REPORT

ADVISORY COMMITTEE MEETING OF THE MEKONG ROLL BACK MALARIA IEC PROJECT

Ha Noi, Viet Nam
19-20 November 2004

Manila, Philippines
July 2005
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Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

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NOTE

The views expressed in this report are those of the participants in the Advisory Committee Meeting of the Mekong Roll Back Malaria IEC Project and do not necessarily reflect the policies of the Organization.

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This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Advisory Committee Meeting of the Mekong Roll Back Malaria IEC Project held in Ha Noi, Viet Nam, from 19 to 20 November 2004.
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**Keywords:** Information, Education and Communication, Greater Mekong Sub-region, malaria
SUMMARY

During the one and one-half day Advisory Committee meeting, each country - including Cambodia, China, the Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam - made several presentations highlighting their information, education and communication (IEC) materials development, training and advocacy activities, lessons learnt and future intervention plans to build on what has been accomplished to date. Several other presentations were made on IEC research and activities conducted in the Greater Mekong Subregion (GMS) during the past two years. The IEC project is fulfilling a need for malaria control in remote and hard-to-reach ethnic minority populations throughout the GMS that has, until now, not been met. Countries have developed a series of contextualized IEC materials addressing malaria prevention and control problems for selected ethnic minority groups. Support for these groups should continue, not only for IEC development and advocacy, but also for malaria control issues.

Cambodia shared a need to improve monitoring and evaluation; China emphasized poverty issues and the need to upscale; Myanmar utilized volunteers, franchising and social marketing and reflected on financial constraints; and Thailand discussed the need to improve monitoring and evaluation and scaling up of IEC materials for refugees. Achievements in strengthening malaria control for ethnic minority groups in the GMS need to be pulled together into a regional strategy. Gender-specific and migrant issues should not be forgotten in future activities. Results from spin-off research projects should play a significant role during government planning and results from these research projects should be made available to all GMS countries. Changes in population distribution and migration trends caused by farming cultivation, specifically poppy eradication programmes, clearly show that there are other issues that should not be overlooked during future IEC development and malaria control efforts.

Each country is ready for IEC reproduction and field implementation. Identifying how to refine, simplify and scale up replicable interventions will add value and impact to a regional concept. This project accomplished its objectives; sensitive and appropriate materials for selected communities have been developed; and GMS countries no longer ignore vulnerable and hard-to-reach ethnic minority populations. However, much more work needs to be done to provide proper care and treatment for malaria. For communities that have sufficient supplies to control and prevent malaria, future IEC messages need to include treatment and diagnosis, ACT policies, and fake drug issues.

The Mekong IEC project is unique, not only because it targets hard-to-reach and marginalized ethnic minority populations, but also because it adopts a participatory approach to IEC development and malaria control. Not always chosen by their governments for mainstream activities, ethnic minority groups have been the focus of attention during this project. National malaria control programmes should now be able to adopt and scale up IEC activities for these selected groups and later expand to other geographical areas or include more ethnic minority groups for IEC development and other malaria control activities.
### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<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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<td>BCC</td>
<td>Behavioural change communication</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
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<td>GMS</td>
<td>Greater Mekong Subregion</td>
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<td>IEC</td>
<td>Information, education and communication</td>
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<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<td>KAP</td>
<td>Knowledge, attitudes and practices</td>
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<td>NMCP</td>
<td>National malaria control programme</td>
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<tr>
<td>RDT</td>
<td>Rapid diagnostic test</td>
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<td>RBM</td>
<td>Roll Back Malaria</td>
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<td>VHV</td>
<td>Village health volunteer</td>
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1. INTRODUCTION

1.1 Background

The Mekong Roll Back Malaria (RBM) Information, Education and Communication (IEC) project is a joint initiative between the Asian Development Bank (ADB), WHO and countries of the Greater Mekong Sub-region (GMS) and was established as part of the Mekong RBM Initiative, a joint effort between WHO and the United Nations Children’s Fund (UNICEF). The project was introduced in the Mekong Biregional Meeting in Manila, the Philippines, in October 2002, with three objectives: to develop user-friendly IEC materials and guidelines; to enhance government capacity for community-based activities; and to make national malaria control programmes (NMCPs) more responsive to the needs of target communities by supporting a common regional plan.

A technical consultation was held in January 2003 to identify target ethnic groups and revise country action plans. Malaria situation analyses began and potential partners were sought. In June 2003, a workshop was held to strengthen situation analyses. The aims of the workshop were to improve knowledge for basic field research methods, strengthen regional capacity to conduct participatory action research and develop field research action plans. In October 2003, a regional workshop was held to further develop IEC materials. During the workshop, countries identified and agreed on two main behavioural change messages to incorporate into country IEC materials: encourage proper use of insecticide-treated bednets (ITNs) and encourage early and appropriate treatment for malaria. By the end of the workshop, each country had developed an IEC implementation plan, and by the end of December, each country had produced a set of IEC materials. First drafts of the materials were presented during a technical consultation held in February 2004. Materials have since been reviewed, revised and finalized for field implementation.

The Mekong IEC project is unique, not only because it targets hard-to-reach and marginalized ethnic minority populations, but also because it adopts a participatory approach to IEC development and malaria control. After two years of project implementation, IEC materials and packages have been drafted and spin-off initiatives, including anthropological and sociological research, have been conducted. Because sustainable behavioural and social change takes a long time to successfully accomplish, more work is needed. The initial project grant received from ADB has been fully obligated and additional funding is being sought.

1.2 Objectives and expected outcomes

In June 2004, ADB agreed to extend the project deadline from 31 August to 31 December 2004. During the four-month extension, countries finalized their IEC materials and guidelines and the Project Coordinator drafted a regional malaria IEC strategic plan. The IEC materials, guidelines and strategic plan require review and input from GMS countries and the Advisory Committee before field implementation. For fundraising purposes, mechanisms for sustaining community participation, public and private partnerships and reoccurring costs for IEC development need to be identified and justified. Strategies to harmonize project activities with national or provincial programmes having different priorities need to be determined and integrated into national communicable disease control programmes. A simple, but comprehensive regional package, together with delivery
mechanisms, needs to be developed. Research ideas need to be explored regarding social aspects of IEC and malaria control interventions and ethnic minority beneficiaries and to what extent each will be of benefit.

The objectives of the meeting were:

(1) to present project implementation updates to the Advisory Committee members;

(2) to present malaria IEC educational materials, guidelines and draft regional malaria IEC strategic plan; and

(3) to discuss and plan for next steps and future project elements.

The expected outcomes of the meeting included:

(1) shared IEC packages and lessons learnt;

(2) listed recommendations on how IEC packages can be used by NMCPs for different geographical settings; and

(3) listed suggestions for continued financial and political support of broader project elements.

