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Mapping of Civil Society Organisations in South Asia

ASIA PACIFIC LEADERS MALARIA ALLIANCE

ASIA PACIFIC MALARIA ELIMINATION NETWORK

CS4ME
CIVIL SOCIETY FOR MALARIA ELIMINATION

ISA
IMPACT SANTE AFRIQUE

Contents

Executive Summary


Photo by Mumtahina Tanni

Malaria is a mosquito-borne disease that is both preventable and treatable. Unless properly treated, malaria patients may develop severe complications like cerebral malaria which could lead to death. In 2020 alone, an estimated 241 million cases of malaria occurred worldwide and 627,000 people died.[1]

Community participation is essential for disease eradication and elimination, and should be centred in all malaria programmes. Malaria elimination requires multi-sector collaboration and civil society involvement. Civil Society Organisations (CSO) have been implementing the malaria interventions to reach the hard-to-reach and remote community members, and CSOs play an important role to complement and support the National Malaria Programs (NMP) for malaria elimination on time.

In February 2022, Asia Pacific Leaders' Malaria Alliance (APLMA) and Asia Pacific Malaria Elimination Network (APMEN) in collaboration with Civil Society for Malaria Elimination (CS4ME) hosted by Impact Santé Afrique (ISA), conducted this CSO mapping study in four South Asian countries: Bangladesh, India, Nepal, and Pakistan.

This study mapped the landscape of CSOs working in public health, particularly with malaria-vulnerable and malaria-risk communities, at the national and sub-national levels. In total, the study collected information from 48 CSOs: 25 in India, 5 in Bangladesh, 12 in Nepal, and 6 in Pakistan. The summary of results shows that:

- The majority of identified CSOs were established in the 1980s-90s, although some were established in 1960-70s, and a few formed during the 2000s.
- The main areas of intervention of identified CSOs were promotion of community health, education, livelihood, and human rights working for vulnerable marginalized populations.
- These CSOs employed people of both genders, with the largest CSOs having more than 20,000 staff and the smallest having around 10.
- These CSOs operated at the national (33%), regional/ provincial (46%) and district (21%) levels.
- These CSOs targeted women, children, and migrants for the majority of their community activities.
- The respondents wanted their CSOs to be strengthened in the areas of resource mobilization, advocacy for malaria, and malaria control in the context of COVID-19.
- In general, these CSOs had work-plans that they implement, as well as activity reports and strategic documents for the fight against malaria.
- Their activities and projects were generally financed by foreign donors, and in many cases the government intervened effectively.
- The majority of the CSOs collaborated with NMPs either directly in a formal way or through collaborative platforms. All CSOs generally benefitted from the capacity building offered by the NMPs.

[1]World Health Organisation. World Malaria Report 2021

Background


Photo by tpsdave (Public domain photo)

Eliminating malaria by 2030 in the South Asia region calls for greater collaboration and coordination among multiple stakeholders engaged in the fight against malaria.

Countries in this region are at varying stages of malaria elimination. Pakistan with 372,416 malaria cases and India with 186,532 cases, and Afghanistan with 105,445 reported the 2nd, 4th and 5th highest burden of malaria in the Asia Pacific region respectively in 2020.[2] With 53 out of 64 districts free of malaria, Bangladesh's progress towards malaria elimination has been steady - however, some places in Bangladesh such as Sajek in Rangamati district are facing an increase in malaria cases in the monsoon season compared to last year.[3] Sri Lanka was certified malaria-free in 2016, and Nepal and Bhutan are set to achieve elimination by 2025.

Malaria is increasingly becoming a disease of the rural poor, affecting the most vulnerable. Furthermore, as countries move closer to elimination, the last pockets of malaria are found in remote, conflict-prone, and hard-to-reach areas. In some countries, particularly the near elimination countries, Mobile and Migrant Population (MMP) along the borders continue to be at risk of malaria and constitute a large proportion of imported cases. Thus, interventions such as case detection, treatment, distribution of vector control products, Information Education Communication (IEC) targeted towards vulnerable populations are critical for malaria programs in these countries. To achieve the goal of malaria elimination, malaria services and commodities must be made available to communities which are not easily accessible by existing public health infrastructure.

Civil Society Organisations play a critical role in malaria control and elimination as well as in improving access to services in remote areas and among hard-to-reach populations. Malaria disease control and elimination require not just consulting with communities, but directly partnering with communities to implement interventions to reach out to the last mile. CSOs, who have built trusted relationships with their communities over many years, are therefore important in the fight against malaria to complement the efforts of national malaria programs. This mapping of CSOs working with communities affected by malaria will improve the ability of malaria programs and national, regional, and global health partners to better engage with CSOs for targeted malaria interventions and service delivery.

In collaboration with APLMA and APMEN, ISA conducted a mapping of CSOs in Bangladesh, India, Nepal and Pakistan. This study was implemented to assess the CSO engagement landscape and propose recommendations for strengthening CSO engagement in NMP/ Country Coordinating Mechanism (CCM), as well as for strengthening the CSO network in South Asia.

The goal of this study was to conduct mapping of CSO landscape of those working in the public health area, particularly with communities impacted by and at risk of malaria, at national and subnational levels.

