Regional CSO consultation on leveraging the roles of Community Malaria Workers/Volunteers to eliminate malaria and maximize public health benefits at community level

8-9th July 2019, Bangkok, Thailand

Abbreviation

ACT	Artemisinin-based Combination Therapy
AMW	Auxiliary Midwife
ANC	Antenatal Clinic
APLMA	Asia Pacific Leaders Malaria Alliance
ARC	American Refugee Committee
ARI	Acute respiratory infection
ASEAN	Association of Southeast Asian Nations
BEmOC	Basic Emergency Obstetric Care
BHS	Basic Health Staff
CBO	Community-Based Organization
CCC	Cambodia Coordination Committee
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control and Prevention
CHV	Community Health Volunteer
CHW	Community Health Worker
CMAT	Community Malaria Action Teams
CMC	Community Malaria Corner
CNM	Cambodia National Malaria Center
CPA	Complimentary Package Activities
CSO	Civil Society Organization
DHA-PQP	Dihydroartemisinin-piperaquine
DHSI	Dynamic Health Systems Initiative
DoA	Date of Advance
DoH	Department of Health
DOT	Directly Observed Treatment
Dx	Physical Diagnosis
EHO	Ethnic Health Organization
EMT	Emergency Medical Technician
EPI	Expanded Program on Immunization
FEI	France Expertise Initiative
FMCG	Fast Moving Commercial Group
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GF RAI	Global Fund-Regional Artemisinin Resistance Initiative
GMS	Greater Mekong Subregion
HC	Health Center
HE	Health Education
HIV/AIDS	Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome
HTM	HIV, TB and Malaria
HTR	Hard-to-Reach
HWM	Home Management of Malaria
iCCM	Integrated Community Case Management
ICMV	Integrated Community Malaria Volunteer
IEC/BCC	Information Education and Communication/Behavior Change Communication
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
Lao PDR	Lao People's Democratic Republic

LF	Lymphatic Filariasis
LLIN	Long-Lasting Insecticide Net
M&E	Monitoring and Evaluation
MC	Malaria Consortium
MHW	Malaria Health Worker
MHV	Malaria Health Volunteer
MMW	Mobile Malaria Worker
MNCH	Maternal, newborn and child health
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MoHS	Ministry of Health and Sports
MoPH	Ministry of Public Health
MP	Mobile Populations
MW	Malaria Worker
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NCHP	National Center for Health Promotion
NCMCH	National Center for Maternal and Child Health
NGO	Non-Governmental Organization
NHP	National Health Program
NHSO	National Health Security Office
NIMPE	National Institute of Malaria, Parasitology, and Entomology
NMCP	National Malaria Control Program
NSA	National Strategy Application
NSP	National Strategic Plan
PNC	Post Natal Care
PP	Private Provider
PR	Principal Recipient
RAI	Regional Artemisinin Initiative
RDT	Rapid Diagnostic Test
RMNCH	Reproductive Maternal Newborn Child Health
RSC	Regional Steering Committee
RTI	Respiratory Tract Infection
STI	Sexually Transmitted Infection
TAO	Tambon or Subdistrict Administrative Organization
TB	Tuberculosis
TBA	Traditional Birth Attendant
TCHW	Traditional Community Health Worker
TSG	Malaria Technical Strategy Group
Tx	Treatment
UHC	Universal Health Coverage
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
VBDU	Vector Borne Disease Control Unit
VHSG	Village Health Support Group
VHV	Village Health Volunteer
VMW	Village Malaria Worker
WHO	World Health Organization

Executive Summary

Civil society organizations (CSOs) have been working alongside governments and the private sector, contributing to the significant progress in reducing malaria incidence and mortality in the GMS region. The expansion of community malaria volunteers bringing services closer to the community has made a significant contribution to reduce malaria cases. However, the role of community malaria volunteers in the changing epidemiology of malaria across GMS countries are different and not widely recognized by the governments. There are missed opportunities to leverage their roles to maximize the public health benefits of these existing well trained and supervised community-based health staff especially in remote area where access to formal health providers is limited.

From regional workshop on disease integration, the discussion results apparently revealed that the current status and role of malaria volunteers as well as their services provided have still been relevant to the communities' needs and the needs of the National Malaria Control Programs. In order to further achieve malaria elimination, it is unanimously agreed that program implementers integrate community needs and intervention in policy and program planning, formulate comprehensive service packages to cover diseases prevalent in their hard-to-reach service areas, and advocate these concepts to higher level in countries for national strategy planning.

Logistics and facilities unavailable for hard-to-reach areas are the main problems found in general, and professional health care officers are not living in those locations. CSO-supported health cares and volunteers become complementary system, especially for mobile populations and illegal migrants, to bridge the gaps between official health system and the communities' needs by improving access to health care and strengthen the capacity of community health workers in these hard-to-reach communities.

Burnet Institute presented the evidence from scientific research on community-delivered models and their impact on malaria control and elimination. It reveals that the use of community-delivered models has been proven effective due to the consequential decrease in malaria mortality and improved bed net usage and IPTp coverage. In real case of Myanmar, the community requested community health workers to provide a full spectrum of services for malaria and covers prioritized/common health problems in the community along with prevention and referral services. With current Global Fund support, program implementers in the country successfully provide health service for Malaria, TB, HIV, lymphatic filariasis, dengue and leprosy through Integrated Community Malaria Volunteer (ICMV) model.

Towards the end of current program cycle and the new Global Fund opportunity, CSO platform members are invited to complete the costed National Strategic Plan (Q3 2019), country program review (Q4 2019), and the country funding request (Q4 2019) for the Regional Artemisinin Initiative 3 Elimination (RAI3E). For the Global Fund new funding opportunity, CSO platform members are recommended to consider and include those crucial elements discussed above, as well as other elements such as sustainability, cost effectiveness, and incentives (monetary and non-monetary) in the new country funding requests to strengthen health system, satisfy communities' needs, and attract (more) donor funding. The overall landscapes of the national health systems in countries presented in discussion section shall act as evidences supporting the formulation.

In order to move forward under the theme of service integration, the regional CSO platform requires to identify practical steps which may be varied between countries. As a result, CSO partners through Regional Malaria CSO Platform developed draft statements for advocacy at high-level targeting

government and Global Fund. The secretariat shall consult with respective country steering committee members on the finalization of these regional statements, and release the final results by September 2019. These regional statements must be included for key stakeholders' consultation for agreement, and later be mainstreamed into key national documents such as national advocacy plan, national strategic plan, and country action plan.

Next step, it is clear that advocacy work requires long term efforts to influence governments, donors, and other key stakeholders to join force and take actual actions on this new initiative. All CSO platform members are invited to think strategically on (i) how to advocate the government, donors, and other relevant stakeholders on ICMV approach, (ii) how to start the integration in each country while many resistances may exist e.g. attitudes of general public, and the government's unwillingness to acceptance, and (iii) how to sustain CSO activities in communities and volunteers' motivation.

Background

Civil society organizations (CSOs) have been working alongside governments and the private sector, contributing to the significant progress in reducing malaria incidence and mortality in the GMS region. The expansion of community malaria volunteers bringing services closer to the community has made a significant contribution to reduce malaria cases. However, the role of malaria volunteers in the changing epidemiology of malaria across GMS countries are different and there are missed opportunities to leverage their roles to maximize the public health benefits of these existing well trained and supervised community-based health staff especially in remote area where access to formal health providers is limited. Indeed, as malaria cases going down in most communities, sustaining the malaria volunteers in place to serve their vital role in surveillance as well as case management is becoming a challenge.

The GMS CSO Platform[1] is a network of CSOs from the Global Fund-Regional Artemisinin Resistance Initiative (GF RAI) implementing countries in the region. It also serves as a constituency at both country and regional levels to engage with national programs and other stakeholders. To date, there are more than 50 CSOs, CBOs and community networks participating in the platform. The American Refugee Committee (ARC) is the host of the platform for 2018 to 2020.

