

TECHNICAL ASSISTANCE COMPLETION REPORT

Division: MKSS

TA No. and Name RETA 5958: Roll Back Malaria Initiative in the Greater Mekong Subregion			Amount Approved : \$600,000.00	
			Revised Amount: ---	
Executing Agency Asian Development Bank	Source of Funding Japan Special Fund	TA Amount Undisbursed 0.00	TA Amount Utilized \$600,000	
Date			TA Completion Date	
Approval 7 Dec 2000	Signing 25 Sep 2002	Fielding of First Consultant 24 Oct 2002	Original 31 Dec 2002	Actual 31 Dec 2004
			Account Closing Date	
			Original 31 Dec 2002	Actual 30 Sep 2005
Description				
<p>The malaria situation in the Greater Mekong Subregion (GMS) has improved within the past 10 years through the introduction of insecticide-treated nets, promotion of health seeking behavior, and appropriate treatment. However, malaria remains a major threat for the general population due to increasing drug resistance of the parasite, and pockets of high malaria morbidity and mortality continue to exist among ethnic minorities, remote communities, and mobile populations. Information, education and communication (IEC) interventions are generally not geared towards these groups. Access to remote areas in the GMS is difficult, especially during the wet season, and appropriate strategies including IEC are needed to encourage and mobilize communities to take an active role in malaria prevention and control.</p> <p>The Mekong Roll Back Malaria (RBM) Initiative is a regional partnership of some 20 agencies to pool resources in the fight against malaria in the GMS. The RBM goals are to reduce malaria in the GMS by 50% by 2010 relative to 1998, and halt progression of multidrug resistance in the GMS. The RBM initiative targets poor and vulnerable populations living in remote and isolated areas, ethnic minority groups (EMGs), and migrant workers with a high burden of malaria, who are physically, socially and economically isolated and often not covered by national malaria control programs (NMCPs). Within the RBM initiative, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) formulated a joint project to expand services of NMCPs to reach these groups, and requested Asian Development Bank (ADB) to assist with developing effective IEC materials for selective EMGs in the GMS using a participatory approach and regional know-how; and sharing the findings at national and regional levels to boost efforts of NMCPs to control malaria among these groups.</p>				
Objectives and Scope				
<p>The goal of the regional technical assistance (RETA) was to improve the health status of poor and vulnerable population groups in the GMS by reducing morbidity and mortality due to malaria. The TA was to support the Mekong RBM Initiative and had three objectives, namely, to (i) develop user-friendly IEC materials and guidelines for poor and vulnerable population groups at high risk for malaria infection; (ii) enhance capacities of the governments in community-based activities in malaria prevention, control, and treatment; and (iii) make NMCPs more responsive to the needs of the target communities, particularly poor and vulnerable population by supporting a common regional plan. The scope of the TA included a situation analysis, drafting and field testing of IEC packages, developing a common regional strategy for malaria control in these groups, training and workshops, and establishing regional cooperation for implementing activities of joint interest. The RETA was to be implemented by UNICEF and WHO, and guided by a steering committee consisting of representatives from ADB, UNICEF, WHO, and participating NMCPs. UNICEF, the largest RBM donor, was to be directly appointed as the consultant. The TA implementation period was to be 24 months, from January 2001 to December 2002.</p>				
Evaluation of Inputs				
<p>The TA is considered well designed, based on extensive discussions with the six NMCPs and the United Nations partners, albeit ambitious in scope. Ownership and participation of NMCPs was strong. Implementation arrangements were changed. First, ADB and UNICEF could not agree on the wording of the TA agreement for one and a half years, up to May 2002, and WHO stepped in as the leading partner and signed a TA agreement with ADB in September 2002. WHO implemented the TA in 27 months compared to an original implementation period of 24 months, and a contractual period of 22 months. This was sufficient to implement the TA using a participatory approach.</p>				

Second, consulting services were changed. The TA paper lists three IEC specialists to be stationed in three different locations for a total of 31 person months (pm), and one domestic information system specialist for 17 pm. The TA agreement with WHO states different consulting services. These include a project coordinator/community development expert for 21 pm (actual 23.5 pm), short-term consultants 4 pm (actual 4 pm), training specialist for 1 year (Asian Collaborative Training Network for Malaria [ACT Malaria] was contracted for a lumpsum), and national experts 60 pm (actual 65 pm). The performance of the experts was generally satisfactory. The project coordinator, stationed in the WHO office in Lao People's Democratic Republic (PDR), was competent in IEC and excellent in networking, but less proficient in academic skills. The five national experts (excluding Thailand) acted as team members to provide technical support in community-based approaches and assist national malaria control staff in everyday project implementation. Their performance was overall satisfactory.