[2]World Health Organisation. World Malaria Report 2021
[3]https://dailyasianage.com/news/266138/sajek-declared-as-red-zone--for-malaria--outbreak-amid-covid

The specific objectives of this study were:

1. To identify CSOs who work in public health, particularly in the malaria domain, and with communities impacted by and at risk of malaria in Bangladesh, India, Nepal and Pakistan
2. To map CSOs based on their geographic focus, field of expertise, technical and management capacities
3. To explore the existing relationships/partnerships/ collaborations between the identified and mapped CSOs and between those CSOs and national malaria programs

The framework for selection CSOs working in the countries

Country	Population of focus	Geographic focus	Expertise
 Bangladesh	• Working with communities • Working with people displaced from Myanmar	• 3 Chittagong Hill Tract districts - Bandarban, Rangamati and Khagrachari • Cox's Bazaar	
 India	• Working with Mobile and Migrant populations • Working with communities	• Districts in India where MMPs usually come for work	
 Nepal	• Working with Mobile and Migrant populations • Working with communities	• Districts in Nepal with majority of MMPs • Districts nearing elimination/ districts implementing prevention of reintroduction	• Project implementation, surveillance, community engagement, M&E, BCC/IEC
 Pakistan	• Working with communities	• Provinces highly endemic for vivax malaria - Khyber Pakhtunkhwa (including FATA), Sindh and Balochistan	

Methodology


Photo by Simon (Public domain photo)

This CSO mapping study used structured questionnaires to collect quantitative data paired with some open-ended questions for in-depth qualitative responses. The data collection tool was developed with support from the CS4ME secretariat and a key representative from APLMA. Then, the mapping tool was revised and finalized during a joint meeting between the CS4ME secretariat team and consultants.

During the training of country consultants, theoretical evidence was provided by the CS4ME team and then the consultants practiced with their smartphones or tablets. Based on the Kobo Toolbox, an open-source application for collecting survey data, Kobo Collect (mobile application) and the online form were used to first test the questionnaire for improvement and later for the actual data collection. The questionnaire contained a total of 43 questions, allowing for both quantitative and qualitative data to be collected.

One of the modules in the training was devoted to data quality. Consultants learned what constitutes good quality data, the consequences of poor-quality data collection, the steps they can take to ensure the quality of the data they collect, and the steps taken by the CS4ME secretariat to monitor data quality.

Eligibility criteria for data collection were: (i) CSOs working in health, (ii) CSOs working in high-burden areas, and (iii) CSOs working with malaria-affected communities throughout each target country. Based on this, a literature search was conducted to identify an initial group of eligible CSOs.

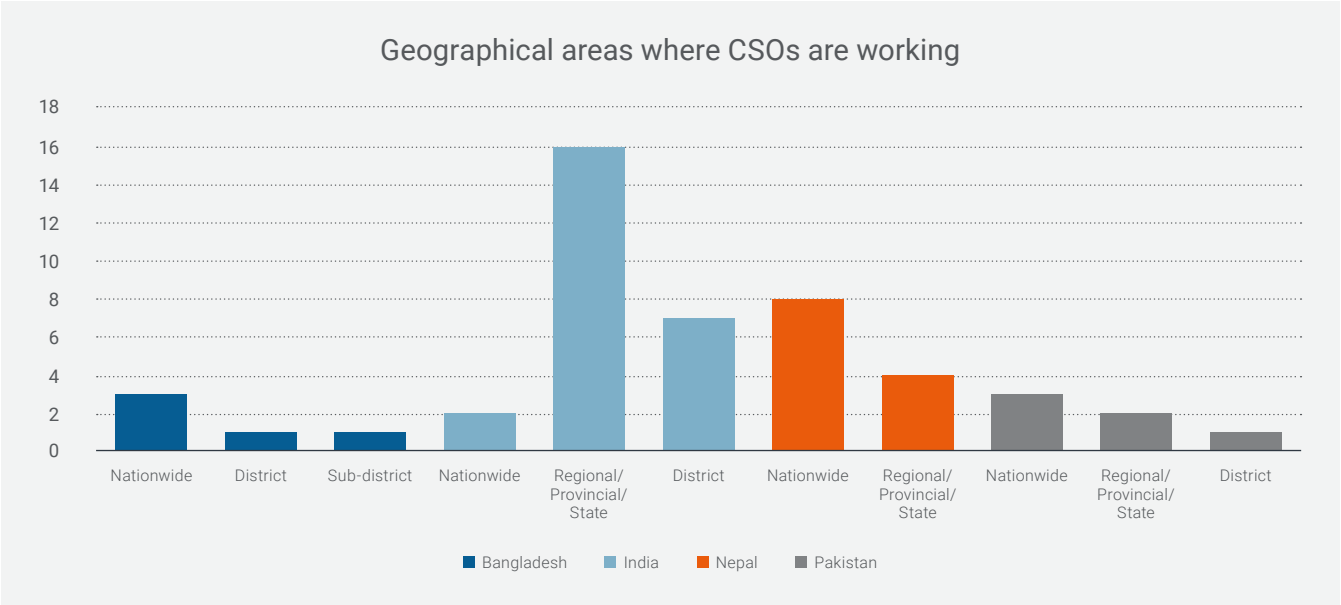
APLMA-APMEN sent introductory letters to CCMs, NMPs, and other national stakeholders such as Prime Recipients and Sub-recipients in each of the four countries. The letter introduced the consultants and mentioned the objective and expected results of the mapping. Following the APLMA letter, the consultants met personally with the relevant stakeholders and discussed the assessment process.

Each of the national stakeholders, such as the CCM and NMP, provided the consultant with a list of CSOs that have worked or are currently working on malaria eradication/elimination programs. The consultants then gathered information by conducting interviews with representatives of the identified CSOs. The snowballing method was also used to reach out to other CSOs, in that each CSO interviewed was encouraged to put the consultants in contact with one or more other CSOs.