2. COUNTRY UPDATES

When the project commenced in 2003, situation analyses were conducted to determine appropriate developmental processes for malaria control IEC materials. Results from the situation analyses helped teams to identify and develop appropriate messages and materials. Materials and packages are complete and countries are beginning to assess them through field implementation. Lessons learnt have been consolidated and future steps are being discussed. Integration of packages into NMCPs has been slow, but focus is shifting to sustainable use. In many of the GMS countries, the IEC participatory development process was the first experience of its kind to involve staff from different levels and sectors together with individuals from ethnic minority groups.

2.1 Cambodia

Cambodia conducted a situation analysis in Ratanakiri, Mondulkiri, Kratie and Phnom Penh and conducted a more in-depth research study of the Kreung ethnic group living in three villages in Ochum district, Ratanakiri Province. IEC materials, including a flipchart, a video, a song, an informational booklet and user guidelines, were developed to help mitigate such problems as lack of general knowledge about malaria, improper use and care of bednets and lack of proper treatment-seeking behaviour. Increasing awareness throughout the district, both governmental and nongovernmental departments were involved during the situation analysis and development of materials, including the song, originally written in Khmer and translated into the local Kreung dialect. Each product was pre-tested
through field interviews before finalization. Suggestions and feedback from partners and locals have been consolidated and will be incorporated into Cambodia's materials before final dissemination and field implementation.

2.2 China

China conducted a situation analysis in Ruili Xian, Ximeng, Mengia, and Yuanijiang counties of Yunnan Province because many hard-to-reach, ethnic minority groups live there and no locally appropriate IEC materials exist. China chose the Wa ethnic minority group (approximately 72,000 people living in Ximeng County) to conduct its research because they are among the poorest and most vulnerable for transmitting malaria. Two primary messages were determined from the research: prompt and effective treatment-seeking behaviour and proper use of bednets and insecticide-treated nets. These primary messages and other secondary messages, such as signs, symptoms and causes of malaria, prevention, high-risk areas, alternative treatment courses and their costs, and risks of delayed treatment, were conveyed through a video, story booklets, flipcharts and other materials. User guidelines were produced for health educators, who initially targeted schoolchildren. The video was the largest production as it was shot at various stages, cut and edited, and pre-tested. Wa leaders helped develop the video's storyline. In addition, two posters, a teacher's manual and an educational flipchart were produced. A dissemination workshop was held to share drafted materials and lessons and experiences learnt with project leaders from other counties. China is enthusiastic and ready to scale up material production for field implementation.

2.3 Lao People’s Democratic Republic

Seventeen of the eighteen provinces in the Lao People’s Democratic Republic share at least one international boundary with a neighbouring GMS country. Nearly 80% of the country's total population lives in rural areas, and approximately 40% is from 47 recognized ethnic minority groups. The Lao People’s Democratic Republic conducted a situation analysis in Phouvong and Sanxay districts of Attapeu Province in the southeastern part of the country. Further research was conducted among the Brau-Lavae group to determine effective communication channels and appropriate materials. Results of the research showed that most (60%) of the Brau people buy bednets from the market, almost half (45%) do not know that malaria is caused by a mosquito bite, and just over half (54%) self-medicate without having seen or been advised appropriately by health personnel. Provincial malaria staff visit villages annually to distribute bednets, reapply insecticide and talk to the villagers about malaria.

The Brau-Lavae group participated in several workshops and developed their IEC materials, including a flipchart, a story with pictures, songs in Brau and Thaliang languages, other visual material and IEC user guidelines. All materials, pre-tested and revised, are simple and easy to understand, with effective layouts. As concluded from follow-up interviews, the target groups generally understood the materials' intended messages. The IEC development process was the first experience of its kind in the Lao People’s Democratic Republic, as it involved staff from various government levels and sections. The participatory approach was invaluable because it allowed government staff to work directly with community members to develop an appropriate IEC package. The next step is to reproduce IEC materials and guidelines for dissemination and field implementation.
2.4 Myanmar

Myanmar conducted its situation analysis in Tarcheleik (Eastern Shan), where many malaria patients delay seeking treatment and access self-medication. A situation analysis and several workshops were held with basic health staff, schoolteachers and drug vendors to gather information on appropriate IEC materials. In August 2004, materials were drafted and pre-tested to measure comprehensiveness, attractiveness, acceptance, involvement and utilization. Findings were integrated into revised materials and now the team is finalizing materials for dissemination and field implementation.

2.5 Thailand

Thailand conducted a situation analysis in village number 3 Ban Sivadur, Mae Sam Lap Sub-district, Sob Muey District of Mae Hong Son Province, targeting the Karen ethnic minority group. Thailand considers men and children at highest risk of transmitting malaria, even although results from survey show a consistent lack of knowledge about malaria transmission, proper self-protection and vector breeding areas, regardless of gender or age. Men are considered at highest risk because they generally do not buy bednets to use in the forests during their frequent expeditions. Previously, IEC materials were available to the locals, but contained inappropriate messages; but even although the Karen regard smoke as a natural and effective mosquito repellent, smoke is not recommended as part of the national IEC malaria control programme because of other related health risk factors.

Thailand developed, field-tested, edited and finalized IEC materials during several workshops. During field-testing, the Karen found the materials appropriate and user-friendly and the villagers were proud to participate in the IEC process because it brought together their communities. The materials were made into a package and disseminated for field implementation in September 2004, targeting men, children, forest-goes and visitors. Materials included a jigsaw puzzle, a poster, a calendar and informational pamphlets and leaflets. Control messages focused on transmission, vector breeding areas, signs and symptoms, prevention and control, and seeking early diagnosis and treatment. The IEC team will continue to monitor and evaluate its ongoing field implementation.

2.6 Viet Nam

Viet Nam is politically committed to IEC development and malaria control. It conducted a situation analysis in two communes of Khanh Vinh District on the south central coast (this area is considered the cradle of malaria in Viet Nam). Information-gathering focused on the Raglai people (approximately 72,000) who are among the poorest in Viet Nam and who have no written script. Poverty was identified as the root cause of malaria for the Raglai, who perceive malaria to be a problem, but lack appropriate IEC materials. Three key messages were determined during the situation analysis: carry a bednet when going to the forest; carry antimalarial drugs when going to the forest; and use a bednet properly.