This workshop was aimed to

(1) Explore the current status and role of malaria volunteers and whether the services they provide remain relevant to the communities' need and the needs of the National Malaria Control Programs (NMCPs) for case-based data to take forward malaria elimination strategies
(2) Explore what opportunities exist to maintain the volunteer's motivation and improve delivery of other public health benefits
(3) Identify Ministry of Health interdepartmental policies and strategies as well as donor programs and other support, which would be needed to maintain or expand the role of malaria volunteers to improve their public health role and reach and sustain malaria elimination.

<u>Rationale</u>

During the previous regional and country consultation workshops organized by the CSO platform, some of the key common challenges raised by CSOs in the region are

[1] https://www.malariafreemekong.org/

(1) How to make services by malaria volunteers more relevant to the community needs as disease burdens goes down, and at the same time maintaining community interests and participation in malaria elimination activities. In some GMS countries
(2) The roles of malaria volunteers in integrated service delivery are more constrained than in others, and indeed more constrained than in many African and South American countries. These differences in service delivery roles as well as the level of education and ability of malaria volunteers are not yet recognized. Global evidence of integrating services delivered by community volunteers exist and could be applicable to GMS countries and need to be explored
(3) Furthermore, CSOs in the region may also have different understandings of the value of integrating community-based services. There are also different levels of understanding among CSOs of how they can engage with country coordination mechanisms (CCM), NMCPs, MoH and different departments, and other government officials in adopting context-specific policies and how to program them at country-level. It will also be worthwhile to identify the associated program management needs of more integrated services such as training, supervision, supply chain management, and data reporting.

It is expected that another funding cycle of RAI will continue to build on the progress and the significant investment made. Countries will initiate strategy development; concept notes and submission of funding proposals. This workshop provide an opportunity to include CSO voices and engagements with CCM and RSC to review the current model in each country and advocate for new policy adoption which can then be linked to funding requests. Global Fund project has promoted the role of community health workers/volunteers in delivering integrated services especially in remote areas where access to care is limited and reductions in overall mortality can be achieved especially in areas where mortality as a result of malaria is reducing and the causes of non-malaria fever and overall mortality and morbidity needs to be addressed including neonatal and nutritional interventions.

Objective of the workshop

1. To gain a better understanding of the role of community health volunteers through health systems lens in GMS countries
2. To identify country-specific opportunities and options to move towards greater integration with enhanced role of malaria volunteers including process and mechanism to achieve that
3. To formulate advocacy messages and country specific advocacy plans aimed at supporting the inclusion of integrated service delivery approaches and enhanced malaria volunteer roles in National Strategic Plans and funding requests to the next round of RAI grant

Expected output from the workshop

1. A common regional statement from civil society organizations asking for a more integrated community health worker policy/model that is relevant to each country's context
2. Outline of advocacy plan for action at country-level

I. Welcome Speech

Dr. Htin Kyaw Thu, RAI RSC CSO alternate representative and Technical Specialist for Malaria Consortium welcomed the participants to Bangkok and provided overview of the agenda to the participants as shown in Annex 1. He also informed that the CSO Platform is in the process of community consultation and redesigning the whole Regional Artemisinin Initiative (RAI) program. As a result, the workshop this time was designed to change from discussion on implementation issues to a brainstorming session with aim to extract community needs and other improvements we need in the next RAI grant. The results from discussion today shall be summarized and presented to the Regional Steering Committee (RSC) as well as integrated as inputs and recommendations for the Global Fund (GF).

II. Next Global Fund RAI Funding request (2021-2023)

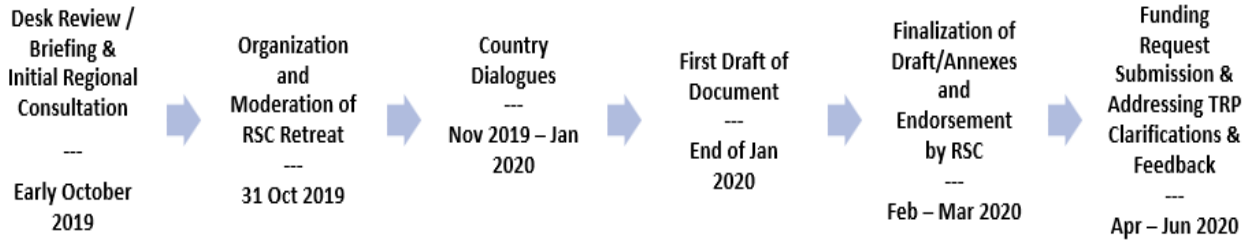
Ms. Severin Calza, Executive Secretary from RAI RSC shared with the participants an update on decision points from the last 13th RSC meeting, and the RAI funding request.

She updated that key decision points discussed during the 13th RSC Meeting are resolved as followed - (i) the four-reinvestment plan for Cambodia, Laos, Myanmar, and Thailand was reviewed with additional high-level guidance to target high burden areas. The detailed proposals were endorsed by CCMs on May 21st, 2019; (ii) the issue of Dihydroartemisinin-piperaquine (DHA-PQP) replacement in Vietnam was solved by Pyramax procurement; and (iii) specific session on integration of services must be included in the next RSC meeting for each country to present their plans, achievement, and related financial sustainability.

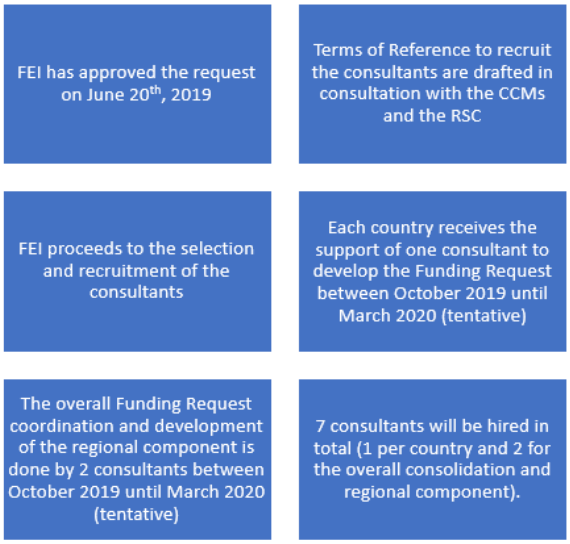
It is noted that the next RSC meeting shall take place on October 31, 2019 in Yangon, Myanmar, where the results from this CSO platform meeting shall be presented. An Executive RAI RSC Meeting will take place this week to discuss more specific on governance aspect.

In regard to the Funding request, RAI RSC submitted a request to the France Expertise Initiative (FEI) for funding the hiring of 7 consultants to support on drafting the next RAI funding request 2021-2023, and it was approved. Each CCM will still be in charge of coordinating the development of the national component of the funding request with the support of designated consultant.

Relevant process and timeline of above activities are pictured as below for reference. The Secretariat shall disseminate a template to CCMs for completion by October this year.



Picture 1: Timeline for Funding Request



Picture 2: Process of Funding Request

Discussion:

1: In previous round of proposal development, the funding request was discussed at the CSO platform with inputs from communities and CSOs collected prior to the event. To achieve similar outcome, RAI RSC expects to brainstorm with member countries on (i) what each member country wants to see in the upcoming funding request, (ii) what to include to make impact, (iii) what need to be changed, and (iv) what was not funded but should be funded.

RSC shall collect this information and collate them between now and October 2019 for further discussion in October for the benefits of funding request development. Noting that this information must be included in each country's National Strategic Plan prior to inclusion. It is the role of CCMs to ensure the inclusion of these ideas into the National Strategic Plan or put together these ideas with the RSC into a recommendation paper for the Global Fund.

2: It is necessary to focus on maintaining the success momentum in the Funding request for next phase implementation, especially funding to support the consistency of community dialogues to voice their opinions up to international level, and the maintenance of volunteers working in communities.

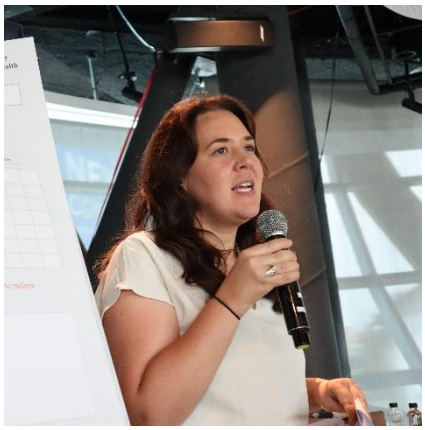
3: Although the proportion of financial assistance shared between national program and the CSO sector was not divided on equal basis, and not consistent across countries. The request for funding should target those hard-to-reach communities e.g. ethnic minorities, migrants, and others. It is also important for the CSO community to speak in one voice. Recommendations from this meeting shall be used to advocate the Global Fund in the next phase for communities' benefits.

