

Questionnaire Analysis Report

Funding Priorities for Communities and Civil Society Most Affected by Malaria 5 May 2026

1. Background

Malaria remains an important public health challenge in Indonesia, particularly in areas with persistent transmission and high disease burden. In these settings, effective malaria control requires biomedical interventions that are supported by strong attention to geographic access, social conditions, economic realities, and local cultural context influencing prevention, diagnosis and treatment.

Communities and civil society organisations play a strategic role in malaria elimination because they are closely connected to the people most affected by malaria. These include women, children, Indigenous communities, migrant and mobile populations, persons with disabilities, and residents of remote or hard-to-reach areas. Their perspectives are important for understanding how malaria programmes operate in everyday life, including whether services are accessible, acceptable, inclusive and responsive to local needs.

Funding priorities for malaria should combine epidemiological and programme indicators with community experiences of exposures, delayed diagnosis, treatment access, service quality, community participation, and financial sustainability. This is especially important as malaria programmes prepare for changing funding arrangements, including the transition from Global Fund support towards stronger domestic financing.

This questionnaire analysis was conducted to identify funding priorities among communities and civil society groups most affected by malaria. The findings are intended to support malaria programme planning, service integration, GEDSI-responsive approaches and sustainable funding transition. The overall aim is to inform a malaria response that is closer to communities, more inclusive, and better aligned with the realities faced by affected populations.

2. Method

Questionnaire responses were analysed using a descriptive and interpretive approach. Quantitative responses were first exported from Google Forms and organised in Excel. Variables and response categories were reviewed, unclear entries were cleaned, and response labels were aligned to ensure consistency across six questionnaire domains.

The quantitative analysis focused on descriptive statistics. Respondents were allowed to select more than one answer for relevant questions; therefore, frequencies represent the number of respondents selecting each option, and percentages were calculated using the total number of respondents as the denominator. This approach was used to identify which activities were most frequently prioritised by respondents, rather than to test statistical associations.

Open-ended responses were analysed qualitatively to explain the meaning behind the numerical priorities. The analysis focused on identifying the rationale for prioritisation, expected outcomes, contextual barriers, and concerns related to programme implementation. Responses were read repeatedly to understand key ideas and wording. Codes were then developed to capture recurring concepts, explanations, and recommendations. Similar codes were grouped into broader themes, which were interpreted in relation to equity, service access, programme sustainability, and GEDSI implications.

The final synthesis integrated both quantitative and qualitative findings. Quantitative results identified the most frequently selected priorities, while qualitative themes explained why these priorities mattered to respondents and what outcomes they expected. The analysis produced frequency tables, thematic narratives, and an integrated interpretation across all questionnaire domains.

3. Characteristics of Respondents

A total of 127 respondents participated in the survey. Female respondents accounted for a larger proportion, with 75 participants (59%), compared with 52 male respondents (41%). Most respondents were from outside Java (107 respondents, 84%), while 20 respondents (16%) were from Java. Overall, respondents came from 28 districts/cities across Indonesia.

The seven districts/cities with the highest number of respondents were Mimika (35 respondents), Jakarta (20 respondents), Sumba and Jayapura (12 respondents each), Keerom (6 respondents), Mappi (5 respondents), and Asmat (4 respondents). The remaining 33 respondents came from other districts/cities in Indonesia.

4. Priority Activities for Vector Control

Community-based larval source control (70%) and larviciding (52%) were identified by respondents as the main priorities for vector control (Table 1). This suggests that activities involving community participation, together with interventions targeting the early stages of the mosquito life cycle, are considered the most effective ways to reduce malaria transmission.

Other interventions, including mass distribution of LLINs (46%), indoor residual spraying (38%), LLIN use among pregnant women (36%), and the use of mosquito bite prevention products (28%), highlight the continued importance of personal protection. These measures are particularly relevant for vulnerable groups and for communities with high levels of night-time outdoor activity.

