CSO platform in Melbourne for the 1st World Malaria Congress: 1st – 5th July 2018

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The role volunteers to support malarai elination in Thailand

Raks Thai Foundation has implemented a number of initiatives aimed at engaging and empowering communities to take control of their health outcomes. In 2016, 12 volunteers in provinces bordering Cambodia and Laos facilitated 2,918 tests within their respective communities and at border crossings, with a 2% confirmed-positive rate. These volunteers also conducted health education sessions on basic transmission and prevention, and distributed long-lasting insecticidal nets.

***Alistair Shaw**, Senior Programme officer, Raks Thai Foundation*

As Thailand entered the elimination phase, case detection became more difficult; requiring health workers to think creatively and prioritize populations most at-risk. The majority of remaining cases have shifted to migrant and mobile populations (MMP), particularly forest-goers. Although Thailand provides free testing and treatment, remote locations, a health workforce not sensitive to varying needs or languages, and a fear of deportation for undocumented migrants, often prevents MMPs from accessing health services.

Raks Thai continues to implement community and worksite-based activities, but is also prioritizing forest and border areas that contain Thailand's highest malaria incidence and see large number of migrants utilizing irregular migration pathways.

We are scaling-up our volunteer network by recruiting additional migrant volunteers from within forest-goer populations who are key to building trust, and ideal candidates to model positive health behaviors. Border areas that contain Thailand's highest malaria incidence and see large numbers of migrants utilizing irregular migration pathways.

These volunteers are trained using a comprehensive toolkit including modules on transmission, prevention, intensified case finding, behavioral change communication, and treatment. Equipped with checklists, IEC materials and LLIHNs, volunteers are incentivized to conduct health education sessions, facilitate testing of over 4000 suspected cases per year, and subsequently manage confirmed-positive cases throughout treatment according to national guidelines.

By engaging migrant volunteers from within MMPs most at-risk, particularly forest-goers, our activities build on their pre-existing knowledge of population movements, health literacy and health behaviors; reducing barriers to delivering health services and maximizing our contribution to malaria elimination in Thailand, and the Greater Mekong Sub region.

THE PROCESS OF OPTIMIZING THE ROLES OF INTEGRATED COMMUNITY MALARIA VOLUNTEERS (ICMVS) IN MALARIA ELIMINATION; MYANMAR EXPERIENCE

Htin Kyaw Thu, Program manager (Malaria),
Save the Children, Myanmar

Htin Kyaw Thu, *Program manager (Malaria),*
Save the children, Myanmar

Background: In Myanmar, malaria volunteers have played a vital role in stable reduction of confirmed malaria cases since 2012. In 2017, 78% of all confirmed malaria cases (n=76,770) were detected by over 15,000 trained community malaria volunteers. Volunteers have important role in service delivery and surveillance, especially in hard-to-reach areas where malaria cases in Myanmar are now most concentrated. As disease burden declines, maintaining volunteer motivation and relevance is vital to reach elimination. This session will focus on Myanmar's experience in optimizing the roles of community malaria volunteers in the elimination setting.

The Process: As Myanmar moves towards elimination, malaria volunteers will continue their vital work providing diagnostic and treatment services, and distributing bed nets in hard-to-reach communities to promote universal access. In keeping with the National Malaria Elimination Plan, elimination activities will be implemented in low malaria transmission areas with manageable caseloads (less than 1 case per 1,000 populations). Volunteers deployed in these areas notify local authorities of confirmed malaria cases within 24 hours, triggering a cascade of surveillance activities.

Given the vast geographic setting in Myanmar, user-friendly mobile applications are now being tested to get the real-time, case-based notification from volunteers. With proper training, supervision, and simplified tools, volunteers assist civil society organizations in case investigation, thus reducing the National Malaria Control Program's workload, and helping address logistical, cultural, and resource barriers to go to the villages and investigate every notified case. Volunteer-facilitated Information can help the national program make timely decisions to interrupt transmission. To ensure long-term relevance, in addition to routine malaria services, volunteer services were expanded to include community mobilization, case finding and referral for common infectious diseases in the communities (tuberculosis, HIV, dengue, filariasis, and leprosy). By doing so, volunteers act as catalysts in malaria elimination and potentially other major infectious diseases, producing wider investment impact.

Challenges:

Though these initiatives are expected to sustain volunteer motivation and build resilient community systems beyond the malaria elimination agenda, important challenges remain. Myanmar must manage limited financing beyond donor grants, complex coordination between public, private and community systems (both in-country and across the GMS region), and external factors such as armed conflicts to ensure successful implementation.

