



New Challenges, Existing Networks: Civil Society Experiences from the GMS during COVID-19

15 June 2020, 3:00 PM Singapore time

Panellists

- Mr. Shreehari Acharya, Project Manager, Regional Malaria CSO Platform, GMS, American Refugee Committee
- Mr. Louis Da Gama, CSO Representative and Executive Member at the RAI RSC, Advisor, Regional Malaria CSO Platform, GMS
- Dr. Hnin Su Su Khin, Operations Director, Medical Action Myanmar
- Dr. Eisa Hamid, Regional Senior Programme, M&E and Health Systems Specialist, Principal Recipient for Global Fund, UNOPS Asia Region

Moderator

- Ms. Lorina McAdam, Independent Consultant (Former Director of PSI's regional malaria elimination program)

Questions & Answer (Q&A Box)

Shreehari explored a very comprehensive overview of the challenges faced by CSOs. What are some opportunities for the Regional CSO Platform to respond to these challenges?

From Alistair Shaw

Regional CSO platform, GMS has developed job aid for volunteers and community workers. Document is in English language, and platform is supporting in translation to other local languages in the GMS. Besides, platform is also monitoring PPE supply and coordinating with donor for sufficient supply.

The CSO platform is collecting examples of best practice in the 5 countries so they can be shared widely and applied in other areas where appropriate.

The platform to continue working with in-country CSO network to address country specific issues as no one size fit all approach would work. For instance, some of the issues raised could be addressed in partnership with local (sub-national) authorities.

Is the CSO platform encouraging countries with large garment production facilities to produce PPE of the right sort of quality as opposed to importation as the Covid problem will be around for some time?

From Prudence Hamade

Some of CSOs are producing cotton face mask in the community but it is not sufficient. This is something for us to explore how we can support Local CSOs.

Unfortunately, we do not have the capacity to do this. BUT it's a great idea and perhaps we should consider how to help. We have monthly calls to discuss Covid impact with all the CSO platform members via our governance structure so we can raise this in our next call. Thanks for the suggestions.

It is interesting that 35 out of 70 cases in Myanmar were in children under 15. In Myanmar, are schools closed and will this mean more children may be involved in forest going activities and therefore may be more at risk?

From Prudence Hamade

The CSO platform is looking into how livelihood activities are developing in light of Covid. Many migrants have lost their jobs and returned to their villages. We need to find out more about what communities are doing to feed their families and how this is impacting malaria incidence. As long as there is local transmission, children are at risk.

We believe that there is within village malaria transmission in the villages of Paletwa. We found positive cases even among very young children who were never involved/went to the forests.

This is not surprising finding in areas where malaria is endemic. Transmission happen within the community. Unlike in areas where Malaria is low or eliminated, transition happen in the forests and hill foot. In the latter case, Malaria is more common among mobile and migrant populations (MMPs). Local transmission may happen from importation of malaria by these groups -MMPs.

Do you think there is any way to quantify how much activities have been disrupted per GMS country? e.g. Country 1 - 50% disruption to case management at community level, Country 2 - 10% disruption to case management etc. so that we could potentially model the impact of COVID on malaria with a view to identifying where resurgence might happen? Resurgence of malaria! Not covid!

From Caroline Lynch

The Global Fund reporting cycle means we should have a much better understanding of the disruption in terms of number in July when all the CSO partners will be reporting their figures on the Key indicators to determine where we are against targets.

We are working with partners to assess the impact of distribution. We will be able to get better idea at the end of June when we receive the semi-annual report. Most of Greater Mekong countries introduced movement restrictions and patchy lockdown between April- June. However, this is a period of 'low malaria' and April is usually a month of holiday in the region (Water Festival). Thus the overall impact of the restrictions on malaria activities (testing and treatment) could be near to somewhere between 30- 50%.

Is there any negotiation with government to test malaria for fever cases in fever clinic related with Covid-19?

From Dr Aye Kyawt Khine

No, CHW/malaria workers are not engaged in COVID-19 test.