Table 1. Priority activities in the vector control programme

Priority activity	Response
Community-based mosquito larval source management	89 (70%)
Larviciding	66 (52%)
Mass distribution and use of LLINs	58 (46%)
Indoor residual spraying with insecticide	48 (38%)
Use of LLINs among pregnant women	46 (36%)
Mosquito repellent	35 (28%)

Overall, respondents considered vector control important not only for reducing mosquito populations, but also for encouraging behaviour change and strengthening community participation (Table 2).

Several responses also noted that vector control is more cost-effective, practical, and sustainable than relying only on case management after people have become ill. Respondents saw these activities as essential to malaria elimination, particularly in high-endemic areas.

Table 2. Rationale and expected outcomes of priority vector control activities

Activity	Rationale for Prioritisation	Expected Outcome
Community-based mosquito larval source management	Many respondents stated that vector control will only be effective if communities are actively involved in larval source management, environmental cleanliness, and behaviour change. This activity was prioritised because it goes beyond killing vectors; it also builds awareness of healthy living, preventive behaviour, and long-term community ownership.	<ul style="list-style-type: none"> - Increase community participation; - Improve healthy behaviours; - Reduce mosquito breeding sites; - Stronger community capacity to prevent malaria transmission; and - More sustainable vector control through community involvement.
Larviciding	Larviciding, larval source management, and habitat management were considered important because they prevent mosquitoes from developing at the larval stage, before they become adult malaria vectors.	<ul style="list-style-type: none"> - Reduce larval populations; lower adult mosquito density; - Reduce malaria transmission; - Greater effectiveness in areas with many mosquito breeding sites; and - A faster contribution to case reduction.
Mass LLIN distribution and use	LLINs help reduce contact between humans and Anopheles mosquitoes, the main malaria vector, thereby interrupting malaria transmission from mosquitoes to humans. Many respondents noted that vector control priorities could help reduce malaria cases, morbidity, hospital admissions, and deaths.	<ul style="list-style-type: none"> - Reduce human–mosquito contact; - Lower exposure to mosquito bites; - Broad protection through mass distribution; - Reduce malaria cases; and - Stronger support for malaria elimination in high-endemic areas.

Indoor residual spraying	<p>Vector control was prioritised because local conditions vary across areas.</p> <p>Interventions need to be adapted to mosquito behaviour, human behaviour, habitat, and the local environment.</p>	<ul style="list-style-type: none"> - Increase mortality of indoor-resting adult mosquitoes; - Reduce indoor vector density; - Reduce malaria transmission; - Provide residual protection for a defined period; and - Maximise intervention effectiveness when coverage is optimal.
LLIN use among pregnant women	<p>The use of LLINs, indoor residual spraying, and environmental management was considered important to protect pregnant women, infants, young children, and other high-risk groups.</p>	<ul style="list-style-type: none"> - Increase protection among vulnerable groups; - Reduce malaria morbidity among pregnant women; - Protect the fetus, newborns, and infants from malaria-related risks; - Reduce malaria-related maternal and infant deaths; and - Increase LLIN use among priority groups.
Mosquito repellent	<p>In areas where night-time outdoor activity is common, vector control cannot rely on LLINs alone.</p> <p>Additional protection is needed to reduce exposure to mosquito bites outside sleeping hours.</p>	<ul style="list-style-type: none"> - Reduce exposure to mosquito bites; - Improve personal protection outside sleeping hours; - Reduce the risk of malaria infection; and - Better align with communities who have frequent night-time outdoor activities.

5. Priority Activities for Case Management

Table 3 shows that active malaria case finding by malaria cadres was the most frequently recommended case management priority (72%). This was followed by screening among pregnant women and children under five (45%), and mass malaria testing and testing among specific populations, each reported by 52 respondents (41%).