Reaching the most marginalised

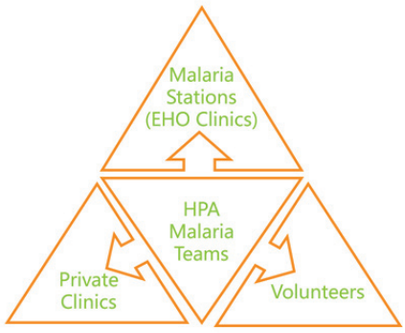
Xianxian Lin, Health Poverty Action

Health Poverty Action (HPA), a British based NGO, has been working in the ethnic communities of Myanmar along the China-Myanmar border since 1994. These areas are mostly under the control of Ethnic Non-State Actors (NSAs), where the national health system of Myanmar is almost absent due to decades of political tension and armed conflict and NSAs run a very basic health system themselves. For many years, there was hardly any communication between the two systems, let alone collaboration.

HPA has started its first malaria program on Myanmar side of the border since 2007 supported by GF China. Instead of having a group of doctors directly provide malaria services, HPA chose to work with the local human resources and help to strengthen their own health systems. HPA supports 119 clinics of the NSAs, 90 private clinics, and 652 community and migrant volunteers to provide free malaria diagnosis and treatment. From 2007 to 2013, parasite rate in these areas dramatically reduced from 13.6% to 0.43%. On China side, the imported cases declined from 1832 cases in 2009 to 441 in 2014.

Xianxian Lin, *Health Poverty Action*

Up to now, there is growing interaction between the national health system (NMCP) and health authorities of NSAs in terms of coordination and planning, supervision and monitoring, etc. This malaria program has thus served as the bridge to peace.



In 2014, HPA transferred its malaria program from GF China to GF Myanmar and started to work with the NMCP of Myanmar. With the support from both NMCP and health authorities of NSAs, HPA facilitated the change of treatment guideline and protocols of all service providers to be in line with Myanmar national one by translating all into ethnic languages and supporting NMCP staff to provide training to ethnic health staff. Meanwhile, HPA adapted malaria reporting system to align national HMIS. It's the first time for NMCP to receive malaria data from NSA areas, which enables NMCP to map malaria incidence in these areas in National Malaria Strategic Plan 2016-2020.

Meeting needs of ethnic populations "Health as a bridge for Peace"

Thet Myo Tun, Project Manager, American Refugee Committee, Myanmar

American Refugee Committee's (ARC) is an international non-governmental organization with over 30 years of relief and development experience in complex operational contexts in Africa, Asia and Eastern Europe.

ARC is implementing Regional Artemisinin Resistance Initiative (RAI) project in Myanmar from 2014 to 2017 with collaborative activity with the Myanmar Ministry of Health and Sports, the National Malaria Control Programme (NMCP), and the Ethnic Health Organizations (EHOs), Karen Department of Health and Welfare (KDHW) and the Mon National Health Committee (MNHC).

This project aim to contribute to the elimination of P. falciparum Malaria in Myanmar and the Greater Mekong Sub region (GMS), and to the prevention of the emergence or spread of Artemisinin resistance to new areas. ARC focus on hard-to-reach and transient populations in Southeast (SE) Myanmar of Mon, Karen, Tanintharyi and Bago East, including ethnic minority and mobile migrant populations. Priority was given to areas most at-risk of Artemisinin resistance in identified Tier 1 areas with credible evidence of Artemisinin resistance and Tier 2 areas with significant inflow of people from Tier 1 areas, including those immediately bordering Tier 1.

Thet Myo Tun, *Project Manager, American Refugee Committee (ARC)*

The programmatic context in cease fire areas of SE Myanmar is particularly unique KDHW, MNHC played a critical role in accessing difficult to reach populations

ARC's RAI project was designed to strengthen community base health system through partnership with ethnic health partners. The joint programme implementation was delicate and need trust, however; this could be bridge for peace and could avoid misunderstanding between state and non-state actors. In this approach, ARC is bridging EHP, government and donor in coordinated response to Malaria through community volunteer to the ultimate goal of access to the sustainable health system for the hard to reach population. With the support from RAI programme, ARC developed capacity of community Malaria volunteer for case management and prevention as well as reporting and monitoring of Malaria data and trend. Furthermore, ARC supported health facility with equipment, training for Malaria National Treatment Guideline, infrastructure for health facility and Lab, and microscopist training.

