Malaria CSO Platform, GMS

Field visit Report Binh Phuoc Province, Vietnam

27-30 January 2019

Malaria CSO platform, learning visit in Binh Phuoc Province, Vietnam

In partnership with PSI Vietnam and SCDI, American Refugee Committee organized RAI2E malaria implementing site visit in Bu Gia Map district and Bu Dang district of Binh Phuoc province during 27-30 January 2019. The province is the highest malaria burden province of Vietnam (70% of reported cases) and one of 4 high burden provinces of Vietnam. The team visited the site where PSI is providing service to the community working with Community Malaria Champions, private clinics, and pharmacies. SCDI has created a team of volunteer called Community Malaria Action Team (CMAT) who are working closely with community and commune health center to provide malaria service. RAI RSC CSO representative Louis Da Gama, platform Thailand Focal Person Alistair Shaw, and CSO Platform secretariat Shreehari Acharya participated the visit. The team has arrived in Dong Xoai Town, Binh Phuoc on 27th January and left on 30th January.

Objectives:

1. To interact with government partners and health service providers, community people, village malaria workers, and volunteers, community leaders, and malaria at-risk population to get field updates on malaria situation and identify the successes, and challenges of RAI2E implementation at the community level.
2. To document evidence of successes and challenges in RAI2E implementation in order to improve services.

28th January 2019

Meeting with government officers at the CDC office in Bin Phuoc province,

In the morning of Monday 28th January 2019, the team met Deputy director of Communicable Disease Center (CDC) and representative of provincial malaria unit (also known as Project Management Unit) to inform about the visit and its objectives. This was an opportunity to meet with provincial government staff to gain an understanding of the malaria situation and expectations during the visit.

According to an update from the meeting at the CDC, the population of Binh Phuoc province is approximately 1 million people, comprising of 11 districts, 1 city, 2 towns, 8-subdistricts, 100 communes, and 800 villages. There are 41 ethnic monitory groups in the province, of which total 20% of the provincial population. 4 districts in the province share a border with Cambodia that extends approximately 200km north to south. The province hosts many seasonal migrant workers (both internal and cross-border) who travel to the area according to the crop harvesting season, specifically cashew nut farms and rubber tree plantations.

The total number of migrant workers is unknown and difficult to track. There are also many local Vietnamese who travel to Cambodia for work. These migration pathways lead to imported cases in both Vietnam and Cambodia and cross provincial borders. HPA, SCDI, PSI, and the

National Programme are all malaria project implementers in the province with different interventions. Between 2017 and 2018, there was a case decrease of approximately 10%, and one death (Pf) recorded in 2018 which was a forest goer who traveled from Vietnam to Cambodia to work. Peak malaria season in the province is October to February. The annual Lunar New Year holiday drives migration within Vietnam and increases activities within the forest as people attempt to collect extra supplies for the celebrations.

CSO contribution to malaria response under the Global Fund grant has only commenced at the end of 2018, so there is hope that the 2019 data will demonstrate the expected impact by Civil Society Organizations. Provincial government indicated that they are very positive and receptive to working with civil society organizations.

It is important to note that the Provincial Authority of Binh Phuoc province has requested to extend the 2025 target elimination to 2030, as they do not believe that they can meet the expectation.

Visit at Phu Thinh Rubber Plantation, Bu Gia Map district

Following the meeting with Provincial Project Management Unit, the team traveled from Dong Xoai town to Bu Gia Map district to observe PSI implementing sites. In Bu Gia Map, the first stop was Phu Thinh Rubber Plantation to speak with the worksite director and view the geographical environment. Mr Hai, the worksite Director provided an overview of the site. The rubber plantation covers 1224 hectare, which covers to plantations comprising of approximately 612,000 rubber trees (500 per hectare). There is a total of 259 workers, mostly employed year-round, however, there are an additional 100 estimated casual staffs that joins during high season or based on demand. Some of these workers also travel with their families or temporarily reside nearby. The age of worker range is 18-45, 45% female, and 55% male. Most of the workers are local, and from within 50km of the worksite. Standard working hours are 5:30 am to 4:30 pm, with only security and other key staff working during the night. The worksite provides health insurance to the contracted workers, with the nearest healthcare center being between 20km to 30km away. Even though they have health insurance, most people tend to go to a pharmacy as first-point of contact for health, rather than a health center. Nets are not provided at the worksite; however, the worksite does provide coils during the rainy season which workers attach to their belts, and PSI provides a limited number of hammock nets to the staff working in the nights. High season for the rubber plantation is September-December each year.