Table 3. Priority activities in the case management programme

Priority Activity	Response
Active malaria case finding by malaria cadres	92 (72%)
Screening among pregnant women and children under five	57 (45%)
Mass malaria testing	52 (41%)
Malaria testing among migrant and mobile populations	52 (41%)
Malaria testing at health facilities	50 (39%)
Mass drug administration for malaria	15 (12%)

Table 4 shows that active case finding by malaria cadres was considered as key strategy to improve early detection, particularly in remote areas where access to health facilities remains limited. Respondents noted that geographic barriers contribute to delays in diagnosis and treatment, allowing cases to remain undetected and transmission to continue. Strengthening cadre-led case finding at community level can help identify cases earlier, support timely referral and treatment, and reduce onward transmission.

Screening among pregnant women and children under five, mass malaria testing, testing among specific population, and facility-based testing should be implemented as complementary approaches to strengthen case detection. These activities can improve early diagnosis, support timely treatment, reduce missed cases, and contribute to reducing ongoing malaria transmission.

Table 4. Rationale and expected outcomes of priority malaria case management activities

Activity	Rationale for Prioritisation	Expected Outcome
Active case finding by cadres	<p>Many malaria cases remain undetected because people do not access health facilities, particularly in remote areas with geographic barriers. This leads to delays in diagnosis and treatment.</p> <p>Early detection therefore needs to be strengthened at community level, with cadres playing a frontline role in screening, monitoring, and health education.</p> <p>Strengthening cadres and community participation can accelerate case detection and help interrupt malaria transmission more effectively.</p>	<ul style="list-style-type: none"> - Identify cases that do not present to health facilities; - Reach asymptomatic or mild cases earlier; - Accelerate referral and treatment; - Reduce local transmission; increase community engagement; and - Extend programme reach to household level.
Screening among pregnant women and children under five	<p>Pregnant women and children under five are among the most vulnerable groups to malaria. They face a higher risk of complications, including anaemia, increased morbidity and mortality, and adverse effects on pregnancy and child development.</p> <p>Active screening is needed because many malaria cases in these groups may remain undetected without targeted intervention.</p>	<ul style="list-style-type: none"> - Improve early detection among vulnerable groups; reduce the risk of severe malaria and pregnancy-related complications; - Accelerate case management and treatment; reduce morbidity and mortality among vulnerable groups; and - Increase service coverage for pregnant women and children under five.
Mass malaria testing	<p>Many malaria cases are not detected through passive case detection alone. Mass testing can</p>	<ul style="list-style-type: none"> - Identify positive cases at scale within a short period;

	<p>provide a clearer picture of malaria distribution and help identify high-risk areas or hotspots more quickly.</p> <p>Targeted and simultaneous responses are particularly important in focus areas, where they can help reduce transmission and accelerate malaria control.</p>	<ul style="list-style-type: none"> - Detect asymptomatic infections; - Map the malaria burden more accurately; - Provide prompt treatment for identified cases; - Reduce transmission in targeted areas; and - Support rapid programme response.
Malaria testing among specific populations	<p>Many malaria cases remain undetected among high-exposure populations, such as forest workers and miners, who face frequent contact with malaria vectors.</p> <p>High mobility can also contribute to malaria spread between areas, making these groups potential sources of transmission.</p> <p>These populations are often difficult to reach through routine health services and may form transmission hotspots, requiring a more targeted approach.</p>	<ul style="list-style-type: none"> - Reach high-risk groups that are often missed; - Improve early detection in groups or communities with higher exposure; - Reduce transmission to and from surrounding communities; - Ensure appropriate treatment for high-exposure groups; and - Support more targeted interventions.
Malaria testing at health facilities	<p>Testing at health facilities is essential to ensure timely and accurate malaria diagnosis, so cases can be identified and managed appropriately.</p> <p>It also helps prevent misdiagnosis, as malaria symptoms often resemble other illnesses.</p> <p>Facility-based testing can reduce delays in treatment and strengthen routine surveillance through more accurate case recording and programme response.</p>	<ul style="list-style-type: none"> - Improve access to timely malaria diagnosis; - Increase diagnostic accuracy and case management quality; - Accelerate treatment following confirmed diagnosis; - Reduce hospital admissions, severe malaria cases, and deaths; and - Strengthen routine surveillance mechanisms.
Mass drug administration for malaria	<p>Many malaria infections are asymptomatic and can act as parasite reservoirs that are difficult to detect through routine approaches.</p> <p>Rapid interruption of transmission is needed because these reservoirs can sustain malaria transmission in the community.</p>	<ul style="list-style-type: none"> - Reduce parasite reservoirs in the community; - Interrupt transmission in focus areas; - Reduce new malaria cases more rapidly; - Reduce the risk of reintroduction or onward transmission; and