There are total 337 community malaria volunteers, 43 health facilities, 19 border malaria posts which covered 335 villages and worksites, 19 border crossing points along Thai-Myanmar border, 18,880 household, 110,940 population.

More than 90% achievement for all performance indicator from 2014 to 2017. With the effort of ARC RAI Malaria programme, the number of Malaria cases in the project area reduced significantly. Malaria prevalence is decreasing in the project villages and overall decrease in Malaria Positivity Rate (MPR) from 20% in 2014 (test total -13,250, positive total - 2,690) to consistently below 3% in 2016 (test total - 53,754, positive total - 1,460) and 2017 (test total - 56,290 , positive total - 1,148). From 2014 to 2017, 91.69% of total positive cases (7,017 cases out of 7,653 cases) received the treatment accordingly with National treatment guideline. There will be opportunity for ARC and NMCP to go forward to "Malaria Elimination" in the near future.

The effectiveness and efficiency of project through community base volunteer has huge impact upon the prevention and control of Malaria in EHP area. However, project modification recommended for decreasing Malaria prevalence as a result of four year project and continued efficient use of volunteer resources by integration of other basic health care services such as awareness raising and referral of other vector borne diseases, Dengue, Filariasis, and referral of TB, HIV, and Leprosy to maintain volunteers' motivation, and improve experiences for health volunteering. And need to provide training as well as necessary support to volunteers such as material (medicines, health equipment, health IEC and promotional materials), and supervision and reporting.

One size does not fit all: A Tailored Approach to Diverse Plantation Worker Preferences

Lorina McAdam, Population Service International (PSI)

The Royal Government of Cambodia aims to eliminate malaria by 2025, with many remaining cases in forested areas - home to many plantations and other agricultural businesses. In 2013, Population Services International (PSI) launched a program to provide malaria services to workers employed on private plantations, which typically include mobile and migrant populations (MMPs) – a group that is considered both more at risk, and harder to reach. Plantation workers are not only more at-risk due to the location and timing of their work, but many cases remain undiagnosed due to their mobility, lack of access to appropriate services, and sometimes their own lack of knowledge. Thus, the program brings malaria testing and treatment services to the plantations by training selected plantation staff as Mobile Malaria Workers (MMWs). MMWs are trained on national treatment guidelines, including conducting RDTs in accordance with global standards, and are required to report testing and cases to PSI for sharing with the NMCP.

2017 data show that private providers not only tested more people, but detected 16 times more malaria positive cases among people who identified themselves as forest goers than MMWs, and twice as many plantation workers. Geo-locating the point of diagnosis for malaria cases revealed a higher utilization of private providers, even in instances where plantations with MMW services were only 3 km away. The 600 private providers supported by PSI conducted 153,800 malaria tests and confirmed 28,850 positive cases in 2017 – representing higher absolute numbers, but also higher testing and positivity rates per outlet. This indicates that some plantation workers prefer to see offsite private providers, even though onsite services are available.

Emerging evidence suggests that not everyone on plantations is at-risk of malaria and targeting those most at risk is an iterative and complex process that requires significant input from the risk group themselves to understand the social norms, movement patterns and health seeking preferences of a heterogeneous group that is often targeted as a homogenous one. PSI is now developing participatory community engagement methods to co-create new interventions to reach those most in need.

Lorina McAdam, PSI

By the end of 2017, PSI supported 24 MMWs on 161 plantations who conducted 18,500 malaria tests and confirmed 1,280 positive cases – representing approximately 4% of the 30.145 cases reported by the private sector networks supported by PSI. In 2017, cases reported by private providers supported by PSI constituted 40% of the official national caseload.

Despite the availability of services, ptake was initially slow. A mix of qualitative methods and analysis of quantitative program data was used to: i) identify barriers to using MMW services, ii) generate insights into beneficiaries' preferences in relation to malaria case management, and iii) identify strategies to increase access to quality malaria case management amongst those most at risk of malaria. Human Centered Design methods, including beneficiary journey mapping, behavioral trials, ideation, and rapid prototyping of intervention options, were used to learn and to co-design potential interventions with plantation workers. This process revealed a preference for access to a wider range of services than malaria alone and also highlighted that the availability of MMWs was limited as they were also full time plantation workers. From the workers' perspective, it would be more time efficient to go to a shopkeeper who would be consistently available and could cater to a wider range of medical and non-medical needs. In addition to now stratifying worksite and the services provided based on need, PSI is exploring ideas such as these with CNM and the at-risk communities to continue.