Posters, calendars, brochures and musical cassettes were developed to convey key messages and user guidelines and flipcharts were produced for primary facilitators and communicators. A participatory approach to developing IEC materials was adopted and used for the first time in Viet Nam. Individuals from different target groups were involved in pre-testing and review and revision of the materials. Edited materials are ready to be produced and distributed for field implementation.
3. OTHER PRESENTATIONS

3.1 Summary of the malaria situation at the Cambodian-Lao borders - Dr Hector Rifa

Research findings were presented on the Mon Khmer and Malay Polynesian linguistic indigenous populations. The main aim of the research was to evaluate local practices and beliefs regarding malaria prevention for two indigenous ethnic groups living in four areas of Ratanakiri and Attapeu Provinces on the Cambodian-Lao border. Surveys were conducted to gather information on knowledge, attitudes and practices (KAP) for malaria-related issues, such as bednet use and sleeping behaviour. Poverty, language differences, unhealthy behaviour and environmental changes generally make those interviewed more vulnerable to malaria infection.

Results of the research suggested that countries should first assess specific needs and the size of families of those households using bednets before deciding what size net to distribute. Although the number of people sleeping under bednets was assessed, the research did not account for the size of bednets used in each household. Cambodia decided to purchase only the larger, family-size nets for the Kreung group because it was determined that it would be expensive to special-order nets. Future research should target families not included in the initial surveys and distribution of insecticide-treated nets should be scaled up in the study areas.

3.2 Summary of malaria situation on the Thai-Myanmar border - Dr Peter Kunstadter

Research findings were presented on several mixed-ethnic minority groups living along the Thai-Myanmar border. Study populations were chosen based on estimates showing high antimalarial drug resistance and high malaria prevalence. For sample selection, houses were mapped and randomly selected for surveying. Survey facilitators were trained, informed consent was obtained, and the surveys were facilitated in local dialects. Selected malaria patients within two months of diagnosis, as well as pre-controls for each patient, were surveyed.

Analysis of data concluded, among other results, that households with migrants are three times more likely to have too few bednets in their households than citizens of Thailand or Myanmar. A lack of a sufficient number of bednets is due to a lower household income rather than a misunderstanding about how to use bednets properly. Generally, nets were not treated with insecticides, but respondents believed that bednets were effective for preventing diseases. Evidence clearly showed strong support for the use of bednets to prevent malaria.

The rate of falciparum malaria infection was much higher among border migrants than Thai citizens. Only 7% of Thais were diagnosed as having malaria and none of those patients were able to transmit the parasite. Thirty-six percent or about one-third of migrants surveyed had gametocytes present. The increased number of people with gametocytes is not known as there was no difference in the delay in treatment-seeking behaviour. The results imply that malaria transmission comes from migrants and, therefore, migrants should be targeted for IEC and other preventive and control services.
Malaria control programmes have often focused on earlier treatment-seeking behaviour. Survey results showed differences between migrants and citizens of Thailand and between those diagnosed as malaria-positive and malaria-negative in regards to the time treatment was sought. Those who were diagnosed negative for malaria sought treatment after four days, on average, whereas those surveyed with malaria symptoms and who were diagnosed positive for malaria waited longer, sometimes a whole day. Migrants, as a group, waited longest to seek treatment. These results suggest that early symptoms for non-malarious individuals are more serious than symptoms for individuals who actually have malaria.

Two-thirds of Thai citizens had previously sought treatment before going to a clinic. This may have caused a delay in their seeking appropriate treatment. Treatment may be free and effective in some cases, but this alone does not mean it will be sought and utilized. In addition, language barriers exist that may prevent migrants from seeking appropriate treatment; many migrants from Myanmar are unable to speak enough Thai to communicate with clinic workers and so there is a need to provide translation for migrants.

The first of several conclusions mentioned is that malaria-related, treatment-seeking behaviour seems to correlate with migration status. As such, there are distinct and systematic differences between migrants and Thai citizens that allow for tailored treatments and IEC materials specific to migrants. Better educational materials regarding early symptoms and prompt diagnosis and treatment could be developed. Because migrants generally live in poverty, responsibility for IEC development and malaria control interventions need to shift to employers, possibly in the private sector. The employers could provide bednets or cash subsidies to employees; theoretically, employees would avoid malaria and work more efficiently. If employers adopted benefits on this scope, they would need to be assured of labour regulation standards to avoid unnecessary hassle, especially regarding migrants. Also, programmes should consider follow-up blood tests after treatment in order to determine drug efficacy. If drug resistance exists, so too does a hazard for all people around.

Several issues regarding migrants were raised. Delegates from Myanmar raised a discussion point on country affiliation categorization for migrants. It seems more appropriate to categorize these groups based on a combination of their current place of residence and how long they have lived there, rather than their place of birth. Many migrants from Myanmar live in the field and work as sustenance farmers, while most of the Thais live in an urban setting or the nearest town. More information is needed regarding migration history and country affiliation. Delegates from the Lao People’s Democratic Republic commented on treatment-seeking patients. It makes sense to reach people who have a fever and train them to seek treatment. Obviously, if there were problems finding appropriate treatment, malarious and non-malarious individuals would not seek treatment.

More research is needed in order to classify the origin of migrant peoples: where they come from and where the live. More migratory data are needed and should be put into a database for programme planning and implementation. Also, to help mitigate language difficulties, interpretation or translation services should be made available in basic health institutions. Analysis of this study will be finalized and made available to the public.
3.3 Kokang Special Region Number 1 – Japan International Cooperation Agency (JICA) IEC Development Project

Kokang is situated on the border area between Myanmar and Yunnan, China. The Kokang (Chinese, Han), Palaung (Ta-ang), Shan, Wa, Kachin and other ethnic minority groups live in Kokang. The area is politically autonomous, but depends on China for telecommunications, currency and other goods and services. Once the main income source for local people, opium poppy plants were destroyed a few years ago when the Government established a national opium eradication scheme. Since eradication efforts began, local people have encountered debilitating health-related problems such as malnutrition and malaria. Currently in Kokang, there are no malaria control activities, no public health systems and no reliable epidemiological or entomological data.

An unusually high occurrence of malaria was reported in 2003 and, with assistance from the Japan International Cooperation Agency (JICA), Myanmar's Department of Health showed interest in malaria control throughout the Kokang area and began selected malaria control measures, including early diagnosis and proper treatment, epidemic preparedness, IEC health education materials and operational research targeting people in epidemic-prone areas. An IEC component was initiated as part of the Eradication of Opium Poppy Cultivation and Poverty Reduction Project (cross-linked as a health, education and agriculture project).

IEC materials were developed based on results from KAP, malarriometric and entomological surveys. Several key issues were concluded from these surveys: low literacy rates were found (only a few people could read and write Chinese); most houses did not have a mosquito net; and most information was being transmitted via personal communication. Generally, people did not understand how malaria was transmitted, but many did know about malaria signs and symptoms. More malaria cases were found in the lowlands and consequently entomological and epidemiological results showed that there is a different distribution pattern of Anopheles mosquito between lowland and highland areas. Before the destruction of opium crops, there was a substantial amount of vertical population movement during harvesting season, but when the poppy fields were eradicated, there was less movement to the highlands and epidemics began.

