Report

Strengthening Malaria Control for Ethnic Minorities in the Greater Mekong Subregion

Final Project Advisory Committee and Advocacy Meeting

Simao, Yunnan Province, China
26-28 November 2007

Manila, Philippines
October 2008
Report

Strengthening Malaria Control for Ethnic Minorities in the Greater Mekong Subregion

Final Project Advisory Committee and Advocacy Meeting

Convened by

World Health Organization
Western Pacific Region

Simao, Yunnan Province, China
26-28 November 2007

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NOTE

The views expressed in this report are those of the participants in the Final Project Advisory Committee and Advocacy Meeting and do not necessarily reflect the policies of the Organization.

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This report has been prepared by the World Health Organization Western Pacific region for governments of Member States in the Region and for those who participated in the Final Project Advisory Committee and Advocacy Meeting held in Simao, Yunnan Province, China from 26 to 28 November 2007.
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### ABBREVIATIONS

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<tr>
<td>ACD</td>
<td>Active case detection</td>
</tr>
<tr>
<td>ACT</td>
<td>Artemisinin-based combination therapy</td>
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<td>ACTMalaria</td>
<td>Asian Collaborative Training Network for Malaria</td>
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<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ARI</td>
<td>Acute respiratory infections</td>
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<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control</td>
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<tr>
<td>CHC</td>
<td>Commune health centre</td>
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<td>CMPE</td>
<td>Centre for Malaria, Parasitology and Entomology, the Lao People’s Democratic Republic</td>
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<tr>
<td>CNM</td>
<td>National Center for Parasitology, Entomology and Malaria Control, Cambodia</td>
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<tr>
<td>CoMC</td>
<td>Community malaria clinic (Thailand)</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability adjusted lifeyears</td>
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<tr>
<td>DOT</td>
<td>Directly observed treatment</td>
</tr>
<tr>
<td>EDAT</td>
<td>Early diagnosis and treatment</td>
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<tr>
<td>EMG</td>
<td>Ethnic minority group</td>
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<tr>
<td>EPI</td>
<td>Expanded programme on immunization</td>
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<td>EWRS</td>
<td>Early warning and response system</td>
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<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<tr>
<td>GMS</td>
<td>Greater Mekong Subregion</td>
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<tr>
<td>HC</td>
<td>Health Center</td>
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<tr>
<td>HP</td>
<td>Health Post</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>IMCI</td>
<td>Integrated management of child illnesses</td>
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<tr>
<td>IMPE-QN</td>
<td>Institute of Malarialogy, Parasitology and Entomology, Quy Nhon, Viet Nam</td>
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<tr>
<td>IRS</td>
<td>Indoor residual spraying</td>
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<tr>
<td>ITN</td>
<td>Insecticide-treated net</td>
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<tr>
<td>Lao PDR</td>
<td>Lao People’s Democratic Republic</td>
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<tr>
<td>LLIN</td>
<td>Long-lasting insecticidal net</td>
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<tr>
<td>MCV</td>
<td>Malaria control volunteer (Viet Nam)</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MBDS</td>
<td>Mekong Basin Disease Surveillance Project</td>
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<tr>
<td>MCH</td>
<td>Mother and child health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOLISA</td>
<td>Ministry of Labour and Social Affairs</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NIPD</td>
<td>National Institute of Parasitic Diseases, Shanghai, China</td>
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<td>NMCP</td>
<td>National Malaria Control Programme</td>
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<td>NMI</td>
<td>National malaria institution</td>
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<tr>
<td>Pf</td>
<td><em>Plasmodium falciparum</em></td>
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<td>POA</td>
<td>Plan of action</td>
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<tr>
<td>PPM</td>
<td>Public-private mix</td>
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<td>PPP</td>
<td>Public–private partnerships</td>
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<tr>
<td>Pv</td>
<td><em>Plasmodium vivax</em></td>
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<tr>
<td>RDT</td>
<td>Rapid diagnostic test</td>
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<tr>
<td>SEARO</td>
<td>South-East Asia Regional Office</td>
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<tr>
<td>SPR</td>
<td>Slide positivity rate</td>
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<tr>
<td>VBDC</td>
<td>Vector-Borne Disease Control</td>
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<td>VHA</td>
<td>Village health assistant</td>
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<tr>
<td>VHV</td>
<td>Village health volunteer (Cambodia, Lao PDR)</td>
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<td>VHW</td>
<td>Village health worker (Viet Nam)</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>VHSG</td>
<td>Village Health Support Group (Cambodia)</td>
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<td>VMCV</td>
<td>Village malaria control volunteer</td>
</tr>
<tr>
<td>VMW</td>
<td>Village malaria worker (Cambodia)</td>
</tr>
<tr>
<td>VMV</td>
<td>Village malaria volunteer (China)</td>
</tr>
<tr>
<td>VD</td>
<td>Village doctor (China)</td>
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<tr>
<td>YIPD</td>
<td>Yunnan Institute of Parasitic Diseases, Simao, China</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>Western Pacific Regional Office</td>
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1. INTRODUCTION

1.1 Background information

Malaria control is a health priority in the Greater Mekong Subregion (GMS). Ethnic minorities in the GMS are among the most vulnerable groups at risk for malaria. In 2005, the Asian Development Bank (ADB) agreed to provide financial support through the WHO Western Pacific Regional Office to the GMS member countries to control malaria for marginalized and hard-to-reach populations with a project entitled "Strengthening Malaria Control for Ethnic Minorities in the GMS". The aim of this project is to strengthen national capacity to deliver effective malaria prevention and control measures with the specific objectives to (1) build capacity of national malaria institutions to develop acceptable, affordable and effective strategies for malaria control for ethnic minorities; (2) scale-up malaria control efforts for these populations through national malaria control programmes (NMCPs); and (3) promote regional collaboration for malaria control. The Project was launched in October 2005 and ended in December 2007.

The Project gave the opportunity to the national malaria control programmes in the six member countries to pilot community-based comprehensive malaria prevention and control interventions among specific ethnic minority groups (EMGs): increasing bednet coverage, usage and re-treatment rates; strengthening village health volunteers' capacities to implement malaria prevention and control strategies; improving malaria diagnosis and treatment obtained from trained personnel through promoting utilization of local health facilities and stressing the importance of correctly adhering to complete doses of artemisinin-based combination therapy (ACT). The Project put a strong emphasis on education and community mobilization as well as on monitoring and evaluation of the interventions.

The project teams in the six countries identified target populations to work with; collected baseline data on malaria cases, bednet use, knowledge and practices of the population regarding malaria prevention and control and perceptions of local health care services; introduced community-based interventions through trained village volunteers including use of rapid diagnostic tests (RDTs) and ACT, Information, Education, Communication (IEC) and social mobilization; strengthened collaboration among malaria partners; improved local capacity to provide effective malaria control through strengthening of logistics and monitoring and supervision.

The Project Evaluation – Data Analysis Workshop was held from 22-27 October in Phnom Penh, Cambodia, bringing all country teams together to analyze post-intervention survey and interview data as well as data from monthly routine project monitoring in the pilot villages; to compare country project achievements with the set project targets; to draw lessons learned; to outline the country final project reports; and to draft a regional strategy for malaria control among marginalized populations.

The Final Project Advisory Committee and Advocacy Meeting in Simao, Yunnan, China, was intended to share the achievements and lessons learnt of the Project among all GMS member countries and a wide range of partners, suggest adequate malaria control intervention packages and their scaling up, and discuss and adopt a regional malaria control strategy for marginalized populations.
1.2 Meeting objectives and expected outcomes

The aim of the meeting was to strengthen regional collaboration and advocate the scaling up of malaria control for ethnic minorities in the GMS.

The specific objectives of the meeting were:

1. To share country projects’ achievements and lessons learnt;
2. To discuss country strategic plans on malaria control for marginalized poor ethnic communities;
3. To discuss and finalize a regional strategy for malaria control among EMGs in the GMS;
4. To discuss how to further advocate and scale up malaria control among EMGs and other marginalized populations in the GMS.

Expected outcomes were:

- Project achievements and outcomes of country project interventions are shared among malaria partners;
- Country strategic plans for malaria control for ethnic minorities are discussed and recommended;
- A regional strategy for malaria control among ethnic minority groups in the GMS is discussed and finalized;
- A plan for further strengthening, advocating and scaling up of malaria control among ethnic minority and other marginalized groups in the GMS is discussed and finalized; and
- Collaboration among GMS country teams is strengthened.

1.3 Organization

The meeting was attended by 35 participants, including country participants from the South-East Asia and Western Pacific Regions, a temporary adviser, three observers and 12 WHO secretariat members from the Western Pacific and South-East Asia Regions (SEAR, WPR). Annex 1 shows the programme of activities and Annex 2 contains the final list of participants.

1.4 Opening session

The three-day meeting started with opening remarks by Dr Eva Christophel, WPRO, welcoming all participants and thanking Yunnan Institute for Parasitic Diseases (YIPD) for organizing the project Final Advisory Committee Meeting.

Dr Gao Songshan, Governor of Simao, welcomed the participants to the meeting in Simao City. Mr Duan Hong, Deputy Director General, Yunnan Health Bureau, gave an overview of the malaria situation in Yunnan province, especially along the border of Yunnan and Myanmar – Shan State and Kachin States. Dr Wang Liying, Director of Disease Control, Ministry of Health China welcomed all National Malaria Control Programmes (NMCPs) and participants to the meeting.
Dr John Ehrenberg, Regional Adviser, WHO Regional Office for the Western Pacific (WPRO), acknowledged all NMCPs’ efforts for implementation and contribution to the project. Dr Charles Delacollette, WHO Mekong Malaria Programme (MMP) Coordinator, gave his opening remarks emphasizing the reduction of malaria in the Mekong area, advances in treatment with availability of ACT and long-lasting impregnated bednets (LLIN), the continued problem of *Plasmodium falciparum* resistance and quality of drugs that reach vulnerable populations, among others.

Professor Tang Linhua, Director of the National Institute of Parasitic Diseases - China CDC, Shanghai, called for more cooperation between the Mekong countries.

