and remote communities
- We must speak our clients language
- We need improved diagnostic tools
- Protection innovation
- Volunteer testing
- Treatment follow-up

Group Work

Formulating strategic priorities for the future - thematic discussions 1 and 2

During the afternoon session, CSO representatives participated in smaller group discussions in order to develop a list of recommendations to be presented to the RSC. In addition the CSO network also considered governance issues in the discussion.

The network agreed that across all GMS countries the first priority for elimination is still early diagnosis and treatment with effective drugs and reliable reporting to identify source of case. Group discussion then centered on strengths and expertise existing within the CSO network which could help national and regional elimination efforts. Across the network strengths and expertise vary. Three common strengths shared by all CSO in the regions were regularly referred in the discussions, which were,

- Existing relationships with the target communities,
- Services provided in remote and high risk areas
- Experience in providing technical assistance which sounds crucial in strengthening early diagnosis and treatment services.

Within case management the network felt that they could support or lead in the following areas:

1. Expanding and/or strengthen VMW/VHW programmes
2. Expand role of VMW into VHW (especially fevers, 1st aid, diarrheal diseases, LRTI, support for other health campaigns and activities).
3. Extend malaria cases management DOTs, follow up of every P.f. case to ensure treatment was successful

4. Improve data collection and surveillance (approaching elimination, the difference between indigenous and imported cases is crucial and determines the epidemiological significance and the response required)
5. Work with the private sector where they are present (ensure correct drugs are used and recording of cases, many areas still rely on treatment from the private sector).
6. Replacement of ACTs with TACTs (& single low dose primaquine) will be a major activity, needs a lot of capacity so this happens at the periphery.

In addition CSO also demonstrated the capacity to support or lead:

1. Development and provision of locally appropriate strategies dependent on the type of population and level of transmission – "risk based packages of effective interventions"
2. Mapping and modeling at a high level of detail the level of risk, define population at risk, estimate value of more aggressive activities based on subclinical reservoir).
3. Evaluation of MSAT with new ultra-sensitive RDTs needed. There are still strong arguments for targeted MDA in some contexts e.g., epidemics, or where there is a proven pf reservoir and if MDA is practicable.
4. Community engagement and outreach activities

Across the GMS the roles of CSO would vary in each country depending on the particular national circumstances.

Governance Discussions

The role and size of the CSO Network and continuous grow. It's an extremely important platform that provides CSO a direct link to the RSC as does the CSO representative on the RSC. To date Raks Thai Foundation (RTF) have been crucial to the success of the network, they have provided both management support and momentum to this group. As we move forward the CSO Network felt it was timely to consider two governance points:

1) How to manage the network as continuing to rely on the goodwill of one organizations is not sustainable
2) How to avoid possible conflicts of interests, especially in regards to the preparation of the Concept Note.

The question of "does being on the writing committee, exclude you from bidding for a grant" was discussed. Opinions across the network varied.

To get more input from participants we broke into smaller groups to discuss the following:

a) Go with the system we have
b) Hire external consultants?

Furthermore, the participants in the room divided into six groups for discussion. At the end of the discussion opinions were still mixed. Three groups felt it was more appropriate to hire external consultant. One group reported they were happy with the current system, another felt there was no conflict of interest at the Concept Note stage, but that there could be at stage 2 and 3 of the bidding process, whereas one group suggested that at staff member of RTF could assist to the Writing Committee as a host of platform.

Although no firm decision was made it was clear that the group felt that this was worthy of ongoing consideration and as was exploring options for hiring external consultants for the concept note writing committee.

Presentations - day 2

Integration of TB, HIV and Malaria in global fund grant

Discussions centered on the role of the VMW/VHW and how expanding the services they provide could achieve a number of things, increasing their value to the communities they work in, improving job satisfaction and providing a more cost effective service. Participants gave examples of where integration was already happening or had happened in the past.

In Cambodia, it seems as though some integration is already occurring at a community level but to be sustainable, it needs to be led by the central level and the issue of multiple health volunteers supported by different programs need to be addressed. Participants from Thailand reported that under GF R6 an integrated approach was adopted, however, under current programs integration is more opportunistic. In Myanmar, integration wasn't seen as a high priority. As the diseases had a strong geographical focus (malaria in rural areas, TB/HIV more common in urban areas) the benefits of integrating the different programs were limited.