Data was checked daily on the Kobo Toolbox platform to ensure quality and reminders were sent via email and a WhatsApp group created for the study. In addition, in order to solve the problems encountered by the consultants during their mission, a coordination meeting was organised every Friday morning during the whole process. Each consultant analysed the data in Excel and provided country reports with the provided template. Finally, the four country reports were consolidated into a regional synthesis report.

Findings

Sociodemographic Background

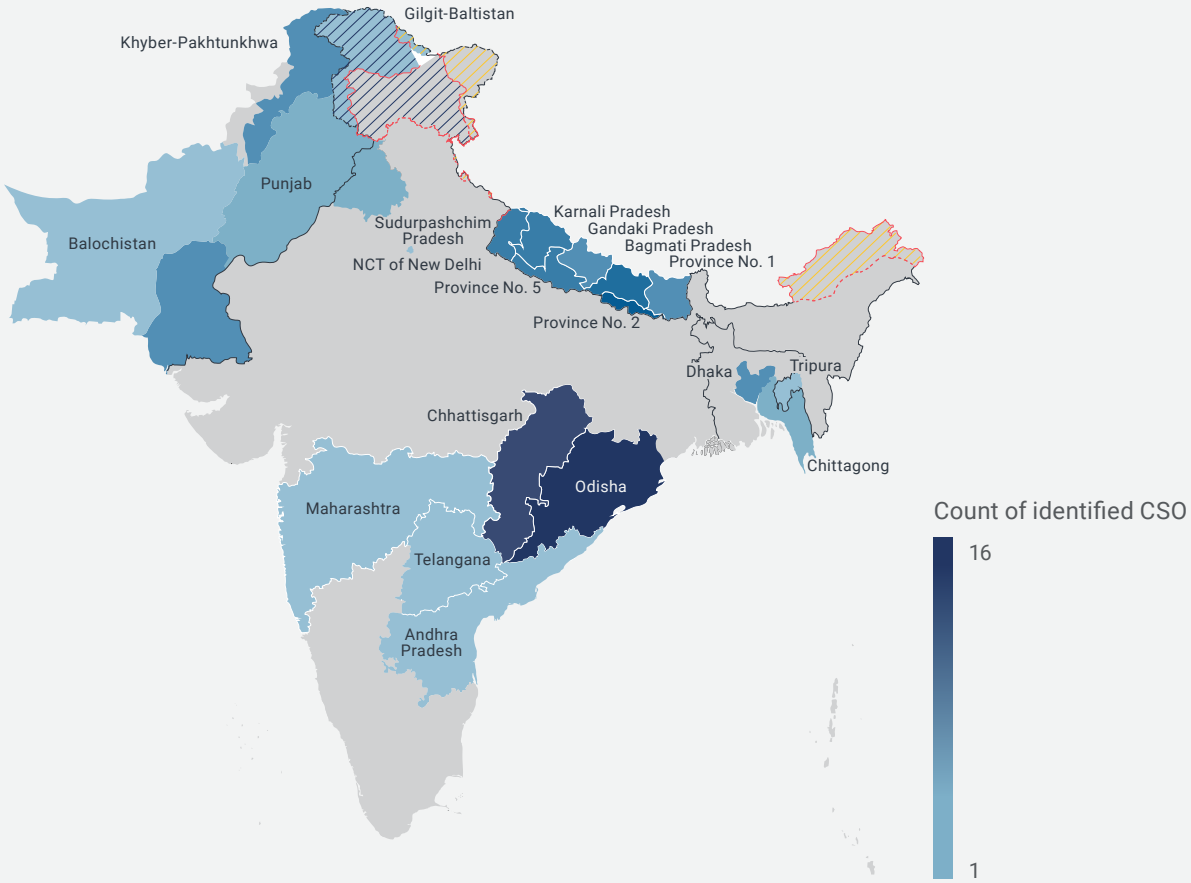


- Forty-Eight Civil Society Organisations, including 25 in India, 5 in Bangladesh, 12 in Nepal, and 6 in Pakistan, participated in the study.

The main missions of CSOs included the promotion of community health, education, livelihood, and human rights targeting vulnerable and marginalized populations. Nearly two-third of CSOs were established in the 1980s-90s while seven CSOs were established in the 1960s-70s and one-fifth of total CSO were established during the 2000s. All mapped CSOs are legally registered as Local Non-governmental and Community Based Organisations except for International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), which is an International Non-governmental Organisation.

These CSOs employed people of both genders, with the largest two CSOs having more than 20,000 staff and the smallest having around 10. Sixteen CSO (33%) operated at the national while 46% and 21% of total CSOs worked at regional/provincial and district levels respectively. Most of the CSOs were located in Odisha State, India.

Number of identified CSOs working in each province



Bangladesh

- Out of 5 CSOs identified, 3 were based in Dhaka working at the national level while 2 were based in Chottogram working in Cox's Bazar district and Lama sub-district, Bandorban.
- Females outnumbered males in most organisations.
- One national organisation had up to 64,000 staff including volunteers.
- These 5 organisations covered a wide range of populations from women and children to mobile migrant populations and refugees.

India

- Identified CSOs belonged to a total of 7 different Indian States, of which 64% of the CSOs were from Odisha State.
- 16 CSOs had operations in more than 2 districts within the state while 7 were limited to a particular district.
- 8 CSOs had 100 or more staff including volunteers.
- 5 CSOs described having been a part of an existing network though not related to malaria.