III. Presentations and Panel Discussion

(1) Global Fund High-Level Interests and Commitments

Ms. Alyssa Davis, Public Health Consultant and Co-Facilitator, shared with the participants the Global Fund high-level interests and commitments as they were used to frame our workshop together with the formulation of the funding request.

The Global Fund interests and commitments include strengthening health system, supporting to the reproductive maternal newborn child health (RMNCH), and integrated community case management (iCCM) while supporting a wide range of HIV, TB and Malaria (HTM) intervention across the continuum of care.



Other global commitments such as Alma Alta Declaration (Article VII), Sustainable Development Goal 3 ("Ensure healthy lives and promote well-being for all at all ages"), and Astana Declaration also focus on strengthening health system and support community health workers also demonstrate how policy makers at global level contribute their efforts and support to health system strengthening, and other health initiatives at practical level (communities) to eliminate Malaria. These global commitments are interlinked in some ways and we can refer to these global commitments as our reference at work.

Discussion:

1: It is necessary for CSOs to keep in mind the Global Fund interests and commitments, while balancing out with the ability to implement the actual programs on the ground. As an option, we can be proactive by drafting a recommendation paper with communities' perspectives and donor's accountability emphasized and submit it to the Global Fund for their awareness raising prior to the release of its fund allocation letter.

2: If the goal was to hold Global Fund accountable for impactful program delivery, CSOs must start advocating the host Ministries to embrace the service integration based on community needs and perspectives, as well as to mainstream it into the national strategy.

(2) Impact of Community-Delivered Models of Malaria Control and Elimination: A Systematic Review

Dr. Win Han Oo from Burnet Institute presented the evidence from scientific research on "community-delivered models and their impact on malaria control and elimination" to participants. The aim was to prove that this approach could work for implementation in the region. The World Malaria Report 2018 recently demonstrated that the development and widespread use of LLIN, RDT and ACT contributed significantly in global reduction of malaria burden.

To achieve malaria elimination, we are required to reform the community intervention method. The common models currently used to distribute the malaria interventions involved government health

facility and community-based models, non-government not-for-profit health facility-based models, for-profit health facility-based models, and community-delivered models.

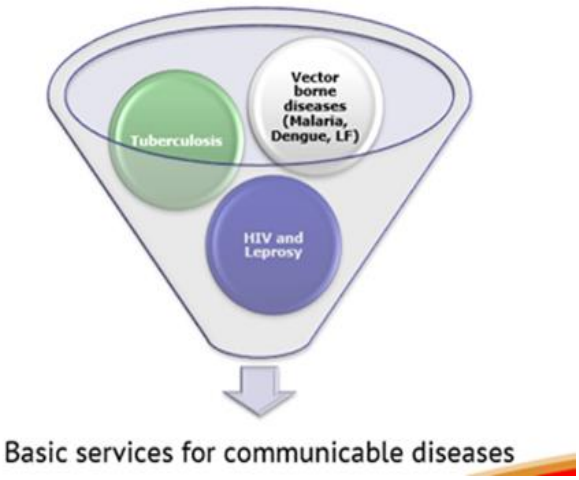
Relevant to our work, community-delivered models are classified into different types:

(i) Traditional Community Health Workers (tCHW)
(ii) Home Management of Malaria (HMM)
(iii) Integrated Community Case Management of Malaria (iCCM)
(iv) Integrated Community Malaria Volunteer (ICMV)
(v) School based model, and
(vi) Pharmacy model

The latter two is rarely used. These models shared the common characteristics where the community health workers (CHW) are the key players. They are selected by the communities, provided with standard treatments, and responsive to communities' needs and demands. From the survey, the use of community-delivered models has been proven effective because it decreased malaria mortality and improved bed net usage and IPTp coverage.

Despite its success, the community-delivered models have faced some obstacles in their implementation such as over expectation of the community on services and service providers, community norms, perceptions and service utilization from non-trained provider, attrition of service providers at grass root level, lack or minimal contribution of community for sustainable malaria services in the community, and Malaria stock out at the bottom level service points.

In the case of Myanmar, community-delivered models started providing services in 1980s on malaria control having CHW acted mainly for communicable diseases and auxiliary midwife for maternal and child health. Now with Global Fund, Myanmar applied ICMV model to provide services for Malaria, TB, HIV, lymphatic filariasis, dengue and leprosy. The community requested an integrated community-delivered model that provides a full spectrum of services for malaria and covers prioritized/common health problems in the community along with prevention and referral services. The health problems prioritized among communities are flu (fever, sneezing, and coughing), diarrhea, dengue, TB, and Malaria.

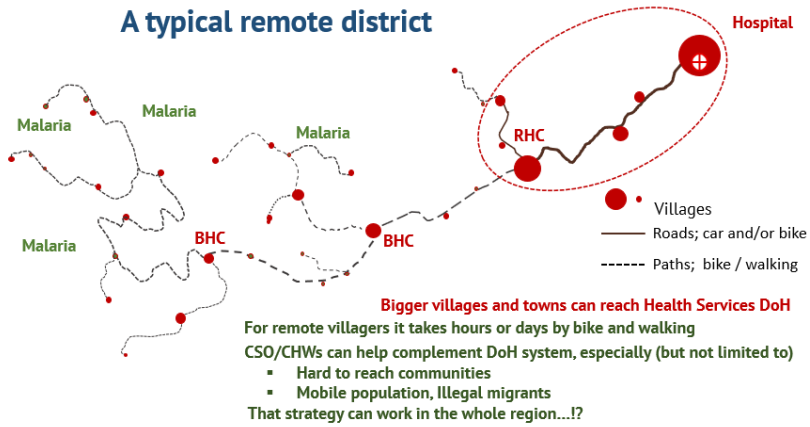


Picture 3: Integrated Community Malaria Volunteers (ICMV) Model

It is recommended that communities' needs must be included in the formulation of health care models and national policies. Multi-stakeholders' perception on community-delivered models needs to be explored. For the cost effectiveness of the models, program implementers need to assess and replicate best practices in other communities while realizing community needs for integrated services. Country specific community-delivered integrated Malaria elimination models in GMS are yet to be developed through multi-stakeholder consultation, while other developed models still require continuous evaluation.

(3) Implementation Experiences from Myanmar Integration Model (ICMV)

Dr. Frank Smithuis, RSC CSO Representative, presented that the main problems of health care are with logistics and facilities unavailable for hard-to-reach areas, and professional healthcare providers not living in those locations. CSO-supported health cares and volunteers become complementary system for them especially mobile populations and illegal migrants. To achieve malaria elimination, CSO needs to bridge the gaps between official health system and the communities' needs by improving access to health care and strengthen the capacity of community health workers in these hard-to-reach communities.



Picture 4: Malaria Spread and Facilities Available for Services

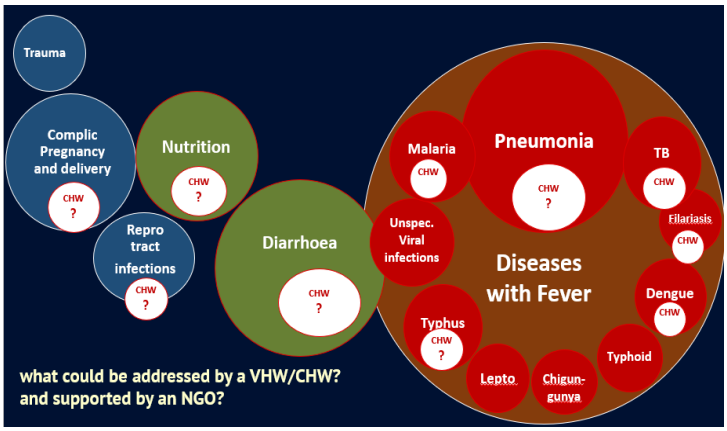
Before the introduction of community health workers, quacks[2] were the only available services in most remote areas to provide treatments including intravenous fluid injections, steroids, antimalarials and antibiotics, with lack of proper training and guidelines to assist them. Although their poor service quality, it had been proven successful in life savings and stopping further transmission.