In the midst of the 2003 epidemic, IEC materials were developed in ten days. A prototype, with English captions, was drafted based on a very brief situation analysis. The prototype was translated into Chinese and pre-tested before printing. Field-testing showed that additional information on the malaria transmission cycle was needed and so a poster was developed to help facilitate understanding of malaria transmission. A field team demonstrated proper bednet use, performed a role-play on how to prevent mosquito bites and distributed bednets. Since the outbreak, plans have been made to conduct more ethnological surveys, actively monitor bednet use and develop information-sharing mechanisms across the border between Myanmar and Yunnan. Other communication channels, such as schools, local authorities and agricultural training sites, will be sought and a manual will be developed and distributed to village health workers.

There is an urgent need to improve information-sharing to control malaria outbreaks among border area migrants. Eighty cases of malaria were found in the Kokang area in 2004 alone, and three people died. It is believed that the epidemic was a direct result of opium eradication efforts, when many migrants moved to the lowlands after the poppy
plants were destroyed. Myanmar has planned strategies to prevent further epidemics through appropriate IEC messages and materials on prevention and treatment measures, such as bednets. Staff of the Myanmar Department of Health monitor Kokang, even although migration to the highlands is not as predominate as in the past. The area should now focus on exchange of information between border districts.

The first step may be to channel information between cross-border malaria contacts using the Internet, if available. Otherwise, malaria focal points for each border area could meet on a monthly basis to share information. In some cases, the same ethnic group lives in two or more countries across several borders. In the Lao People’s Democratic Republic, for example, there are numerous ethnic groups living across the border between Thailand, Viet Nam and Myanmar. Clearly IEC materials and messages should be applied across borders if political hurdles can be overcome. An effective mechanism for cross-border communication is urgently needed. The RBM IEC Project Coordinator should list potential target groups and identify mechanisms to improve cross-border communication.

The Kokang Development Project will cost its activities and attempt to link the number of deaths caused from malaria in order to determine the cost-effectiveness of the intervention. JICA is trying to measure financial losses incurred from family heads that may no longer be able to work.

3.4 Letter of appreciation and call for continued support - Dr Holly Williams

A special adviser to the project, Dr Holly Ann Williams, has written a letter requesting continued support to the project, encouraging continuation of what has been done to date. She outlines justification for the extension and highlights some important facts. The letter is attached as Annex 1.

4. NATIONAL IEC PLANS

4.1 Cambodia

Cambodia will continue to work with the Kreung ethnic minority group in Rattanakiri, Mondulkiri, Kratie and Phnom Penh. It plans to translate and distribute IEC materials and guidelines for field implementation. Bednets will be distributed to at least 20 villages and quarterly meetings will be held for project staff to share experiences and project outcomes and to obtain further training on health education activities. At the national level, village health volunteers (VHVs) and malaria focal persons will contribute articles on personal experiences and lessons learnt for publication in newsletters. At the provincial level, malaria focal persons and VHVs will review and revise project work plans and, at the village level, VHVs will provide training and health education materials to villagers and disseminate information on malaria prevention and control. Mobile teams will regularly disseminate materials to villages and continue collaborative support.

4.2 China

China will disseminate its IEC materials for field implementation in eight townships and 366 villages in Ximeng Wa autonomous County, for a population of approximately
82,000 (>80% Wa ethnic minority people). Approximately 65,600 Wa people make up the primary target population and about 16,400 Lahu and Dai make up the secondary target population. IEC materials will be produced, and a dissemination workshop will be held to distribute the materials to each of the three ethnic groups. The intervention will be implemented and monitored and evaluated for two years.

Technical assistance will be provided to other existing areas to support other ongoing IEC malaria control activities. China has included an IEC component in its 5th round proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), including activities to increase community awareness and demands for effective malaria treatment and prevention. Proposed activities include local production of behaviour-change communication (BCC) materials; support for schools, youth leagues and private health providers; media announcements; and short courses on malaria.

China believes that IEC should focus on positive-behaviour promotion and negative-behaviour change, not just awareness enhancement. IEC is a process that works to change behaviour and, although products such as videos and posters can help raise awareness, it is the participatory process to which behavioural change is most attributable. IEC should be combined with local malaria control activities implemented as part of NMCP objectives, and, as the project progresses, China plans to adjust its IEC messages to best match community needs with those NMCP objectives.

4.3 Lao People’s Democratic Republic

The Lao People’s Democratic Republic will develop and produce IEC materials and guidelines for the Brau and Taliang ethnic groups for field implementation. Communication channels, including village leaders, schoolteachers and local health staff, will be trained to effectively use the materials and mobilize local communities for malaria control and prevention. Advocacy activities will be implemented to mobilize communities regarding proper use of insecticide-treated nets. The country aims to scale up IEC development for ethnic populations in different geographical areas and integrate its current IEC package as part of the NMCP objectives. The programme will shift focus, targeting teenagers and older people. Criteria will be written for free distribution of insecticide-treated nets and distribution will be regulated and monitored.

4.4 Myanmar

Myanmar will continue to target Tarchileik and Kunlo and selected ethnic groups, including the Shan, Lahu, Akham Wa and Kokant, for IEC intervention through field implementation. All people from these groups live in remote and forested foothills where malaria prevalence is high and only a limited number of individuals own bednets. Efforts will be made to increase awareness regarding treatment policies and counterfeit drugs. Nationwide advocacy is critical for the future success of the IEC project and Myanmar will continue to involve health staff, drug vendors, schoolteachers and groups from other sectors in the IEC project. Multisectoral involvement will continue, and it is important for local administrative authorities to commit to social mobilization and logistical arrangements such as bednet distribution. The country is exploring new channels for IEC dissemination, such as local leaders, schoolchildren, lay preachers and village volunteers, in order to develop a sustainable, community-based partnership. Myanmar is committed to making IEC
development a central activity in the Department of Health and it plans to scale up the IEC project in Tachileik and Kunlon and eventually extend into Kayah State.

Myanmar plans to promote proper use of insecticide-treated nets and early diagnosis and treatment practices through community mobilization. The national team will seek intersectoral cooperation and intercountry and regional collaboration in the hope of improving the role of health care providers. It will strengthen efforts to increase capacity-building for programme monitoring and evaluation. Myanmar will work to increase private sector involvement in all areas of its NMCP, including distribution and use of bednets, impregnation of existing nets, and diagnosis and treatment with rapid diagnostic tests (RDTs) and artemisinin-based combination therapy (ACT). The NMCP will continue to distribute bednets freely to those that qualify and to monitor their use.