Individual case management alone may not be sufficient, so a population-based strategy may be required to accelerate elimination in targeted areas.

- Sccelerate malaria elimination efforts.

6. Areas for Improvement in Global Fund Malaria Implementation

Table 5 shows that the most frequently suggested area for improvement was stock-outs of malaria medicines and RDTs, together with the need to strengthen logistics and data management. This was reported by 83 respondents (65%). The finding suggests that supply chain performance, availability of essential commodities, and reliable logistics data remain critical for timely malaria diagnosis and treatment.

The next priorities were access, quality of care, diagnosis, and active surveillance, as well as strengthening malaria cadres, health education, and community engagement. Each was reported by 29 respondents (23%). This highlights the need to strengthen both facility-based services and community-based approaches.

Respondents also highlighted the importance of programme coordination, communication, and financing (20%), LLIN distribution and vector control (15%), as well as planning, monitoring, programme sustainability, data, and reporting. Together, these areas point to the need for stronger programme governance and more integrated implementation.

Table 5. Programme strengthening priorities based on respondents' suggestions for Global Fund Malaria implementation

Areas for Improvement	Response	
Stock-outs of malaria medicines and RDTs, and logistics and data management	83	(65%)
Access, quality of care, diagnosis, and active surveillance	29	(23%)
Strengthening malaria cadres, health education, and community engagement	29	(23%)
Programme coordination, communication, and financing	26	(20%)
LLIN distribution and vector control	19	(15%)
Planning, monitoring, and programme sustainability	16	(13%)
Data and reporting	7	(6%)

7. Prioritas Kegiatan Integrasi Layanan HIV, TB dan Malaria

Table 6 shows that the main priority identified by respondents was community-based integration through health cadres (39%), including multiprogramme cadres or PERKASA cadres. Informants viewed cadres as a practical and effective entry point for integrating HIV, TB and malaria services because they come from the community and understand local social relationships. They can support health education, early symptom identification, referral, and treatment follow-up.

The second priority was integrated screening and active case finding (36%). For example, malaria testing during household visits could be combined with TB symptom screening and HIV-related education or referral. At facility level, several respondents also highlighted the importance of TB-HIV cross-screening and integrated testing at Puskesmas.

The third priority was prevention and health communication, including information, education and communication activities. Informants stressed the need to improve community knowledge about HIV, TB and malaria, reduce fear and stigma, and encourage people to recognise symptoms and seek care earlier.

Other important priorities included referral and treatment follow-up, integrated data, reporting and governance, one-stop primary care services, and outreach to vulnerable groups and remote areas.

Table 6. Distribution of priority activities for integrated HIV, TB and malaria services

Priority Integration Activity	Scope of Activity	Response
Strengthening multiprogramme cadres in the community and household visit services	Multiprogramme cadres, household visits, village/community outreach, cadre-led referral, cadre-led monitoring, and the role of cadres as a link between communities and health services.	49 (39%)
Integrated screening, testing, and active case finding	HIV, TB and malaria screening in one activity; active case finding; mass screening; contact investigation; early detection; testing at Puskesmas and in the community; and TB-HIV cross-screening.	46 (36%)
Health education, IEC, community mobilisation, and prevention	Community education, information, education and communication/IEC, socialisation, prevention messages, improved knowledge among cadres and communities, healthy behaviour promotion, and increased awareness of HIV, TB and malaria risks.	45 (35%)
Treatment, referral, adherence support, and case management	Referral systems, follow-up of suspected cases, treatment support, adherence monitoring, sputum transport, Voluntary Counseling and Testing (VCT) support, completion of malaria treatment, and management of co-infection or comorbidity.	25 (20%)
Integrated reporting, surveillance, data systems, and governance	Integrated surveillance, reporting, monitoring and evaluation, data systems, cross-sector coordination, planning, financing transition, regulation, supervision, and programme governance.	24 (19%)
Integrated or one-stop primary care model	One-stop services, integrated patient flow at Puskesmas, one patient–one visit–	22 (17%)