The Team Leader or Manager on Duty has been trained by PSI and responsible for testing by RDT. So far, 3 out of 14 possible positions have been trained by PSI in partnership with the CDC. RDT kits are procured and provided to the site by PSI. 6 cases were identified in 2018, all of which were falciparum. The worksite Director was not aware of any case investigation. Families of these cases were not tested, even though national guidelines recommend. There is no screening, rather only testing based on symptoms. The reporting of identified cases takes approximately 1 month to reach the government via PSI. Health sessions are conducted twice per year by PSI during the workers' lunch break. This is coordinated by the worksite manager who tries to get the most people to the session as possible.

Visit Commune Health Centre (CHC), Bu Gia Map district

After visiting the rubber plantation team went to Commune Health Centre to meet with the senior doctor. According to CHC doctor, the CHC covers a population of approximately 7000 people. 3 cases were identified on the previous day of visit (27 Jan), and 2 malaria cases on the day of site-visit (28 Jan). One of the patients was still at the hospital and allowed for visit team to meet wither her (age <16,). There had already been 20 cases during January.

At the same Commune Health Clinic, the team had the opportunity to meet with a Community Malaria Champion (CMC) who had been trained by PSI to conduct RDT in their place of work under the PSI project. Liu Thai (Mr Thai), male, 26, was a forest guard in Bu Gia Map national park. He also identified as being from an ethnic minority and serving as CMC. Each forest guard is assigned an area within the forest to patrol and arrest people who are illegally hunting, gathering or logging. The forest guards are normally in a group of 5-6 and stay in the forest up to 10 days, on rotation with other groups of 5-6.

Ina question to why he decided to become a CMC, and he mentioned that he had malaria before (in 2018) and knows about malaria. PSI convinced him to work with his respective community. Mr Thai was able to carry RDT test into the forest and test people that he suspected had malaria, however, there were concerns from the site visit team that he would find a limited number of people because of his role as a forest security guard. Similarly, there were concerns about the location of the CMC, as Mr Thai lived less than 50 meters from the CHC. It became clear that Mr Thai did not test community people, and mostly just tested his friends, family, and colleagues. He had no issues with conducting the test kid and thought that it was easy. Mr Thai identified 2 cases during 2018 and referred them to the CHC.

In addition to RDT, the CMC also gives basic prevention instructions (sleep under a net). The CMCs gain this information through training by PSI at their homes or at local public health centers. They are also given a poster and banner to use, however they do not have any commodities or materials to distribute during prevention sessions. CMCs are not allowed to give treatment. Mr Thai felt that there was a significant benefit to his family and friends because

of his ability to conduct RDT. He likes that he can help the community and feels empowered 'like a doctor'. Based on the feedback from PSI and Mr Thai, it is clear that there is no proactive case finding or investigation in areas where cases are detected.

Visit Fast Moving Commercial Groups (FMCG) stores, Bu Gia Map district

The next stop of the visiting team after the CHC was to visit two Fast Moving Commercial Goods (FMCG) stores, which are commercial properties (community stores). The PSI has trained FMCG owner to conduct RDT and refer patients for testing. PSI select key people according to criteria and must demonstrate a willingness to support their community fight against malaria. The model for selecting FMCG as an intervention site is to increase sustainability, as when funding stops, the FMCG will maintain their site due to their primary income. FMCGs are trained to conduct RDT at their place of work. Positive cases are referred to CHC for a second test, no treatment can be given to positive cases. Negative cases are also referred to the CHC for a second test. The non-financial incentive was provided for the identification of positive cases. Community members learn through word-of-mouth and community meetings that the FMCG is local for testing. PSI also provide signs that can be placed at the outside of the FMCG properly, which includes the messages "if >37 degrees body temperature, get a test" and "malaria is serious" and "malaria testing here".

The first FMCG worker (Mrs Ha) had conducted 15 tests (0 positive) since starting. Mrs Ha's reason for joining the project was to support her community, and she is now identified as the first place to go if anyone gets sick. Not only because of malaria testing but because she has a relationship with the CHC. Mrs Ha gave a detailed summary of a 'success story'. Her younger brother came to her store to buy a drink and he was unwell. She asked him to do an RDT. The test was negative, but another customer (rubber worker) who was in the store at the same time, noticed that she can test and asked for the same test. She realized that there was demand from the community and that over time, the cascade model would increase community knowledge about malaria and where to test. Mrs Ha mentioned that RDT was easy and that she believes she can do anything if she is trained, as she is very motivated to support her community.

