Malaria Elimination

Who is Really at Risk?
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The regional and national strategies in the Greater Mekong Subregion (GMS) pay special attention to mobile and migrant populations (MMPs) as the key at-risk group in the region, often identifying them as a significant barrier to malaria elimination (Box 1). This generalization, however, can mask the reality that not all MMPs are at risk malaria, and that some people who are neither mobile nor migrants, are at-risk. This document presents an alternative approach to thinking and talking about risk factors, and how this can be translated into strategy and action. This thought paper draws on existing literature and data, as well as PSI’s experience in malaria programming in the GMS.

Box 1 MMPs in GMS Malaria Elimination Strategies

GMS
“Focus on detecting, protecting and providing access to diagnosis and treatment for priority population groups (e.g. mobile and migrant populations)”
Strategy for Malaria Elimination in GMS, WHO.

Cambodia
“Due to the high risk of infection among mobile and migrant populations, special efforts will be enacted to reach this population with strategic interventions”
Malaria Elimination Action Framework, CNM.

Lao PDR
“The malaria burden remained high in Southern Provinces, with spikes in incidence occurring due to influx of migrant and mobile populations related to development projects and large scale industrial and agricultural projects”
National Strategic Plan, CMPE.

Myanmar
“Provide comprehensive services to meet the needs of all at risk populations, including mobile populations and migrants”
National Strategic Plan, NMCP.

Vietnam
“Coordinate activities related to malaria control amongst migrants, mobile and other difficult to reach populations”
National Strategic Plan, NIMPE.

Key Takeaways

• Not all MMPs are at risk, and not all at-risk populations are MMPs.

• Rather than problems for malaria elimination, at-risk groups become key beneficiaries of malaria service.

• MMPs represent extremely diverse groups, rather than stigmatizing these groups, terminology and programs should focus on key risk factors:
  - Proximity and time spent in or near forests;
  - Access to quality health care services;
  - Personal vulnerability due to low knowledge of malaria and personal protection practices.

• Worksite-based activities are an effective way to reach MMPs, however more needs to be done to reach other at-risk groups, including ethnic minorities, and forest-dependent farmers and hunters.
As the GMS now has malaria elimination in sight, a more focused and targeted approach is necessary in order to find and treat every last case. Identifying the groups most at risk is therefore a wise strategy to interrupt transmission. MMPs have been identified across the Asia Pacific region as a particularly vulnerable group. It is important to keep in mind, however, how much diversity lies with the term “MMP.” Mobile populations can include anyone who moves, from tourists, businesspeople and students, to plantation workers, itinerant traders and people displaced by conflict or disaster. It is therefore important to consider what it is about the nature of their mobility that puts them at risk.

MMPs tend are identified as a key risk group because they are more likely to have three key vulnerabilities:

- **Visiting or living near the forest:** Forests remain key malaria transmission sites in the GMS, and many worksites that attract MMPs are often in or near forests.
- **Limited access to health services:** Working or moving through remote, foreign areas can reduce access to or use of health services.
- **Limited malaria knowledge or practice of preventative behaviors:** Understanding, or ability to practice preventative behaviors is often limited among MMPs.
With agreement on the key factors that make MMPs vulnerable to malaria, it is possible to see that other groups who may not be mobile, or migrants, are also at risk due to where they live or other socio-economic and demographic factors.

- **Visiting or living near the forest:** some local rural population groups live and/or work in or near the forest, including plantation workers, as well as farmers, hunters, charcoal producers, forest product gatherers, guards, and sometimes their families.
- **Limited access to health services:** some local populations living in remote areas – particularly ethnic or other minorities – experience different barriers to accessing health services. These include lack of availability, or other geographic, socio-economic, or cultural reasons. Available services may not always be appropriate to marginalized groups that may also be stigmatized in some way.
- **Limited malaria knowledge or practice of preventative behaviors:** Groups with limited access to health services may also have limited access to accurate information on malaria.

By narrowing our focus to mobile and migrant populations, we risk missing the most marginalized populations, which may further contribute to their vulnerability.
A new framework

As countries move closer to elimination, targeting the right places (hot spots) and the right people (hot pops) becomes vital. At the same time, challenging what that data means is key:

- **Hot spots**: Is the case surveillance data pointing to the transmission site, or where the cases are presenting?

- **Hot pops**: By focusing on labels of groups, are many at-risk individuals missed by interventions? Are others stigmatized and pushed further away from the health services that should be reaching them?

By adapting Sturrock et al’s popular schematic, and considering key risk factors, intervention opportunities become clear that do not require taking mobility or migration status into account.