Community health services were initiated in 2011 to fill those gaps that quacks could not provide such as diagnosis and quality treatments. This approach later was also proven effective as they have reached at-risk populations e.g. hard-to-reach people, mobile people, and illegal migrants across countries in Southeast Asia region. Sixty percent of malaria incidences reduced through 571,286 malaria RDTs (2011-2016).

Is it sustainable? It is not sustainable in term of CHW uptake and cost effectiveness. Community based broader package of quality health services is recommended to improve access to basic health care and

[2] Quacks, healthcare providers, without formal trainings who are providing medical diagnosis and treatment to the patients

to keep RDT uptake high to eliminate malaria. An integrated CHW program may include: (i) Malaria diagnosis and treatment, (ii) TB active case finding, (iii) nutrition for malnourished children and pregnant women, (iv) basic health care including diarrhea and RTI, and (v) referral system for people with severe diseases.



How to integrate? A mix of diseases in the package will depend largely on each country's context. The selection must start from (i) diseases that are most relevant to community needs, (ii) their frequency of occurrence, severe effect and high mortality rate, and (iii) cost effectiveness after counting trainings and incentives in.

In addition, ICMV approach is not the only option we have.

Picture 5: Main Health Problems in Remote Areas

(4) Program Management Perspective on Implementing Integrated Services

Dr. Tin Me Me Aung, Public Health Officer (Malaria) from UNOPS, presented the program management from the perspectives of services integration. *Dr. Aung* informed the timeline for RAI3E as below.

TIMELINES FOR RAI3E		
Q3 2019	Q4 2019	March 2020
Discussion on timelines and priorities (RSC Ex Com)	Detail discussion on FR (RSC)	Submission of FR to RSC
Costed NSP	Funding Request (FR)	Consolidation of FRs of all country components by RSC
Malaria Programme Review		Development of other components by RSC

Announcement of funding allocation by GF

- Each CCM will be the lead in the development of their country component Funding Request;
- RSC would require at least 2 weeks in Feb/March 2020 to consolidate all the components.

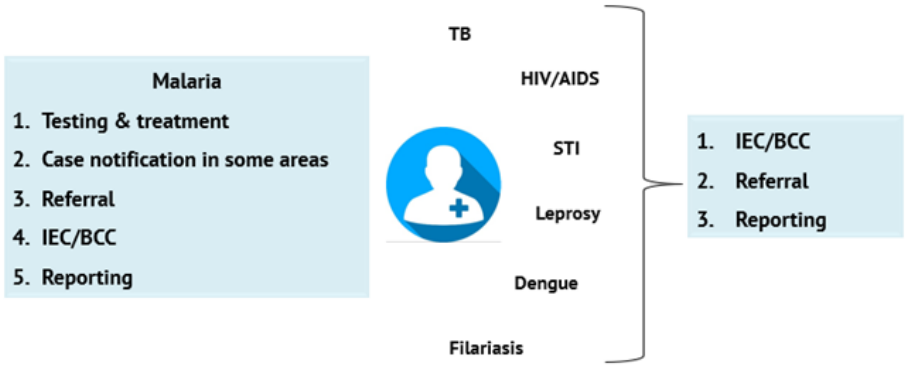
Picture 6: Timeline for Regional Artemisinin Initiative 3 Elimination (RAI3E)

Countries must complete country program review in Q4 2019 including the cost of National Strategic Plan and the country funding request. An RSC meeting is scheduled to discuss timeline and program implementation priorities this week. Each individual country is still be in charge of the development of country-component funding request as usual and submit to RSC before March 2020. RSC will be

responsible for developing other components and overall consolidation during Feb/March 2020. Global Fund plans to announce the funding allocation in December 2019.

Why service integration? Taking this new funding round opportunity, CSO platform members are invited to start thinking about how to include service integration into the National Strategic Program. From the perspective of program management, it is necessary to do service integration to achieve resilience and sustainable health system. The apparent advantages for this are sustaining volunteers, accessibility of services, and value of money where one volunteer can accommodate more diseases, and community resilience especially in Myanmar where the access to health services is difficult.

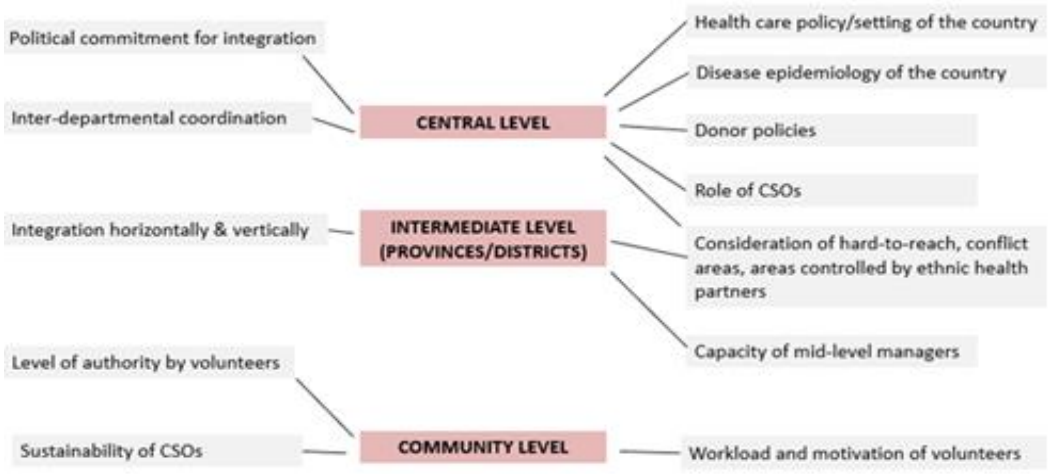
For *ICMV approach, Dr. Aung* presented UNOPS experiences in the countries for participants' ideas and consideration in accommodating donor's interests and commitments during this upcoming round of funding request.



Picture 7: Current ICMV Model in Myanmar

In Myanmar, Integrated Community Malaria Volunteer (ICMV) approach started in 2017. Other diseases they cover are namely TB, HIV/AIDS, STI, Leprosy, Dengue, and Filariasis. The Ministry of Communicable Diseases needed to be advocated of Malaria due to resistences among government officials from their different departments. Coordination is a major issue.

Bottom-up planning is a key mechanism recommended and required to increase coordination, fund attractiveness, goal achievement, stakeholders' accountability at different levels (central, province and community level), efficiency and effectiveness of program delivery. In addition, the management needs to factor in the perspectives from stakeholders and mainstream them into the bottom up planning process in order to generate the right integration and commitments across levels.



Picture 8: Bringing into Action (Perspectives from Stakeholders)

At intermediary level, ethnic minorities, migrants and other vulnerable groups may require different assistances from the regular communities. In bottom-up planning, the provincial and district government officials need CSO guidance, intervention and assistance in service integration. Sustainability of services and trained community volunteers is another issue. So, the targeted beneficiaries could gain access to fair amount of service assistances despite of wider spread of locations.

In addition to those key elements, below are activities required for implementation during the bottom-up planning process for ICMV approach.

<u>Basic Activities</u>

- Mapping out existing services and community level workers at village level for integration
- Development of training curriculum for all levels of trainings
- Capacity building of mid-level managers for bottom-up planning
- Development and distribution of IEC/BCC materials

<u>Supply System for Commodities</u>

- Types of commodities
- Procurement
- Development of volunteer toolkit
- Delivery up to village level
- Monitoring and replenishment
- Expiry/stock-out management
- Quality assurance
- Non-health items for volunteers

<u>Establishment of M&E and reporting system</u>

- Supervision team and frequency
- Content of supervision and data collection
- Tools for data collection and reporting
- Verification and feedback mechanisms
- Reporting to higher levels
- Maintenance of reporting equipment
- Data analysis and data utilization
- Evaluation mechanisms

Referral Support
- Affordable range at a national scale
- Type of support
- Payment procedures & DoA
- Control mechanisms

Incentives to volunteers
- Performance based or fixed
- Payment amount
- Payment procedures & DoA
- Control mechanisms

Management of Complications

From UNOPS experiences (including national partners, national program implementers, and communities) in countries, during the roll out of ICMV, the followings are possible challenges each of us can confront.