Two questions that remained for the CSO Network at the end of the session:

- What can be done in a practical way &
- What can we measure?

Process for country consultation for concept note development

The RSC retreat and meeting was scheduled to take place the week after the CSO Network meeting. The purpose of these two events is to set the higher-level principles to guide the next round of funding from Global Fund.

By late October a writing committee, process for engagement and timelines would be set.

Mid November Consultations with CSO would commence and the Global Fund board will meet to set allocations, the results of which will be announced late November.

Consultations with CSO will be done in country not a regional level, with the aim being to have substantive consultations with organizations.

The final date for submission of concept note is to be confirmed.

CSO focal points and working groups should ensure that consultations involve as many groups as possible. Consultations should not be limited to those working in malaria; we should bring in groups also working with key affected populations. APCASO (http://apcaso.org/) through the APCRG supports initiatives to help civil society groups, key population networks, non-governmental and community-based organizations to push for the inclusion of CRG-related. They have a number of resources, as well as small grants available that could support the consultation process.

Private Sector participation in malaria

Myanmar Health and Development Consortium- Dr. Sandii Lwin,

Myanmar accounts 75% of total malaria burden and 33% malaria deaths in Southeast Asia in 2010. In 2016 more than two-thirds of the population live in areas at risk of malaria, 284 out of 300 townships are malaria endemic and the Thai-Burma and India-Myanmar borders are hotspots for artemisinin resistance. The rapid increase in FDI in infrastructure projects (gas, oil, mining, highways) can also increase the vector population and are attracting large numbers of MMP (1.2m-1.6m) to the area.

MHDC are working with private sector partners to reach populations at risk, including workers and MMP. This has taken place through two mechanisms Corporate Sector Engagement and Private Provider Engagement.

Corporate Sector Engagement	Private Provide Engagement
Accreditation Scheme under a Private Public Partnership	Social Franchising Model (PSI) SUN Quality Health Franchise Clinics
Strategic Engagement (mapping exercise)	Artemisinin Monotherapy (AMT) Replacement project (PSI)
Engagement with Corporate Social Responsibility Programs	

CSO Priorities for the future malaria programming (regional concept note)

1. **Integrated Community Based Management / Health Systems Strengthening**

   NGOs could expand the network of VMVs by-

   i. Direct hiring and management of Volunteers by NGOs,
   ii. NGO –supported VHVs who are recruited by public sector (as in Cambodia where MC provide support to VMVs)
   iii. Working through local CBOs/Ethnic Health partners (as in SMRU, CPI in Myanmar) or
   iv. Working in close the public sector facilities/MPs where NGOs could establish a MP and have the government BHS to supervise it (this is not tried in Malaria but in HIV in satellite sites).

   The last model could be suitable for Thailand since the government won't allow them to do testing and treatment.

   a) Village Malaria Workers and Village Health Workers
   b) Malaria Posts
   c) Role of Private Sector
   d) Case investigation/Follow up / DOT (day 28 follow up)
   e) Quality / coverage / package of services
   f) CSO can provide technical support to VMW/VHW (especially in remote areas) and to help ensure these services providers do not experience any stock outs.
   g) BCC / IEC

2. **Quality routine data and surveillance**

    i. We need real time reporting for VMW/VHW, monthly reporting is not adequate for response investigations / case investigation
    ii. MMP mapping
    iii. Genetic surveillance

3. **Expand services to neglected populations**

    i. Ethnic populations
    ii. MMP
    iii. Remote communities
    iv. IDP
    v. Plantation / farm workers / forest goers/mining/factories
    vi. Forest packages / survival packs

4. **Working with private providers and informal sectors to support quality testing, treatment and follow up**

    i. Monotherapy
    ii. Real time reporting

5. **Monitoring and Operational Research of community based interventions**

    i. Community based services
    ii. Assessing feasibility of NGO providing testing services in specific circumstances

