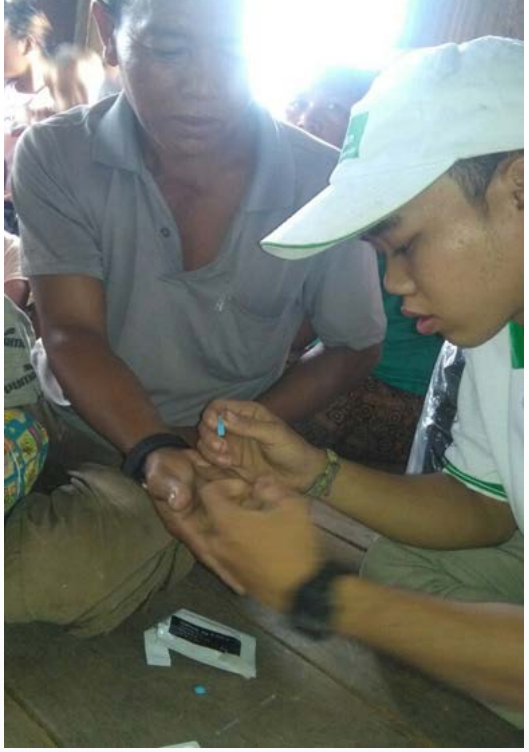


Mobile malaria services reaching forest goers in North East Cambodia

From words to action

Malaria Consortium / CNM

Malaria forest transmission : the equation

- Observation and project's reports suggest that malaria transmission in Cambodia is mostly (only?) happening in forest

- Malaria incidence is higher in forest goers than in any other population

  (including plantations or other working sites)

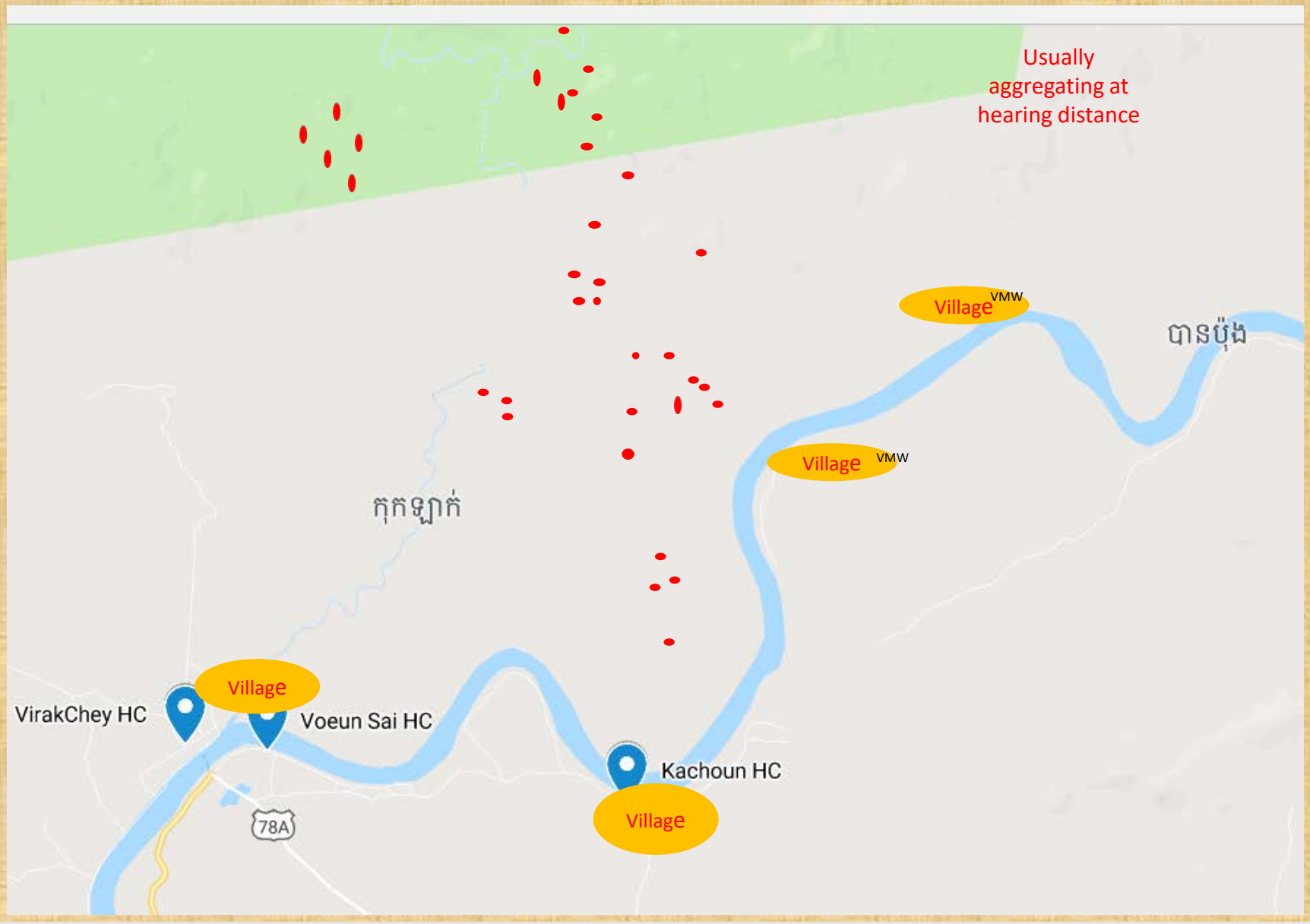
- People going or living in the forest have less access to health services than people living in villages or towns with Health Facilities or VMWs