Due to the workload of NMCP staff, counterpart staff contributions tended to slow down in between workshops, making efforts more dependent on national experts. WHO put in far more time and effort in this TA than required under the TA agreement. The Communicable Diseases Department of the Western Pacific Regional Office (WPRO) of WHO was directly responsible for overseeing TA implementation, which ensured that TA work was properly mainstreamed and more likely to be sustained. In terms of counterpart funding, WHO inputs likely surpassed the \$75,000 required in cofinancing as per TA agreement. ADB support was more of a facilitating nature.

The TA was implemented according to the original scope in terms of undertaking a situation analysis, making IEC packages, providing training, and developing a common regional strategy for malaria control in EMGs. While it engaged in regional cooperation for malaria control, it could not fully establish this within the timeframe of the TA.

Three steering committee meetings, 1 regional consultation, 3 regional training workshops, 3 project workshops and 2 national training workshops, 5 country dissemination workshops were held. After the launch of the Project in October 2002 and the first steering committee meeting in Manila, a planning consultation was held in January 2003 in Chiang Mai, with the participation of anthropologists familiar with the region, especially discussing EMGs at greatest risk of malaria and who live along international borders. The project midterm review meeting was held in September 2003 in Vientiane, Lao PDR, and the final Advisory Committee Meeting in Hanoi, Viet Nam in November 2004 reviewed the project achievements. Regular visits of the project coordinator provided close supervision and strengthened country teams' capacity to apply knowledge and skills gained during the workshops for implementing project activities. It also gave opportunity for country teams to discuss implementation issues, unforeseen constraints and improve performance of the team members.

Six EMGs were selected as pilot groups, namely Karen in Thailand, Kreung in Cambodia, Wa in Yunnan/People's Republic of China (PRC), Brau in Lao PDR, Shan in Myanmar, and Raglai in Viet Nam. The total target population involved in the field studies and development of IEC materials and guidelines in each country was around 1,000 people. During the workshops, the teams developed protocols for implementing the IEC development activities in six pilot sites. The target communities provided important inputs to the TA teams to develop appropriate IEC materials and guidelines. Their participation in every step of the IEC development made the TA teams understand the local situation and their needs for effective malaria prevention and control.

A total of three regional workshops were held to build the capacity of NMCP staff. The topics were (i) field research for EMGs and data collection, Vientiane, June 2003; (ii) participatory IEC materials development training workshop, Yangon, October 2003; and (iii) technical consultation workshop on IEC field materials production and design, Bangkok, February 2004. In addition, there were two national workshops held at country level on item (i) in Yangon, July 2003, and item (ii) in Simao, Yunnan, December 2003, and six dissemination workshops. The workshops helped to prepare protocols for household surveys and focus group discussions, design IEC strategies and plans, and strengthen capacity of country teams to develop user-friendly IEC packages for target communities using a participatory approach. The workshops also provided a mechanism for sensitizing and motivating staff, and for enhancing regional information exchange and networking.

WHO and consultants provided expert support for increasing planning efforts to make NMCPs more responsive to the needs of EMGs and other isolated communities. A draft regional IEC strategic plan for poor and vulnerable groups in the GMS was prepared by WHO. Funds for sustaining services in the pilot areas and scaling up interventions was provided by NMCPs using the Global Fund to Fight AIDS, Malaria and Tuberculosis (GFAMT). ADB followed up with supporting RETA 6243 for Strengthening Malaria Control Among Ethnic Minorities in the GMS, to test malaria packages for EMGs, incorporate these strategies in NMCPs, and finalize the regional plan.

Evaluation of Outputs

Develop user-friendly IEC materials and guidelines for poor and vulnerable population groups at high risk for malaria infection. NMCP staff, experts, local staff, and community members worked together to assess knowledge, attitudes and practices related to malaria control among EMGs, and develop appropriate IEC materials

and strategies. During the pre-testing of the materials, the teams found that the materials developed were easier to understand by EMGs and easier to use by local health staff and village volunteers compared to previous materials developed by NMCPs. The prototype materials produced range from printed materials (interactive flipcharts, posters, calendars, leaflets, brochures, question and answer booklets, flyers for migrant workers, comic books for children, jigsaw puzzles, pictorial card sets for story-telling) and audio cassettes with traditional music and songs composed for this purpose, to outstanding video films made by Cambodia and PRC. In addition, guidelines were developed on how to best use these materials by local health staff and village volunteers, how to strengthen communication skills, and how to implement specific approaches like the “buddy system” for school health education in Yunnan. Staff also helped develop IEC materials for other ethnic groups (e.g., the Dai in Yunnan), using funds from other projects. The Yunnan team also developed IEC materials for other EMGs. Some IEC materials were reproduced by NMCPs and local health and education departments.