	multiple services, primary health care-based integration, private provider engagement, and integration across health facilities.	
Equitable outreach for remote, vulnerable, and high-burden groups	Outreach to remote villages, high malaria burden areas such as Papua, poor communities, women and children, pregnant women, infants and children under five, migrant/mobile populations, and areas with transport barriers.	20 (16%)

8. Priority Factors for Expanding Malaria Service Access for Vulnerable Groups

Table 7 shows that expanding access to malaria service for women, children, persons with disabilities, Indigenous communities, and remote populations requires a combination of structural, community-based, and inclusive approaches. The main priority was to expand service coverage to remote areas and vulnerable groups (67%), followed by strengthening health cadres and community-based service delivery (56%). This indicates the need to move services closer to communities, particularly in areas affected by geographic, social, and economic barriers.

Respondents also highlighted the importance of culturally and linguistically appropriate health education (41%), reliable access to medicines, diagnostics, and referral systems (41%), and quality services that are inclusive, welcoming, and non-discriminatory (38%).

Table 7. Key factors to improve inclusive malaria services and reach vulnerable groups

Priority Factors	Response
Expanding service coverage to remote areas and vulnerable groups	85 (67%)
Strengthening health cadres and community-based services	71 (56%)
Education and information tailored to local culture and language	52 (41%)
Adequate availability of medicines, diagnostics, and referral systems	52 (41%)
Improving quality of care that is welcoming, inclusive and non-discriminatory	48 (38%)
Transport access or mobile services	47 (37%)
Engagement of vulnerable groups in malaria programming	39 (31%)
Disability-friendly and gender-sensitive services	29 (23%)
Reducing service-related costs	9 (7%)

Therefore, GEDSI-responsive malaria services should be built through a combination of expanded access, stronger community roles, well-prepared health services, and communication approaches that are sensitive to local social and cultural contexts.

9. Recommended Activities to Support Funding Transition

Respondents' inputs suggest that the transition from Global Fund support to domestic financing should be prepared through policy advocacy, integration into government budgets,

phased planning, and health system strengthening. The most frequently mentioned area was advocacy and policy (17%), particularly the need for commitment from district heads, local parliaments (DPRD), and regulations that secure budget allocation.

Respondents also highlighted the importance of government financing through the national budget (*Anggaran Pendapatan dan Belanja Negara*, APBN), local budgets (*Anggaran Pendapatan dan Belanja Daerah*, APBD), special allocation funds (*Dana Alokasi Khusus*, DAK), health operational funds (*Bantuan Operasional Kesehatan*, BOK), village funds (*Dana Desa* or *Kampung*), and special autonomy funds (Otonomi Khusus, Otsus) (16%). Domestic financing is needed to ensure that core activities, including cadres, logistics, surveillance, case finding, and field services, are included in routine national and/or local budgets. Transition planning and governance, as well as health system strengthening, were each reported by 15% of respondents. These include the need for a clear funding transition roadmap, integration of the programme into local planning and budgeting documents such as RPJMD, Renstra, and RKA, and stronger data systems, logistics, laboratories, reporting, and service capacity.

However, four responses highlighted structural challenges in the transition from Global Fund support to domestic financing. These mainly relate to limited local fiscal capacity due to budget efficiency measures, as well as unequal financing capacity across regions, particularly in areas with low local own-source revenue (*Pendapatan Asli Daerah*, PAD).