2. COUNTRY PROJECT EXPERIENCES

2.1 Project overview

**Dr Christophel**, WPRO, provided a brief overview of malaria trends in Mekong countries where malaria mortality and morbidity in 2005 was much reduced compared to 1998. Malaria confirmed cases in 2005 were around 272,000 whereof 151,000 cases in Myanmar alone. Malaria reported deaths in 2005 were 2,296, to which Myanmar contributed 75% of all deaths. Following this overview, Dr Christophel reminded about the Project's goal and objectives, and then explained the objectives of this Final Project Meeting:

1. Share and review country projects’ achievements and lessons learnt;
2. Develop draft country strategic plans and a regional strategic framework for malaria control for EMGs in the GMS;
3. Identify steps to further advocate, sustain and scale up malaria control among EMGs and other vulnerable groups at risk of malaria in the GMS.

**Mr Pricha Petlueng**, Project Coordinator, presented an overview of the project interventions and a summary of country results and project outcomes and achievements, highlighting issues of access to malaria services: physical (geographical barriers) and non-physical (quality of services etc.). In the target villages, the six countries achieved a high coverage of bednets and ITNs compared to baseline, and increased utilization of insecticide-treated bednets (ITNs) and of malaria diagnosis and treatment. He also presented the malaria educational materials from the six countries, pointing at commonalities and additionalities. Discussion points included:

- sustainability of village health volunteers (VHWs) – defining possible role/s, incentives and integration into the health system;
- integration of service delivery with other disease programmes;
- partnerships with other health and non-health agencies.

**Dr Barbara Lochmann**, ADB Social Sector Specialist, raised points observed during project implementation for further consideration and discussion:

1. Individual country approaches need to be scaled up and specific country operational obstacles addressed;
(2) Examine the burden and capacity of national staff, and how service delivery can be shared with other agencies.

(3) VHW sustainability and what is/are their role/s in the future.

(4) What is needed for regional collaboration is the involvement of other ministries in addressing related issues like migrants, etc.

2.2 Cambodia

The Cambodia project was presented by Dr Bouakheng Thavrin, Chief of IEC unit, National Center for Parasitology, Entomology and Malaria Control (CNM), Phnom Penh.

Salient highlights of the Project:

Ninety percent (115,042 people) of the total population (127,825 people) in Rattanakiri is at risk of malaria. The project intervention covered 3,725 of the Kreung ethnic group in ten villages of Ochum district. Although these villages have been covered by the NMCP, the project has put additional activities to deliver the control programme more effectively: advocacy and services at village level; training on research methodology, IEC and monitoring; IEC materials in Kreung language; distribution of bednets for forest-goers; keeping insecticide for bednet impregnation with village volunteers; and conducting monthly meetings among village volunteers and local health staff to report and discuss the malaria situation.

The results from the project implementation showed a dramatic increase of bednet and ITN coverage from 2.9 persons/bednet and 6.9 persons/ITN to 1.7 persons/bednet and 1.8 persons/ITN. Utilization rate for ITN increased from 24% to 87%. Seeking early malaria diagnosis and treatment also increased from 31% to 54%.

Recommendations:

- Scale up EDAT and prevention of malaria to other ethnic groups in Rattanakiri as well as to other provinces;
- Integrate malaria control with other disease control activities (IMCI, diarrhoea, ARI, helminths, etc.);
- Improve referral from community to health center (HC) or hospital;
- Strengthen community capacity and use local resources in support of patients who need to be referred to HC or hospitals;
- Provide routine screening of pregnant women and treatment for malaria;
- Provide LLIN to ethnic minorities in remote and malaria hyper-endemic areas as a priority;
- Provide additional nets to forest-goers (hammock nets) and to adolescents;
- Replace old torn nets;
- Make insecticide for re-treatment of nets available at village level;
- Train village health volunteers (VHWs) on bednet dipping through HC staff;
- Increase number of VHWs to ensure information is accessible to all villagers;
- Provide IEC on prevention of mosquito bites and how to sew nets;

- Provide benefits to VHWs and their families, similar as for the members of the Village Health Support Groups (VHSGs), e.g. free treatment at HC

- Certify VHWs who have completed training.

Discussion:

- What kind of mechanisms have been considered to enable communities to support referral of patients
  
  A village fund exists to help refer patients. However, these are voluntary contributions from the villagers. The NMCP would like to consider offering additional support for this, but no mechanism has been defined yet.

- What is the added value of this project beyond the NMCP routine programme?
  
  The project has strengthened the relationship among health staff and ethnic minorities in the project areas.

2.3 China

The China project was presented by Mr Xu Jianwei, Yunnan Institute of Parasitic Diseases (YIPD), Simao, Yunnan. The target population comprised of the Wa ethnic minority group in 32 villages. The intervention focused on improving access of the target population to malaria control services and commenced in September 2006. In addition, a school-based malaria education programme was initiated.

Salient highlights of the Project:

- The geographical accessibility was improved by recruiting village malaria volunteers (VMVs) and training village doctors (VD) to provide malaria control services (village volunteer to population ratio 1:1116 at baseline vs final 1: 248).

- The economic accessibility was improved by supplying subsidized mosquito nets, free impregnation of nets with insecticides, and malaria diagnosis and treatment.

- In order to ensure cultural accessibility, VMV and health staff members at township hospital were from the Wa ethnic population.

- The information accessibility was improved by using VDs and VMVs to communicate with their fellow villagers.

  Malaria incidence and prevalence were decreased based on mass blood surveys (using the indirect fluorescence assay technique, IFAT). Malaria knowledge of the target population significantly increased as well as ITN coverage and usage and utilization of diagnosis and treatment.

Lessons learnt:

- Free antimalarial drugs does not mean free malaria treatment, because health facilities charge for services.

- Different sizes of bednets are needed according to the needs of the people.

- Different tools/methods of health education are needed to ensure interest and effective learning of the community.
- Intensive training for local health staff and village volunteers are needed.

**Recommendations:**

- Conduct further research on how to improve the accessibility of primary health care for ethnic minority and migrant populations along the international borders.

- Employ health staff and village volunteers to provide malaria prevention and control measures.

- Intensify training of health staff at grass-roots level to improve their capacity.

- In areas where vulnerable ethnic groups live, pay village volunteers a salary matching the salary level of primary school teachers in the same village.

- Put emphasis on malaria education for behaviour change in primary schools.

- Conduct malaria education and community mobilization using varied methodologies over time to promote and sustain interest in malaria prevention and control.

**Proposed Scaling Up:**

Through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) Round 6 grant "Malaria Control along China and Myanmar Border Areas."

**Discussion:**

- What are the roles of VDs and VMVs? How to sustain VMVs in light of declining incidence of malaria positive patients?
  Village doctors [former barefoot doctors] are paid 150 Yuan/month through the provincial government, they are dealing with all kinds of health issues. Malaria-specific VMVs are a new approach introduced through this project and challenges exist, for example high turnover and drop out rates. Maintaining VMVs is prioritized only in very remote malaria-endemic areas/villages.

- Does national policy (not specific to China) allow for VHWs to diagnose and treat?
  According to medical regulation, non-medical persons cannot diagnose or prescribe treatment. VMVs do not give treatment but rely on diagnosis from doctors in the township hospitals. More discussion is needed to explore where diagnosis and treatment needs to be delivered by VMVs. Affordability, sustainability and accountability issues also need to be considered.

- What was the frequency of monitoring and supervision?
  County / township monitoring was done monthly, from the province / central levels once in two months.

- How can we help the population to overcome the opportunity cost?
  The central government has committed free treatment of malaria through a national policy. Some of the village doctors charge for malaria treatment as a means of livelihood as they are supported by the provincial government. Overcoming this problem has to be explored.
2.4 The Lao People’s Democratic Republic

The Lao People’s Democratic Republic project was presented by Dr Rattanaxay Phetsouvanh, Senior Technical Officer, Center of Malariology, Parasitology and Entomology (CMPE).

Salient highlights of the Project:

The project intervention took place in eight villages of Brau-Lave and Taliang ethnic groups in Phouvong and Sanxay districts, Attapeu province, in Southern Laos. The estimated target population was 3500. CMPE adopted a community-based intervention using village health volunteers (VHWs) to deliver malaria prevention and control services. This included strengthening and utilizing existing NMCP infrastructure and approaches with emphasis on service delivery to ethnic minorities through a specific education strategy and monitoring and supervision activities.

A baseline survey was conducted in August 2006 and final survey during the same period in 2007. The results showed good coverage and utilization of bednets and ITNs, and an increasing percentage of people seeking malaria diagnosis and treatment within 48 hours. Village volunteer and local health staff capacity was improved through training and supervision visits. The team has adapted the monitoring forms to suit the local needs and established a monthly reporting system, enabling the district health staff to closely monitor their local malaria situation.

Lessons learnt:

- ITN treatment rate is high (>80%) but ITN usage is not as high as it should have been. ITN use needs to be improved.
- The rapid diagnostic test (RDT) used in the Project (Paracheck™) only detected Plasmodium falciparum (Pf) malaria parasites while other causes of fever, for example Plasmodium vivax (Pv), dengue fever and typhus, were not addressed through the service delivered by trained VHWs (and also not on district level where laboratory capacity is mostly weak). There is no appropriate solution to overcome this problem for the communities.
- Training of VHW needs to be more effective and comprehensive.
- Free distribution of nets and free treatment needs to be equitable, but how to define poor?
- Community approach is desirable but probably not cost-effective in support of VHW activities (incentives, rewards etc).

Recommendations:

- Mobilize and educate people to increase usage of ITNs;
- Introduce RDTs which detect both Pf and Pv, and train VHWs to deal with other fever issues;
- Strengthen VHW capacity to provide more effective malaria prevention services through training and regular supervision visits;
- Governor/district head should support directives for free bednet distribution and malaria treatment;
- Conduct regular effective supervision of VHW which is essential;
- Sustain the provision of essential commodities (diagnostics and drugs) and IEC campaigns, both of which are critical;
- Consider LLIN for remote and marginalized populations; and
- Find ways to support cost-effective community approaches for malaria control.

Proposed Scaling Up:
A specific component for scaling up the ethnic minorities pilot project has been included in the recently approved GF Round 7 proposal.

Discussion:
- *Is there a policy for VHW?*
  National policy allows for registered medical practitioners to diagnose and treat. Nurses are also not allowed to give injections. However, there are specific areas where this policy cannot apply. This has been discussed with relevant health authorities, and as a transitional measure, VHWs especially in remote areas need to diagnose and treat malaria.

- *Deworming campaigns have achieved >75% coverage in schools. What policies exist in this that could be used as a framework for malaria service coverage?*
  Schools are more accessible and not comparable to reaching remote villages. Mass deworming strategies may not reduce actual prevalence over time as supporting change (i.e. construction of latrines, continued education) is necessary.