6. **Capacity Building / Technical Assistance and Support**

7. **Targeted MSAT / Reactive Case Detection / MDA / Chemoprophylaxis / investigations of Hot Spots of infections**

    i. Community mobilization
    ii. Health education/information for MDA unique added value

8. **Cross border collaboration and information/data sharing**
    - Provincial level collaboration
    - Malaria CSO platform and activities at national and regional level securing financial resource in concept note

(Annex B- CSO Priorities detail)

Malaria platform working group meeting

CSO representatives from all 5 countries meet after the CSO consultation meeting to analyze the work and progress of the platform. All members showed the satisfactory progress with voluntary participation of CSO working group members and focal persons. Working group member agreed to re-visit member, structure and platform hosting arrangement in next CSO consultation meeting. CSO focal person in country also agreed to facilitate country consultation for new concept note development process.

Annex

ANNEX A- Lists of Participants

Regional Malaria Civil Society Organization (CSO) Consultation meeting
The Frangipani Living Arts Hotel & Spa
15, Street 123, Toul Tom Pong I, Khan Chamkarmon,
Phnom Penh, Cambodia
4-5 October 2016

No	Country	Organization	Focal person	Email	Position
1	Thailand	Raks Thai Foundation	Shreehari Acharya	Shree222shree@gmail.com	Program Officer
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3	Thailand	Raks Thai Foundation	Aonrutta Pornphatjinda	jindaphat2014@gmail.com	
4	Thailand	ARC International Thailand	Sai Ti	SaiTi@arcrelief.org	Program Manager
5	Thailand	ARC International Thailand	David	davidc@arcrelief.org	Country Director
6	Thailand	Malaria Consortium (regional)	Siddhi Aryal (Asia Technical Director)	s.aryal@malariaconsortium.org	Asia Director
7	Thailand	Shoklo Malaria Research Unit	Gilles DELMAS	gilles@shoklo-unit.com	Director
8	Myanmar	ARC International, Myanmar	Dr. Ye win	yew@arcrelief.org	Field Program Coordinator
9	Myanmar	Myanmar Health and Development Consortium (MHDC)	Sandii Lwin	slwin.mhdc@gmail.com	Manager Director
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Annex B- Key CSO Priorities and supportive activities

A more aggressive approach is necessary to eliminate falciparum rapidly, CSOs can play a key role to make this happen in diverse contexts and levels of transmission in the GMS & the role of CSOs can fit with governments' existing malaria elimination plans.

The first priority for elimination is still is early diagnosis and treatment with effective drugs and reliable reporting to identify where cases come from.

Most malaria is transmitted from clinical cases and these people are the source of de novo resistance. Early and complete treatment reduces transmission & also prevents cases becoming persistent subclinical infections

Areas where CSO may not always be able to take that lead, but can play an important role in supporting:

1. Expand VMW/VHW programme to reach the periphery (we need a region-wide response and important populations are not yet covered). Ways of doing this could include:
    a. Direct hiring and management of volunteers by CSO
    b. CSO supported Village Health Volunteers who are recruited by public sector
    c. Working with CSO / ethnic health partners
    d. CSO run Malaria Posts that are monitored by Public Health sector
2. Sustain and strengthen the VMW/VHW programme. CSO could support the programs through various mechanisms
    a. Managing payments where appropriate,
    b. Assisting to organize regular meetings and distribution of supplies
    c. Provide support to VMW/VHW in remote areas or who are working with groups not typically reached via the public health system (MMP, ethnic groups etc)
3. Expand role of VMWs into VHWs (especially fevers, 1st aid, diarrheal diseases, LRTI, support for other health campaigns and activities)
4. Extend malaria case management DOTs, follow up of every pf case to ensure treatment was successful
5. Improve data collection and surveillance (approaching elimination, the difference between indigenous and imported cases is crucial and determines the epidemiological significance and the response required)
    a. Close follow up and proximity from CSO to the most remote areas where data problems usually emerge, CSO can support finding missing data/improve data completeness if they work alongside and are alerted by the immediately upper layer of data management. For example, if CSO are routinely aware of VMW/HF whose reports/data is missing, they can complement the system function by addressing this gaps (with field visits to collect data)
6. Work with the private sector where they are present (ensure correct drugs are used and recording of cases, many areas still rely on treatment from the private sector).
7. CSO participation in replacement of ACTs with TACTs (& single low dose primaquine). There should be approaches such as learning by doing for the capacity development. In some GMS countries CSO are already involved in this process. This will provide others with an opportunity to learn from what already has been done, to understand the challenges and what tools are available to implement this as soon as possible.