4.5 Thailand

Thailand will continue to target the Karen ethnic group living in Northern Thailand through field implementation. It plans to conduct monthly meetings to improve public relations for malaria control, develop warning systems in target villages and conduct a KAP survey for malaria transmission. It would like to scale up the current IEC project to other ethnic groups living in other geographical areas and possibly across borders. Field malaria staff and related health personnel will be trained before scaling up the project and both pre- and post-KAP surveys will be performed to measure the impact of the intervention. Thailand will continue to convey key messages, including proper bednet use, early diagnosis and treatment, and self-protection.

4.6 Viet Nam

Viet Nam aims to relieve poverty through malaria control. It will continue its IEC project with the Raglai in two districts in Ninh Thuan Province by reproducing its IEC materials and guidelines and conducting field implementation. It will train health care workers to produce IEC materials and advocate for political and community commitment to IEC to control malaria and other communicable diseases. Viet Nam IEC staff will visit homes and hold community meetings to improve communication and use mass media in the Raglai and Trang Lai languages. It will facilitate short training courses for district and commune levels and involve mass organizations and projects to increase exposure. The NMCP will hold pre- and post-intervention surveys during IEC field implementation to measure the impact on bednet use, treatment-seeking behaviour and morbidity and mortality rates.

5. LESSONS LEARNT AND CHALLENGES

Ethnic minority groups living in hard-to-reach, border areas of the GMS, such as those participating in this project, are often unable to access proper preventive or curative care for malaria. The challenge is to expand and scale up appropriate and affordable malaria prevention and control strategies, including the use of bednets, to all ethnic minority groups. IEC packages need to be tested for cost-effectiveness and impact on behavioural change. Project processes and products will be evaluated, but a viable methodology must first be
established and adopted. It is critical to motivate governments and target groups to commit to IEC development and adopt strategies for successful and sustainable behavioural change through advocacy and social mobilization activities.

5.1 Lessons learnt and challenges

Lessons learnt can be used across borders to improve health services. Problems and successes were encountered during country situation analyses and during pre-testing and development of IEC materials. The Lao People’s Democratic Republic, Myanmar, Thailand and Viet Nam outlined the lessons learnt during meeting discussions.

Delegates from the Lao People’s Democratic Republic emphasized the importance of implementing a situational analysis for information gathering. Community participation is vital for production of effective IEC strategies and materials appropriate to the local situation, while involvement of different sectors provides more meaningful and comprehensive materials. Training workshops strengthened the team's capacity to effectively plan and implement IEC activities and strengthened the overall NMCP through national capacity-building. Effective strategies were developed during the workshop. A great strength of the IEC project was the bottom-up approach taken to develop its materials, as it brought to light the country's indigenous populations for the first time.

Delegates from Myanmar suggested that advocacy is very important to gain commitment from administrative authorities. Influential people, such as village and religious leaders, village elders and schoolchildren, are effective channels for communication and these people should be encouraged to participate in future advocacy components. The country's IEC project focused on core messages based on local situations, which helped local communities to adopt and sustain project interventions. In some instances, the IEC intervention was considered an add-on activity, whereas it should have been considered a stand-alone initiative with complete funding and full-time commitment from staff. Myanmar did not adopt and sustain monitoring and evaluation activities, but could have done so by holding key interviews and surveys.

Thailand found its project to be generally successful. Its draft materials were acceptable and user-friendly and villagers were generally proud to participate in IEC production because it brought their communities together. However, communication between the villagers and project leaders was sometimes poor, and there is a need to develop a better strategy for two-way communication.

IEC is one of six components used in Viet Nam to control malaria. The other five are vector control, diagnosis and treatment, integration of activities, active surveillance, and training. Viet Nam has successfully increased public awareness by incorporating IEC messages for malaria and other health-related issues into popular national TV quiz and game shows, but ethnic minority groups often do not own televisions. Furthermore, IEC materials have been made available in languages of larger ethnic groups, but little research has been conducted on the appropriateness of these materials. It was determined during the country's situation analysis that only a small proportion of Viet Nam's national budget is allocated for IEC activities (<6% of the overall health budget) and a top-down approach is used to develop its materials, which leaves many ethnic groups with inappropriate materials. It is suggested that a combination of a top-down and bottom-up approach be taken for IEC development in order to minimize a potential social gap. The project's primary bednet
recipients usually take their nets to the forest during frequent expeditions, and household members are left behind with no net. Therefore, insecticide-treated nets should be made available to all individuals in the household, if possible. The country's IEC programme usually lacks pre-testing of materials and there are normally no incentives for health educators to develop and implement IEC materials.

Other meeting participants discussed lessons learnt. Through a participatory approach, NMCP staff and IEC teams gained a better understanding of local malaria situations and prevention needs. Training workshops were very useful in enhancing and strengthening IEC team members’ knowledge and skills for developing appropriate and effective IEC strategies and packages, while interactive materials encouraged community participation and increased the attention of target audiences during educational sessions. A step-by-step IEC guideline enhanced the capacity of local health staff and, even although a participatory approach is a longer process than a conventional top-down approach, outcomes were more appropriate and local ownership increased. Information-sharing between GMS countries and project leaders has been unsatisfactory. Because it is the role of the Mekong Roll Back Malaria (RBM) network to facilitate information exchange, the Project Coordinator should develop a mechanism to improve communication between all parties.

5.2 Constraints on and threats to regional IEC development

Several constraints on regional IEC development were discussed.

- Counterfeit drugs are a threat to any malaria treatment initiative. Public and private sectors and prescribers are not always aware of counterfeit drugs in the region. Awareness should, therefore, be raised among both the target populations and the prescribers alike regarding interactions as well as the influences of counterfeit drugs on all people at risk.

- A lack of drug-resistance monitoring threatens, not only regional IEC development, but also larger primary health care programmes. In Myanmar, for example, drug resistance caused by migration is clearly a common problem that must be addressed and mitigated through policy and treatment regime change. In the future, it is crucial to integrate drug resistance issues as part of an IEC package.

- Improper identification of poverty may threaten the initiative's success. For example, as defined by a World Bank index, indigenous people are not always poor, but are vulnerable. Targeting border areas may only capture a small percentage (about 5%-10%) of the entire ethnic group. Long-term uplifting of the entire ethnic community should be considered during future planning stages. A matrix with both short- and long-term objectives should be developed regarding how to advance ethnic minority communities as a whole.

- Lack of interest and support to migrants, as well as their illegal status in many cases, may threaten successful malaria control strategies for these groups. More research and attention needs to be given to migrants.

- Without a behavioural-change communication (BCC) component, gaps will exist in a potentially strong behavioural-change initiative. Because BCC concepts mainly
surround health promotion, consideration should be given to integrating BCC into national plans and advocacy activities.

- The unwillingness of governments to integrate IEC development into routine malaria control programmes will threaten the success of regional IEC development. Having many other priorities, NMCPs may not want to fully commit to spending time and resources integrating IEC activities into mainstream activities. Strong efforts should be made to link IEC activities with ongoing national malaria activities, such as those funded by the GFATM.