- *If a two-day training is not enough for VHWs, should there be a more extensive training programme for VHWs?*
  Level of education/literacy is critical. Technical improvements to training curriculum are possible, however, other areas e.g. storage of commodities also need to be emphasized and suitable infrastructure created in support.

2.5 Myanmar
Unfortunately Myanmar representatives were not able to participate.

2.6 Thailand
Ms Kesanee Kladphuang, Project technical focal person from Vector-Borne Disease Control (VBDC), Bangkok, presented the Thai Project.

Salient highlights of the Project:
The Thailand project intervention took place in 11 hamlets of five villages in two districts of Maehongson Province, and covered 560 households with 2447 people. These are mainly ethnic Karen. There have been increasing malaria cases among non-Thai populations moving into two villages. Language barriers are notable in the getting population to understand educational messages. Like in other member countries, a community-based approach was chosen: in the pilot area, Community Malaria Clinics (CoMC) were established, and one villager per village was chosen to be a CoMC worker and trained to provide malaria prevention and control services, including malaria education and mobilizing communities. Three CoMCs were using microscopy, and three were using RDTs for malaria diagnosis.
Lessons learnt:

- The results showed an increasing coverage and usage of bednets and ITNs.
- People suggested and requested provincial and district health departments to continue to support operations for the CoMCs and to include services for diagnosis and treatment of other diseases.
- Border health issues are complicated and sensitive and involve various agencies, due to the diversity of ethnicity, culture, customs, beliefs and languages of the border population.

Recommendations:

- Scale up health services for EMGs and marginalized populations through community-based services with active community participation, malaria integrated with other diseases, and including other vulnerable populations;
- Improve the CoMCs with well-equipped qualified staff and sufficient resources as well as IEC interventions to change health care seeking behaviours of the local people;
- Vector control techniques should be suited to the local malaria transmission pattern - LLIN may be the most appropriate for personal protection if staff and budget to impregnate existing bednets are limited;
- Recruit health care providers from ethnic minorities (through scholarships and other incentives) and local staff who will be key to promote community participation and long-term support for health programmes;
- Partners should contribute to achieve a reduction of malaria and sustain it, through innovative public-private partnerships and involvement of local organizations;
- With the integration and decentralization of malaria control within the health care system, the capacity of local health personnel on malaria control should be improved and human resources at the community or grass-root level be further developed;
- For implementation of border health programmes, establish collaboration and effective coordination between health authorities and other government sectors and private sector agencies;

A *Regional framework for malaria control among EMG / vulnerable populations* should include the following:

- It should not ignore the importance of the demand side, in many cases highlighted in the Project: The problem is not just to ensure physical access but also to encourage people to take advantage of services. Governments and development partners must work to enhance incentives and allowances to help ensure programme access and service use.

- It is important to directly involve minority communities more in identifying what programmes and policies are most appropriate, and what methods of programme delivery are in demand and acceptable. Thus, interventions require tailoring to better fit with the cultural uniqueness of ethnic minorities.

- The implementation of border health programmes, including for vulnerable populations, by Thailand requires cross-border collaboration and coordination...
between border provinces of Thailand and neighbouring countries, including information sharing and joint action programmes.

Proposed Scaling Up:

GF Round 7 funds (approved end 2007) will be used for sustaining the project interventions and scaling up. During the transitional phase, Thailand will continue the interventions from its own resources.

Discussion:

- **What is the added value of this project intervention beyond the NMCP routine programme?**
  The project documented indicators for improved knowledge and net coverage and usage. Provincial and district health officers who were involved also benefited with knowledge gained on malaria control strategies and activities. CoMC workers were considered as malaria workers or ‘malaria staff’ and not volunteers. Free distribution of bednets proved necessary to increase good net coverage for these target populations. Specific IEC tools were developed for the Karen population.

- **Were non-Thai populations targeted in this project?**
  EMGs in Thailand who do not have Thai citizenship are not entitled to get financial support from the Thai government. Access to any health services by EMGs is mainly through out of pocket payment and/or agreement with local authorities and local health service providers. The project has been instrumental to provide free service delivery of malaria commodities to non-Thai populations in the target area (EMGs), and positive outcomes and experiences were used by the Thai NMCP as the basis to develop the successful GF Round 7 proposal targeting non-Thai mobile populations and EMGs countrywide.

- **Is Community Malaria Clinic (CoMC) a newly developed structure? Any support from GF to this new setting?**
  CoMC is not a new initiative for the malaria control programme but it is needed as there was no existing public malaria control service in these villages. The NMCP will try to have local administration and GF to provide continued support for these CoMCs.

2.7 Viet Nam

Dr Truong Van Co, Senior Technical Officer, Institute of Malariology, Parasitology and Entomology (IMPE) Quy Nhon, presented the Viet Nam project implementation, achievements and recommendations.

**Salient highlights of the Project:**

Seven villages with over 4000 people in Khanh Trung and Khanh Vinh communes, Khan Vinh district, Khan Hoa province were selected. The majority population in these villages are the Raglai ethnic people. A previous study on the Raglai in Khanh Hoa province showed that the risk of malaria infection among forest and plot-hut goers is 2.23 times higher than among villagers (Luc Nguyen Tuyen, 2004). The Project aims to strengthen malaria control for forest and plot-hut goers as high risk groups as well as stationary villagers, through training, equipping and providing extra support to existing village health workers (VHWs) and commune health center (CHC) staff to ensure effective malaria control activities.
Lessons learnt:

The results showed positive outcomes with higher usage of ITNs and utilization of malaria diagnosis and treatment due to extra activities providing extra bednets and hammock nets for forest/plot-hut goers; producing relevant IEC material and conducting malaria education with individuals and families in Raglai language; and conducting regular monitoring, supervision and monthly meetings between VHWs and CHC staff.

Recommendations:

- Collaborate between health sector, relevant other sectors and local authorities for malaria control planning and policies in order to support VHWs and CHC staff;
- Sustain on-the-job training for CHC staff (e.g. on microscopy) and VHWs (on RDT, case monitoring and management, providing malaria control services for high risk groups);
- Diversify and scale up communication and health education models in order to motivate villagers, especially the high-risk groups, to seek and use appropriate malaria treatment and prevention;
- Recognize and raise more incentives for VHWs and CHC staff;
- Provide more individual protection materials such as bednets, hammocks, hammock nets, repellents, etc.

- A Regional framework for malaria control among EMG / vulnerable populations should include the following:
  o Sharing of experiences on malaria control between GMS countries;
  o Strengthening intercountry collaboration, especially in malaria control and prevention along the international borders;
  o Integration of malaria control with other disease control and health programmes, for example soil-transmitted helminthiases and malnutrition, which are essential to improve the health status of ethnic minorities and hard-to-reach populations.

Proposed Scaling Up:

GF Round 7 funds (approved end 2007) will be used to address malaria control for ethnic minority groups and migrants.

Discussion:

- What is the added value of this project beyond the NMCP routine programme? The capacity of malaria staff improved regarding project data analysis and project evaluation, and also indirect training and experiences were gained from external consultants. VHWs increased capacity in diagnosis and treatment. IEC materials were specific to the population and so the messages were well understood by the population.

- Are VHWs allowed to diagnose and treat according to national policy? VHW policy now allows for RDT use and limited antimalarial drugs. For forest-goers, if they go for ten days or more, chloroquine and dihydroartemisinin-piperaquine
are provided. Chemoprophylaxis is no more provided to pregnant women but standby treatment is provided (ACT in 2nd and 3rd trimester and chloroquine for 1st trimester).

- What is the EDAT package used in the project site?

VHWs take a blood smears and results are obtained from CHCs. However, VHWs can take blood slides and can give presumptive treatment with artesunate for seven days.

2.8 Regional point of view

Dr Christophel summarized the project experiences from the regional point of view:

Project strengths

- Through the ADB support, it was possible to focus on one especially vulnerable group for malaria (EMGs) (as the 2nd ADB-supported project!);
- Countries succeeded in placing malaria control for EMGs on the agenda of national and regional stakeholders;
- A community based ‘bottom-up’ approach was tried out and adopted by all countries;
- With the support of this project, countries optimized existing interventions (complementarity), filled in programme gaps and introduced new interventions (additionality, e.g. China and Thailand);
- Countries shared resources: within countries (e.g. GF supplies, NMCP staff) and between countries (more resources given to MMR and CHN);
- Strong community mobilization components, using the IEC/communication materials developed in a participatory way in the 1st ADB-supported EMG project;
- A wealth of village-based data was generated;
- Capacity building took place, esp. on district level;
- A regional approach was taken, through the Mekong country network; and
- Project intervention packages for EMGs were included in GF proposals.

Project constraints

- Project overambitious, as per design;
- Too heavy monitoring and evaluation (M&E) component (per design):
  - increased routine monitoring (causing issues with data management), and
  - pre- and post-intervention quantitative and qualitative surveys, which overstretched local and NMCP staff and esp. for qualitative monitoring went beyond existing capacity (qualitative assessments are not part of the NMCP M&E in most GMS countries);
- Lack of conceptual distinction between the provision of malaria services for resident (village) populations and for people moving in and out of forests, or both, making it difficult to identify and address programmatic gaps;
Not enough emphasis was put on the regional perspective during the early phase of the Project, in order to guide design and country implementation – however the regional perspective is crucial when dealing with vulnerable groups in the GMS;

Introducing the Day 2 group work on developing "Country Scale Up Strategic Plans for EMGs and other Vulnerable Populations (2008 – 2012)", Dr Christophel then provided suggestions on what should be considered for the future scale-up of interventions:

**WHO** - Target groups/areas, selection criteria, population numbers

**WHAT** - Definition of intervention packages, routine versus additional activities, community-based, women and small children, policies, interventions beyond malaria

**HOW** - Implementation modalities, including incentives/salaries for volunteers, health system strengthening, cooperation/integration with other health programmes and other sectors, funding, political commitment.

**Discussion of Day 1 presentations:**

- **J. Ehrenberg, WPRO:**
  1. Countries should start thinking horizontally – integration within and outside health system.
  2. National EMG agencies and other policy/planning agencies/ministries need to be involved, including education, defence, interior.

- **Cambodia:**
  What happens to the project sites in the interim until funding for scale-up is available?
  J. Ehrenberg: Since the target project population is small, countries should consider how to ‘piggyback’ with other health programmes – government or other donor/aid/NGO agencies for the interim period.

- **The Lao People’s Democratic Republic:**
  Recommendation:
  Scale up is to be focused where malaria is and will be. Proper mapping, stratification should be done. Gradual scale up is necessary. Although funding may be available through GF, utilization of existing resources – especially human resources, is still limited.