Nepal

- All identified CSOs previously implemented malaria related activities but without direct funding for Malaria, and all malaria activities are now being implemented by the government.
- Out of the 12 identified CSOs, 50% had less than 20 staff, 33% had between 20 to 50 staff, and 17% had more than 50 full-time staff.
- Most of the CSOs worked in different community development projects with different donors.

Pakistan

- All CSOs had more than 100 staff including volunteers.
- Most CSOs belonged to Khyber Pakhtunkhawa, Sindh, or Punjab provinces.
- The Indus Hospital and Health Network, a private sector organisation, was the principal recipient of the Global Fund grants and worked in Balochistan and other provinces.

Key Activities of CSOs In the Fight Against Malaria

- The main areas of intervention of identified CSOs were Malaria prevention (65%) followed by Health and sanitation activities (54%), Training and capacity building of Community Health Workers (CHW) on malaria (50%), Distribution of Long Lasting Insecticide-treated Nets (LLIN) (48%), and Malaria diagnosis, treatment and referral (44%).

  The main population CSOs targeted were women, youth, children under five years of age, mobile migrant population, and forest goers.

Bangladesh

- Most CSOs provided trainings to community health workers and their sister organisations, and participated in malaria surveillance activities.
- 3 organisations worked in malaria prevention, diagnosis and treatment, referral, and M&E.

India

- All organisations had more than one malaria control and prevention activity under the projects they implemented.
- 15 CSOs had experience in implementing projects with a focus on malaria prevention.

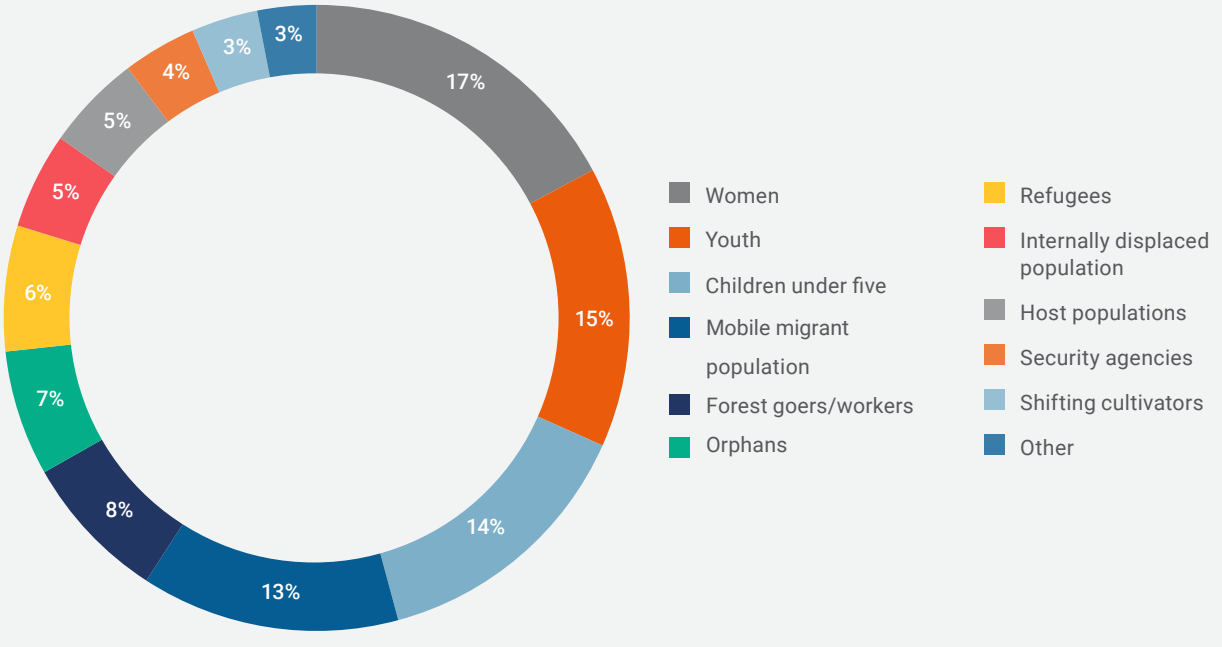
Nepal

- Malaria activities were primarily led and implemented by Epidemiology and Disease Control Division, Ministry of Health and Population.
- A limited number of activities were implemented by CSOs.
- The external aids such as Global Fund and WHO funded the national program through the Central Treasury.

Pakistan

- The CSOs working in Punjab, Sindh and Balochistan focus on rural communities including children and women, and CSOs in Khyber Pakhtunkhawa target an additional group – mobile migrant population.

Targeted population of mapped CSOs



Assessment of CSOs Strengths and Weaknesses

The reported main strengths and expertise of the identified CSOs across all four countries were capacity building (14%); working and serving key vulnerable populations including tribal, indigenous, ethnic minority groups and other groups (11%); working in conflict and/or hard-to-reach areas for malaria interventions (11%); advocacy for malaria interventions (11%); and implementing of malaria prevention, diagnosis, and treatment (10%).

More than half the identified CSOs expressed a limited knowledge of funding ecosystems or donors, and more than one-third of the identified CSOs declared a shortage of technical experts specialized in malaria control and elimination.

Bangladesh

- All identified CSOs had proven capacities in training, working for key and vulnerable populations, advocacy, implementing malaria prevention diagnosis and treatment.
- All CSOs noted insufficient financial resources.

India

- Most identified CSOs described strengths in community mobilization as well as work in remote areas with tribal or migrant populations.
- 15 CSOs had experience in implementing projects with a focus on malaria prevention.