Mobile malaria services reaching border crossers, ethnic communities and forest goers in North East Cambodia

Kylie Mannion, Project Manager, Malaria Consortium, Cambodia

Kylie Mannion, *Project Manager, Malaria Consortium, Cambodia*

As growing evidences are suggesting that malaria transmission is happening mostly in forested areas Malaria Consortium (MC) is working with the National Program to deploy community services to reach forest-goers in some of the most endemic areas in the region.

MC has been working with mobile and migrant groups in the North East of Cambodia since 2013. Initial activities focused on quantifying Plasmodium infection among border-crossing population and mapping mobility patterns (Edwards HM, 2015). This study identified the borders that have the highest number of individuals passing by harboring Plasmodium parasites, risk factors amongst border crossers and the importance of operating targeting mobile services, such as malaria posts at border crossings. Informed from this research MC designed a program that specifically addresses the needs of this remote and mobile group who are frequently accessing the forest and crossing borders in Laos and Vietnam. This program has been operating since 2015 and to date more than 27,000 MMP have been tested and 4000 treated for malaria.

Border populations and MMPs in this area are at high risk of malaria infection due to their itinerant lifestyles, difficulty in reaching them for diagnostic, treatment and preventive interventions, and occupational and behavioral factors that bring them in close contact to the forest. Due to difficulty in access, populations in remote forested regions rely on local community health volunteers for many health care services.

Mobile Malaria Workers (MMW) are critical in ensuring MMP are able to access malaria services. MC is working with the National Center for Parasitology, Entomology and Malaria Control (CNM), Provincial Health Departments and Health Centers to support a network of 50 MMW who are working in Stung Treng, Ratanakiri and Preah Vihear provinces.

This network of MMW is playing three important roles in assisting the national efforts to eliminate malaria. Once trained by HC staff in accordance with the national guidelines MMW are deployed to malaria posts or on outreach assignments. From these points MMW can easily reach forest goers and border crossers. This has made a significant improvement to the early testing and treatment rates amongst the target population. MMW are also contributing to surveillance efforts. They report Case Management data directly into the national Malaria Information System which is bringing to light the high burden in these communities and improving the provision of testing and treatment stocks in remote areas. The final component of their work includes promotion of preventive measures including distribution of hammock and hammock nets to MMP and ensuring that people living near or going to the forest understand the measures they can take to reduce the risk of infection. The MMW network is operating 7 days per week and working at times that ensures these services are easily accessible to people who need them most.

MMW also support the program to better understand and respond to the needs of forest-goers, border crossers and other mobile groups in the area. Typically MMW are recruited from these groups ensuring there is trust between the program and the target populations and their knowledge of mobility patterns informs where and when to best place mobile services.

The Role of Community-Based Health Workers in Providing Health Services to Hard-to-Reach Populations in the Southern Provinces of Laos Towards Achieving the National Goal of Eliminating Malaria by 2030

Ronaldo Estera, *Country Director, Health Poverty Action, Lao PDR*

Lao PDR set a goal to eliminateall forms of malaria by 2030 in a phased approach.It set specific strategic interventions for each phase zones –northern, central and southern provinces -as outlined in the National Strategic Plan for Malaria Control and Elimination. By 2020, Laos aims to reduce the incidence of P.fmalaria to less than5 cases per 1,000 population in the southern provinces and reduce the incidence of indigenous cases of PVmalaria to less than 1 case per 1,000 population in the Northern provinces. It also aims to prevent the reintroduction of malaria transmission in areas where it has been interrupted.

Health Poverty Action (HPA) in Laos has been supporting the government through the Centre for Malariology, Parasitology and Entomology (CMPE) in implementing the national malaria program since 2014. With funding from The Global Fund, HPA has implementedthe Regional Artemisinin Resistance Initiative (RAI) in the provinces of Attapeu, Champasak and Sekong in the southern parts of Laos where 95% of the malaria cases is found. HPA's work targets hard-to-reach populations that include forest-goers, ethnic minority groups located in remote villages and border areas and mobile and migrant populations who are forest and plantation workers, seasonal agricultural workers in farms and laborers in new development project sites that include road constructions, dams and mines. Reaching these hard-to-reach populations remains a big challenge in the effort to control the spread of resistant malaria parasites and eventually to eliminateall forms of malaria in Laos and in the Greater Mekong Sub-region (GMS). These populations face different barriers to accessing malaria services,which include distance to health service facilities, coverage and quality of services, language, beliefs and cultural differences and economic constraints.