Where there is effective case-based management (of course it does not have to be perfect) CSO could support NMCP with providing:

- Additional locally appropriate strategies which will depend on the type of population and level of transmission – “risk based packages of effective interventions”
- Essential to have the data to map and model at a high level of detail the level of risk, define population at risk, estimate value of more aggressive activities based on subclinical reservoir)
- Evaluation of MSAT with new ultra-sensitive RDTs needed. MSAT with microscopy or conventional RDT does not seem to work. There are still strong arguments for targeted MDA in some contexts e.g., epidemics, or where there is a proven pf reservoir and if MDA is practicable.
- CSO are well placed to support NMCP through community engagement and outreach activities. They are well connected and well placed to easily mobiles and engage communities to MSAT/MDA/FSAT activities that each country define in their strategies.

Simplified scenarios where CSOs could lead activities (some activities apply to several scenarios)

1. No local transmission but imported cases reported (chiefly rural areas that previously had malaria but no longer report indigenously acquired cases):
   - VMWs should become village health workers to keep the system functioning
   - EVERY case is VERY important - CSO could provide close monitoring in villages they work to identify and report each single case (whereas reporting is not immediate) and help in classifying the case, to distinguish between imported or locally transmitted case
   - IEC/BCC
2. Low transmission (occasional locally acquired cases but not enough to keep VMWs busy – most cases among specific risk groups):
   - Sustaining case management, surveillance (by ensuring Stocks of RDT/ACT at village level are available and by giving tools for real time reporting and follow up of cases at the lowest level of care provision.
   - VMWs should become village health workers to keep the system functioning
   - Reactive case detection of people with co-risk factors
   - IEC/BCC
   - All cases are VERY important
3. Intermediate transmission:
   - Targeted screening and treatment of high risk populations
   - Protective packages for high risk groups
   - Support MSAT in areas where there is local transmission (where NMCP deem this to be an appropriate response
   - IEC/BCC
4. High transmission:
   - MSAT
   - Targeted malaria elimination through mass drug administration (MDA). Need to agree which ACT (DHA-piperaquine failing in Cambodia, mefloquine not safe.)
   - IEC/BCC
5. Epidemic situations (depending on absolute risk)
   - MSAT with ultra-sensitive RDT
   - MDA (gets every infection whereas ultra-sensitive RDTs do not)
   - Post intervention surveillance
6. Hot spots and hot pops
   - MSAT with ultra-sensitive RDT
   - Chemoprophylaxis
7. MMP, ethnic groups and hard to reach populations
   - Additional services and education (BCC/IEC) and preventative measures in places where people stay, especially important for constituencies that are not well served by the public health system and/or do not like interventions that come from the government
8. Inter-country collaborations and operational research
   - Our collaborations should not just be limited to cross-border points. Treatment and follow-up services, IEC/BCC and surveillance activities need to extend beyond check points.
   - Sustained efforts needed for data sharing
   - Mapping: has to be set up / updated in order to follow up all determinants: places addressed, holes in the programs, dynamic resistance mapping
9. Vector-targeted measures
   - LLIN, IRS, impregnated clothing to be assessed.
   - Useful / efficient measures in GMS to be promoted - communicated.
   - Surveys to Follow-up species identification, HBR, SI...

Strategies that are NOT worth pursuing in MOST contexts (probably not cost-effective)

1. Focal screening and treatment using RDTs (detects very few infections & is a lot of work to do at scale)
2. Large budgets for bed nets in areas where saturation is already high (opportunity cost)
3. Reactive case detection based on focal approach in areas where infections are acquired outside of villages (similar to point 1. A waste of effort)
4. MDA in places where the community is not highly supportive (won't get good enough coverage and could lead to serious problems and complaints)
5. MDA in populations where infections are acquired outside of villages (waste of effort)
6. MSAT using conventional RDTs (misses almost all infections)

Annex C- Community Based interventions examples and reasoning's

Priorities from Thailand and Myanmar

Thailand
1- Malaria posts: the essential / core element.