- Integration is not properly brought down to the lower levels. Central level agreed to do the integration but not well-informed at the lower levels. What integrated into the service package are what we can, but they might not be of communities' interest.
- Prioritization of diseases.
- Limitation of IEC/BCC materials for diseases other than malaria.
- Volunteer toolkit development
- Issues with referral - referring patients to public hospitals or facilities, linkages and unknown information
- Issues with unsystematic reporting
- Supervision of ICMV implementations by CSO are good but not national program level.
- Potential overlapping of services with existing community health workers.

Beyond the service integration, it is recommended that the project implementers should focus on critical issues like long-term sustainability of volunteers, cross regional learning, continued commitment by countries and donors, as well as evaluation mechanisms and further adaptation of models.

Discussion:

1: Community representatives are significant to the service integration program. On international platform, communities represent 30% in decision making process. Therefore, it is necessary for us to ensure that the program implementers include them in policy, project development, and work planning discussions, as well as working directly with them at qualitative research interviews and other relevant participatory workshops.

2: The term "community-delivered" may cause confusion among project implementers and especially with the Ministry of Health as it communicates the sense of "teach and leave". It is recommended to provide emphasis on "empowerment" as it literally creates long-term sustainability through provision of health education and quality health workers. In remote communities, 1 well-trained health care provider (up to 3) can be provided and supported by CSO to avoid the use of unqualified quack services. In case of referral, it

is agreed that a strong referral system is needed as part of the successful health system but challenging especially in Myanmar.

3: It is agreed that integrated approach is interesting and critical to our work in countries. Next step, we need to think about (i) how to advocate the government, donors, and other relevant stakeholders on ICMV approach, (ii) how to strategically start the integration in each country while many resistances may exist e.g. attitudes of general public, and the government's unwillingness to acceptance, (iii) how to sustain CSO activities in communities and volunteers' motivation.

At this initial stage, it is recommended that (i) the countries produce evidence-based and qualitative research and policy recommendations to advocate high-level officials, (ii) start from replication of effective models in similar geographical and contextual areas, (iii) not compete with the governments' systems but be complementary components for gradual acceptance. Our targeted communities are often located in hard-to-reach locations, and government system is often inaccessible, and (iv) employ satisfactory incentives, both monetary and non-monetary items.

4: The costing of the integrated service package and the Global Fund's country allocation are crucial for us to implement this ICMV initiative. It is informed that the Global Fund has budget allocation for this integrated approach under the national malaria program. In addition, the national government also has budget allocated under the responsible ministry to accommodate the integration implementation. This requires further study because each country has different management and budget allocation structure.

5: One of the participants who used to work in Vietnam mentioned that when discussing the prioritization of diseases for inclusion in the integrated service package, each country may have different needs to address. Key problem occurred to children at current stage is 45% caused by malnutrition with limited service coverage. It affects child development and child cognitive development. Therefore, each country needs to consider carefully when determining the priority needs for integrated service package, and inclusion in the country strategic plan. We also need to mainstream human rights, social inclusion, and gender for marginalized groups.

6: The national strategic plan (objective) must be finalized by December 2019. It is unrealistic for us to finish the disease prioritization, advocacy among all key stakeholders, and a strategic plan for intervention by October 2019. Therefore, it is recommended that we include this integrated service component as recommendations in the regional component of the upcoming funding request to the Global Fund. The plan for drafting recommendation paper shall be further discussed at the Executive Meeting held on July 9th, 2019. The CSO platform members may need to adopt co-financing with other donors.

IV. Group Exercise 1: Identifying Gaps in Service Delivery/Missed Opportunities for Greater Integration

Dr. Htin explained the group work process that each group/country members must brainstorm and answer the following questions. Each country focal point person was responsible for facilitation, note taking and presentation for his/her designated group. Information received from this session shall be used as inputs for the upcoming funding request. Due to time constraints, the participants were requested to mainly focus on health needs the community and its next level (primary care closest to the communities).

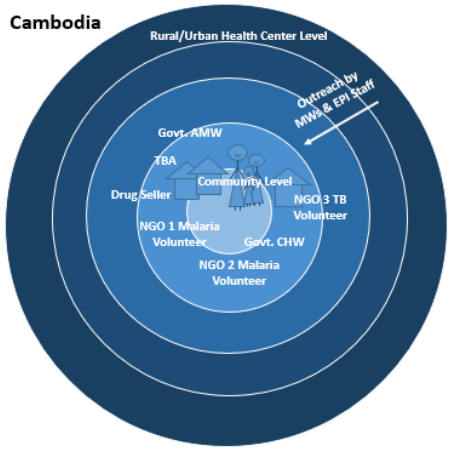
The following are the results from group discussions.

Question 1: What are the health needs of the community? Do needs differ across different parts of the country or particular populations in the country?

Priority	Cambodia	Laos	Myanmar	Vietnam	Thailand
1	Malaria	Malaria (LLIN distribution and outbreak response)	Malaria	Nutrition	HIV/TB
2	Dengue	TB	Dengue	Maternal and child health	Dengue/Chikungunya
3	TB	Nutrition	TB	SRH	SRH
4	Nutrition	Dengue	HIV/AIDS	HIV/AIDS	Nutrition
5	HIV/AIDS	Diarrhea	Diarrhea	TB	NCDs including diabetes, hypertension and obesity
6	Pregnant Women (Antenatal Care; Delivery; Post Natal Care)	Sanitation	Nutrition	Liver diseases	Influenza
7	ARI (Acute Respiratory Infection) including Pneumonia	Surveillance		Cancer	IDU/DU
8	Diarrhea			Sanitation	Immunization
9	Immunization			Tobacco use	Chemical injuries
10	Hypertension			Alcohol use	
11	Diabetes				

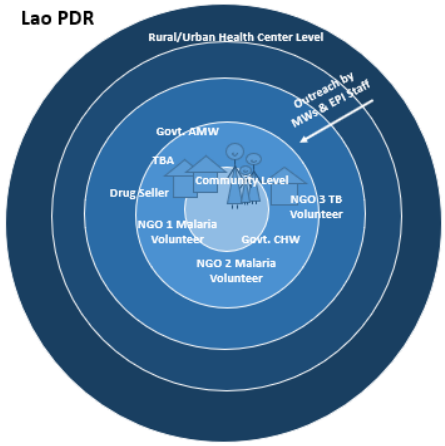
Question 2: How are health services (the national landscape) focusing on primary care provided to and nearest to them (i.e. types of providers)?

Cambodia



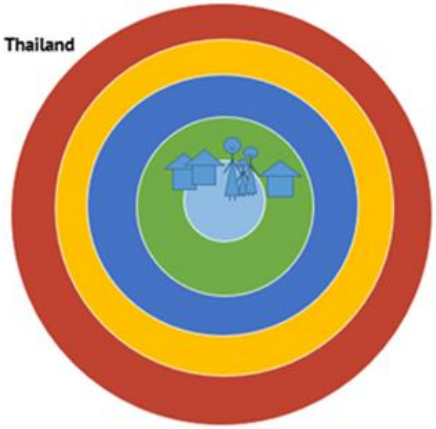
- **Village Malaria Workers (VMWs)/Mobile Malaria Workers (MMWs)**
- **Community DOTS Watchers (C-DOTS Watchers)**
- **Village Health Support Group (VHSGs)**
- **Village Health Volunteers (VHVs)**
- **Private Providers (PPs)**
- **Traditional Birth Attendant (TBA)**
- **Herbal Traditional Healer**
- **Health Post**
- **Health Centers**
- Referral Hospital
- Provincial Hospital
- National Hospital