Mindful of the above constraints, HPA worked with close to 1,000 community-based health workers in remote villages and border areas who were trained as village malaria workers, malaria post volunteers and development project site volunteers. They were trained on their role and responsibilities and to do awareness campaigns and health education; assist in the distribution of long-lasting insecticide treated nets (LLINs); properly identify malaria signs and symptoms; to conduct testing of all suspected malaria cases using rapid diagnostic test (RDT) kits and to provide artemisinin-containing therapy (ACT) antimalarial treatment of confirmed cases according to the national treatment policy and guideline; refer all severe and plasmodium vivax (Pf) cases to district hospitals; record and report all malaria cases using the standard epidemiology forms; identify and provide treatment to mobile and migrant populations who seek their services; manage forest survival kits; and report stock level of malaria commodities.

The experience of HPA in training, supporting and working with community-based health workers indicates that they can effectively contribute to as high as 50% of the total tests conducted for all suspected malaria cases[1] and 64% of the total positive malaria cases detected and provided treatment[2] in the 3 provinces in the southern part of Laos. From 2014 until 2017, the trained community-based health workers conducted a total of 106,313 tests of suspected malaria cases, which accounts for 26% of all the tests conducted in the 3 provinces during the period. They provided treatment to 23,111 malaria positive cases, which accounts for 36% of all positive cases that were detected and provided treatment in the 3 provinces during the same period. Their work helped reduce the total positive cases in the 3 provinces from as high as 24% in 2014 to as low as 8% in 2017. The records indicated that 97% of those who accessed the services of the trained community-based health workers are Lao, of which 31% identified their ethnic affiliation, while 3% are non-Lao who are mostly Khmer or Cambodian, Vietnamese, Chinese and a French national. There are 27 different ethnic minority groups, mostly along the border areas, who accessed their services. The top 10 largest ethnic minority groups are the Bru, Alak, Yalu, Oi, Taliang, Katu, Sou, Laven, Lave and Ta-oi.

HPA's experience also brings to the fore valuable lessons of what works and does not work that can be considered in future work. Positive results were achieved because of the collective effort of the community-based health workers and volunteers and the strong support of village authorities, health center staff and the district project staff and government partners in mobilizing communities and ensuring their active participation. The information and education campaigns were targeted and communications were focused on changing behavior. Materials were translated in at least 4 major languages (Lao, Khmer, Vietnamese and Chinese) and the face-to-face interactions were in the local ethnic languages, when necessary and possible. HPA staff, together with the district and provincial partners, provided supportive supervision, monitoring and support on a monthly and quarterly basis. HPA conducted formative assessments and studies to better understand movements, trends and patterns among mobile and migrant populations. Attention and support was also given to military troops deployed in the remote border areas by training 74 military nurses and providing the military troops with information materials and forest survival kits that they can use to diagnose and treat malaria. HPA initiated an annual recognition of community-based health workers and health center staff to highlight and recognize their valuable contributions and to celebrate together what has been achieved.

What did not work well is that the capacity building support for community case management was limited to test, treat and track malaria cases. The hard-to-reach and vulnerable population and ethnic minority groups access the services of trained community-based health workers when they are sick because they speak their language and trust them. However, if their illness is not related to malaria, the community health worker is unable to provide further advice and help. Consequently, this breaks the trust and confidence of people to access the services of community-based health workers in the future. This could undermine the effort towards malaria elimination. As the reduction in malaria cases continues, it is important that the current role and responsibilities of community-based health workers also evolve including the support that needs to be provided. Awareness raising, health education and malaria screening in formal international border crossings, bus stations and through mobile vendors were not effective and efficient. Stock management at village, health center and district levels can also be improved to avoid stock out of health commodities.