CHWs are not allowed to test for Covid in any of the 5 countries. We must do everything we can to protect our 39,000+ community health workers to carry out their main task of testing for malaria and not allow Covid to derail their focus. We must do much more to mentor them to overcome the fear that exists within the community.

There was no changes in the national guideline for testing fever. All fever cases get tested for Malaria in areas where malaria is endemic. However, there was disruption for malaria services during the period of lock down. There is also fear among VMWs for testing fever cases for fear of COVID-19.

I think door to door distribution of LLIN is very difficult for remote areas since we can reach only by walking of 3-10 days in some villages. How can we distribute LLIN?

From Dr Aye Kyawt Khine

As the Village malaria workers are key for LLIN distribution, it is possible. We may need to provide additional incentives to malaria workers/volunteers and ask them to increase their time contribution.

That is true, but luckily, LLIN were already delivered to cluster points before Covid hits Myanmar. In very remote areas such as in Naga, we can still manage hiring motorbikes to send LLIN to villages. From there, we do door to door.

Yet, door-to-door delivery of bed nets is doable is preceded by detailed microplanning at the village level. VMWs play major role here. With supervision from upper level in the health care system for CSO and MOHs.

How the CSO can operate the worst reporting area especially for malaria in the area where ABER is around 2-3%

From Pradeep Kumar Srivastava

The CSO is well positioned to serve these remote communities and extend the reach of the national health system to these population. We have seen that in current programme financed by the Global Fund where CSO in partnership with local communities have been able to implement complex health programme and report to the national health system.

To Dr Hnin Su Su Khin: Is there any impact on Vector control and entomological surveillance activities?

From Pradeep Kumar Srivastava

We were able to continue LLIN distribution through door to door approach, but entomological surveillance activities might have postponed, I believe. MAM did not conduct entomological surveillance activities.

To Dr Hnin Su Su Khin: When workers are reluctant in fever survey (in one of your slide), how door to door survey is possible (in you adjustment slide)

From Pradeep Kumar Srivastava

Volunteers/ villagers are afraid of strangers (especially who came back from high Covid confirmed cases/other countries). Villagers are living in the same community and so is our MAM mobile team. Thus, they were not reluctant.

How CSO overcome the effects of COVID in Myanmar?

From Dr Nyan Win Phyo

WHO and national program has provided guidance to continue malaria implementation with precaution. Platform has produced Job aid to malaria workers to protect from possible COVID-19 transmission while they provide service to the community.

CSOs have been finding various ways to provide additional support to the entire network of CHWs and MMWs via mobile phones and mentoring and empowering them to keep focused on testing and treating as well as supporting integration of service delivery.

CSO in partnership with UNOPS the PR have assessed the impact of pandemic on their projects and worked on developing and implementing risk-based implementation. For instance, the CSO in Cambodia, have categorized their activities during these period of limited mobility into three categories: low risk that can be implemented these will be implemented. Medium risk, will be implemented with full protective measures (PPE). High risk activities will be postponed. The risk assessment will be repeated periodically to update the implementation plans.

To Shreehari Acharya and Louis Da Gama: Is there any volunteer in GMS who had infected with COVID-19 during providing malaria services in the community, as far as we heard or reported?
From Myo Thet Oo

Yes, in Myanmar. Other countries have not reported.

Any malaria worker infected with Covid19? what is the scenario of Covid 19 cases in the malaria endemic areas? is there any relation ships with the number of malaria cases and Covid cases? Is there any mobile clinics in which both Malaria and Covid tests are carried out together?
From Dr Anju Viswan K

We should encourage more assisted referrals to the local health centers where covid testing is available as CHW are not trained or allowed to test for Covid.

It is important to monitor the situation of infection among health workers including community health workers.

What is the scenario of malaria in this Covid time? Cases reduced? What about the death rates?
From Dr Anju Viswan K

Our reason has very low death from malaria, however we are entering to rainy season and COVID is still with us we need to protect our workers with knowledge and PPE.