Needs:

- 1 MP per basic administrative unit (village)
- Needs to be accessible at all times and to provide test and treat within 24h of fever onset.
- Worker(s) trained / refreshed every year
- System has to be sustainable. Can't rely on volunteers. MPS have to get enough to feed their family / send kids to school.
- MP has to be known and legitimate. Community engagement activities have to be carried out prior to all openings.
- Needs to transmit data every week (ad-hoc on line database, directly fed / fed through smartphone application, centrally located, accessible at all levels)
- Has to be constantly supplied with RDT / ACT / other support medicines
- Able to tackle simple non malaria ailments (children diarrhea, LRTI, with CRP tests...), small dressing activity, and know where to refer more complicated cases (these referral structures to be supported)
- Example: Karen State (Eastern Myanmar): METF Malaria posts 160$/m (direct + indirect) eq. 7$/person/year.

Data to be used to

- Make real time decision (information for action)
- Produce a monthly progress report

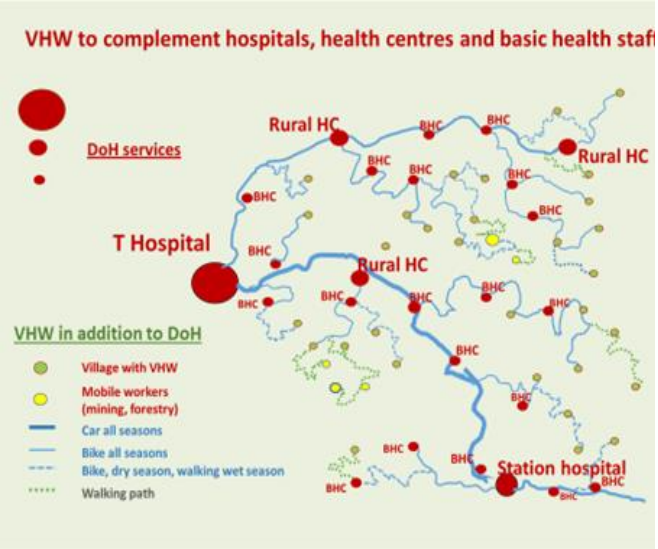
Myanmar
1. Why do we need VHWs.

In Myanmar 2/3rd of the population is rural. A large part of them are in remote, difficult to reach areas. This is mainly due to poor infrastructure.

Most malaria transmission is in these remote areas.

In these remote areas there are no government staff. And they will not go there, because it takes hours travel on a motorbike through the mud to reach the village.

The only people who want to stay in these remote villages are the villagers themselves. And therefore we have to train villagers to become Village Health Workers, to make a diagnosis and treatment.



2. How to support VHWs?

These VHWs usually have a very basic education level. Besides theoretical training, they need on-the-job training; seeing patients together with a qualified medical person. As every doctor knows; this is the way you learn how to recognize and deal with signs, symptoms and diseases.

Some NGO's go to the remote villages and do on-the-job training. MAM does.

Other NGO's ask the VHWs to come to a central town/main village and discuss the project activities there. These VHWs have no on-the-job training.

The DoH projects ask VHWs to come to the main towns (the capital of the township). Also no on-the-job training.

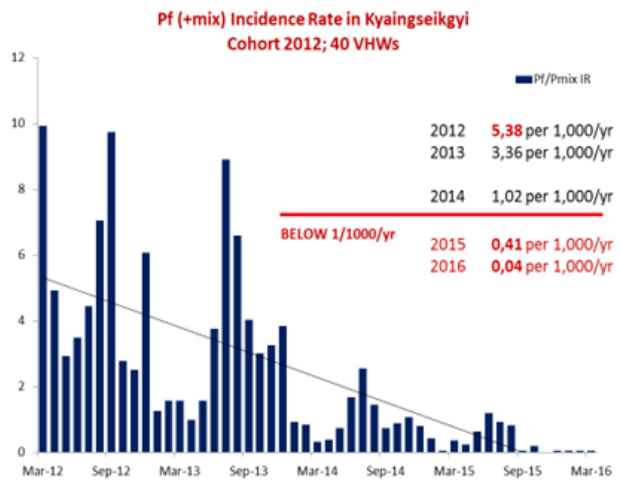
3. What package of services should be provided by the VHWs