Lao PDR



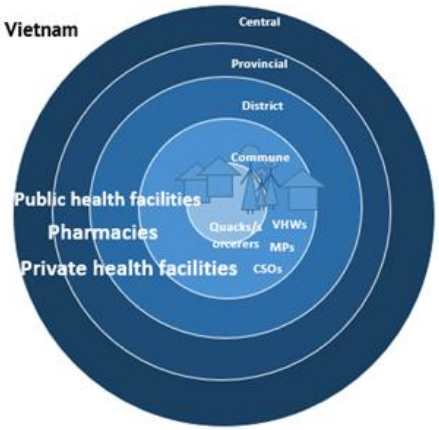
- **Community Health Worker (CHW)**
- **Mobile outreach team**
- **Community Leaders and Influencer**
- **Peer Educator**
- **Quack**
- **Private Pharmacy**
- **Health care provider at the Health center level**
- **District health care provider**

Thailand



Outreach	Community-based	1st referral	2nd Referral
MW	Border Post	Rescue EMT	Provincial H
CHV	NGO	District Hosp	Military H
MHV (Gov)	MP	Private clinc	Police H
MHV (CSO)	MC		
CSO	CSO		
VBDU	VBDU	VBDU	
HPH	HPH		
	Church		
	Teacher		

Vietnam



-**Public health providers:** central/provincial/district/communal facilities, village health workers, malaria posts
- **Private health providers:** clinics, pharmacies, etc.
- **Community health providers:** CMCs, FMCGs, CMATs, etc.
- **Quacks/ sorcerers**

Question 3. What types of health services are provided by the different types of health providers?

Cambodia

Types of Health Providers	Malaria Services						Other health services
	Diagnosis by RDT	Treat ment	Prevention	Referral	HE and BCC	Surveillance	
1. VMWs/MMWs	x	x	x	x	x	x	
2. VHSGs				x	x		Provide health information, health education (HE) and refer patients from community.
3. C-DOTS Watchers				x	x		Provide health information, health education (HE) and refer patients from community.
4. VHVs				x	x		Provide health information, health education (HE), TB DOTs and refer patients from community.
5. PPs				x			Provide wide range of health services including referral.
6. TBA							HE and referral for ANC, PNC, Immunization
7. Herbal Traditional Healer							Herbal medicines
8. Health Post	x	x	x	x	x	x	Minimum package activities (Not full)
9. Health centers	x	x	x	x	x	x	Minimum package activities
10. Referral hospital	x	x	x	x	x	x	Complimentary package activities (CPA)
11. Provincial hospital	x	x	x	x	x	x	Complimentary package activities (CPA) and Specialized services
12. National hospital	x	x	x	x	x	x	Complimentary package activities (CPA) and Specialized services

Lao PDR

Types of Health Providers	Malaria Services							Other health services
	Diagnosis by RDT	Treat ment	Prevention	Referral	HE and BCC	Surveil lance	DHSI2	
1. CHWs	X	X	X	X	X	X	X	1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation, 7. Surveillance
2. Mobile outreach team	X	X	X	X	X			1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,
3. Private Pharmacy	X	X	X	X	X			1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,
4. Community Leaders and Influencer			X	X	X	X		1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,
5. Peer Educator			X	X	X			1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,
6. Quack	X	X	X	X	X			1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,

Types of Health Providers	Malaria Services						DHIS2	Other health services
	Diagnosis by RDT	Treat ment	Prevention	Referral	HE and BCC	Surveil lance		
Health care Provider (HC)	X	X		X				1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,
8. Health Provider (District)	X	X	X	X	X	X	X	1. Malaria, 2. TB, 3. Nutrition, 4. Dengue. 5. Diarrhea 6. Sanitation,

Myanmar

Types of Health Providers	Malaria Services						Other health services						
	Diagnosis by RDT	Treatment	Prevention	Referral	HE and BCC	Surveillance					ARI	Diarrhea	Nutrition
1. **CHWs**	*	*	*	*	*	*					*	*	*
2. **AMWs**			*	*			BEmOC						
3. TBAs			*	*			BEmOC						
4. **ICMV**	*	*	*	*	*	* Noti	TB referral/ Leprosy referral	HIV/ STI	LF	Dengue			
5. Mobile Teams	*	*	*	*	*	* Noti	Rx of other d/s						
6 .GP Doctors	*	*		*	*	* Noti	Rx of other d/s				*	*	*
7. Quacks	?	*					Rx of other d/s				*	*	*

Types of Health Providers	Malaria Services						Other health services						
	Diagnosis by RDT	Treatment	Prevention	Referral	HE and BCC	Surveillance					ARI	Diarrhea	Nutrition
8 .Drug Outlets		*					Sell drugs for other d/s				?	?	?
9. DOTs Provider (TB)							TB referral	DOTs					
10. TB mobile team							TB Dx and referral						
11. BHS	*	*	*	*	*	*	EPI		MNCH	Tx for other d/s	*	*	*
12. EHO Staff	*	*	*	*	*	*	EPI		MNCH	Tx for other d/s	*	*	*

Thailand

Types of Health Providers	Malaria Services					
	Diagnosis by RDT	Treatment	Prevention	Referral	HE and BCC	Surveillance
1. CHV						notification
2. MHV						
3. VBDU						
4. HPH						
5. CSO						notification
6. MP						
7. MC						
Military						

Vietnam

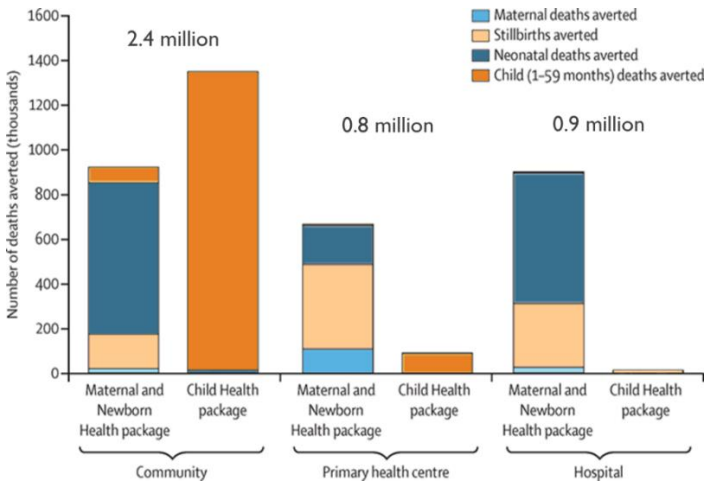
Types of Health Providers	Malaria Services						Other health services
	Diagnosis by RDT	Treatment	Prevention	Referral	HE and BCC	Surveillance	
Central level health facilities	x	x	x		x	x	
Provincial level health facilities	x	x	x	x	x	x	
District level health facilities	x	x	x	x	x	x	
Commune health centers	x	Uncomplicated/pregnant cases Initial Tx for complicated cases	x	x	x	x	
Village health workers	x	Uncomplicated cases Initial Tx for complicated cases	x	x	x	x	
Malaria posts	x	x	x	x	x	x	
Private health facilities	x	Uncomplicated/pregnant cases Initial Tx for complicated cases	X	x	x	x	
Pharmacies			x	x	x	x	
CSOs (CMC, CMAT, FMCGs)			x	x	x	x	
Quacks/sorcerers							

V. Prior to the Group Exercise 2, *Ms. Alyssa Davis* shared with the participants **"Advocacy for Advancing Disease Integration / Primary Healthcare / Universal Health Coverage with Community Health Worker Programs".** The objective is to provide introduction and in-country examples of disease integration in CHW programs, advocacy entry points for advancing disease integration/primary health care/UHC, and the development of an advocacy strategy (leading to Group Exercise 2).

What is Advocacy? This can be explained through different ways of explanations but aiming for few key words highlighted below.

- Attempt to *influence an action* outside our immediate control at national scale such as the ministries' inclusion of disease integration in country strategic plan,
- A process of persuading or convincing key stakeholders to *undertake certain actions* (in this context, malaria) to reach out to hard-to-reach communities
- Collective efforts to influence multi-stakeholders *for wider scale change* through methods outside our usual project implementation mindsets for *long-term impact*.

Examples of disease integration: During the past years, there have been many guidelines, tools, and impact reviews on community's involvement and disease integration around the world, in which the countries can refer to as evidence-based information in our advocacy work. Example is as below and many others.