- Lack of advocacy and social mobilization activities will threaten the success of the IEC initiative. It is recommended that programme managers and others involved in IEC development attend the 2005 ACTMalaria training on partnership-building, social mobilization and advocacy. Vector-control and drug-treatment issues will be included as technical components.

6. CONCLUSIONS AND FUTURE PERSPECTIVES

The IEC project is fulfilling a need for malaria control in remote groups that has, up until now, not been met. Every country has developed a series of contextualized materials that address problems for hard-to-reach groups. It is now essential to scale up activities to meet the needs of these peoples, especially in malaria control. A comprehensive malaria control package for ethnic minority groups, including prevention and treatment measures, should now be integrated into NMCP activities. Many national antimalarial drug treatment policies are changing to ACT and some malaria-endemic countries, especially those supported by the Global Fund, will provide these treatments free of charge. These countries will eventually need to effectively inform citizens about any policy changes regarding malaria prevention and treatment. Myanmar has developed posters highlighting the new treatment regimen. In the Lao People’s Democratic Republic, where treatment is free, the Government is testing ACTs in several communities before full-scale distribution. In many cases, people do not know about a change in treatment policy or access to free drugs until they visit public-sector treatment facilities.

Fundraising and awareness activities are crucial for strengthening malaria control in ethnic minority groups of the GMS. Funds must be raised. Although China, Thailand and Viet Nam are able to appropriate minimal funds for technical support and information sharing, no other countries have committed to funding IEC development or malaria control specifically for ethnic minority populations. Viet Nam will develop its materials whilst distributing drugs and nets, and Myanmar and the Lao People’s Democratic Republic will receive funds from their governments to continue distribution and field implementation. Cambodia will need to seek funds from outside donors. Regarding advocacy, Myanmar has celebrated an annual National Malaria Week since 2002 and it was suggested that the WHO Western Pacific Region adopt a Malaria Day. A Regional Malaria Day would help to raise awareness about IEC and prevention measures, such as proper use of bednets, diagnosis-seeking and treatment.
A simple and standardized IEC and malaria control package should be developed and field implemented before scaling up. If resources are limited, scaling up distribution of products, such as bednets and relevant IEC materials, should be the primary aim before research. As a possible measure to increase revenue, health providers may consider informal charges for bednet distribution. Generally, public health systems have been strengthened throughout the region, but the role of public health services in malaria control still needs to be linked to curative services. Other malaria control strategies, together with bednet distribution, need to be integrated into basic regional health services. Therefore, NMCPs need to determine these strategies, together with focal points from ethnic minority groups, before working to integrate them into national programmes. Subsidization by governments, analyses of cost-effectiveness and use of funding should be considered. Local leaders and other individuals need to be informed about new strategies and research questions specified.

Now that the NMCPs are aware of the IEC project and have a good working relationship with IEC leaders and target populations, effective and economical strategies for malaria control in ethnic minority groups can be developed at the national level. By providing technical inputs and leading the way in terms of regional priorities, the NMCPs should be fully engaged to ensure that the concerns of ethnic minority groups and regional collaboration are integral parts of their programmes.
ANNEX 1

REQUEST FOR CONTINUED SUPPORT: ADB/WHO/RBM IEC PROJECT

Advisory Board Members and Guests:

I regret that I am unable to attend the meeting, but I would like very much to express my desire for continued financial support of the ADB/WHO/RBM IEC Project, through funding for a Phase II.

Since being asked by WPRO to develop a Plan of Action for this project in 2002, I have had the pleasure of serving as a Special Advisor to the project. In spite of tremendous obstacles (such as delays in filling IEC country-level positions, insufficient time for completion of IEC development and lack of understanding about the project), the involved countries embraced the idea of targeting IEC to vulnerable, ethnic populations who often are missed in the delivery of standard malaria control interventions. They have completed the baseline work that is necessary to support social science interventions - country-level teams were developed, trained and tasked with identifying a specific IEC project that they felt was most needed to reach their respective minority populations. Situational analyses were completed, and prototype IEC materials and guidelines have been developed for each country. Links to complementary research (Drs. Kundstader and Rifa) were forged, as well as discussion moved forward with ACTMalaria about developing a course aimed at improving health care communication by providers – an essential element if we are to improve malaria care both in general and, specifically, for ethnic, vulnerable populations. However, this is only the start. Without funding for a Phase II, we will not have the opportunity to learn if the chosen interventions have any impact on lessening the malaria burden on these specific populations.

I urge you to consider extending financial support of this project through a second phase for several reasons. This project is unique in its construction – there are no other regionally based projects for IEC focusing on malaria that I know of anywhere in the world. In addition to identifying key process aspects of IEC development that are applicable to the region, the project also provides a wealth of information about specific groups that are considered vulnerable, which can be used to inform future intervention development for these groups.

Another crucial element of this project is that it recognizes “social vulnerability” as an important construct. When we think about vulnerability in terms of malaria, most frequently it is thought of in terms of physiological parameters or financial restraints. This project is unique in targeting mobile populations who are vulnerable due to factors such as their ethnic backgrounds, employment status and degree of mobility. Having the interventions actually implemented in a next phase, with a concomitant monitoring and evaluation process, would provide excellent examples for malaria control programmes that deal with similar populations. In particular, the information would be very applicable to the countries comprising the Amazon Basin area in South America and to situations of displacement (mostly refugee populations in Africa).
In spite of continuous rhetoric about the importance of social science contributions and community involvement in malaria control, we continue to have a paucity of operational research and intervention development in malaria control that targets social science, including health education and communication. Even when funding for operational research has been available, few projects have been able to build on what was learned in the operational research component by moving forward to intervention development. The IEC Project is a superb opportunity for: a) crossing the bridge from development to intervention, b) demonstrating to the involved national malaria control programmes that the IEC/social science work that has been occurring through the past two years is important enough to continue funding, and c) recognizing that the behavioral changes needed for better malaria control take a long time to occur.

Without a firm commitment from donors to support this project, the unique accomplishments obtained in Phase I will be lost among the more traditionally focused malaria control interventions, which have been shown to be less than successful with the special populations that this project targets. The recently completed preliminary country-level analysis of Phase I, undertaken by Ms. Kate Phillips and Mr. Pricha Petlueng, demonstrated that one of the positive outcomes to date has been an increased awareness of major stakeholders (including staff from malaria control programmes and others) of the unique aspects of these populations and the recognition that previously attempted IEC interventions have missed these particular groups for a variety of reasons. Given the strong links between the behaviors of these specified populations and epidemiological outcomes (including transmission, morbidity and mortality rates), it is critical that we move forward with targeting culturally appropriate interventions for these groups. This project has already made those connections and needs additional support to sustain those linkages.