We will have a much better idea once UNOPS have collated the data.

Too early to say. This is low malaria season.

It is early to full assess the impact of pandemic on Malaria and other diseases. More data and information needed to be collected. Modelling will play a key role in assessing the impact of covid-19 on malaria.

What about other vector borne diseases like dengue, JE? Are cases reduced or hiked in this Covid time?
From Dr Anju Viswan K

As mentioned above, It is early to full assess the impact of pandemic on communicable diseases. More data and information needed to be collected. Modelling will play a key role in assessing the impact of covid-19 on malaria.

I would like to ask a question about the effect of COVID-19 on the communities in malaria endemic areas. Does the COVID-19 affect the perceptions of communities or village health workers in malaria testing? What did the CSO find out in your activities during this pandemic?
From Dr Ei Mon Thinn Kyu

CSOs from the community mentioned that volunteers were hesitating to respond to fever cases as they did not have proper PPE and knowledge about COVID-19 prevention. Now it is improving.

There are anecdotal evidence of mixed effects: on one there is fear of being infected from people with unknown fever or even other symptoms and signs while for some community member and providers there was sense of solidarity and unity against a common enemy. There was wide participation from community health workers in distribution of personal hygiene items, masks, and even fever screening.

Would the panelists like to discuss which changes that they have made due to Covid 19 that may be lessons learnt to carry on as normal improvements to the models of service after the pandemic.

Question followed after Shree's answer: Do other panelists have comments on this. Often form adversity comes innovation that is worth continuing after the "disaster".

From Maxine Whittaker

This situation emphasized the need for integrated health services at the community. We should be looking in to possible service integration and collaboration with other sector at the community.

The CSO platform regularly meet to review activities at the community and share good practice and challenges. We will collect this information about what worked well and should therefore continue or what needs to be modified. One of the major advantages the regional CSO platform is the opportunity to discuss success and challenges and how to overcome them.

I think the example from Cambodia in assessing the risk and redesign the implementation accordingly is good example to follow. Collaboration and information sharing with the health providers is important. Service integration and packaging of delivery of commodities are other good example of reshaping programme and services delivery.

Do you have any suggestion for preparing for the 2nd wave of covid 19?

From Nguyen Luong Hien

In my view taking lesson from what we learned during this time and community empowerment will help to deal with 2nd wave, if any.

We need to focus to bringing services close to the local communities so they are not disrupted in case of reintroduction of travel restrictions

There are lot that we learned from the current phase of epidemic that can be used to inform our future preparedness. Key lesson to note here: the need for early planning and response and effective coordination at all level- from village to national level.

Would you mind to tell me the constraints of your activities because of the fighting between military and ethnic revolutionary forces. Frankly speaking who is given more trouble among these fighting groups?

From Thein Win

The effect of emergencies whether natural or man-made such as armed conflict do cause distributions of services. These conflict are also taken into account when assessing the risk. Good example to mention here is to stock of essential supplies at the community level. Community health can continue to serve the people in these as they are living with the community. This one example of many other examples of working in conflict areas. Communication and coordination with the authorities and other partners are here.

ACD was conducted in every member of community irrespective of symptoms?

From Sanjaya Acharya

Yes but in areas with persistent high malaria (hotspot)

Could anyone share how can we apply patient data protection in using social media/app in data reporting during this period? Thanks a lot!

From Dr Khaing Wai Wai Phyo

This is key issue and parameter in designing any smart data sharing application or platform. One thing is to collect the minimum possible data set, no personal identifiers, restricted use of geolocation etc. All this with strongest system security and data sharing SOP. Training (on data confidentiality) is key as well.

To Dr Hnin Su Su Khin: Is that any strategies for improving communication amongst malaria workers in condition without having access to electricity or the internet connection? How do they send the malaria cases report from rural area? Thank you so much.

From Robertus Guntur

Reports were sent to the cluster points on agreed dates/weeks by volunteers and we collected from there. Travel among villages within the same township is still possible although travel from one township to another is limited/restricted. Thanks.