The second FMCG worker, Mrs Hong, conducted 20 tests (zero positive) since starting to work 6 months prior. Most of her customers are forest-goers who buy supplies before going into the forest. Mrs Hong does not normally offer tests based on symptoms but instead waits for people to request a test. However, she has found that when offering to test, a few people have declined

because she is not a medical professional. Mrs Hong believes that she has a particular advantage for health service provision because her store is open during the evenings and other hours when health facilities are normally closed or understaffed. One issue raised by the site visit team was that both FMCGs were located within 100 meters from each other, which led us to believe that the mapping and identification of appropriate representatives were not effective. That being said, both stores offered different services and therefore it is possible that they engaged with different members of the community.

Visit private pharmacy, in Phu Nghia commune, Bu Gia Map district

Visit team had moved to the local pharmacy after visiting the FMCG. The Pharmacy was centrally located and on the main road through the commune. The pharmacist had worked with PSI for 2 years and been at that location for 10 years total as an independent (private) pharmacist. The pharmacist has been trained by PSI to conduct rapid diagnostic tests, however surprisingly even if positive the pharmacist, who is a registered medical professional, is unable to provide treatment. 5 years ago the pharmacist was able to provide treatment, but the national policy has changed. Other medicines are available from the pharmacist including penicillin, amoxicillin, and azithromycin. All positive cases still need to be referred to a health center for a second test and treatment.

The pharmacist said that people can take a photo of the positive test to show the health center, but normally they still conduct a second test. The pharmacist informed us that there is usually one health center for every commune. In total, the pharmacist had conducted 17 tests, identifying 1 positive case within the last month. The positive case was a forest goer who traveled into the forest for hunting. PSI and the Pharmacist discussed reporting and informed that all positive cases are reported from the pharmacist to PSI, but PSI does not act on this information, rather only reports this further to the government program.

Visit private medical clinic in Dakia commune, Bu Gia Map district.

The final site visit on 28th February with PSI was a private medical clinic in Dakia commune of Bu Gia Map district. The malaria test and treatment in the clinic is supported by the PSI. The commune is very near to the Cambodian border. The private clinic was more resourced and there was a clear difference in the level of service offered and comfort of the patients. The doctor, female, is a Cambodian national who is married to Vietnamese and lives in Vietnam. The private clinic is allowed to provide rapid diagnostic testing and treatment, as they are a registered doctor. Positive cases are followed-up regularly by a phone call. Negative cases are investigated to determine what other condition the patient may have. The doctor identified 11% positivity rate, compared to approximately 2% positivity in other areas. She believed that the higher positivity rate was because people recognized her as an expert and she had a good reputation for malaria in the community, so that is where people with malaria normally attended. The doctor became involved with PSI since 2017 as she found many malaria patients were going untested, and there was an increasing need. She provides monthly reports to PSI, and PSI is responsible for stock and commodities. Most clients at the private clinic are forest-goers and their families. She has seen many people within the same family test positive for malaria, and also one instance of a pregnant woman having malaria. She mentioned that the population in her area are somewhat desensitized to malaria, so she is 'forced' to scare them into taking malaria seriously. One of the key points that became evident at this visit was that there is no mandatory reporting from private clinics to the government program. Even if private data is shared with the government programme, it is not counted at the central level or in the National Malaria Control Program.