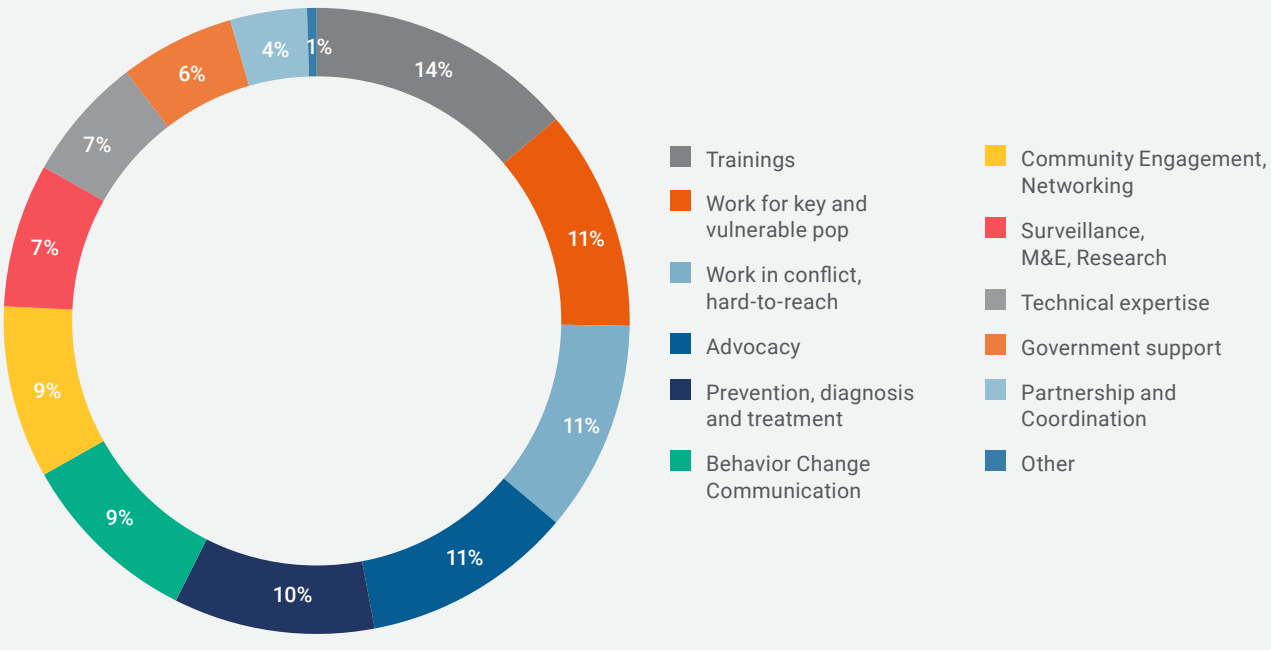
Nepal

- Country sustained zero malaria deaths and all cases identified by RDTs were treated according to the national treatment protocol.
- 10 out of 12 identified CSOs said their main strength was capacity building.
- All CSOs were facing limited or insufficient financial resources.

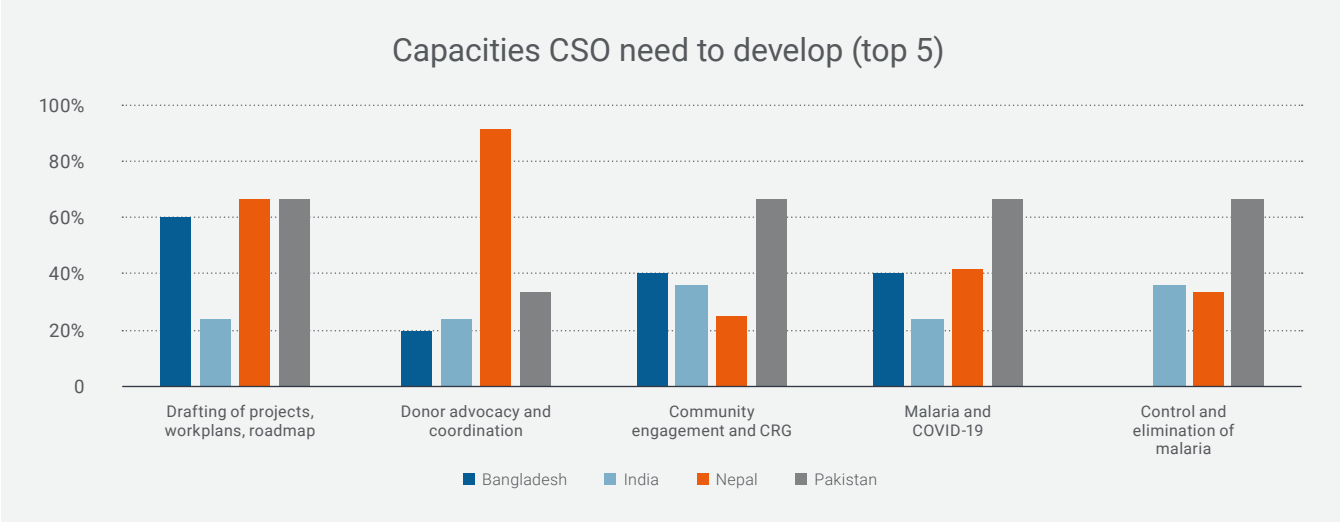
Pakistan

- All CSOs had proven experience in training, malaria advocacy, as well as prevention and case management.
- Most CSOs mentioned inadequate financial resources.

Main strengthens of CSOs in malaria activities



Assessment of CSOs Needs in the Fight Against Malaria



On the large challenge of resource mobilization, identified CSOs reported difficulties in accessing financing (69%), insufficient budget (60%), and scarcity of donors dedicated to malaria (58%).