- Forest goers are becoming the key target to control malaria transmission

Why is forest-going a high risk factor?

- Forest goers spend short to long periods of time in deep (and dark) forests where the vector is present
- They sometimes work at night or sleep at ground level
- Often not equipped with malaria prevention tools (bednets, hammock net, repellent…)
- Isolated from villages and health systems (health centers and village malaria workers)
- Not directly targeted by the existing health system until now

Where do they go and where do they stay?



Why are people going to the forest in Cambodia?

What triggers work in forests of Cambodia could be very difficult to understand or have very remote causes…

Can we predict and anticipate movements of forest goers?

Multiple variables:

- rain, river crossing, road conditions
- period of collection (samrong, mushrooms, bamboo, resin, honey…),
- cost of timber on the market,
- local temporary ban on forest access
- construction sites
- Forest goers hiding because illegal activities
- Border disputes

Some factors can be predicted if good knowledge of the local context and good local informants,

others variables cannot be predicted and we have to live with it!

Do we need to understand everything to beat malaria?

Modelling forest malaria may not be feasible or not good enough to predict all movements of forest goers.

After all, the most important is to hit malaria where it is, not to describe it!

Many programs are designed and steered from the top with reference to models of intervention. It does not always work!

One alternative is to transfer the operational decisions to the field level as the locals will be more reactive, whatever reasons are triggering forest work or movement

How to reach malaria cases: follow the forest goers!

Response to the complexity of forest goers' movements: mobile and reactive services at field level