29th January 2019

Visit the District Health Centre (DHC) and CHC in Bu Gia Map

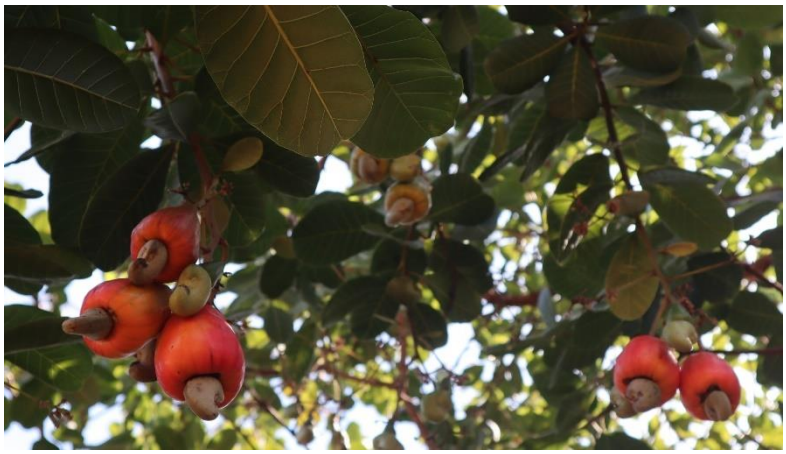
In the morning of 29th January 2019, the team visited the District Health Centre (DHC) in Bu Gia Map DHC.Dr Min, the DHC director briefed us on the situation. There are 8 communes, 80,000 people in the district under the coverage of the DHC. In 2018 there were 700 positive malaria cases, however PF: PV was unknown. Previously peak season was in December; however, this is shifting later each year and peak malaria season is now in January. This is due to an elongated rainy season which prevented people from entering the forests in December. Two communes in the district are a priority due to the highest incidence, and their proximity to the national park. Only the HPA has identified resistance in these communes, but SCDI and PSI are also working in the same communes and it is possible they have seen similar cases. Reporting is done from Commune at the end of the month "A'' to the DHC. From the district

health center to the CDC is in mid-month "B", and then the CDC reports to the national program at the end of the month "B". This is all through email notification. One interesting point that was raised was that people often don't take nets into the forest because the national park authority will assume, they are conducting illegal work and confiscate everything from them.

Visit the Commune Health Centre at Dak Nhau

In the afternoon of 29th January, visit team met with the CHC at Dak Nhau commune with SCDI project team. Treatment adherence and regimens in the commune were discussed in more detail with the senior doctor. Some members of the Community Malaria Action Team (CMAT) also joined the meeting. In the commune, 60% of the population identify as an ethnic minority. In 2018 there were 49 cases. In 2017 there were 47 cases. The CHC covers a population of 12,400 people over 93 square kilometers. Pf: Pv ratio was 60:40, and 30% of Pf cases showed delayed clearance, as a precursor to resistance. In 2018 there has been an increase in the number of people going to the forest compared to 2017 due to increased movement in forest.

Most malaria cases do not occur inside the commune, rather they are people who travel between provinces or into the forest and then return to the commune as an imported case. Most cases are from MMEP, so there are issues with language barriers and access. Both SCDI and HPA work in the same area. HPA role is to support VHW to conduct testing and deliver IEC/BCC. Community Malaria Action Teams (CMAT) are linked with a Commune Health Centre to extend the reach of government services and support with follow-up. Each case is assigned to a CMAT for the full follow-up period according to national guidelines, which increases treatment adherence and notification of adverse events. For all cases followed-up according to national guidelines, the CMATs are given a financial incentive. Candidates to join the CMAT were selected by the CHC. Each CMAT member is provided with 50 LLIHNs to distribute in the community.



The CMAT did not appear to have detailed training on how to demonstrate nets or hammock nets as forms of malaria prevention. They instructed the community based on their own experience. Male CMAT tended to be more active and physically transfer/escort cases to the CHC. Female CMAT tended to be more persuasive to convince people to attend the CHC for treatment, or for investigation of other health condition. CMATs are invited to all CHC meetings, and other events when there is an opportunity to further build their capacity. CMATs are not necessarily selected based on their characteristics, but instead simply based on the area that they live/work. Volunteer Malaria Workers (VMWs) are also located at the commune level and work under the government. They are provided with a monthly salary. Some of them have also been recruited as CMATs which means they are receiving a monthly salary plus an additional incentive from SCDI. The main difference is that VMWs tend to stay within the town, whereas CMATs were more mobile and supported with follow-up. Some issues identified by the CMAT include the difficulty of mobile software for older CMAT members, the difficult geographic landscape, and the large travel distances required with a limited travel allowance.

30th January 2019

Meeting at District Health Centre in Bu Dang

In the morning of the 30th January, visit team traveled back toward the largest District town to meet with the District Health Centre in Bu Dang. Participants were able to discuss the malaria situation and response in a district, and the linkages with CMATs. A group of 10 CMATs also joined the meeting and shared their experience.