**Examples include:**

1. Equip existing shops reaching remote populations with malaria test and treat capability.

2. Extend the outreach of activities of village malaria workers to support non-formal private sector outlets.

3. Ensure worksites near forests screen and treat all workers on arrival and exit.

4. Work with agents/recruiters to gain access to smaller, unregistered worksites, and to share malaria information with workers.

GEMS Elimination of Malaria through Surveillance (GEMS)
The GEMS program is a PSI initiative that is expanding the private sector’s ability to find, test, treat and report on malaria cases in accordance with national policies in Cambodia, Lao PDR, Myanmar and Vietnam. The program provides training, supervisory support, supplies of quality assured RDTs and first-line treatment to private health clinics, pharmacies and worksites. Given that high proportions of people living in the region go to the private sector to seek care for fevers, it is essential that the quality of care provided is high, and that cases are reported into the national system.

In Myanmar, PSI is also working with non-formal private sector health care providers, including grocery shops, drug shops and mobile drug vendors that are present in remote communities where the public and formal private sector services have limited reach. While not registered, the government recognizes that these actors fill an important gap and can be essential health care providers, as well as surveillance points. Myanmar’s network of non-formal providers includes over 21,000 actors across the country, including the most remote and under-served areas. Previously, a staggering 70% of private-sector outlets were stocking oral artemisinin monotherapy, which had been banned by the government. After bringing them into PSI’s network, this fell to 10% in 2014 [2]. In 2015, PSI distributed 406,025 ACTs through this network, and it is currently anticipating increased case surveillance data generation.

Opportunities presented by non-formal actors
Other countries in the GMS are understandably reluctant to authorize non-formal actors with no medical expertise to provide malaria test and treatment services, and instead rely on impressive cadres of malaria/integrated health care workers at the community level, some of which provide outreach services to remote populations. However, as they are unable to be everywhere at once and are often over-burdened and under-resourced, authorizing, training and supporting non-formal private sector actors may be a critical strategy in reaching the most at-risk populations.

Particularly in remote marginalized communities where trust can depend on long-standing relationships, working with known community members can break down many of the barriers that many at-risk populations face in accessing health care. PSI has a proven model that demonstrates the feasibility of supplying non-formal providers with quality products, and training them on their correct use. By supporting existing structures, the cost effectiveness and sustainability of this approach also makes it a viable option.
Putting thoughts into action

With a reduced emphasis on categorising people, and a clearer understanding of the risk factors, the following five conclusions were reached:

1. Language
Strategies and terminology should focus on risk factors rather than identity groups to avoid stigmatising already vulnerable groups. At-risk individuals become elimination beneficiaries, and rather than being viewed as problems, they need to be fully and genuinely engaged as part of each country’s elimination strategy.

2. Evaluation
Despite the increase in concerted efforts to target at-risk groups, there is little evidence of whether or not these approaches are working [5]. Evaluations must be included in program designs and budgets, and information needs to be shared on what is – or is not – effective.

3. Tools
As cases become harder to find, parasitemia drops, and P. vivax increases proportionately often due to recurring cases, elimination programs need to employ improved tools, including more sensitive diagnostics for active case detection [5], as well as radical cure for all species.

4. Worksite programs
Establishing services in remote worksites is an innovative and effective way to reach some at-risk groups – particularly MMPs – and have the potential to interrupt transmission in some hot spots, as well as prevent onward transmission.

5. Activities need to go the extra mile
Additional effort is needed to reach the most at-risk groups, and to reduce at least two of their vulnerabilities: access to quality health services, and limited knowledge of malaria prevention or practice of protective and care-seeking behaviors. This can be achieved through extending the reach of village malaria workers, or equipping the non-formal private sector to play this role.


GEMS is a PSI program that partners with the National Malaria Control Programs in Cambodia, Lao PDR, Myanmar and Vietnam to strengthen case management and surveillance in the private sector to accelerate each country’s progress towards their ambitious malaria elimination goals. GEMS brings together PSI’s longstanding experience working with the private sector in the region, malaria achievements globally, cutting edge technological tools, a solid logistics infrastructure, strategic partnerships, and a new thinking in disease surveillance. GEMS is supported by the Bill & Melinda Gates Foundation.

What is GEMS?

- Mapping private sector health care providers and worksites attracting mobile workers.
- Comprehensive training and routine supervision to ensure high quality malaria care and data reporting.
- Securing supply chains for quality assured RDTS and first line treatments.
- Establishing routine reporting systems for all suspected and confirmed cases and promoting data use.
- Actively finding and investigating cases and contributing to molecular surveillance.

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