[1]Based on 2015 case management data

[2]Based on 2016 case management data

Contribution of Myanmar's Non-formal Private Sector to Malaria Elimination Efforts

M. James Eliades, *MD, MPH, Population Service International (PSI)*

Non-formal private providers can make significant contributions to achieving malaria elimination. In countries where a high proportion of people seek care from these providers, elimination is unlikely without their direct engagement to test, treat, and report. In Myanmar, 50% of people seek care for fever in private sector outlets, both formal and non-formal (2016 household survey). The National Malaria Control Program (NMCP) in Myanmar is supportive of malaria testing and treatment by non-formal providers, including trained health providers, itinerant drug vendors, medical drug retailers, and general retail stores. PSI Myanmar has worked with non-formal providers since 2012 in up to 126 townships nationwide to replace oral artemisinin monotherapies (oAMT) with quality assured artemisinin-combination therapy (QAACT) by working directly with distributers, and ensure quality case management and reporting through training, provision of RDTs, and performance-based supervision.

Among non-formal providers between 2012-2016, the availability of oAMTs decreased from 67% to 20%, while the availability of QAACTs increased from 4% to 50%. Quality of case management was measured through supervision visits and mystery client surveys. Of 4,266 providers receiving a supervisory visit in 2017, 66% scored above 80% on correct tasks performed, with only 8% scoring below 50%. During mystery client surveys in 2017, 91% of providers appropriately described or demonstrated using RDTs, and 97% adhered to negative test results. Of 12,618 outlets active at any point in 2017, 11,248 (89%) reported case data.

Non-formal providers are often considered a liability in malaria elimination efforts because of diversity of skills and knowledge, difficulty in enforcing regulations, and lack of an organizational structure similar to the public sector. Yet the Myanmar NMCP with support from PSI have demonstrated that non-formal providers can accelerate elimination efforts through engagement to provide quality case management and report cases. Challenges however, do exist, and support must be consistent.

Building skills and buy-in from such a large, diverse sector requires an effort that governments alone may not be able or willing to expend. As caseloads drop, it's unclear how social and behavior change strategies and incentive schemes need to change to keep providers engaged. Funding shortages have led to a significant decrease in the number of providers supported in 2018. This runs the risk of erosion of skills, as well as a resurgence of oAMTs into the market. PSI, in addition to continuing to provide support to providers in the network, will work with the NMCP to identify activities that are realistic to transition to be government-led, and will continue to advocate for engagement of non-formal providers as reliable partners in malaria elimination. These efforts can be used as a model for other countries wishing to accelerate elimination efforts.

Migrant Health Volunteers engagement in malaria elimination, Thailand

Sai Ti, *Project Manager, American Refugee Committee, Thailand*

Migrant Health volunteers play a critical role not only in malaria elimination but in other health burdens as well. Their contribution is enormous and unmeasurable. They are locally based, knowledgeable about culture and social norms, and able to address and respond to the problems in prompt and effective manners. These volunteers are frontline workers to tackle the needs and gaps of mobile migrant populations by bridging government agencies and Civil Society Organizations.

As mentioned in Thailand National Malaria Elimination Strategy 2017- 26, it encourages again the collaboration and resources mobilization with and among various community level stakeholders – public and private sectors – to achieve malaria elimination agenda by 2024.

The current Regional Artemisinin Resistance Initiative 2 – Elimination also emphasizes community participation, resources mobilization/integration and volunteers' empowerment. One of the major responsibilities of Civil Society Organizations is to complement National Malaria Elimination Plan by collaborating closely with government agencies concerned. Challenges still persist though.

Challenges:

1. Political commitment

a. The support and friendly policies toward migrants are required to maintain a sound implementation in all levels. On the other hand, CSOs still encounter challenges when trying to have better coordination with relevant stakeholders in village level for responding malaria elimination agenda.

b. The sensitization of malaria issues for integrating into local government's agenda

   i. Working with migrants has to coordinate with several law enforcement units - such as police and military, and local authorities such as Sub-district Administration Organization as well as business sectors.
   ii. Promoting and empowering communities in taking care of themselves and increasing ownership responsibility.

2. Malaria versus other health burdens

a. The integration of malaria with other health services in community level is still challenging given that malaria cases are in downward trend since the past few years

3. Supporting of and empowerment to Migrant Health Volunteers

a. Migrant Health Volunteers are to be trained for engaging more with local health institutions, non-health agencies and community stakeholders. More resources are needed to implement for supporting the government prepare the readiness of community initiated responses after this project completes.

Challenges

Mobile populations pose additional challenges to countries that are often already struggling to cope with day-to-day demands on their health-care systems. Mobile and Migrants also encounter obstacles to accessing basic health care services, as the provision of health services is contingent on their legal and administrative status. Eligibility and capacity to purchase migrant health insurance is a big issue for the migrants working without a legal document, with very low wages and living with families.