Enhance capacities of the governments in community-based activities in malaria prevention, control, and treatment. The capability of NMCP staff to apply participatory planning methods to develop appropriate malaria control communication materials and strategies for EMGs has been enhanced substantially, and some of this knowledge is being applied for the benefit of EMGs. At least two NMCPs (Cambodia, PRC) have continued with a strong focus on IEC among EMGs, which is demonstrated by the emphasis of these activities in recent GFATM proposals. People from the pilot communities (especially village volunteers, village leaders, teachers and local health staff) who participated in the project implementation have gained knowledge and skills in malaria prevention and control. Some have obtained and used the IEC materials to educate their communities. Findings from an evaluation of the IEC materials by the Thai team showed a substantial increase in knowledge among people in Village No. 3, Mae Sam Lab sub-district, Sob May district, Mae Hong Son province, on malaria prevention and control, but did not test practices.

Make NMCPs more responsive to the needs of the target communities, particularly poor and vulnerable population by supporting a common regional plan. The TA made a major contribution in sensitizing NMCPs towards the special needs of EMGs, and in facilitating the adaption of national malaria strategy to their needs. This is an important achievement. In the course of the project training workshops, intercountry networks were also strengthened. A monthly project newsletter regularly gave member countries and a wide range of RBM partners an update of the project activities, and experiences were shared; it also provided links to the latest malaria information and development, for example from WHO, Roll Back Malaria, ACT Malaria, Communication Initiative, and Partnership for Social Science in Malaria Control. At the end of the TA, each country organized a workshop to disseminate the project information, IEC materials developed and lessons learned to malaria agencies and partners from provincial and/or central level (including a country-wide workshop in PRC). Representatives from various health departments, mass media organizations and different development partners attended these workshops. Furthermore, experiences and results gained from this Project were published in academic journals, for example in PRC, and presented during international conferences. ACT Malaria has opened a malaria website for the GMS, providing a source of information and communication.

Based on these experiences, a draft Regional Strategic Plan for Poor and Vulnerable Groups in the GMS was prepared by WHO and discussed during the national dissemination workshops and the final Advisory Committee Meeting. Although the project design did not include an explicit scale-up component, the Project has contributed to scaling up malaria control interventions for EMGs in a number of ways. Several IEC materials developed by the Project were adopted by the NMCP and reproduced either for the same ethnic group in other geographic areas, or were modified for other ethnic groups (using funding from other sources). Some of the materials are being used by local malaria partners, including nongovernment organizations (NGOs), in their project areas. The “buddy system” approach has been adopted country-wide in PRC for malaria school education. NMCPs have adopted the materials and applied the approach and skills learned from the Project to develop new materials for other ethnic groups, using other funds. Several countries have included comprehensive IEC activities especially for remotely living ethnic minority populations in recent GFATM proposals, partially using the draft Common Strategic Plan for the GMS developed by the Project.

Overall Assessment and Rating

The TA is rated as successful. The initial delay was caused by the legal requirements of ADB and UNICEF. Once the TA was underway, implementation was smooth, thanks to the active guidance and support of WHO/WPRO and WHO country offices. The TA succeeded in developing an impressive array of educational materials and guidelines, some of them very innovative. It sensitized national malaria program staff in the GMS towards the special malaria control needs of EMGs, and improved their knowledge and skills to develop appropriate IEC materials using a participatory approach. Some materials were adopted by NMCPs, education and health departments, and local malaria control partners (including radio and television stations and NGOs). A draft Regional Strategic Plan for Poor and Vulnerable Groups in the GMS was shared with NMCPs and used to scale up interventions for EMGs using funds from GFATM and other sources.

Major Lessons LearnedADB

- (i) Partnership with WHO proved essential in obtaining leverage and support for this TA. However, any partnership needs to be carefully assessed and agreed before TA approval
- (ii) Consulting services need to be carefully assessed upfront, including their management requirements and the time it takes to get consultants in place.
- (iii) TA work was highly relevant as it was linked to national institutions and sustainable financing.

NMCPs

(Recipient Agencies)

- (i) IEC is a poorly developed element of malaria control, and needs to be intensified and modernized.
- (ii) Participatory approaches for developing IEC materials and strategies for malaria control among EMGs are essential, and should be replicated for other EMGs.
- (iii) Capacity building for reaching EMGs is a relatively new development for NMCPs.
- (iv) Workshops proved to be useful for capacity building and sharing.
- (v) Regional sharing of information and activities helps motivate NMCPs to improve malaria control for EMGs.

Recommendations and Follow-Up Actions

- (i) Capacity building of NMCPs for reaching EMGs needs more advocacy, capacity, and sustained efforts.
- (ii) IEC, or even better behavioral change communication, needs to be given higher priority by NMCPs.
- (iii) NMCPs should give specific attention to EMGs and other isolated groups in their plans and budgets, reflecting the higher costs of reaching them, and GFATM assistance needs to be adjusted accordingly.
- (iv) The next important step is to test a comprehensive package of malaria control interventions including IEC for EMGs, to be able to complete the draft regional IEC strategic plan for poor and vulnerable groups in the GMS, and incorporate this in NMCPs. This is being supported with RETA 6243 for Strengthening Malaria Control Among Ethnic Minorities in the GMS.

Prepared by Vincent de Wit Designation Principal Health Specialist, MKSS