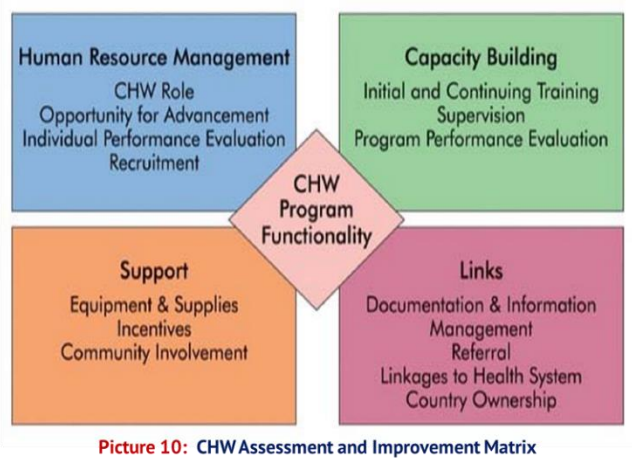


Picture 9: Strengthening and scaling up community and primary health care platforms could prevent 77% of preventable maternal, newborn, child deaths and stillbirths globally

Even though CSOs has not been often explicitly expressed as key player in the community health system but CSOs have important roles as supporters, implementers, and promoters of the complementary services. A strong partnership between government's health system and community health workers are required to reinforce the success and the program's sustainability at larger scale. A recent global review of evidence identified a minimum package of four strategies that make up an integrated approach to strategic partnership between communities and the health system:

1. Joint ownership and design of CHW programs
2. Collaborative supervision and constructive feedback
3. Balanced package of incentives; and
4. Practical monitoring system incorporating data from communities and the health system

Advocacy Entry Points: CHW Assessment and Improvement Matrix below was developed from evidences collected globally to guide and assist in CHW program development, improvement, and related policy development. Countries may refer this framework as advocacy entry points.

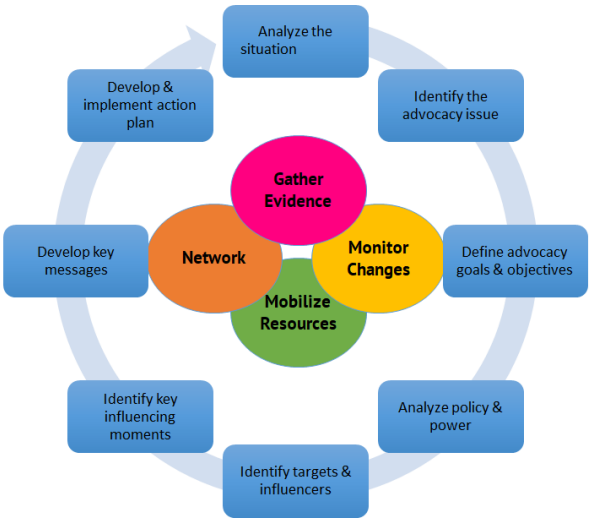


Picture 10: CHW Assessment and Improvement Matrix

For example, in recruitment for community health worker to work on integrated service delivery. This framework guides us where the particular activity locates, what relevant factors are, and how to link them together. These compose opportunities to raise and advocate integration, in combination with local context intervention.

In addition, it is recommended that countries may apply other tools such as community engagement, social responsibility mechanism and any other tool that voice out communities' demands for disease integration as advocacy entry points. These tools should be used when formulating advocacy strategy and action plans in consultation with key stakeholders in countries.

Development of Advocacy Strategy:
Further to the Group Exercise 1 where the countries were required to think through existing health needs and health care services available near the targeted communities, the next step the countries shall need to identify on *gaps for improvement* for advocacy strategy and action plan development.



Basic advocacy framework started from the analysis of the current situation (Group Exercise 1), identify the gaps for improvement or advocacy issue, define goals and objectives, and other activities as shown clockwise in **Picture 11: Basic Advocacy Framework.** Note that these elements require continuous update as the countries' context keep changing from time to time.

VI. Group Exercise 2: Developing Advocacy Action and Plan

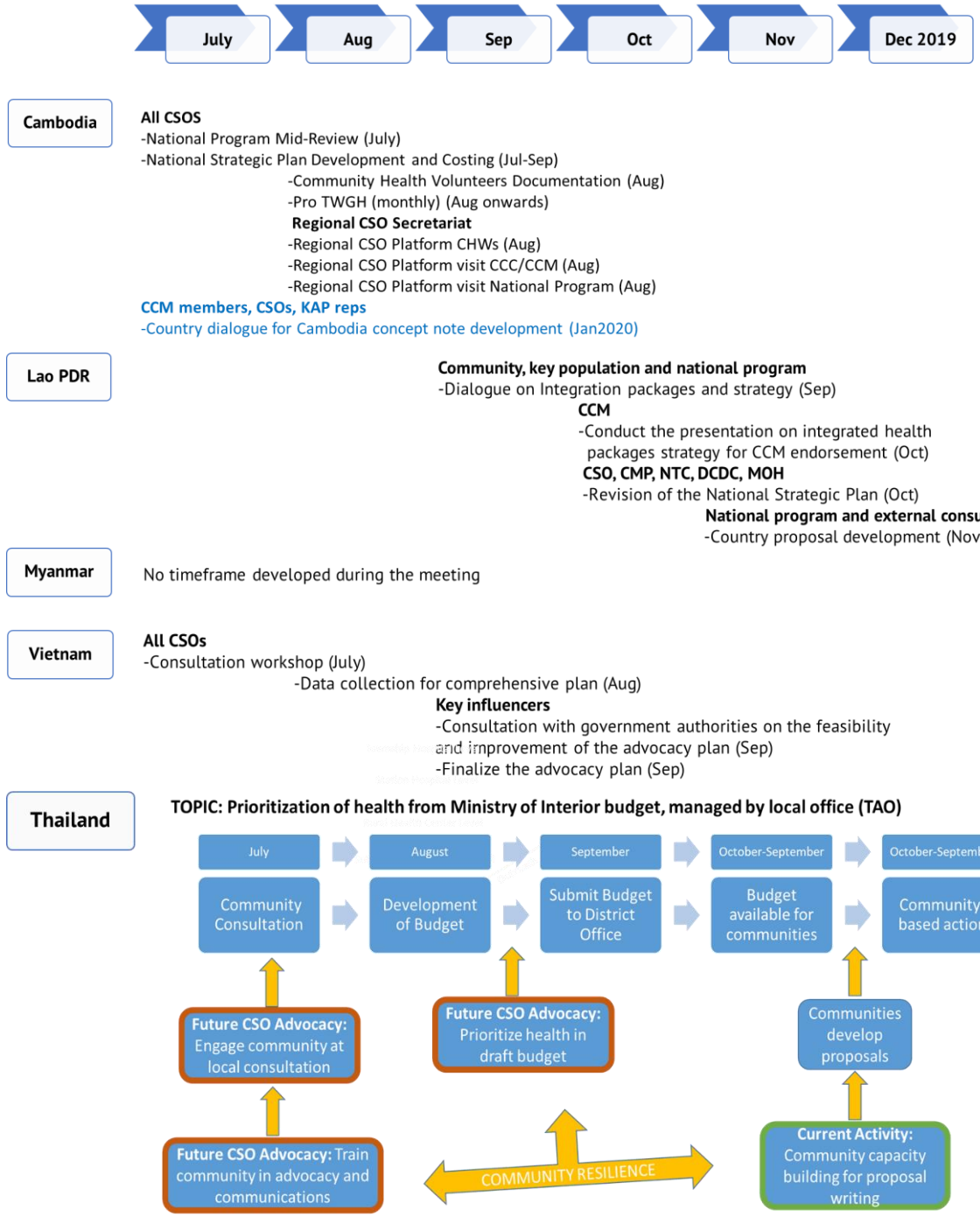
This exercise is not an intent to produce a perfect and comprehensive advocacy strategy and action plan for the country members, but aim for the participants to think through advocacy components and critical factors influencing a successful advocacy work in country.

Discussion result from 5 countries is summarized as below.