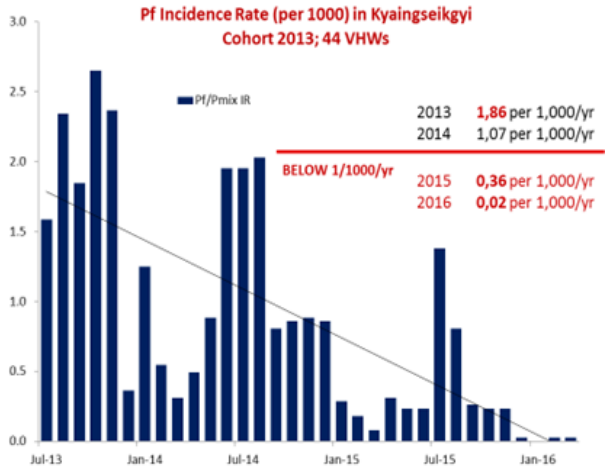
After introduction of a VHW, malaria is going down sharply.

As a result most patients with fever have no malaria but another disease. IF the VHWs are only addressing malaria, then patients will be frustrated and the uptake of VHWs will go down.

And, as it takes hours of travel by motorbike through the mud, sick people are usually not going to the government health facilities. They don't have means of transport and can't afford to rent a motorbike. They usually go to quacks who provide uncontrolled treatment, usually including one or more antibiotics (oral, IM or IV).

To help people in remote areas the VHW should be able to provide a simple basic health care package (diarrhea, pneumonia, malnutrition, skin infections and others) + TB active case detection & referral + a referral service for severely sick patients.





MAM started this in 2012. This is the first time that these people have access to trained basic health. It is a major improvement for their health situation.

Also for this package of services, on-the-job training is essential.

In addition:

- The Global Fund is expecting service providers/implementers to reduce its unit cost which turns out to be extremely challenging if we ought to target communities in remote/hard to reach villages. Although MAM has extremely low overheads/office cost, sending medical teams to train, support, monitor and supervise VHWs on-the-job is expensive but crucial to ensure high quality of care and program success. To reduce our unit cost even further, MAM is considering new ways to monitor VHWs without having a negative impact on the project outcome, though this would require less site monitoring visits and supervision, which may be difficult.
- Integrated care including basic Health care (to provide minimum care to those with fever and RDT negative) which can facilitate RDT uptake, improve perception of VHW by the community, improve relationships between VHW and clients, motivate VHWs with added responsibilities. VHW motivation is not solely based on incentives but on responsibilities, support and recognition. At MAM, our VHWs also screen patients for TB based on clinical symptoms and refer suspected cases to our mobile medical team prior to being sent for lab investigations
- Keep integrated care provision free of charge

Engagement with Private Sector

Multiple studies have shown that the private sector is a major source of health care in Myanmar. Multiple factors contribute to this including the country being under the military government with extremely low health expenditure per capita and high out of pocket expenditure, many regions especially those where ethnic minorities live affected by armed conflicts over many decades, and the coverage of the public health facilities is low due to understaffed or low availability of public health facilities. However, the quality of care provided by the private sector varies and is a major concern especially with regard to the provision of sub-optimal antimalarial drugs and poor malaria case management. According to the supply chain assessment study conducted by PSI, the most commonly used treatment for malaria cases is presumptive

treatment with one or two tablets of oral artemisinin monotherapy which is believed to be one of the major drivers of drug resistance problem. It is against this background that PSI, through the support from DFID, Gates and RAI, has implemented the Artemisinin monotherapy replacement project (AMTR) starting from 2012. Under the AMTR project, PSI partners with leading private-sector pharmaceutical distributors to distribute highly-subsidized quality-assured artemisinin combination therapy (QAACT) into the private sector to rapidly replace oral artemisinin-based monotherapy (oAMT). This was supported by intensive provider behavior change (BCC) communication activity carried out by PSI field staffs among informal private sector antimalarial outlets in the Eastern border of Myanmar. PSI field staffs mapped all antimalarial stocking/selling outlets in the project townships, and carried out one-to-one BCC session using medical detailing approach, a) discourage the outlets from stocking oAMT, b) encourage them to stock/sell QAACT, and c) encourage them to sell/prescribe full course (not to cut the blisters). In 3 years, a total of 16,000 outlets has been reached and visited by PSI field staffs for BCC, and thus are now stocking QAACT.