- **Thailand:**
  Recommendation:
  The national budget can be used to co-fund essential components – nets, diagnostics and treatment, salaries, etc.- for the interim to continue project sites. However, with border issues, neighbouring countries have to be involved in the discussions and possible roles identified in the interim as well as in the scale up. Additional human resources also have to be identified, e.g. retired health staff, for continuation of activities in the target villages.

3. **SCALING UP**

Day 2 of the workshop aimed for individual country team working groups to develop a draft "Country Scale Up Strategic Plans for EMGs and other Vulnerable Populations (2008 – 2012)", building on the experiences made in the Project. A framework/guideline for the plan was introduced (Annex 3), which suggested that countries define target groups (both stationary and mobile) and activities, address challenges, identify potential partners, and seek political commitment and necessary resources.
3.1 Preliminary cost analysis of interventions in selected GMS countries

Before breaking into country working groups, Ms Carol Beaver, health economist consultant, presented a cost analysis exercise she and Dr Xia Gang, WPRO, had carried out within the framework of this Project jointly with the China, Lao People’s Democratic Republic, Thailand and Viet Nam teams during country workshops. The goal was to explore options for scaling-up country specific malaria control strategies for EMGs. The methodology applied was an investment analysis, using a Program Budgeting and Marginal Analysis (PBMA) approach that incorporates an option appraisal.

Various options for the countries were presented (results from Lao People’s Democratic Republic in Table 1, Graph 1). From the costing exercise, it was found that the NMCPs had different ideas for cost analysis, and the information obtained was not sufficient to do a complete cost analysis. Time was not enough in each country, and a definition of an intervention package for EMGs was lacking. It was suggested as next steps of the cost analysis: to decide on the target groups, activities and supplies needed; explore different options for service delivery (vertical programme or integrated primary health care at village level); link cost estimates for each option to expected outcomes; based on cost analysis determine which option the NMCP thinks is feasible; and develop an in-depth plan.

Table 1: Laos Option Appraisal
Cost of Options 1 to 6 by program (mix of inputs/activities) (no analysis of impact due to time limitations)

<table>
<thead>
<tr>
<th>SERVIC DELIVERY MODEL</th>
<th>mainstream supplies plus extra RDTs, ACTs, nets</th>
<th>mainstream supplies RDTs, ACTs, and nets</th>
<th>extra RDTs, ACTs and nets only</th>
<th>no RDTs, ACT, nets or insecticide</th>
<th>IEC only - Include surveys and supervision and support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1 current mainstream service delivery model (government and Global Fund financing) at 46 districts - for 2896 (very poor) villages - village volunteers to be paid $4 per week to be focal point to provide malaria and prevention and treatment - surveys and provision of additional training, supervision for 2006</td>
<td>$4,019,700</td>
<td>$3,099,554</td>
<td>$2,736,259</td>
<td>$1,816,113</td>
<td></td>
</tr>
<tr>
<td>Option 2 = Option 1 plus outreach workers</td>
<td>$5,190,878</td>
<td>$4,270,732</td>
<td>$3,907,437</td>
<td>$2,987,291</td>
<td></td>
</tr>
<tr>
<td>Option 3 = Option2 plus extra provincial staff</td>
<td>$5,206,378</td>
<td>$4,286,232</td>
<td>$3,922,937</td>
<td>$3,002,791</td>
<td></td>
</tr>
<tr>
<td>Option 4 = Option 3 plus extra district staff</td>
<td>$5,275,378</td>
<td>$4,355,232</td>
<td>$3,991,937</td>
<td>$3,071,791</td>
<td></td>
</tr>
<tr>
<td>Option 5 NGO Project based - no outreach workers</td>
<td>$1,469,811</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Option 6 CMPE IEC only includes payment to village workers/outreach workers – 1 new staff CMPE – no new district staff</td>
<td>$2,110,747</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Graph 1: Laos Program Option Appraisal and Program Marginal Analysis, by malaria control sub-programs

SM- Social Mobilization, S-Surveillance, VC-Vector Control, D-Diagnosis, T-Treatment, OR-Operational Research

Comments:

- **J. Ehrenberg, WPRO:** Cost effectiveness for malaria integrated approaches should be done with the view of country up-scaling.

- **Xia Gang, WPRO:** Limitations of project design (small scale), sharing of national and project-based resources etc. limit the usefulness of the appraisal.

- **C. Delacollette, MMP:** What is the cost effectiveness of national programme budgets in averting a very small number of deaths? Perhaps integration needs to be the way. 
  
  **E Christophel, WPRO:** In most GMS countries, a large numbers of malaria deaths at village level is unreported. At most 10% of fever cases are malaria.

- **Rattanaxay Pethsouvanh, Lao PDR:** Country managers need to know what are the minimum budgets required for different interventions.

- **B. Lochmann, ADB:** Different type of cost effectiveness studies have already been done.
  
  **C. Beaver:** Those studies were not good enough to come to a conclusion for addressing malaria control among EMGs.

3.2 Country scale up strategic plans for EMGs and other vulnerable populations

The country working groups presented the following draft plans:

3.2.1 Cambodia

The Cambodia plan is shown in Table 2.
Discussion:

- Comments:
  - MOH Equity Fund to be used to cover the cost of referral
  - Increasing the number of health centres will not improve coverage, since people live in sparsely situated villages
  - Incentives for VMWs and VHVs is a big issue. How to address?

- What are the government’s current efforts in addressing the logistical obstacles? Since the distribution of target population is scattered, can facilities be set up in these areas to improve access?
  Setting up facilities is easy, but staffing and providing service is not so easy.

- Political commitment – how does the technical agency (NMCP) convince the political persons? It is necessary to create international supporting environment for such dialogue to happen?
  Provincial authorities are responsible for dealing with EMGs of their province, but finance is still managed by the central government (in fact in Cambodia there is a department for ethnic minority development at the Ministry of Rural Development)

3.2.2 China

The China plan is shown in Table 3.

Discussion:

- Comments:
  - Communication issues between facilities also need to be looked at

- What is the estimated target population size?
  Can only be determined once groups and townships are determined.

- What are the estimates for the migrant population?
  Total ten million. Further analysis of migrant groups and movements is needed.

- What is the Early Warning and Response System (EWRS)? Why is this a policy issue?
  The EWRS platform was created after SARS to extend to the township level. For malaria, criteria for outbreaks and extending EWRS to the village level is required.

3.2.3 The Lao People’s Democratic Republic

The Lao PDR plan is shown in Table 4.

Comment:

- Difference in the intervention package between accessible and not accessible villages not clear.

3.2.4 Thailand

The Thai plan is shown in Table 5.
Discussion:

- **What is the size of the target population?**
  Target area/population comprises 3200 villages, 2.5 million population (including ethnic minorities, non-Thai, estimated at between 300 000-400 000). The package will not differentiate Thai and non-Thai.

- **Integrating with other health/disease issues?**
  Village health volunteers already exist, one volunteer covering 10 households, shouldering multiple tasks with bare incentives – to integrate malaria with them is not practical, the effectiveness of malaria interventions will be diluted.
  - Health volunteers – take care of ten households
  - Malaria volunteers- responsible for one per village
  - Village malaria workers – responsible for 300 villages (receiving 200 baht per month).

3.2.5 Viet Nam

The Viet Nam plan is shown in Table 6.

Discussion:

- **Please clarify what standby treatment is?**
  For forest-goers, if they go for 10 days or longer, the NMCP provides chloroquine and the ACT dihydroartemisinin-piperaquine as stand-by treatment. Chemoprophylaxis is not provided to pregnant women, but standby treatment (ACT in 2\textsuperscript{nd} and 3\textsuperscript{rd} trimester and chloroquine for 1\textsuperscript{st} trimester) is provided.

- **20 000 reported cases out of a population at risk of 30 million - what is the rationale of establishing malaria-specific VHWs, especially with a declining trend? Is this just an interim measure for hard to reach areas?**

- **How would you convince the GF CCM in Viet Nam for added on/changes?**
Table 2: CAMBODIA Scale Up Strategic Plan for EMGs and other vulnerable Populations (2008-2012)

<table>
<thead>
<tr>
<th><strong>Target population</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Ethnic Minority Groups</td>
<td>– Living in malaria endemic areas, border areas</td>
<td></td>
</tr>
<tr>
<td>● Far and difficult to access to public health facilities</td>
<td></td>
<td></td>
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<tr>
<td>● Migrants - new settlers (from non-endemic areas settling in the same area as the targeted EMG)</td>
<td></td>
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<tr>
<td>● Geographical location: Rattanakiri &amp; Mondulkiri</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Population: 178 000 (Rattanakiri + Mondokiri)</td>
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<td></td>
</tr>
<tr>
<td>– 90% are population at risk (160 000)</td>
<td></td>
<td></td>
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<tr>
<td>– 70% of 90% are ethnic minorities (112 000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– 30% of 90% (others-Khmer- new settlers, (48 000)</td>
<td></td>
<td></td>
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<tr>
<td>– target population 103 590</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Routine activities</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● ITN- distribution and re-impregnation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● LLIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● EDAT for malaria (RTD and ACT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● IEC, health promotion</td>
<td></td>
<td></td>
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<tr>
<td>● Monitoring and supervision</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Added activities</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Hammock nets for forest-goers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Screening for malaria in pregnancy (MCH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Integration with other health programmes (IMCI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Diarrhoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– ARI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Deworming and Vitamin A distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Strengthen referral from community to health facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Health Equity Fund</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How to ensure the women and small children are adequately covered?</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● In collaboration with MCH programme, screening for malaria will be organized during the anti-natal care visits at the HC/HP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● VMW will routinely screen for malaria in pregnancy in their own villages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Extra bednets to pregnant women (during anti-natal care visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Provide treatment for diarrhoea and ARI for under 5 year old children (by VMWs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Deworming for children integrated with EPI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Policies which need to be in place to address the target groups</strong></th>
<th>Current activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Community-based volunteers (VHSG) are already in place, implementing community IMCI - based on MOH policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● VMWs provide diagnosis and treatment – national malaria control program activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Bednets, malaria diagnosis and treatment free of charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Volunteers receive only US$ 2 per month to attend monthly meeting</td>
<td></td>
<td></td>
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<tr>
<td>Need to add in the policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Treatment for malaria, diarrhoea and ARI by VMWs will need be added as an supplementary package of activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Volunteers: incentives?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Should the package address other major community health problems?</strong></th>
<th>YES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>● Diarrhoea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● ARI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Helminths + Vitamin A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Others – bring information on other health problems from community to HC and vice versa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HOW?