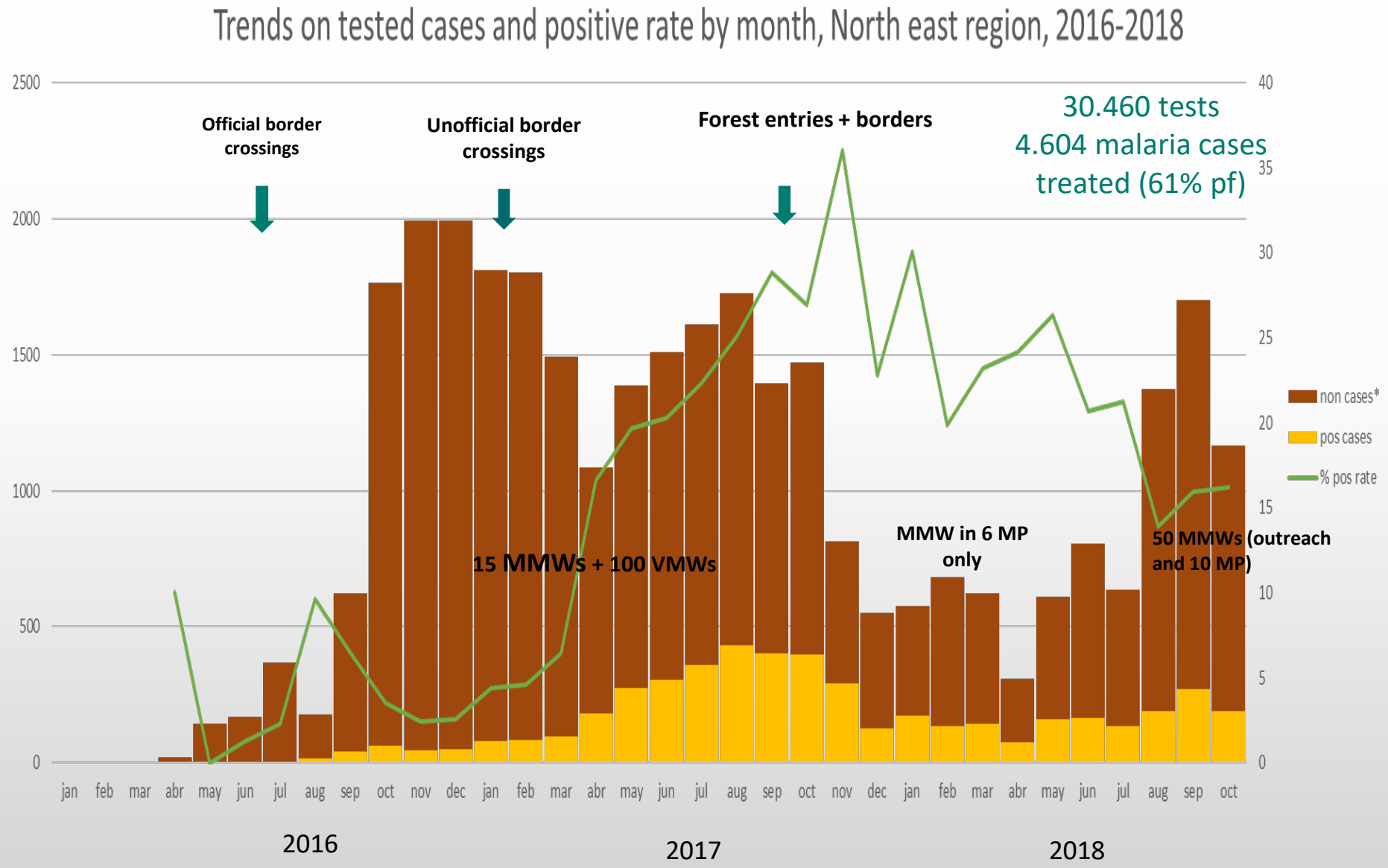
Malaria Mobile Workers are selected from local community for their knowledge of the forest and of forest goers and on their capacity to conduct outreach activities and hold mobile posts at entry of forests

Similarity with peer-educators for most –at-risk-populations in HIV programs!