There are 16 communes within the District. There were 15,969 suspected cases in 2018. Total 85 cases were confirmed positive, this was a decreased compared to 111 cases in 2017. Of the 15,969 cases, approximately 9000 attended the DHC with a fever, 3000 were from case investigation and the remaining are from CHC or VMWs. One commune accounts for 50% of the 85 cases. Pf:Pv is 43:40, and 2 Mix. 2 of the Pf cases were not parasite clear after 3 days. 16 of the 85 cases were from within the

district, 5 from another province, others are from other districts within the province. Case investigation only occurs for local cases. The DHC refers cases back to the CHC for case management. CHC is responsible for treatment adherence, with 60-70% of cases reporting to have completed treatment. The Malaria Officer, who manages cases and is responsible for coordination, medicine stock, and reporting, attends quarterly meetings with other districts in 2019, a decrease compared to monthly in 2018.

Out of the 8 CMATs interviewed, only 2 had found cases, both of which were in the highest burden commune. There is no clear differentiation between the CMATs who area also VMWs. The CMATs were asked for recommendations to improve the program. They responded:

- Need to choose CMATs from within ethnic monitory populations, as they represent 60% of the commune population
- The person selected has to be passionate, they must want to be a CMAT
- The person selected needs to be able to use a smartphone
- The person selected must be from within the target population or have had malaria before
- The person selected must know the geography and know the behaviors of the forest goers.
- There is a need to increase communication skills so that they can approach their clients more effectively
- The allowance for travel is not sufficient for cases that require long-distance travel, particularly if treatment adherence requires daily follow-up for 14 days.

Recommendations

1. It is critical that all malaria actors coordinate their activities and regularly communicate with each other to ensure no duplication and integrated service provision. This should be done through regularly planned meetings at all geographical areas of work.
2. There is limited value in pre-planned activities, particularly for screening. There would be more benefit in an active response to an identified case. Project management teams should regularly review malaria incidence reports and mobilize an active response by screening, providing health education and other necessary service to the community where cases are detected.
3. Volunteers and other community workers need to be selected according to the population they represent, not only the geographical area. There should be a strict selection criterion for the project which is followed by all actors, to avoid overlap of responsivity and appropriateness of worker to the community.
4. There is an increasing need to advocate for comprehensive data collection and management by both civil society and government services. Private providers should not be excluded from local, provincial or national reporting.
5. It is important that the quality of services provided by volunteers and community workers is consistent across working areas and organizations. There should be a single training handbook that covers all aspects of prevention (including net distribution and maintenance), testing, treatment, and case management.
6. It is important to consider the capacity of community workers, particularly for reporting purposes. IT systems should be user friendly and not limit participation of less computer-literate community members – or sufficient training and mentoring

should be provided to ensure workforces are inclusive and representative of the affected community.

7. Each organization should consider appropriate incentives according to the role and activity of each respective worker. For example, incentives for travel should be calculated according to distance and time required to access the key population rather than flat rate. This is particularly relevant for treatment adherence and follow-up of hard-to-reach population.
8. Civil Society Organizations should review community approaches by specifically considering sustainability and value of different community workers. For example, FMCG (convenience stores) in Vietnam are an ideal location for testing and overseeing treatment adherence as they are open outside of normal health centre hours, and do not reply on incentives given that they already have a secure primary income from their business.

About the platform

The Regional Malaria CSO Platform in the Greater Mekong Sub-region (GMS) is a network of Civil Society Organizations (CSOs) from the Global Fund RAI implementing countries: Myanmar, Thailand, Cambodia, Lao PDR, and Vietnam. The Platform serves as the CSO constituency engagement mechanism for the RAI RSC. The Platform was established in 2014 with the initiative of the RAI RSC CSO Representatives, to fill the gap of coordination and communication at the national and regional levels. It also aims to address the issue of malaria vulnerable and at-risk populations who are not always reachable through health facility staffs due to their legal status or nature of work. To date, the Platform is able to create a network of more than 50 CSOs, CBOs and community network at national and regional levels.

The Regional Malaria CSO Platform aims to provide a common space to the community, and the CSOs from the GMS that are working on malaria or working with malaria vulnerable and affected communities in the region through other development programs (e.g. for education and other health services). It is a Platform for sharing good practices, lessons learned, challenges and capacity strengthening and coordinated actions for advocacy and policy change to address malaria issues in the community.

During the establishment phase, the Platform was hosted by Raks Thai Foundation with support from the RAI RSC Secretariat and APLMA. The Platform has received Global Fund grant for the period 2018-2020 under the RAI2E and it is currently being hosted by the American Refugee Committee (ARC) in Bangkok, Thailand.