Address specific challenges

Improve logistic access to target areas:
- Piggyback on to other public services – EPI, outreach activities and other non health related activities.

### Synergies

With
- Rural development programmes
- Commercial, private (NGOs)

### Address language and cultural barriers:

- Use existing local volunteers
- Strengthen local health and authority

### What is needed for health system strengthening to make it work?

- Routine monitoring and supervision from health staff to village volunteers – local health staff to villages
- Regular meetings and reporting from village volunteers to health centre
- Capacity building at all levels
- Incentives (training, certificates, materials, attendance to meetings, study tours)

### Potential synergies with other public health interventions

- Integrate services delivery with EPI, ARI, diarrhoea, deworming (preschool) for delivering control services to community
- MCH programme for screening pregnant women for malaria
- NGOs working in health programme in the provincial level

### Potentially synergies beyond the health sector

- Integrate with the school health program
- Ministry of Women and Veteran Affairs
- Ministry of Interior- Commune Council
- Ministry of National Defence
- Provincial Rural Development Committee (PRDC)

### How to get the necessary political commitment needed to operationalize package, incl. policies, and channel more funds to these vulnerable groups

- Advocacy by the programme authorities, WHO and other stakeholders.
- In close collaboration with the national programme, incorporate into the WHO Regional Strategic Plan, for endorsement by the Regional Committee (RC)
- The RC will need to consider resolution(s), political and financial commitments.
- National programme proceed to incorporate into the national plan.
- Ministry of Health will need to coordinate with other relevant ministries (in the case of Cambodia, the provincial authority deals directly with ethnic minorities) including the Ministry of Finance.
Table 3: CHINA Scale Up Strategic Plan for EMGs and other vulnerable Populations (2008-2012)

<table>
<thead>
<tr>
<th>Target population</th>
<th>Selection criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>● Ethnic minority townships</td>
</tr>
<tr>
<td></td>
<td>● Malaria incidence criteria:</td>
</tr>
<tr>
<td></td>
<td>– Annual incidence &gt; 1 per 1000/year</td>
</tr>
<tr>
<td></td>
<td>– Annual incidence &lt; 1 per 1000/year, with trend of increasing incidence and potential of outbreaks</td>
</tr>
<tr>
<td></td>
<td>– Annual incidence &lt; 1 per 1000/year, with outbreak villages in previous year</td>
</tr>
<tr>
<td></td>
<td>● New settlers</td>
</tr>
<tr>
<td>Target Areas:</td>
<td>Yunnan Province: border, Red River basin, northwest and northeast</td>
</tr>
<tr>
<td></td>
<td>Guangxi: border with Viet Nam</td>
</tr>
<tr>
<td></td>
<td>Guizhou: southeast</td>
</tr>
<tr>
<td>Target Populations:</td>
<td>• Migrants</td>
</tr>
<tr>
<td></td>
<td>• Chinese across border;</td>
</tr>
<tr>
<td></td>
<td>• Foreigners entering China from other neighbouring countries;</td>
</tr>
<tr>
<td></td>
<td>• People staying overnight in crop fields and forest.</td>
</tr>
<tr>
<td></td>
<td>• Ethnical minorities (the specific groups are to be identified through discussion with health authorities)</td>
</tr>
</tbody>
</table>

| Intervention packages | 1. Strengthen capacity of village doctors (village committee, previously administrative village) |
|                       |   ● Retraining existing village doctors |
|                       |   ● Recruiting new village doctors for remote villages |
|                       |   ● RDT use by village doctors as routine diagnostic tools |
|                       | 2. Establish teams of village health assistants (VHA, in natural villages) for: |
|                       |   ● Malaria surveillance and case-finding |
|                       |   ● Preparing blood smears of febrile patients |
|                       |   ● Monitoring malaria patients to complete full treatment courses (DOT) |
|                       |   ● IEC activities |
|                       |   ● Other health promotion and services, such control of other vectorborne diseases and diarrhoea |
|                       | 3. Increase net coverage |
|                       |   ① LLIN for each family (GF R5 2.5 persons/net, target 1.5 persons/net) |
|                       |   ② Extra LLIN for migrants (neighbouring country goers, field and forest goers) |
|                       | 4. Other prevention methods, such as repellents |
|                       | 5. Expanding pre-packed treatment (chloroquine/primaquine) for 
<p>|                       |   $Pv$ and ACT for $Pf$ |
|                       | 6. Social mobilization: participation of village leaders, VD, VHA and women leader to mobilize villager participation. |
|                       | 7. Strengthening IEC campaign |
|                       |   ● School-based, such as the “buddy system” |
|                       |   ● Community-based, such as daily malaria information &amp; |</p>
<table>
<thead>
<tr>
<th><strong>Policies need to be in place to address the target groups</strong></th>
<th>Policy development</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Strengthening primary health care system</td>
</tr>
<tr>
<td></td>
<td>• Strengthening referral system</td>
</tr>
<tr>
<td></td>
<td>• Strengthening early warning and response system (EWRS)</td>
</tr>
<tr>
<td></td>
<td>• More public health staff at township level</td>
</tr>
<tr>
<td></td>
<td>• Establish public health positions at village committee level</td>
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</tbody>
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<table>
<thead>
<tr>
<th><strong>Challenges</strong></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td>• Too remote and difficult transportation; solution: better transportation tools, employing intensive training of local ethnic people</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Potential synergies with other public health interventions</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• EPI</td>
</tr>
<tr>
<td></td>
<td>• MCH</td>
</tr>
<tr>
<td></td>
<td>• Primary health care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Potentially synergies beyond the health sector</strong></th>
<th>Immediate and long term</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Women's Union</td>
</tr>
<tr>
<td></td>
<td>• Youth Union</td>
</tr>
<tr>
<td></td>
<td>• Family planning</td>
</tr>
<tr>
<td></td>
<td>• Education sector at each level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How to get the necessary political commitment needed to operationalize package, incl. policies, and channel more funds to these vulnerable groups</strong></th>
<th>Political commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Establish enabling environment</td>
</tr>
<tr>
<td></td>
<td>• International concerns</td>
</tr>
<tr>
<td></td>
<td>• Leadership and advocacy</td>
</tr>
</tbody>
</table>

Ensure the necessary resources |

|  | • Advocacy to government officials and external donors |
|  | • Reprogramming activities of existing programs |
|  | • Harmonization of activities, if donors are willing |
Table 4: LAO PDR Scale Up Strategic Plan for EMGs and other vulnerable Populations (2008-2012)

<table>
<thead>
<tr>
<th><strong>Target population</strong></th>
<th>Scale up in target areas is based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• NGPES and classification of 47 poorest districts (the 47 designated poorest districts represent 1.26 million of the country’s population, covering 2935 villages and 111 850 poor households = 55% of total poor households in the country and contributing 53% of the total number of malaria cases in 2006)</td>
</tr>
<tr>
<td></td>
<td>• Malaria high risk areas as of the planned malaria stratification (to be updated every two years)</td>
</tr>
<tr>
<td></td>
<td>Vulnerable populations within these 47 poorest districts:</td>
</tr>
<tr>
<td></td>
<td>a. Stationary – village (EMG and others)</td>
</tr>
<tr>
<td></td>
<td>b. Seasonal mobile – forest-goers</td>
</tr>
<tr>
<td></td>
<td>• Rubber plantations: undecided on foreign workers (still in early phase of cultivation)</td>
</tr>
<tr>
<td></td>
<td>• Other crop plantations, mining, hydro dams – covered under Ministry of Health HIA policy.</td>
</tr>
<tr>
<td></td>
<td>• GF R7 proposal establishes networking, trainings and reporting</td>
</tr>
<tr>
<td></td>
<td>• No significant influx of cross-border migrants due to guarded borders</td>
</tr>
<tr>
<td></td>
<td>Target area:</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health operationally classifies population access to nearest health facility:</td>
</tr>
<tr>
<td></td>
<td>- not accessible at all</td>
</tr>
<tr>
<td></td>
<td>- accessible seasonally</td>
</tr>
<tr>
<td></td>
<td>- well accessible.</td>
</tr>
<tr>
<td></td>
<td>The NMCP proposes through its GF Round 7 proposal to adopt an intensive advocacy, communication and social mobilization project, involving a total of 782 villages in five provinces (over the five year term of this proposal) where malaria transmission is intense and ethnic minorities are predominant, reaching an estimated 15 major ethnic groups with an approximate population of 260 000.</td>
</tr>
</tbody>
</table>

| **Routine activities** | EDAT (Objective 1): Improve access to early diagnosis and appropriate treatment for malaria for population at risk [maintaining 80% coverage of all villages in the designated 47 poorest districts + maintaining EDAT in all other risk areas (old stratification) for Year 1] |
|                       | ITN/LLIN (Objective 2): Improve access to good vector control measures and improve malaria prevention practices among population at risk [maintaining 100% coverage of all villages in the designated 47 poorest districts + other selected high risk districts by maintaining at least 80% population coverage with ITN/LLNs (old stratification)] |
### Intervention packages

**Minimum package**

- Health Centre (accessible)
- Health Centre (non accessible)
- Not accessible
- Seasonal Access

#### Routine package:
- **HC**
- EDAT, ITN/LLN (mainstream)
- Supervision (added HSS)
- IEC (R7 partnership with NGO/civil/military)
- **VHV**
- IEC/community mobilization
- No EDAT for malaria (scale down)
- Incentive (by activity, free health/medical ITN for VHV+family)

#### Added value

GF ROUND 7 (Objective 3): Establish innovative village-based IEC interventions in malaria-endemic ethnic communities that are currently underserved (budget US$ 2.3 Million, over 5 years)

- Partnerships with 2 NGOs: Health Unlimited (supervision/monitoring/co-ordination), PEDA (implementation), other partners: Lao Women's Union, Military, Lao National Front
- Activities:
  1. Conduct baseline survey for knowledge, behaviour and practices related to malaria prevention and control and mass blood surveys in five provinces/13 districts/49 villages. The repeat survey is conducted in the fourth year
  2. Planning and consensus workshop by CMPE and all partners at eight target provinces with stakeholders
  3. Implementation though all partners: EMGs in pilot areas receive, accept and understand IEC messages
  4. Lessons learned and results of the pilot interventions will be disseminated at country level to the relevant stakeholders,
and the policy recommendations for scaling-up malaria control plans for poor EMGs will be made available.