Several respondents also noted that programme dependence on international donors remains high, while government financing is not always sufficient to sustain programme activities. This may affect field implementation and create a risk of declining programme performance in the longer term.

Tabel 8. Prioritas masukan responden untuk transisi pendanaan Global Fund ke pendanaan lokal

Supporting Activity	Response	
Advocacy and policy	21	(17%)
Government financing	20	(16%)
Transition planning and governance	19	(15%)
Health system strengthening	19	(15%)
Partnership and alternative funding sources	9	(7%)
Programme sustainability and local ownership	8	(6%)
Strengthening cadres and communities	7	(6%)
No response	20	(16%)

Overall, the table indicates that an effective funding transition should be phased, planned, regulation-based, and integrated into local government systems. The transition is not only a shift from donor to government financing, but also a process of building local ownership, sustaining services, and ensuring that essential activities such as cadres, logistics, diagnosis, surveillance, and community-based services continue when Global Fund support is reduced or phased out.

10. Priority Activities Identified by Communities and Civil Society Most Affected by Malaria

Based on inputs from communities and civil society groups affected by malaria, seven priority areas were identified to guide future programme strengthening. These priorities cover prevention of transmission, active case finding, protection of vulnerable groups, logistics and financing readiness, and the expansion of services closer to communities.

The first and second priorities are **community-based larval source management**, and **larviciding and vector habitat management**. Both focus on addressing transmission at source, before mosquitoes develop into adult vectors. Community-based larval source management is important because it encourages local participation in environmental management and the reduction of mosquito breeding sites. Larviciding strengthens this approach through a more targeted technical intervention in larval habitats. Together, these activities show that malaria prevention should not rely on treatment alone, but also on the capacity of communities and programmes to reduce transmission risk in the places where people live and work.

The third and fourth priorities are **active case finding by cadres** and **malaria screening among pregnant women and children under five**. These activities address delays in diagnosis and treatment, particularly in areas with limited access to health facilities. If programmes rely only on people presenting to services, many cases may remain undetected. Cadres have a strategic role because they are close to communities and can reach households directly. Screening among pregnant women and children under five is also essential, as these groups are more vulnerable to the biological and social consequences of malaria. Through these two activities, the programme can shift from a passive service model towards a more active and protective approach.

The fifth priority is **strengthening supply chains, logistics and data management**, and **sustainable financing**. This is a core operational priority because malaria activities depend on the availability of medicines, RDTs, reliable logistics, good-quality data, and stable financing. Findings indicate that stock-outs of medicines and RDTs, together with weak logistics and data management, remain major barriers to programme implementation. At the same time, the transition from Global Fund support to domestic financing requires stronger regulation, planning, and budget commitment. Strengthening these areas is therefore needed to keep early detection, surveillance, cadre activities, and field services running as donor support is reduced.

The sixth priority is **integration of HIV, TB and malaria services through multiprogramme cadres and integrated screening**. This priority reflects the fact that sometimes communities often face more than one health problem, while services are still frequently delivered through separate programmes. Through cadres, household visits, and integrated screening, services can become more accessible, efficient, and responsive to community needs. This approach can also strengthen health education, clarify referral pathways, and support better coordinated treatment follow-up across diseases.

The seventh priority is **expanding inclusive malaria service access for vulnerable groups and remote areas**. This is important because malaria does not affect all groups equally. Women, children, persons with disabilities, Indigenous communities, and remote populations often face multiple barriers, including distance, cost, language, social norms,

and limited access to services that are gender-sensitive, disability-friendly, and non-discriminatory. Service expansion should therefore be supported by communication approaches that are appropriate to local languages and cultures. In this way, equity and inclusion become central to malaria control, rather than additional programme components.

Overall, these seven priorities show that communities and civil society expect malaria programmes to be **closer to communities, more active in finding cases, stronger as a system, more integrated, and fairer for vulnerable groups**. By combining vector control, case management, service integration, logistics strengthening, domestic financing, and a GEDSI-responsive approach, malaria programmes can better respond to community needs and support sustainable malaria elimination.