The training tools identified CSOs needed most included training needs assessment (69%), monitoring and evaluation (M&E) tools (69%), and communication tools such as flyers, leaflets, posters, flipcharts (67%).

For planning current and future activities, 58% of identified CSOs had a strategic plan, and 67% had proper workplans. Additionally, 75% (n=36) had internal performance evaluation tools and annual reports. For financing activities, 73% had proper resource mobilization plans.

All identified CSOs listed capacity development needs, however the desired capacities listed were quite varied. Still, the most common capacity development needs included: drafting of projects, workplans, operational plans and roadmaps; donor advocacy and coordination; community engagement and Community Rights & Gender; malaria and COVID-19, and control and elimination of malaria.

Bangladesh

- 4 out of 5 identified CSOs highlighted needs of advocacy with in-country/ international partners/ donors, and private sector.
- CSOs desired improvements in M&E, understanding of the Global Fund, detailed community engagement, project and plan development, and the effective use of social media platforms.

India

- Most identified CSOs focused on capacities to manage malaria control programs, community health, and UHC.
- Majority (75%) of CSOs had no strategic plan or workplan. However, 35% had action plans based on annual planning documents.

Nepal

- Identified CSOs noted need for increased funding for malaria response; engagement with CSOs in training, LLIN distribution, survey, school health program and advocacy activities; cross-border malaria engagement between CSOs of neighbouring countries; and mobilisation of CSO staff/volunteers for malaria awareness activities border area point of entries.

Pakistan

- Most identified CSOs noted needs such as drafting projects & operation plans, community engagement, malaria & COVID, control and elimination of malaria, and documentation (writing of reports, case studies, success stories).

Assessment of Community Needs in the Fight Against Malaria


Photo from Pixabay

- About half of all identified CSOs noted that the communities need more malaria awareness to reduce barriers and inequities to access malaria services as well as LLINs for personal protection coverage of entire household.

  The majority of malaria control and elimination services for communities are provided by the National Malaria Program/Ministry of Health (60%), followed by CSOs, charities and foundations (23%).

Bangladesh

- The needs of communities identified by CSOs included increased availability of malaria diagnosis , treatment interventions, and LLIN.

India

- 44% of identified CSOs believed that funding for malaria interventions came from government, either through the Health Ministry or National Malaria Program.

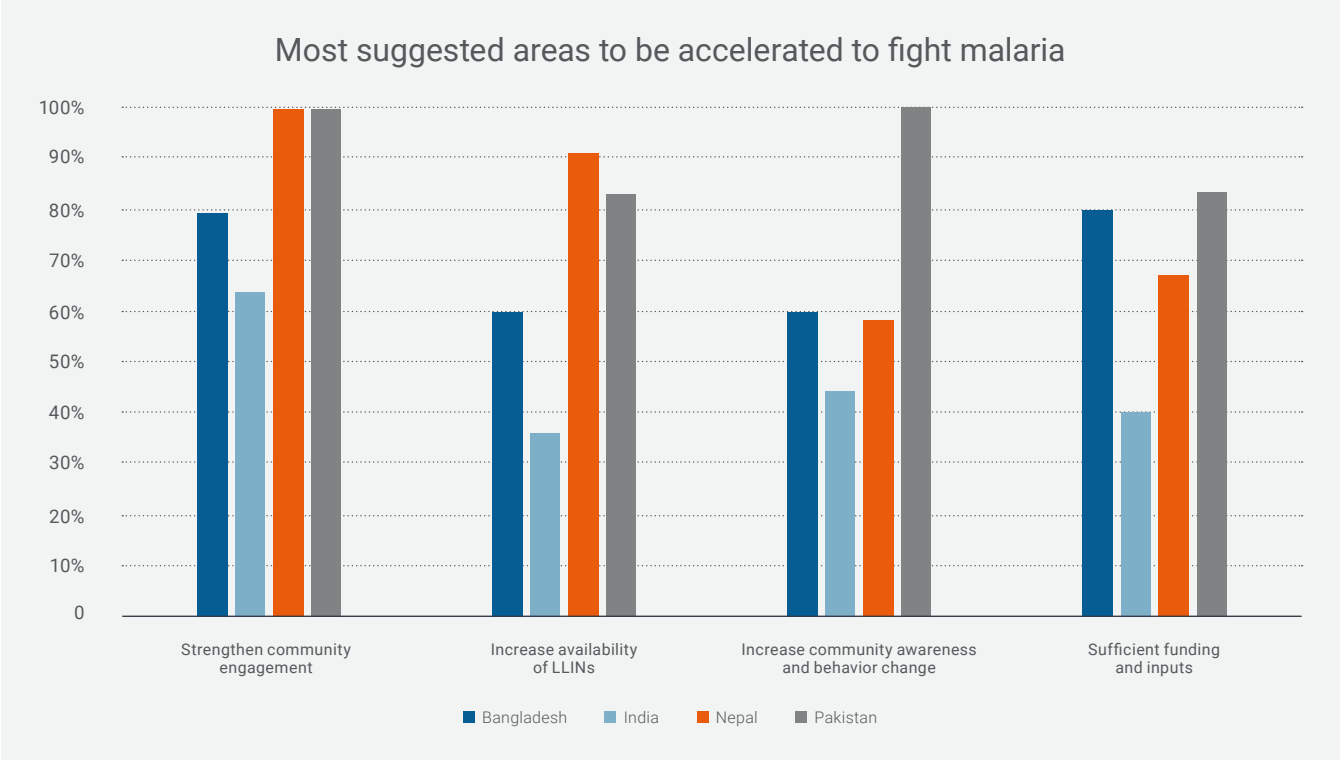
Nepal

- A high-level meeting among Bhutan, Bangladesh, India and Nepal was held for cross-border initiatives to ensure access of malaria services for border-crossing mobile migrant populations. This meeting needs to be continued.
- Opportunities existed for collaboration with other community-based groups and institutions such as mothers' groups, Ward Citizen Forums, and youth clubs as well as collaboration with the local government in the new federal system.
- Almost all CSOs expressed that malaria services were from the National Program.