5. Technical Assistance: Ethnic IEC Project Manager/Social Scientist

| Policies need to be in place to address the target groups | 1. Village drug kit:  
- RDT/ACT will be included in village drug kit only in non-accessible villages through VHW; CQ needs to be quality assured and if possible procured through GF, treatment of malaria ($Pf$, $Pv$) free  
2. Incentive/recognition mechanism for VHWs:  
- Value of money for VHW in remote areas (vs rice? pig? chicken?)  
- Currently being discussed at MOH  
3. Free bednet distribution and treat/re-treatment:  
- Current NMCP policy needs to be advocated among provincial/district governors |
| --- | --- |

| Potential synergies with other public health interventions | Health sector  
- Piggyback with EPI mobile delivery  
- More thought needed – ITN for women beyond existing/planned coverage? Before or after completion of immunization schedule? |
| --- | --- |

| Potentially synergies beyond the health sector | Beyond health sector:  
- Committee for Planning and Investment (Prime Minister department) – poverty eradication  
- GF R7 address this to some extent – informal at provincial level, but more political will is needed at central level. Still possible within R7 plans. |
Table 5: THAILAND Scale Up Strategic Plan for EMGs and other vulnerable Populations (2008-2012)

<table>
<thead>
<tr>
<th>Target population</th>
<th>Target areas: control area with transmission (classified as A1 and A2 areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>– A1 refers to perennial transmission areas (transmission reported throughout the year or at least six months per year)</td>
</tr>
<tr>
<td></td>
<td>– A2 refers to periodic transmission areas (transmission reported five months or less per year)</td>
</tr>
</tbody>
</table>

**Target population in the target areas**

– EMGs  
– Migrant population  
– Hard-to-reach population

• Poor and vulnerable populations  
• Target hard to reach and those with insufficient health care service  
• Strategies that are currently in place for control methods such as distribution of insecticide-treated nets (ITNs) and early diagnosis and treatment with artemisinin-based combination therapy (ACT) are not effective. There is also a lack of personal protection against malaria.

<table>
<thead>
<tr>
<th>Routine activities</th>
<th>Disease surveillance: Active case finding by malaria staff and volunteers and passive case finding by malaria clinics, some health centres, and hospitals</th>
</tr>
</thead>
</table>
|                    | Disease management: Malaria clinics and malaria mobile clinics  
|                    | Home visits by malaria volunteers for following-up the patients and providing health education  
|                    | Vector control: IRS, ITNs  
|                    | Health education by IEC materials, malaria campaigns  
|                    | Capacity building for health personnel (e.g. microscopists) and malaria volunteers  
|                    | M&E at all level  
|                    | R&D: e.g. drug resistance, social marketing for behaviour changes, development of RDTs |
## Intervention packages

- Community-based interventions
  - Provision of EDPT by Community Malaria Clinics/workers
  - Increase coverage of ITNs for the target group
  - Develop IEC packages that are suitable for the target group
  - Establishment of and capacity building for migrant health volunteers/workers and migrant health system in collaboration with other relevant ministries (for sharing responsibilities, e.g. financial).

## How to ensure the women and small children are adequately covered?

- Women and small children will be one of the target populations in the National Malaria Control Program covered by the intervention package.

## Policies need to be in place to address the target groups

- Political commitment at all levels (national, provincial, district level) to address malaria problems among migrants and ethnic minorities.

## Should the package address other major community health problems? NO

- The package should not address other major community health problems other than malaria because there are already health volunteers in all villages responsible for other health problems.

## Potential synergies with other public health interventions

- Surveillance of fake/counterfeit drugs
- School health promotion
- Environmental health
- Maternal and Child Health

## Potentially synergies beyond the health sector

- Education sector: Ministry of Education
  - Development of school health curriculum
- Security sector: Ministry of Interior, Immigration
- Social sector: Ministry of Social and Human Security, Ministry of Labour
- International collaboration: Ministry of Foreign Affairs
To reduce logistical difficulties for hard-to-reach areas, drugs and medical supplies will be stocked at CoMc before the rainy season and communication linkage will be established in order to timely provide additional support when epidemics occur.

For health system strengthening, capacity building of the existing collaborative mechanisms, e.g. health task forces at provincial, district and community level should be strengthened in order to help support the intervention package.

National Border Health Committee composed of Permanent Secretary as a chairperson and representatives for related departments in the MOPH, related ministries, NGOs and international organizations have been established to address health development in the border areas and among the migrants and ethnic minorities. (e.g. evidence-based interventions/recommendations will be proposed to this mechanism for policy commitment and support)

Border Health Master Plan and Migrant Health Master Plan have been already endorsed to address strategies for health development among the target population and areas. With this commitment, we can raise more funds for the vulnerable groups.

The five-year national malaria control programme (2008-2012) has been developed and endorsed by the Government, therefore, a routine intervention package will be implemented as planned.

The GF R2 (2004-2008) ensures community-based interventions in 300 villages in malaria transmission areas.

The GF R7 will ensure the necessary resources for malaria activities for the target populations.
**Table 6: VIET NAM Scale Up Strategic Plan for EMGs and other vulnerable Populations (2008-2012)**

<table>
<thead>
<tr>
<th><strong>Target population</strong></th>
<th>Criteria selection for target communes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Malaria incidence estimated at 30/1000 per year</td>
</tr>
<tr>
<td></td>
<td>2. Proportion of EMGs &gt;30% of commune population</td>
</tr>
<tr>
<td></td>
<td>3. Vulnerable groups: forest-goers, plot-hut goers and border-crossing people, remote area population.</td>
</tr>
<tr>
<td></td>
<td>Target groups (40 500/135 000):</td>
</tr>
<tr>
<td></td>
<td>• Van Kieu-Pako ethnic group in Quang Tri – 10 communes (9000/30 000)</td>
</tr>
<tr>
<td></td>
<td>• Sedang ethnic group in Quang Nam – 30 communes (27 000/90 000)</td>
</tr>
<tr>
<td></td>
<td>• Raglel ethnic group in Ninh Thuan – 5 communes (4500/15 000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Routine activities</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. ITN</td>
</tr>
<tr>
<td></td>
<td>2. IRS</td>
</tr>
<tr>
<td></td>
<td>3. Microscopy</td>
</tr>
<tr>
<td></td>
<td>4. Case management</td>
</tr>
<tr>
<td></td>
<td>5. IEC materials (not specific for target groups)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Intervention packages</strong></th>
<th>Interventions delivered by existing village health workers (VHW) and village malaria control volunteers (malaria control volunteers, MCV, to be established in hard to reach areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Vector control: LLIN; mosquito repellents and hammock-nets for personal protection for forest/plot-hut goers</td>
</tr>
<tr>
<td></td>
<td>2. Diagnosis and treatment: RDT, ACT; stand by treatment for forest/plot hut goers and border crossers</td>
</tr>
<tr>
<td></td>
<td>3. IEC - Specific IEC materials for target groups (local language, culture, situation) - educate and mobilize villagers for malaria prevention and control, monitor bednet usage and malaria education, follow up with malaria patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How to ensure the women and small children are adequately covered?</strong></th>
<th>Emphasis on women and children are top priority groups for interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• 100% bednet coverage</td>
</tr>
<tr>
<td></td>
<td>• Provide standby treatment to pregnant women</td>
</tr>
<tr>
<td></td>
<td>• Integrate with IMCI, MCH and EPI programmes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Policies need to be in place to address the target groups</strong></th>
<th>Establish malaria control volunteers (MCV) in hard to reach areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Provide appropriate incentives for VHW and MCV</td>
</tr>
<tr>
<td></td>
<td>• RDT and ACT use by VHW</td>
</tr>
<tr>
<td></td>
<td>• Cooperate with border military health staff for villages along international borders</td>
</tr>
<tr>
<td></td>
<td>• Establish village malaria recording and reporting forms</td>
</tr>
<tr>
<td></td>
<td>• Integrate with other health programmes, e.g. helminthiasis control and nutrition program</td>
</tr>
<tr>
<td><strong>Should the package address other major community health problems?</strong></td>
<td>The package should not address other major community health problems other than malaria because there are health volunteers (VHWs) in all villages responsible for other health problems (such as helminthiasis, diarrhea, ARI, nutrition)</td>
</tr>
<tr>
<td><strong>Potential synergies with other public health interventions</strong></td>
<td>IMCI, MCH and EPI programmes</td>
</tr>
<tr>
<td><strong>Potential synergies beyond the health sector</strong></td>
<td>Cooperation with private sector (doctors, healers, drug sellers) and other health centres belonging to plantations, rubber and coffee companies</td>
</tr>
</tbody>
</table>
| **Specific challenges** | To improve access and address logistical constraints:  
- engage border military health  
- through EPI programme  
- cooperation with authorities at different levels |
| **What is needed for health system strengthening to make it work?** | 1. Refresher training for CHCs, VHWs and MCVs. TOR for MCVs  
2. Integration with other public health activities  
3. Cooperation with private sector (doctors, healers, drug sellers) other health centres belonging to plantations, rubber and coffee companies |
| **How to get the necessary political commitment needed to operationalize package, incl. policies** | Advocacy meetings with different levels and signing Memorandum of Understanding with Ministry of Health, MOLISA, Ministry of Finance, Ministry of Agriculture and Rural Development, and Committee for Ethnic Minorities in Mountainous Areas |
| **How to ensure the necessary resources** | • Existing resources from NMCP  
• GF and other donors. |
4. GMS FRAMEWORK FOR MALARIA CONTROL FOR VULNERABLE POPULATIONS

4.1 Summary of scaling up malaria control for EMGs in the GMS, and further considerations of cost and political commitment

Ms Carol Beaver gave a presentation on Cost Analysis – Considerations for Scaling up Interventions: What information does the health economist need? When do you engage with a health economist?

She laid out the information needed by NMCP, Ministry of Health/Ministry of Finance/donors to make their decisions to support such a strategy. Issues are not only the effectiveness of the intervention package, but also whether is equitable, meets the needs of the worst off. An economist should be included in the planning team. Before finalizing the Strategic Plan, the best service delivery approach needs to be determined: vertical approach versus integrated primary care approach at the village level ("If we spend $1 million on a vertical program and get $2 million of benefit in terms of DALYs saved - should we do that? – or should we spend $1.5 million on an integrated program and get $5 million worth of benefit in terms of DALYs saved?"). Ms Beaver suggested a five country research project, starting with an economic analysis training for countries during which the cost analysis methodology will be developed (perhaps jointly with ACTMalaria).