How has COVID-19 affected the number of people going to the forest? May be numbers have gone up as a result of repatriated migrants going to the forest to find food... or maybe numbers have fallen as a result of reduced market for forest products due to travel restrictions? If this information is not available, could CSOs liaise with formal sector forest goers and MMWs in key forest hotspots to clarify?

Interesting... thank you. Would be great to get more data on this.

From Sean Hewitt

Based on anecdotal information, some GMS countries people look for alternative livelihood in forest as they lost their job because of COVID-19. Specially people who return to their country from the neighboring countries.

Feedback from our field staffs was that some villagers left their homes at village and stayed at their farm cottage to stay away from Covid. However, this is just anecdotal evidence and no formal data existed. Good question.

Questions from Chat Box

Is CSO synonym of Community support group (CSG)?

Follow up question: Any specific definition for "hot spot"

From Dr Nu Nu Khin

CSOs include a wide group of non-government, non-private groups, so community support groups can definitely be a type of CSO. As Louis mentioned, CSOs are very diverse, from small community groups, faith-based organizations, and large international NGOs.

Questions from Registration forms

Is there any technical sharing information on role of case management and case investigation in Malaria elimination agenda?

From Dr Moh Moh Lwin

The CSO regularly conducts information sharing of best practice and how to overcome challenges including technical information

These malaria surveillance activities are integral interventions in malaria elimination. Unlike in situation of malaria control, surveillance for elimination is an intervention itself. In simplistic form: Every malaria case needs to be reported ideally within 24 hours, then health workers carry out confirmation of the case with 2-3 days (additional testing and interview) to ascertain the species and possible place/location of infection. This is called case investigation. Once the possible sources of transition mapped, health workers from the malaria programme would carry field visit to do further assessments and identifications of other cases (secondary cases). This called foci investigation

What are the functions and roles of the Civil Society Organisations in malaria elimination program that will distinguish them from that of the health?

From Arlene G. Bertuso

It is different in counties. But main role is to support national program in malaria response in a rea where government system is not fully able to reach.

I have mentioned few examples: CSOs constitute a veritable, low-cost labour for health service delivery, especially in remote hard to reach places (forest areas in terms of malaria control and elimination); and where they are developed, they can easily be plugged into the existing data systems for reporting; they can be trained to use new technologies (all the new malaria testing tools) and given their organizational capacity, CSOs can be relied upon as a true partner in delivering malaria and other health services because they live with the beneficiaries of the health system. In fact CSOs can even be tapped as a source of resource mobilization to finance strengthening the health service. etc.

Most of the CSOs are donor funded or depend on external funding sources. Are there any experience or example in APMEN areas that CSOs has plan or sustain resources locally for their malaria work?

How successful CSOs in advocacy for domestic resource mobilization or funds raising including influencing host government to adequately fund their malaria control programs?

From Gune Dissanayake

Work is beginning in Thailand on local resource mobilization to support malaria elimination activities once global Fund ends or is significantly reduced. The CSO platform need to increase focus on resource mobilization at community level in partnership with the private sector. UMFCCI in Myanmar is also exploring ways that the private sector can help sustain malaria elimination activities going forward.

What are the characteristics of Mobile Migrant Population (MMP)?

From Dr Khin Maung Wynn

They are at risk as they do temporary work in the remote areas and along the international border, mainly in agriculture and forest. some of them on the international border do not have proper document which allow them to work legally therefore unable/fear to access the available health services.

CSOs have identified and trained Mobile Malaria workers from within the mobile population so that they are known and trusted by this community as first line providers of health services

This a key challenge to the malaria CSO. They need to work on the transition model (from external funding/donor) that support sustainability. The examples we have heard about the work done by CSO such as health service integration, carry out surveillance activities and knowledge transferring and deskilling are key activities to support this transition and sustainability.

APMEN would like to thank all of our panelists for their time and sharing their knowledge.

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