Pakistan

- Identified CSOs noted that communities need increased malaria awareness to reduce barriers and inequities for accessing malaria services and LLINs for personal protection or coverage of entire household.

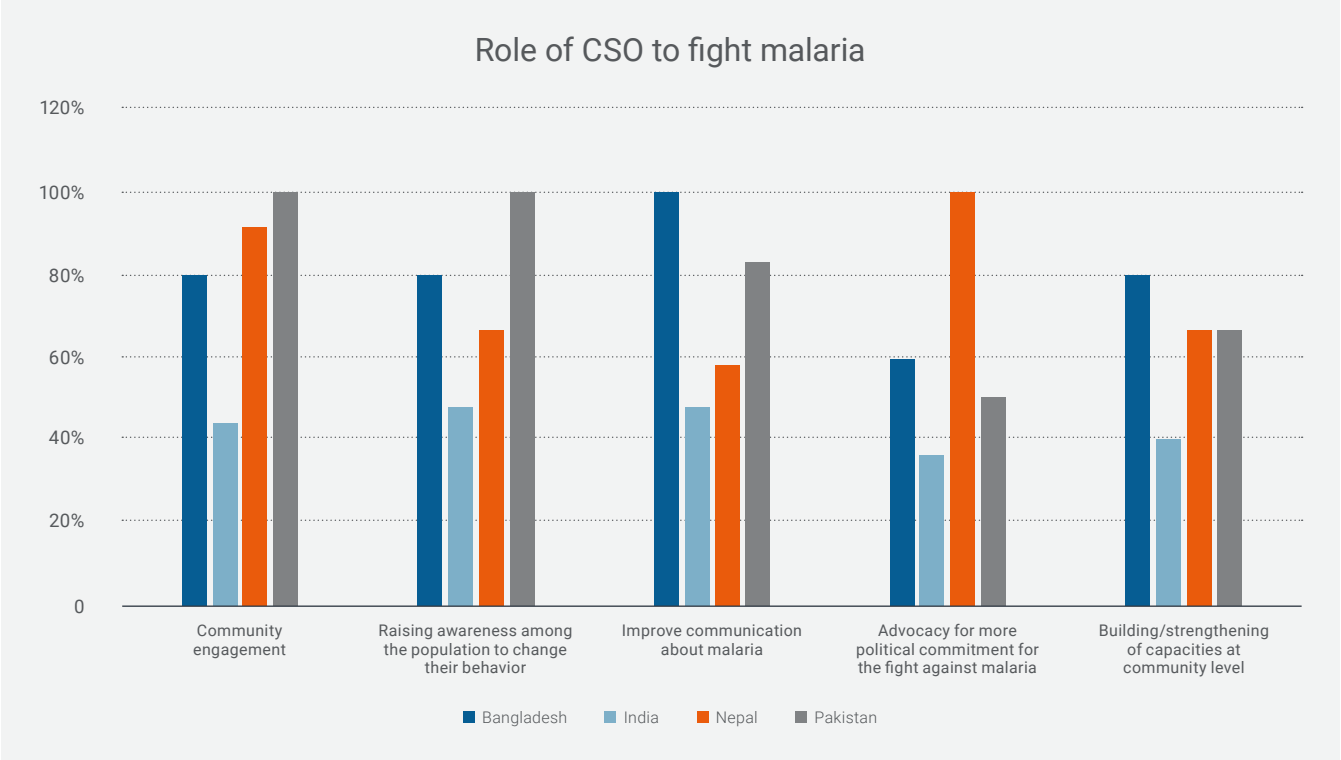
Collaboration with National Malaria Programs and Other Partners



- The identified CSOs suggested some areas for improvement to better combat malaria including strengthened community engagement (79%), increased availability of LLINs (58%), increased community awareness and behaviour change (56%), and sufficient funding and inputs (56%).

Nearly all identified CSOs collaborated with respective Ministries of Health in their countries through a Letter of Agreement and Memorandum of Understanding, work with Technical Committees/Task Forces, or in partnership with the projects. The exception was 8 CSOs from India who did not directly collaborate with the Ministry.

There were 11 CSOs who stated they were a part of a platform, network, or mechanism for collaboration between the National Malaria Programs and Civil Societies in their respective countries. Almost all malaria-implementing CSOs in each country share a common vision, goal, or objective, and collaborate through partnership to fight against malaria.



A majority of identified CSOs responded that the role of CSOs in the fight against malaria are around community engagement (67%), followed by raising awareness on malaria prevention and treatment (63%), improving behaviour change communication (60%), advocacy to increase political commitment on malaria (56%) and capacity building at community level (54%).

Bangladesh

- All identified CSOs collaborated with each other through partnership and/ or consortium to tackle malaria.
- Responses showed that the perceived roles of CSOs are mainly in the areas of communication, M&E, capacity building, awareness raising, and community engagement.