There is great variability in the capacity of health-care systems in the region to address migrant health. Thailand has demonstrated good capacity in this regard and has signed a MoU with Cambodia, Myanmar and Lao People's Democratic Republic, providing support for health service access to migrants. However, discrimination, fear of arrest, and language is being biggest challenges to migrant population in accessing services in the region. Currently the Global fund is supporting with free malaria service in high risk areas, sustainability of this investment with regards to mobile and migrant population is a concerned as Malaria is getting down.

Overview of mobility and access to universal health

Shreehari Acharya, *Project Manager, American Refugee Thailand*

The advent of ASEAN Economic Community has increased cross-border mobility between different countries in the Greater Mekong Sub-region (GMS), which poses serious threats to malaria elimination in the region. Thailand is one of the most viable destinations for labour migrants from the neighboring countries. It is estimated that Thailand hosts nearly four million migrants from Myanmar, Laos and Cambodia, with around 80% of them coming from Myanmar. Financial hardships and search for better job employment opportunities is a key driver of migration in the GMS.

In Thailand, most of the mobility with malaria risk is happening along the border with its neighboring countries. Myanmar, Cambodia, and Laos have a large number of internal seasonal migrant in addition to cross-border migration. Seasonal mobility for the forest and farm work farm work has put people to the high risk of Malaria along and across the border. Large number of an ethnic community in Myanmar and Vietnam are still living in malaria risk area with limited service access. In general, most of the mobile and migrant workers in the GMS work in the farm, forest, mining, construction and plantation and they are highly at risk of Malaria.

Malaria is a disease, which not only has the pathological causes; it bears the cultural, social, economic, and geographical significance too. The underestimation of malaria might lead to re-emergence of malaria in the eliminated areas. Hence, human mobility is the important factor for elimination agenda. GMS has the target of malaria elimination within 2030 collectively, with the strategy of reducing malaria in all high transmission areas and prevent the reintroduction of malaria in areas where it has been interrupted. Moreover, it works to eliminate malaria in areas with multidrug resistance, including ACT resistance.


2018
Engaging and Sustaining Community involvement: Identifying, mobilising, influencing and supporting community involvement in malaria control/elimination
10:30AM – 12:30PM
Chair: Prof Lenore Manderson, Monash University
Presentations followed by Q&A
10:30AM
Dr Oanh Khuat Thi Hai, Center for Supporting Community Development Initiatives
CSS Overview and how it is critical to effective malaria responses
10:45AM
Maurice Odindo, Kenya NGO Alliance Against Malaria (KENAAM)
Importance of, and challenges around sustaining and scaling up work of village health workers
11:00AM
Shreehari Acharya, American Refugee Committee
Financing CSS: Case of Global Fund funding of Malaria CS Platform work under RAGE
11:15AM
Kate Thomsen, The Global Fund to Fight AIDS, Tuberculosis and Malaria
Malaria Matchbox as a tool for ensuring community, rights and gender programming in malaria responses
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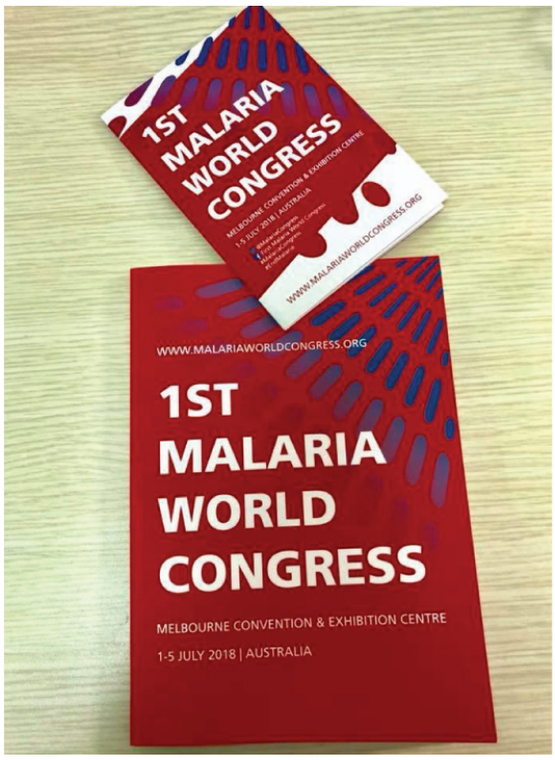
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