Finally, I would like to also suggest that there are complimentary activities that could be undertaken to support the progress of this project. Capacity building for social science and IEC has been a challenge – the IEC government staff would benefit from attending the ACTMalaria’s course (Broadening Involvement Team Training Workshop [BITTW]) that focuses on building community and stakeholder partnerships. Conversely, control staff from the Mekong countries whom have attended ACTMalaria’s MMFO course could be asked to assist with the IEC projects, as they have all received a basic introduction to social science and how components of social science can be applied to improving malaria control. Lastly, this project should not be thought of in terms of a vertical approach to malaria. Rather, it should be perceived as an opportunity to improve skills in dealing with difficult-to-reach populations. Once developed, those skills are applicable to any public health concern, particularly in the area of communicable disease.

Thank you for your time and interest,

Dr. Holly Ann Williams
15 November 2004
Special Advisor: ADB/WHO/RBM IEC Project
CDC Malaria Branch
PROGRAMME OF ACTIVITIES

Friday, 19 November 2004

8:00 – 8:30  Opening speeches by MOH and WR, Viet Nam
8:30 – 8:40  Self-introduction
8:40 – 8:50  Meeting objectives - Dr Palmer, RA WPRO
8:50 – 9:15  Group photo and coffee break

Project progress and products:
9:15 – 9:25  Background of the RBM IEC Project - ADB representative (possibly together with Dr Palmer)
9:25 – 9:40  Overview of the RBM IEC Project - Pricha Petlueng
9:40 – 12:30  Country presentations Cambodia, China, Lao, Myanmar, Vietnam and Thailand (20-30 minutes, 5 minutes discussion):
  Project implementation and IEC packages
12:30 – 13:30  Lunch break

Lessons learnt and draft regional RBM IEC strategic plan:
13:30 -14:00  Beliefs and practices among Mon-Khmer– Hector Rifa
14:00 – 14:30  IEC in malaria control programmes –H. Williams and P Kunstadter
14:30 – 15:15  Lessons learnt from the Mekong RBM IEC project – country inputs
15:15 – 15:45  Coffee break
15:45 – 16:45  Presentation regional RBM IEC strategic plan – Pricha Petlueng

Saturday, 20 November 2004

The way forward
8:00 – 8:30  Presentation Phase II project proposal to ADB – Pricha Petlueng
8:30 – 10:00  Country working groups: How to sustain and integrate
10:00 – 10:15  Coffee break
10:15 – 11:15  Country working group presentations
11:15 – 11:45  Conclusions and recommendations
11.45 – 12.00  Closing
ANNEX 3

FINAL LIST OF PARTICIPANTS, TEMPORARY ADVISERS, REPRESENTATIVES/OBSERVERS AND SECRETARIAT

1. PARTICIPANTS

(ADVISORY COMMITTEE MEMBERS)

CAMBODIA

Dr Doung Socheat (Chairperson)
Director
National Centre for Parasitology, Entomology and Malaria Control
Ministry of Health
372 Monivong Blvd.
Phnom Penh
Tel: +855 12 815 950; Fax: +855 23 219 271
E-mail: socheatd@cnm.gov.kh

Dr Bou Kheng Thavrin
Chief of Health Education Department
National Centre for Parasitology, Entomology and Malaria Control
Ministry of Health
372 Monivong Blvd.
Phnom Penh
Tel: +855 12 874 490; Fax: +855 23 219 271
E-mail: thavrinb@cnm.gov.kh

CHINA

Dr Wang Liying
Director, Division of Schistosomiasis Control
Department of Disease Control
Ministry of Health
No. 1 Xizhimenwai, Nanlu
Beijing 100044
Tel: +86 10 68792372; Fax: +86 10 68792372
E-mail: wangly@moh.gov.cn
Annex 3

Dr Tang Lin-hua
Director/Professor
National Institute of Parasitic Diseases
Chinese Centre for Disease Control and Prevention
207 Rui Jin Er Lu, Shanghai 200025
Tel: 86-21-64373359; Fax: 86-21-64332670
E-mail: ipdcckjc@sh163.net

Dr Zhang Zaixing
Associate Professor and Director
Yunnan Institute of Parasitic Diseases
6 Xiyuan Road
Simao, Yunnan 865000
Tel: 0086 879 2122152; Fax: 0086 879 2122163
E-mail: zzx@public.km.yn.cn; zzxin@126.com

Ms Xia Min
Research Practical Member
Yunnan Institute of Parasitic Diseases
6 Xiyuan Road
Simao, Yunnan 865000
Tel: 0086 879 2122152; Fax: 0086 879 2122153
E-mail:

LAO PEOPLE'S
DEMOCRATIC
REPUBLIC

Dr Samlane Phompida
Director
Center for Malariology, Parasitology
and Entomology (CMPE)
Ministry of Public Health
Vientiane
Tel: (007856-21) 214040; Fax: (007856-21) 218131
E-mail: cmpe@laotel.com

Dr Soudsady Oudomsouk
Deputy Chief of Health Education Unit
Centre for Malariology, Parasitology
and Entomology (CMPE)
Ministry of Public Health Vientiane
Tel: +856-21-214040/252673; Fax: +856-21-218131
E-mail: cmpe@laotel.com
Annex 3

Dr Rattanaxay Phetsouvanh
Head of Administration and Technical Office
Center for Malariology, Parasitology
and Entomology (CMPE)
Ministry of Public Health
Vientiane
Tel: +856-21-214040; Fax: +856-21-218131
E-mail: cmpe@laotel.com

MYANMAR
Dr Saw Lwin
Deputy Director (Malaria)
Vectorborne Disease Control Programme
Ministry of Health
27 Pyidaungsu Yolktha Road
Dagon, P.O. 11191
Yangon
Tel: 951 640031/640749; Fax: 951 212604
E-mail: 

Dr Ye Myint
Deputy Director-General
Public Health and Disease Control
Department of Health; c/o Ministry of Health
27 Pyidaungsu Yolktha Road
Dagon, P.O. 11191
Yangon
Tel: c/o 951 229299/210652/210518; Fax: c/o 951 210682
E-mail: 

THAILAND
Dr Chaiporn Rojanawatsirivet (Vice Chairperson)
Director
Bureau of Vector Borne Disease
Department of Communicable Disease Control
Ministry of Public Health
Tiwanong Road
Nonthaburi 11000
Tel: 662-5903132; Fax: 662-5918422
E-mail: chaiporn@health.moph.go.th

Ms Nardlada Khantikul
Technical Officer
Office of Prevention and Control Disease No. 10
Ministry of Public Health
Bangkok
Tel: 662-5903132; Fax: 662-5918422
E-mail: ornardlada@hotmail.com
Annex 3