India

- 8 identified CSOs were part of some form of technical committee or task force of a state or national health department.
- Majority of interviewed CSOs believed that community engagement, awareness, and behaviour change, along with sufficient funding and inputs were needed to fight malaria.
- Responses indicated that civil society could play a greater role in community engagement, communication, and awareness raising.

Nepal

- All collaborated with the Ministry of Health through Letters of Agreement or implementation of a partnership in projects.
- Areas to be strengthened included community engagement and availability of LLINs.
- Identified roles of CSOs were mainly community engagement and advocacy for more political commitment.

Pakistan

- Although there was no formal network or consortium, CSOs were working under a Prime Recipient -either Indus Hospital or Directorate of Malaria Control.
- Identified roles of CSO were mainly in community engagement and awareness raising to of vulnerable populations in order to improve behaviours which would prevent and control malaria.

Conclusion


Photo by Sadman Chowdhury

Engaging communities and civil society in any public health effort is a key priority for all countries.

From policy design to implementation and monitoring of health activities, civil society is an integral part of each country's public health response. Engaging with communities through civil society contributes to resilient and sustainable health systems.

The National Malaria Strategic Plans of Bangladesh, India, Nepal, and Pakistan included participatory, equitable, and community-centric civil society engagements. This shows that communities and CSOs play a vital role in determining and implementing malaria activities and approaches to reach the most vulnerable and at-risk populations. However, the identified CSOs face numerous challenges to control and eliminating malaria. There are several grassroot organisations in India which are operating in high burden areas with limited support, knowledge, and funding to fight against malaria. Continuous funding from various sources and technical support can accelerate the efforts and momentum of malaria elimination. Hence, strengthening CSO engagement in the response to malaria should be a top priority for achieving the goal of malaria elimination by 2030.

Annexes

Acknowledgement

National Programs

National Malaria Elimination & Aedes Transmitted Diseases Control Program, Bangladesh
Directorate of Malaria Control, Pakistan
National Center for Vector Borne Diseases Control, India
Epidemiology and Disease Control Division, Nepal

Partners and CSOs

Malaria Free Mekong, Regional CSO platform
Alliance for Cooperation and Legal Aid Bangladesh (ACLAB)
BRAC Centre
International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b)
Mukti Cox's Bazar
N.Z. Ekata Mohila Samiti (EKATA)
Anchalika Kunjeswari Sankrutika Sansad
Association for Social Reconstructive Activities
Community Advancement and Rural Development Society
Family Health India
Gopinath Juba Sangha
Gram-Utthan
Jan Mitram Kalyan Samiti
Jan Swasthya Sahyog
Jana Unnayan Samiti
Livolink Foundation
National Youth Service Action and Social Development Research Institute
Nepal Red Cross Society
Orissa Voluntary Health Association
Palli Vikash
Prakalpa
Self Employed Workers' Association Kendra
Serve Train Educate People's Society
Society for Education, Action and Research in Community Health
South Orissa Voluntary Action
Sparsha
Swasthya Swaraj
Udyama
Universal Service Organisation
Utkal Sevak Samaj
Welltech foundation
Association of Medical Doctors of Asia (AMDA Nepal)
Association of St. Mary's Aluminae Nepal (ASMAN)
Bagmati Sewa Samaj
Backward Society Education (BASE)
InfoAids
Janaki Women Awareness Society (JWAS)
Life Line
Nepal National Social Welfare Association
Nepal Red Cross Society
Rural Development Forum (RDF)
SUDIN Nepal
Youth for World Nepal (YWN)
Association for Community Development (ACD)
Awami Welfare Society Swat
Indus Hospital and Health Network
National Rural Support Program
Pakistan Lions Youth Council (PLYC)
Sindh Rural Support Organisation (SRSO)

Funding Support

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Annexes

Abbreviation

APLMA	Asia Pacific Leaders Malaria Alliance
APMEN	Asia Pacific Malaria Elimination Network
BCC	Behaviour Change Communication
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CS4ME	Civil Society for Malaria Elimination
CSO	Civil Society Organisation
IEC	Information Education Communication
ISA	Impact Santé Afrique
LLIN	Long Lasting Insecticide-treated Net
M&E	Monitoring and Evaluation
NMP	National Malaria Program
RDT	Malaria Rapid Diagnostic Test
UHC	Universal Health Coverage

The institutions that hosted and conducted this CSO Mapping

About APLMA-APMEN

Asia Pacific Leaders Malaria Alliance (APLMA) is an alliance of heads of government committed to achieving a region free from malaria by 2030. APLMA is a distinctive platform facilitating collective regional leadership for malaria elimination and health security.

Asia Pacific Malaria Elimination Network (APMEN) is a network of 21 countries and 52 partner institutions. APMEN facilitates regional and multi-sectoral collaboration around evidence-based practices and fosters innovation. Jointly, APMEN and APLMA act as an 'evidence-to-policy' vehicle that links directly to leadership levels across the region.

About CS4ME

Civil Society for Malaria Elimination (CS4ME) is a global platform of civil society organisations dedicated to the abolition of malaria. The mission of CS4ME is to strengthen, organise, and unite civil society, as well as to engage and empower affected communities to be creative, bold change agents to accelerate malaria elimination. One of the primary objectives of CS4ME is to increase the capacity and commitment of CS4ME members to achieve malaria elimination. The CS4ME platform currently has 450 members from 48 African and Asian countries.

About ISA

Impact Santé Afrique (ISA) is an African non-governmental organisation specialized in advocacy and strategic communication, with the main objective to contribute to the improvement of the health of populations. Impact Santé Afrique, based in Cameroon, hosts the CS4ME Secretariat.

Photo by James Wheeler

For further information, please contact:

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