Discussion:

- **Comments:**
  - Costing exercise before finalizing any proposal plan is important
  - Countries need to be shown how to budget for integrated approaches
  - Costing exercise should also be used as a resource/advocacy tool, and experiences with such approaches should be documented and published
  - Sustainability cannot rely on donor funding, and countries should look at costing more closely to streamline cost effectiveness of programmes. Also look at the continuity of community/VHW strategies after donor/external funding ceases
  - The objective should be to cost not just malaria but health care/delivery in general for these vulnerable populations as an interim measure, until geographical access and access to social services (roads, schools etc.) is improved.

- **Costing is essential for new strategy development; how could we do costing of existing projects?**
  Need to revisit planned and budgeted projects.

Dr E. Christophel summarized the major points of the Day 2 country presentations for scaling up malaria control intervention for EMGs and other vulnerable populations:

1. WHO: Target population

   **Cambodia** aims to target EMGs with difficult access to public health facilities in in two provinces (Ratanakiri and Mondulkiri) and new settlers from non-endemic areas (in total approximately 102 000, whereof 70% EMGs).

   **China** would focus on EMG townships with high malaria incidence in Yunnan, Guangxi, Guizhou provinces, and mobile populations/migrants (both cross-border and forest goers).
The Lao PDR is planning to expand the intervention to cover 1.2 million people in the 47 poorest districts.

Thailand would like to cover 2.5 million people in A1 and A2 malaria areas: EMGs, migrants and hard-to-reach populations.

Viet Nam would want to put emphasis on communes with more than 30/1000 malaria incidence and where EMG constitute >30 of the population, and other vulnerable populations, such as forest goers, plot hut goers, border crosser, remote area and pregnant women.

2. WHAT: Intervention packages (beyond routine activities, and ensuring adequate coverage of women and children)

Cambodia would like to provide hammock nets to forest goers, integrate malaria village services with other major disease control interventions (diarrhoea, ARI, deworming), screen for malaria in pregnancy and strengthen referral through Equity Fund.

China would strengthen village doctors, establish village health assistants for surveillance, case finding and treatment, provide prepackaged malaria treatment, increase LLIN coverage and personal protection for mobile populations/migrants (extra LLIN, repellents), strengthen IEC and mobilize the community jointly with other sectors.

The Lao PDR aims to provide >100% ITN coverage beyond the current plans (especially focusing on women as some deliver in the forest), improve access to diagnosis and treatment through RDTs/ACTs for VHVs in villages which are not accessible all year round, and conduct IEC jointly with other sectors (Lao National Front, Women's Union, military).

Thailand would strengthen community-based interventions (surveillance, active case detection, EDAT) through expansion of CoMCs/ Workers and provide adequate incentives (quota for their children to get scholarships to study, reduced bus fare etc). Women and children will be a focus of the programme.

Viet Nam would provide personal protection (hammock nets, repellents) and stand-by treatment for forest goers, RDTs/ACTs for villagers, 100% net coverage and stand-by treatment for pregnant women; and appropriate IEC for the target groups.

3. HOW to deliver interventions

Cambodia would try to integrate with other health programmes: malaria in pregnancy with MCH, outreach with EPI and others, and explore synergies with other sectors' programmes such as rural development (Provincial Rural Development Committee for community-level planning process), education, Women's Affairs, defence.

China would mainly work through local people and strengthen their capacity and logistics. And explore synergies with EPI, MCH and PHC.

The Lao PDR would work with EPI and MCH programmes, the GF, the Committee for Planning and Investment (Prime Minister's Office) in charge of poverty eradication, and the formal private sector (e.g. rubber plantations, hydropower, mining).

Thailand would improve logistics and address specific issues, and seek synergies with other programmes (MCH, counterfeits), partners and relevant ministries (education, interior, immigration).

Viet Nam plans to establish village malaria volunteers in hard to reach villages, integrate with other health programmes (helminths, nutrition, diarrhea, ARI, EPI) and
cooperate with the border military health department and the private sector (rubber, coffee plantations, etc.).

4. Policy support

Cambodia requires a policy for provision of ARI and diarrhea treatment through village volunteers and a policy for village volunteer incentives.

China requires policies on malaria diagnosis and treatment for village health assistants; on criteria for classification of malaria cases and outbreaks for the Early Warning and Response System; on strengthening the primary health care system including patient referral and increase of public health staff at township level and establishment of public health positions at village committee level.

The Lao People’s Democratic Republic needs a policy on inclusion and free distribution of RDTs and ACTs in village drug kits, on incentives for VHWs, on free net distribution in provinces and districts, and on cooperation with the private sector.

Thailand needs a policy to ensure political commitment for malaria control for ethnic minorities and migrants.

Viet Nam requires policies on RDT and ACT use by village volunteers; appropriate incentives for village volunteers; establishment of the proposed village malaria volunteers in remote areas and village malaria recording and reporting forms; and on cooperation with other disease control programmes (such as EPI) for integrated village volunteer service delivery as well as with other sectors such as defence to be able to cooperate with border military health staff in villages along international borders.

5. Advocacy - gaining political commitment

In Cambodia, there is a law ensuring access of EMGs to social services, but provincial authorities (not the national level) are responsible for dealing with EMGs in their provinces (while finances are allocated from the central level). Strong advocacy for EMGs is needed through programme authorities, WHO (through including EMGs in the WPRO Regional Strategic Malaria Plan, to be submitted to the Regional Committee, who will issue a RCM resolution including vulnerable groups) and other stakeholders. The national policy/law for EMGs should be reinforced, a national committee for ethnic minorities should be established, MGs should be incorporated in the national health plan, and MOH should coordinate with other relevant ministries especially Finance.

In China, advocacy is needed among government officials and external donors to strengthen the political commitment and ensure the necessary resources in order to be able to implement the interventions addressing the needs of EMGs and migrants.

The Lao People’s Democratic Republic needs advocacy to be able to gain central level political commitment and support for public-private partnerships with the formal private sector (rubber plantations, hydropower and mining).

In Thailand, advocacy is needed at all levels to address issues for EMGs and migrants. The engagement of the National Border Health Committee (composed of Permanent Secretary as a chairperson and representatives for related departments in the MOPH, related ministries, NGOs and international organizations), addressing health development in the border areas and among the migrants and ethnic minorities, is necessary. The Border Health Master Plan and Migrant Health Master Plan have been already endorsed to address strategies for health
development among the target population and areas. With this commitment, more funds for the vulnerable groups can be raised.

**Viet Nam** plans meetings to advocate at all levels for EMGs and migrants, and suggests a Memorandum of Understanding to be signed with Ministry of Health, MOLISA, Ministry of Finance, Ministry of Agriculture and Rural Development, and Committee for Ethnic Minorities in Mountainous Areas in order to be able to implement the intervention package for EMGs and other vulnerable populations, especially migrants.

4.2 The WHO Mekong Malaria Programme

**Dr Charles Delacollette**, WHO Mekong Malaria Programme (MMP) Coordinator, presented an overview over the MMP, its Strategic Plan, planned activities and expected results for 2008 and funding prospects” Mekong Malaria Programme.

Discussion:

- Can MMP support Mekong countries with its agenda with only two staff? Technical assistance for countries (especially those with GF funding) on technical issues as well as programme management is needed.

- Drug resistance activities are they only for the Cambodia-Thailand artemisinin tolerance issue? They are for all Mekong countries

- Does MMP and countries (e.g. Cambodia) have a business plan? For Cambodia, a costing exercise is required. To achieve MDG goals requires US$ 4 billion globally.

4.3 The GMS Framework for Malaria Control for Vulnerable Populations

**Mr Pricha Petlueng** presented the draft Mekong Regional Framework for Malaria Control for EMGs / Vulnerable Populations, which had been prepared by the WHO secretariat based on:

- Experiences and results of the country pilot interventions of the ADB/WHO-supported EMG project (taking into account conclusions from the baseline and final project surveys);

- Recommendations from the countries presented during this meeting;

- Experiences of the involved persons.

The Framework was then discussed and revised point by point in plenary during this meeting. The final outcome is the following:

**Rationale**

- Access to health services is a human right

- Mekong malaria is epidemiologically forest related (*A. dirus* and *A. minimus* transmission areas, incl. some agro-forestry sites and rubber plantations)

- Malaria is a disease of poverty
- Populations living in or close to forest and populations whose activities (temporary or permanent) are related to forest occupations are at increased risk of malaria

- Antimalarial drug resistance in the GMS is the most serious in the world

- Mainstream malaria control programmes may either not or not adequately cover these populations as they are often not defined and hence would not be the target of specific strategies

**Vulnerable populations**

- Sedentary/Stationary unreached populations:
  - Traditional forest and forest fringe inhabitants:
    - Ethnic minorities
    - Others
  - New forest settlers
    - Internal migrants
    - Illegal aliens

- Mobile populations:
  - Forest and forest fringe inhabitants (ethnic minority groups and others - individuals and/or families) who are temporarily moving into forests for livelihood
  - Seasonal workers especially from non-endemic areas moving into endemic areas (both alien and national)
  - Workers on development projects in malaria endemic areas (roads, dams, mining, plantations etc) and their families
  - Border crossers to high endemic areas

Note: Among both stationary and mobile vulnerable groups, women and children are especially vulnerable.