**VIET NAM**

Professor Le Khanh Thuan  
Director  
National Institute of Malariaiology,  
Parasitology and Entomology (NIMPE)  
BC 10200 Tu Liem  
Ha Noi  
Tel: +84 4 5530803; Fax: +84 4 8543015  
E-mail: itnimpe@netnam.org.vn

Dr Le Xuan Hung  
Head, Epidemiology Unit  
National Institute of Malariaiology,  
Parasitology and Entomology (NIMPE)  
BC 10200 Tu Liem  
Ha Noi  
Tel: +84 4 5530803; Fax: +84 4 8543015  
E-mail: itnimpe@netnam.org.vn

Dr Nguyen Quy Anh  
Malaria Technical Staff  
National Institute of Malariaiology,  
Parasitology and Entomology (NIMPE)  
BC 10200 Tu Liem  
Ha Noi  
Tel: +84 4 5530803; Fax: +84 4 8543015  
E-mail: itnimpe@netnam.org.vn

**ACTMALARIA**

Ms Cecilia T. Hugo  
Executive Coordinator  
ACTMalaria Foundation, Inc.  
11th Floor, Ramon Magsaysay Center  
1680 Roxas Boulevard  
Malate, Manila  
Tel: (632) 5213166 loc. 170; Fax: (632) 5360971  
E-mail: cecil_hugo@actmalaria.org
Annex 3

ASIAN DEVELOPMENT BANK

Mr Vincent de Wit
Senior Health Specialist
Mekong Department Social Sectors Division
Asian Development Bank
6 ADB Avenue, Mandaluyong City
Tel: (632) 6324444; Fax: (632) 6364444
E-mail: v dewit@adb.org

2. TEMPORARY ADVISER

Dr Hector Rifa
Associate Professor of Behavioural Research Methods
Universidad de Oviedo, Oviedo, Spain
c/o WR, Cambodia
Tel.: c/o +855-23-216610; Fax: c/o +855-23-216211
E-mail: rifa@uniovi.es

3. REPRESENTATIVE/OBSERVER

JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

Dr Masatoshi Nakamura
Project Officer
Malaria Control and Infectious Disease Control
Japan International Cooperation Agency
Yangon, Myanmar
Tel: 00951-379038; Fax: 00951-379038
E-mail: naka@myanmar.com.mm
Annex 3

4. SECRETARIAT

SEARO

Dr Krongthong Thimasarn
Acting Regional Adviser in Malaria
WHO South East Asia Regional Office
World Health House
Mahatma Gandhi Road
New Delhi 110002, India
Tel: 0091 112 337 08 04/09/10/11; Fax: 0091 112 237 01 97
E-mail: thimasarnk@whosea.org

Dr Leonard Ortega
Medical Officer
World Health Organization
7th Floor, Yangon International Hotel
330, Ahlone Road, Dagon Township
Yangon, Myanmar
Tel.: +951-212608; Fax: +951-212605
E-mail: ortegal@whomm@undp.org

Dr Maung Maung Lin
National IEC Specialist
Office of the WHO Representative in Myanmar
Yangon, Myanmar
Tel: +63-951-212608; Fax: +63-951-212605

WPRO

Dr Kevin Palmer
Regional Adviser in Malaria, Vectorborne
and Other Parasitic Diseases
WHO Western Pacific Regional Office
U.N. Avenue, P.O. Box 2932
Manila 1000, Philippines
Tel: (632) 5289725; Fax: (632) 5211036
E-mail: palmerk@wpro.who.int

Dr Eva-Maria Christophel
Medical Officer, Malaria, Vectorborne
and Other Parasitic Diseases
WHO Western Pacific Regional Office
U.N. Avenue, P.O. Box 2932
Manila 1000, Philippines
Tel: (632) 5289723; Fax: (632) 5211036
E-mail: christophele@wpro.who.int
Annex 3

Dr David Bell
Scientist (Diagnostics), Malaria, Vectorborne and Other Parasitic Diseases
WHO Western Pacific Regional Office
U.N. Avenue, P.O. Box 2932
Manila 1000, Philippines
Tel: (632) 5289756; Fax: (632) 5211036
E-mail: belld@wpro.who.int

Mr James Kelley
Technical Officer, Malaria, Vectorborne and Other Parasitic Diseases
WHO Western Pacific Regional Office
U.N. Avenue, P.O. Box 2932
Manila 1000, Philippines
Tel: (632) 5289754; Fax: (632) 5211036
E-mail: kelleyj@wpro.who.int

Dr Antonio Montresor
Public Health Specialist
Office of the WHO Representative in the Socialist Republic of Viet Nam
Ha Noi, Viet Nam
Tel.: +844-943-3734; Fax: +844-943-3740
E-mail: montresora@vtn.wpro.who.int

Dr Reiko Tsuyuoka
Malaria Scientist
Office of the WHO Representative in Cambodia
Phnom Penh, Cambodia
Tel.: +855-23-216610; Fax: +855-23-216211
E-mail: tsuyuokar@cam.wpro.who.int

Mr Pricha Petlueng
Short-term Professional/Technical Coordinator
Mekong/Roll Back Malaria IEC Project
Office of the WHO Representative in the Lao People's Democratic Republic
Vientiane, Lao People's Democratic Republic
Tel: +856-21-413-431/21-413-023; Fax: +856-21-413-432
E-mail: petluengp@lao.wpro.who.int

Dr Kim Sovann Yadany
Medical Officer
Office of the WHO Representative in the Lao People's Democratic Republic
Vientiane, Lao People's Democratic Republic
Tel: +856-21-413-431/21-413-023; Fax: +856-21-413-432
E-mail: kims@lao.wpro.who.int
Annex 3

Dr Tran Cong Dai
Project Assistant for Malaria
Office of the WHO Representative in the Socialist
Republic of Viet Nam
Ha Noi, Viet Nam
Tel.: +844-943-3734; Fax: +844-943-3740
E-mail: dait@vtn.wpro.who.int

Mr Nguyen Ngoc Thuy
National IEC Specialist
Office of the WHO Representative in the Socialist
Republic of Viet Nam
Ha Noi, Viet Nam
Tel.: +844-943-3734; Fax: +844-943-3740
E-mail: thuyn@vtn.wpro.who.int

Mr Un Bunphoen
National IEC Specialist
Office of the WHO Representative in Cambodia
Phnom Penh, Cambodia
Tel.: +855-23-216610; Fax: +855-23-216211
E-mail: unb@cam.wpro.who.int

Mr Xu Jianwei
National IEC Specialist
Yunnan Institute of Parasitic Diseases
6 Xiyuan Road
Simao, Yunnan 865000
People's Republic of China
Tel: 0086 879 2122152/2128101; Fax: 0086 879 2122153
E-mail: xiw426@163.com