	Cambodia	Lao PDR	Myanmar	Thailand	Vietnam
Advocacy Goals / Objectives	-	To present the health packages of diseases integration in to the national program strategic plan in 2019 for 2021-2023 investment and funding request to the GFATM. The Integration packages will be conducted by the list of community health care providers and other providers nearest in the community Disease Package: -Malaria (LLIN distribution and outbreak response) -TB -Nutrition -Dengue -Diarrhea -Sanitation -Surveillance	Integration in volunteer service package -Resource mapping VHV overlapping at same implementing sites -Many types of service provider with more or less the same services -Linkage with minimal health service package in NHP Integration of donor funding -Donor Screening To increase Union expenditure on health To advocate NSA for UHC to be in line with NHP	-	1st -Malaria testing to be done by community volunteers 2nd- Coordination/reporting among all partners to be improved 3rd-Other health issues to be integrated into community volunteers' service package for HTRs

	Cambodia	Lao PDR	Myanmar	Thailand	Vietnam
Key Advocacy Targets & Influencers (who?)	-Ministry of Health (MoH); -National Programs: CNM, CENAT, NCHADS, NCHP, NCMCH; -Provincial Health Departments -Donors: Global Fund, USAID, and others -World Health Organization (WHO) -Cambodia Coordination Committee (CCC)/CCM	-Provincial Health Department/National Program/DCDC -Ministry of Health (MoH) -CCM	-Donors -MOHS -Parliament and Union Government NSA (Non-state actors) -CSO Representatives (country and regional) -Each CSO Focal from PR teams	-MoPH -Ministry of Interior -Other relevant government agencies -CSO Platform -Local authorities -Religious leaders -UN Agencies -Migrant working group -NHSO -ASEAN -APLMA -CCM/RSC -CBO/CSO/NGO	1st- NMCP/NIMPE, MOH, Provincial CDCs, General Department of Preventive Medicine 2nd -NMCP/NIMPE, Provincial CDCs 3rd-MOH, General Department of Preventive Medicine, Provincial CDCs, Provincial DoHs, other health programs
Key Influencing Moments (what & when?)	-National Program Mid-Review (In progress) -National Strategic Plan Development and Costing (Sep19) -Country dialogue for Cambodia Concept Note Development (Jan20) -Provincial Technical Working Group for Health (Aug19) -Regional CSO Platform Visit with WHO, National Programs and Ministry of Health	-National Strategic Plan (NSP) Development Process -Funding guideline requirement on diseases integration for cost efficiency and sustainability -Learning model from different regional for Malaria elimination -Community Health needs -Conduct by Q3-Q4, 2019	-RSC meeting -MHSCC meeting -NSP preparation -Concept Note preparation -TSG	-Train community in advocacy and communications, and engage community at Community Consultation (July19) -Prioritize health in draft budget during Budget Development (Aug19) for submission to District Office (Sep19) -Community develop proposals with disease integration (Oct-Sep19)	1st- Partners' meetings at central and provincial levels, national consultations, leadership meetings 2nd-Partners' meetings at central and provincial levels 3rd-National consultations, leadership meetings

Next steps and timeline to develop and implement country advocacy plans (who, what & when?)



VII. Conclusion

In order to move forward under the theme of service integration, the regional CSO platform requires to identify practical steps which may be varied between countries. As a result, the Secretariat developed draft statements for advocacy at high-level targeting government and Global Fund. Below are the draft statements collated from the discussions for comments from the participants for further revision and finalization by the Secretariat. Overall, the CSO platform members unanimously agreed in principle. CSO platform secretariat will take lead in finalizing the draft regional statements in consultation with RSC CSO representatives and respective country steering committee members after the workshop.

Draft regional statements can be seen as following:

Regional statement (1)

CSOs recognize that malaria-only services are not the solution for malaria elimination within the framework of sustainable health provision.

Discussion:

1: Services for malaria alone are no longer adequate for eliminating malaria anymore within the framework of sustainable health provision by malaria volunteers. Additional component like surveillance, an information system consists of the tools, procedures, people and structures) is also required for planning, monitoring and evaluating malaria control programs.

2: It is suggested that this statement should include “by malaria volunteers” to imply the significance and the maintenance of malaria volunteers’ role and capacities. However, it is good to note that the ultimate goal is to achieve the elimination of malaria, not the malaria volunteers themselves as priority, even though a lot of investment was made on their capacity development. They require motivation through addition of valuable tasks (disease and service integration), attractive incentive package (both monetary and non-monetary), and inclusion of their roles in the National Strategic Plan for further advocacy at RAI RAS meeting and Global Fund Board meeting.

3: It is suggested that this statement should include “epidemic diseases” as to open for integration of other diseases and services in the future.

Regional statement (2)

Build up the Integration: targeting the government recognized cadre and integration of service package defined by the needs of the community

Discussion:

1: In some countries, community health volunteers and their efforts have not been recognized by the government. Communities do not often recognize the prevalence of diseases in their locations. Situation is different in Cambodia. Cambodia relies so much on community health volunteers as they

directly respond to communities' needs. It is necessary to align with government policy and one volunteer system to create effective health system, instead of factoring in various systems.

2: Further to comment 1, it is suggested that we recognize the formal health system provided by the governments while ensuring marginalized and hard-to-reach populations (our target groups) receive required and suitable services. Government usually provides services to people living in main cities and their neighboring towns. The words "government recognized" and "community engagement" are suggested for adding. However, we need to be mindful of national context like in Lao PDR where the "government recognized" implied the prohibition of other players (such as peer educators, people injecting drugs, etc.) in the system.

Regional statement (3)

Government Ownership: The health provision to the community primarily is the responsibility of the government. The role of CSOs is to facilitate the government to achieve those goals. We want to avoid setting up the parallel systems irrespective of donors or diseases and create move away from the multiple providers set up by donors-driven system to government-owned community health workers program.

Discussion:

1: In regard to the "government-owned community health workers program", some countries implement government-owned but not allow community health workers to officially work in government-owned health system. It was suggested to probably consider using "government-oversight" for some countries. For Cambodia, this wording is suitable.

2: In Cambodia, VHSGs are category that is suitable to serve disease integration initiative. Forty percent of them are the same populations as VMWs. Financial support to volunteers from the government is not possible unless it is officially specified in the government's official documents. It is necessary to factor this financial issue into the sub-national (provincial) authority budget plan even though unreliable, as well as advocating donors and the government to have ownership over our complementary system.

3: CSO partnership with the government was suggested for transitioning to the sustainability of program and volunteers. So, instead of using the word "facilitate", it was also suggested to use "complement"

Regional statement (4)

Resourcing the Integration Package: GFATM should not use their investment for separating out the HIV, TB, and Malaria but rather invest in single system.

Discussion:

1: Disease like HIV/AIDS requires special intervention due to its sensitiveness, drug use and different targeted populations (high-risk) such as MSM, transgender, and sex workers. Such complicated disease must be single out.

2: Thailand agrees with this statement. The team plans to raise support to fund malaria-infected people who have HIV/AIDS, for example, to fill the gap. Major concern is with key affected populations

like migrant workers and undocumented groups that are usually neglected from the government's official health system.

Regional statement (5)

Meaningful System Linkage: National Strategic Plan should coherently link to the National Health Policy/Plan. Diseases plan should not be done in isolation but aligned within the framework of such national health plan.

Discussion:

1: It is suggested to

- remove "in isolation" and change to a word with constructive meaning
- communicate the "disease integration at community level" in the statement
- specify which "National Strategic Plan" to be for disease integration in each country
- not interfering other irrelevant national plan such as National Plan for HIV/AIDS which requires different interventions
- include other measurement indicators outside malaria cases achieved such as child-affected populations to present wider coverage/integrated achievements
- include antibiotics and other necessary items for "minor injuries" and "assisted referral" for malaria, women dying of obstructive labours, and others into the integrated service package.

Next steps for the Secretariat and the countries:

- The Secretariat to finalize these regional statements by September 2019
- Country focal point persons to integrate them into country action plan for key stakeholders' consultation, adapt into agreed national statements, and influence the process of national strategic plan development.
- Agreed regional / national statements to be reflected in the national advocacy plans and the National Strategic Plans to be developed.

END.