In order to monitor and measure the changes in private sector antimalarial market, PSI carried out annual antimalarial drug outlet survey adopting ACTwatch methodology. In just two years, it was found that the proportion of private sector outlets stocking oAMT has decreased significantly from 66.9% in 2012 to approx. 10.3 % in 2014, and the proportion of outlets stocking QAACT has increased from 4.2% in 2012 to 79.4% in 2014. However, in 2015, PSI has found a resurgence of oAMT back to 27% at national level with even a higher availability in the western north border (>50%) where there is no provider BCC activities by AMTR project (Fig 1, Fig 2 and Figure 3). There are multiple reasons behind this resurgence, including weak regulation, and frequent stock out of QA ACT.

Figure 1: Availability of QAACT (2012-2015)

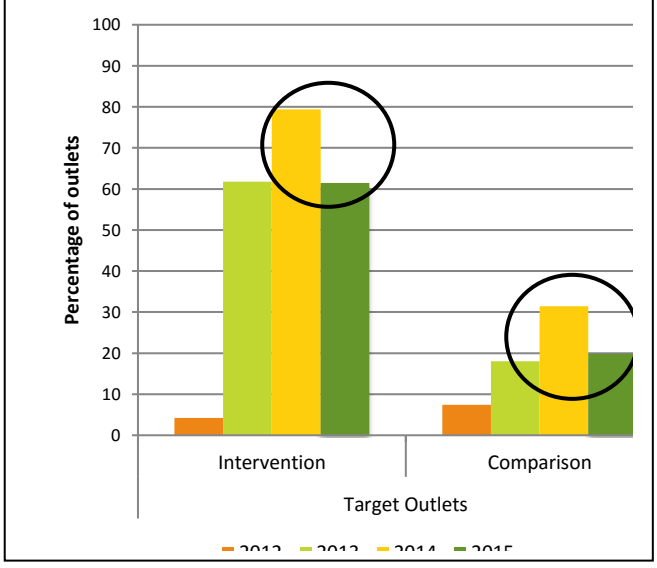


Figure 2: Availability of oAMT (2012-2015)

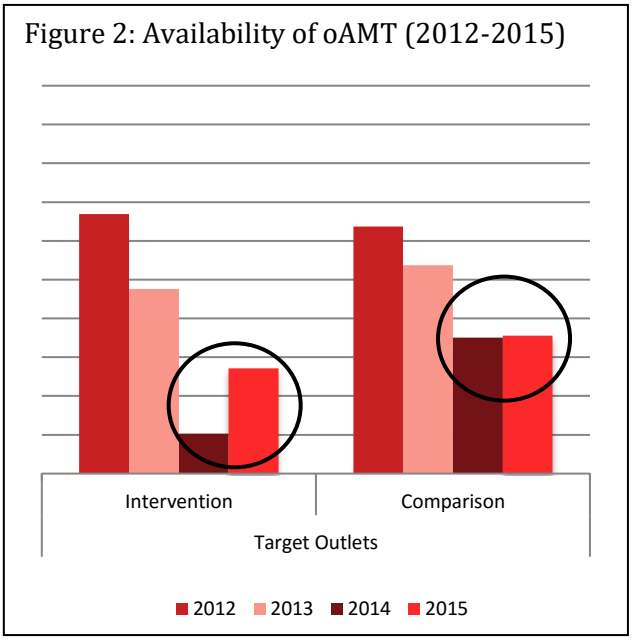


Figure 3: Availability of QAACT and oral artemisinin monotherapy, by domain (2015)