**Regional strategies to address malaria control for vulnerable populations:**

(1) Political commitment through advocacy

- National advocacy, including sub-national advocacy

- Regional advocacy

(2) Intersectoral cooperation and coordination

- With legislation

- With regulatory agencies

- Governmental bodies for ethnic affairs (e.g. national committees in Laos, Viet Nam, China; )

- Governmental bodies for migrant affairs (national committee in Thailand), inter-country committee for border issues (CAM)
- Interministerial
  - With civil society (e.g. NGOs, faith-based organizations, community organizations)
  - With private sector (for-profit and non-profit)
  - Intergovernmental (ASEAN+)
  - International organizations (e.g. IOM, FAO, UNICEF, UNHCR, ILO, WB, ADB)

(3) Community empowerment and mobilization
- Analysis of ongoing efforts through other programmes/projects/NGOs
- Collect examples/good practices of ongoing efforts of government/health/malaria control programmes (e.g. Thailand with migrant populations, Laos’ village health kits)

(4) Health services expansion and strengthening in underserved/marginalized areas
- Short-term: staff capacity building (e.g. peripheral staff in supervision/monitoring), management training in rural areas, supply management
- Medium-/long-term
- Decentralization: capacity building at provincial and local levels
- Shift from national/provincial planning and management to district planning and management

(5) Community-based service delivery
- interim:
  malaria-specific volunteers?
  multifunctional volunteers?
  village health support groups (CAM)?
- medium-/long-term:
  multifunctional volunteers?
  health workers?
  formal health staff?
- Making maximum use of existing resources
- Recruitment of peers (to overcome language/cultural barriers)
- Define TOR
- Incentives
- Policy issues regarding volunteers
- How to manage community based data?
(6) The malaria intervention package

PRINCIPLES:
- Comprehensive
- Free
- Tailored to needs of target groups
- Addressing special needs women and small children

THE PACKAGE:
- strong health promotion component, incl. target-group specific IEC
- provision of ITN, preferably LLIN, to achieve high coverage at village level
- additional nets/hammock nets and other personal protection measures for mobile persons
- indoor residual spraying (e.g. for outbreaks or where appropriate according to national strategy)
- early quality diagnosis, including rapid diagnostic tests (combined Pf/Pv) in remote locations
- appropriate quality treatment of falciparum malaria (ACTs) and vivax malaria
- pre-referral treatment of suspected severe malaria
- timely referral of (suspected) severe malaria patients
- human resource development incl incentives and adequate training
- adequate supervision
- good reporting and surveillance

(7) Programme integration

- Integration of malaria with other health programs, e.g. EPI, ARI, nutrition
  - include other interventions in malaria control
  - include malaria control activities in other programmes
  - identify what aspects of these programs can be used to strengthen malaria programs

- Link to poverty alleviation programs /interventions

- How to operationalize? Explore feasibility

- Policies needed

- Research needs

(8) Public-Private Partnerships

- Mobilize the private sector to support operations, logistics and other relevant aspects of reaching vulnerable groups (e.g. mapping of formal and informal health providers – if needed cooperation with private formal and/or informal providers)

- Encourage corporate social responsibility (rubber, mining companies)
- Define mechanisms how to operationalize PPP/PPM, e.g. with umbrella NGO organizations, PPM DOTS for tuberculosis

(9) Policies

- Based on national development strategies and/or poverty reduction and/or rural development strategies, include policy recommendations for vulnerable groups in the national health policies
  - how to operationalize? define mechanisms
  - bring to the attention of ASEAN and others

- Ensure that policies and regulations are in place and/or not contradicting to enable malaria control service delivery

(10) Strategies for mobile populations/ migrants

- in-country migration:
  develop strategies, packages and mechanisms
  > inventory and information exchange of ongoing efforts (e.g. Cambodia, Thailand, Viet Nam)

- regional/cross border migration:
  develop strategies, packages and mechanisms
  > inventory of ongoing efforts (e.g. Thailand), structures and MOUs (e.g. Thailand with Cambodia, Laos, Myanmar)

Operational research

Including on:

- personal protection measures for mobile populations
- barriers to access
- how to deliver malaria control to vulnerable populations in decentralized systems
- mapping of vulnerable populations
- mapping of malaria burden in vulnerable populations
- clinical treatment algorithm
- treatment compliance
- how to maintain quality of RDTs and medicines
- stand-by treatment
- strategies for different categories of mobile populations
- strategies for controlling malaria at borders
- economic analysis
Regional cooperation

- Define model for health system strengthening to address needs of neglected/vulnerable populations
- Develop Mekong strategy/model for mobile populations
- Operationalize multi-sectoral involvement
- Operationalize integration with other health programmes
- IEC: strategies, development, materials, involving other sectors
- Economic analysis
- Advocacy (good documentation needed!)
- Cross-border issues
- Resource mobilization, e.g. regional GF proposal
- Information exchange, incl surveillance data and Early Warning/Response and on counterfeit drugs (available)
- Establish database / information system on vulnerable populations
- Tackling issues of decentralization influencing MC for vulnerable groups
- Training / Meetings
- Partnerships
- Research and research exchange
- Joint action programme

Regional networks

**WHO Mekong Malaria Programme** will provide support to development of
  - roles and functions of village volunteers in GMS
  - models for migrants
  - joint GF proposals
  - documentation of practices

**WHO WPRO** will provide support to development of
  - regional policies for vulnerable populations
  - strategies/guidelines on involving the private sector

**Asian Collaborative Training Network for Malaria (ACTMalaria)**

**ASEAN**
**Others**

**Next steps / Recommendations National:**

- Discuss recommendations for scaling up with MOH and others involved
- Organize meeting/s with government bodies for ethnic affairs or migrant affairs to brief them
- Explore feasibility to integrate MC activities, collect examples and best practices, and define mechanism of cooperation and integration (taking into account budgets)

**Regional:**

- Forward document to ASEAN Secretariat
- Include in WHO WPR Regional Committee Meeting
- Establish policies for integration, e.g. with EPI and MCH (incl literature review)
- Use existing mechanisms for regional cooperation (eg MBDS, ACMECS).

**Discussion:**

- Do we define vulnerable populations by forest habitation – fringe, dwellers, seasonal workers, settlers, etc? The vector species are different in forest fringe and deep forest. Does the intervention package differ from forest fringe and forest population? Can it be grouped together?
- Can we define neglected populations and highlight as a human rights issue and draw necessary political commitment? Or is this politically too sensitive?
- Border crossers – who is vulnerable?
  Defining: Border crossers = own nationals, Aliens = foreign nationals. Vulnerable are all mobile populations in malarious areas.
- How can we strengthen health systems to address EMGs and mobile populations? HSS component in GF Round 8 should be explored early for capacity building of staff in health management: rural health, health centres, managing VHWs, monitoring and supervision etc. Adequate funding/budget needs to be ensured in support of relevant activities.

**4.4 Closing Remarks / Acknowledgements**

**Dr J. Ehrenberg, WPRO,** thanked the Government of China and the Yunnan provincial authorities for hosting the meeting, and the organizers from the Yunnan Institute of Parasitic Diseases for the excellent organization of the meeting and their hospitality. He congratulated the country teams for their hard work and successes in implementing this Project, and for frankly sharing their views. He thanked ADB for supporting this Project and the excellent cooperation, and Dr Lochmann for her valuable inputs. He thanked the Project consultants for all their valuable contributions to the success of this Project, notably Ms Holly Williams and Ms Jane Bruce. Finally he thanked the WHO Secretariat for their tireless effort for the project and this meeting.
Dr B. Lochmann, ADB, thanked the organizers for the excellent organization of the meeting. She acknowledged the obstacles in this second ADB-supported project on malaria control for ethnic minorities. She expressed that she was looking forward to bigger, better and integrated scale up plans. She thanked the project coordinators and all WHO staff for their excellent support.
PROGRAMME OF ACTIVITIES

Day 1: 26 November 2007

8:00 – 8:45  Registration

8:45 – 9:15  OPENING CEREMONY:
   1. Vice Governor of Simao City
   2. Deputy Director General of Yunnan Health Bureau
   3. WHO WPRO MVP Regional Adviser
   4. Director of National Institute of Parasitic Diseases, China CDC

9:15 – 10:00  Group photo, followed by tea break

10:00 – 10:20  Meeting objectives – Dr Eva Christophel

I. COUNTRY EXPERIENCES / CAPACITY BUILDING

10:20 – 10:45  Issues with malaria control for ethnic minority groups (EMGs) in the Greater Mekong Subregion (GMS) and description of the Project – Pricha Petlueng

10:45 – 12:30  Country presentations on issues of malaria control for EMGs, and experiences & results of the project pilot interventions
   • China
   • Lao PDR

12:30 – 14:00  Lunch
14:00 – 15:00  Country presentations continued
  •  Thailand
  •  Viet Nam
  •  Cambodia

17:00 – 17:30  The regional point of view: Project experiences and what should be considered for future scale-up of interventions
  – Dr Christophel / Dr Xia Gang

18:30  Reception

Day 2: 27 November 2007

II. SCALING UP

8:30 – 12:00  Country Working Groups on Scaling Up:
  Identification of target groups, identification of interventions to be scaled up, policy issues, sustainability, coordination with other programmes and projects, existing resources, critical challenges to be addressed

12:00 – 13:30  Lunch

13:30 – 15:00  Preliminary cost analysis of interventions in selected GMS countries – Carol Beaver / Dr Xia Gang

15:00 – 15:30  Tea break

15:30 – 17:30  Presentations and discussion of country group work – recommendations country framework for scaling up

17:00 – 17:30  Summary of results and recommendations
III. MEKONG REGIONAL FRAMEWORK FOR MALARIA CONTROL FOR EMGS / VULNERABLE POPULATIONS

8:30 – 9:00  WHO Mekong Malaria Programme – Strategic Plan and funding prospects - Dr Delacollette

9:00 – 9:20  Cost analysis – consideration for scaling up interventions – Carol Beaver

9:20 – 10:30  Summary of scaling up interventions and recommendations for political commitment – Dr Christophel

10:30 – 10:45  Tea break

10:45 – 12:00  Presentation of draft Mekong Framework for Malaria Control for EMGs and recommendation for next steps – Pricha Petlueng

12:00 – 12:30  Closing remarks

12:30  Farewell lunch
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WORKING GROUP INSTRUCTIONS

Outline of a Country Scale Up Strategy/Plan

Five country working groups with assigned facilitator

Product expected is a Country Scale Up Strategic Plan for EMGs and other Vulnerable Populations (2008 – 2012)

Composition of Plan:

WHO
1. Define target groups/areas and give criteria why selected
   - target group: stationary vs mobile population
   - target areas: geographical, logistical issues
   mention estimate population numbers

WHAT
2. Taking into account your country report data and experiences and potential gaps, define intervention package for your selected target group/area.
   Please define which activities are part of the routine malaria control, and please define which activities need to be added to optimize interventions tailored to these special groups/areas?
   - Which component of the package should be community-based?
   - How can it be ensured that women and small children, who are especially vulnerable, are adequately covered and their needs addressed?
   - What policies need to be in place to address your target group/area?
   - Should the package address other major community health problems other than malaria?

HOW
3. How will you address specific challenges (e.g. logistical difficulties)?
4. What is needed for health system strengthening to make it work?
5. Potential synergies with other public health interventions?
6. Potential synergies beyond the health sector (immediate and long-term)?
7. How to get the necessary political commitment needed to operationalize your package, including policies and being able to channel more funds to these vulnerable groups?
8. How to ensure the necessary resources (e.g. Global Fund)