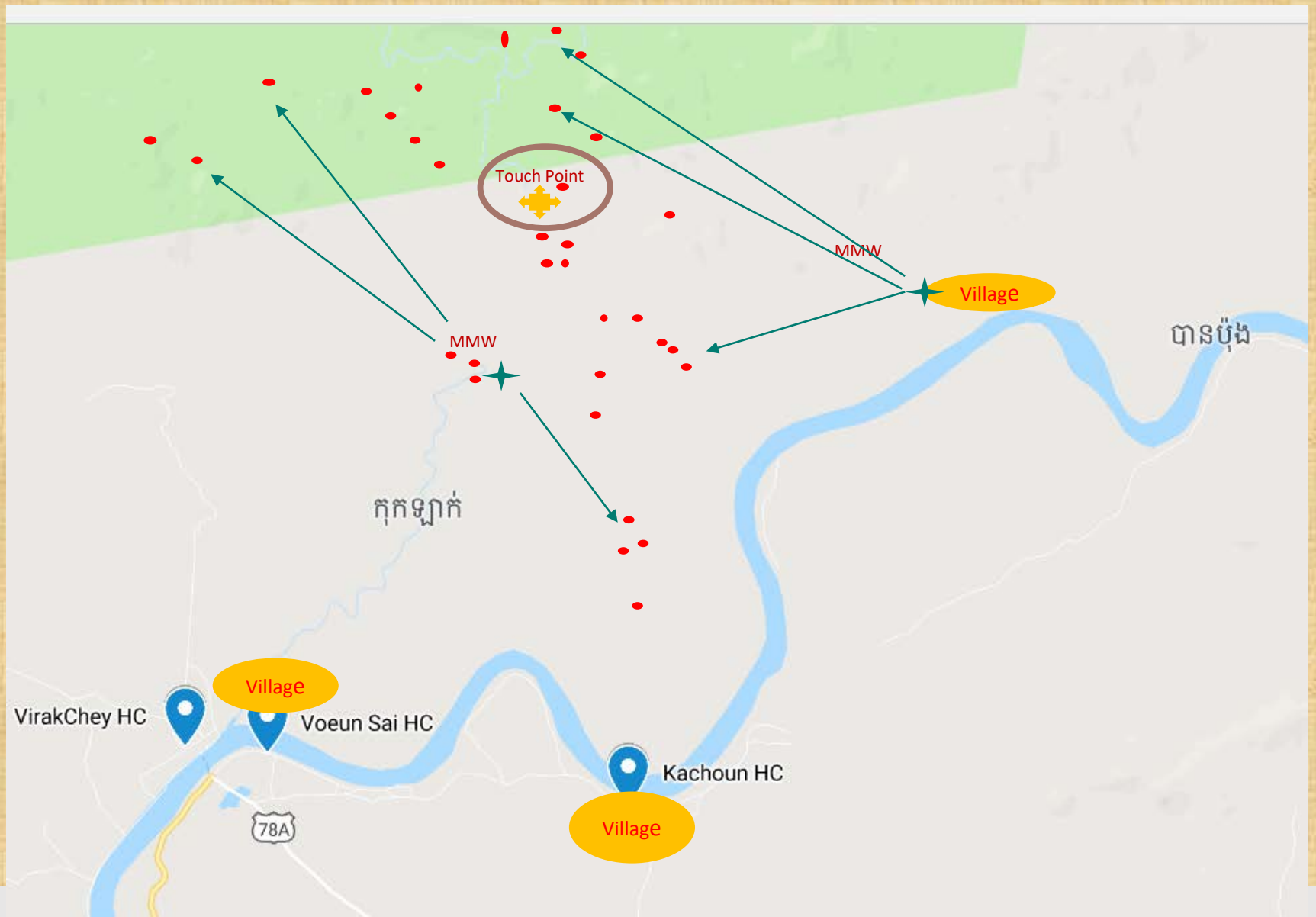
Malaria Mobile services MC/CNM
Border areas in Preah Vihear, Stung Treng and Ratanakiri

Touch' Points (Mobile Malaria Posts) Mobile Malaria Workers MC offices

MC has tried different systems of malaria forest workers on Cambodia borders



Mobile Malaria Workers working areas (example)



Services provided by mobile services
(Outreach activity + Malaria Touch Points)

Reach people residing or working in forest (Pro-ACD) + conduct **co-traveller** tracking (R-CD) or semi-passive detection in touch' points

1. **Rapid Test**: target of 30 tests per month for outreach MMW and 100 test per month for each malaria touch' points
2. **ACT treatment** for confirmed cases

1. **Referral** to Health Centers for severe cases, pregnancy, <5

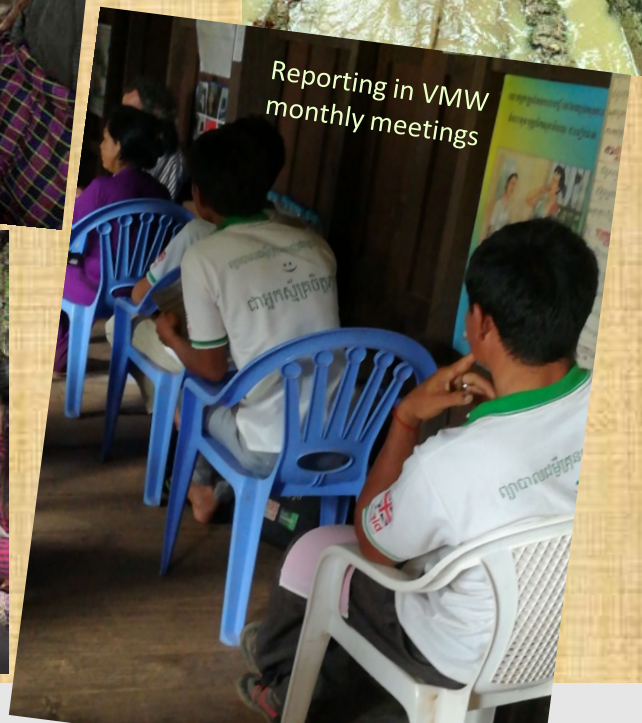
2. **IEC/BCC** in face to face interaction

3. **Vector Control** tools distribution: LLIN, LLHIN, Treated clothes, repellent?… (depending on CNM strategy)

4. **Report** cases monthly in VMW meeting at Health Center

→ Need of a permanent monitoring and support

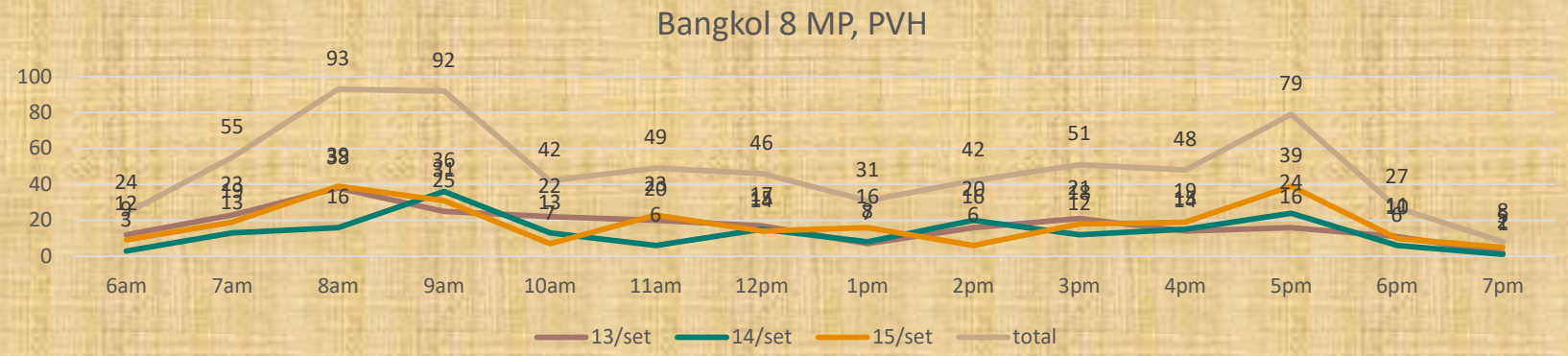
Initial training by HC



Forest entry
or hot spots

Mobile Malaria Posts/ Touch Points

- Located on hot spots with frequent passage of forest goers: entry of forest, cross road, shop..
- Open 7/7 6.00 AM to 6.00 PM (most passage early morning or late afternoon) – assessment of traffic



- 2 MMWs on alternate shift for each Mobile Post

Efficiency and effectiveness of Reactive Case Detection, Mobile Post and Pro-ACD

Positivity rate by type of intervention (Jan-Oct*, 2018)

Surveillance Delivery Points	Tested	Positive	Positivity rate (%)
Co-Traveller investigation	329	45	13,7
Mobile Touch Points	4054	991	24,4
Outreach Activity	4094	604	14,8
Total	**8477**	**1640**	**19,3**

Trust

Connections

Relevance


UNOPS


UNOPS

Thank you

malaria consortium
disease control, better health

Demanding a people centered approach

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