10th MALARA IN PREGNANCY WORKING GROUP MEETING MINUTES
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WHO REGIONAL OFFICE FOR AFRICA
BRAZZAVILLE, CONGO

A JOINT ROLL BACK MALARIA PARTNERSHIP AND
WORLD HEALTH ORGANIZATION
SPONSORED MEETING

Report prepared by:

Noel Chisaka (WHO/AFRO/MAL)
Triphonie Nkurunzinza (WHO/AFRO/DRH)
Juliana Yartey (WHO/HQ/MPS)

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List of Acronyms

ANC	Ante-Natal Care
AFRO	World Health Organization Regional Office for Africa
CARN	Central Africa RBM Network
CDC	Centres for Disease Control
CHW	Community Health Worker
CHW/HW	Community Health Worker/ Health Worker
CSO	Central Statistics Office
DHS	Demographic Health survey
DOT	Direct Observed Therapy
EARN	East Africa RBM Network
FANC	Focused Antenatal Care
GFATM	Global Fund for AIDs, TB and Malaria
GMBP	Global Malaria Business Plan
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
IST	Intercountry Support Team
ITN	Insecticide Treated Net
IVM	Integrated Vector Management
LLIN	Long-lasting Insecticidal Net
MDG	Millennium Development Goals
MIP	Malaria in Pregnancy
MIPESA	Malaria in Pregnancy for East and Southern Africa
MIPWG	Malaria in Pregnancy Working Group
MIS	Malaria Indicator Survey
MMR	Maternal Mortality Rate
MSH	Management Services for Health
PMI	President's Malaria Initiative (US)
PSI	Population Services International
QN	Quinine
RAOPAG	Réseau d'Afrique de l'Ouest contre le Paludisme pendant la Grossesse
RBM	Roll Back Malaria
RCH	Reproductive and Child Health
RDT	Rapid Diagnostic Test
SARN	Southern Africa RBM Network
SP	Sulphadoxine Pyrimethamine
TBA	Traditional Birth Attendant
TOR	Term of Reference
UNICEF	UN Children's Fund
USAID	US Agency for International Development
WARN	West Africa RBM Network
WB	World Bank
WHOPES	WHO Pesticide Evaluation Scheme

1.0 Background:

The Roll Back Malaria (RBM) Partnership Working Group for Malaria in Pregnancy (MIP) was established by the RBM Board in May 2003 to advance the efforts of partners in the prevention and control of malaria during pregnancy. In May 2003, a terms of reference (TOR) for the MIP working group was developed in accordance with the RBM partnership strategic plan for "going to scale" with implementation of key interventions for the control of malaria during pregnancy. The MIPTOR which was revised in 2006, is aligned with the new direction of the RBM Partnership and its working groups in achieving its mission of "working together to enable sustained delivery and use of the most effective prevention and treatment, for those affected most by malaria by promoting increased investment in health systems and incorporation of malaria control into all relevant multisectoral activities".

The MIP working group acts as an advisory body to the RBM Partnership Secretariat on all matters pertaining to the implementation and scale-up of interventions for the prevention and control of malaria during pregnancy at the global, regional and national levels. The group documents and analyzes implementation experiences across countries and disseminates and promotes best practices emanating from these experiences to countries in order to inform country strategies on implementation and scale-up of MIP interventions. Because a high proportion of the burden of disease occurs in Africa, the initial geographic focus of this working group is Africa, although this does not preclude working on issues from other regions when merited.

The MIP working group interacts directly with countries through the MIP coalitions established with the support of the MIP working group partners. Currently, there are two networks established in the Africa Region: The *Malaria in Pregnancy Eastern and Southern Africa Coalition* (MIPESA) and the *Réseau d'Afrique de l'Ouest contre le Paludisme pendant la Grossesse (*in the West Africa sub-region (RAOPAG) in the West Africa sub-region, These coalitions consist of country representatives from malaria and reproductive health programs and foster collaboration between malaria and reproductive health programs at the regional and country levels. The coalitions enable exchange of experiences and best practices regarding MIP implementation issues among countries, and provide technical and other support for advocacy, resource mobilization and addressing implementation bottlenecks in countries.

In line with overall objectives set out for the MIP Working Group, the 10th MIP meeting focused on issues related to the scale-up of MIP interventions as follows:

1.1 Purpose:

The purpose of the 10th MIP Working Group is to review progress, foster participation for eligible countries and support the collaborative efforts between MPS and MAL at both Regional and IST level.

1.2 Specific objectives:

1. To review the status of MIP implementation and identify bottle necks and necessary actions towards the scale-up of interventions to achieve RBM goals.
2. To provide updates on relevant technical issues, research and tools in development.
3. To discuss how the MIP WG and RBM sub-regional network for Central Africa (CARN) can effectively support the establishment of the Central African MIP coalition (RACPAG) in order to help scale up MIP interventions in the sub-region.
4. Strengthen inter-departmental collaboration between malaria and Reproductive Health Programs at WHO AFRO and country levels.

1.3 Expected outcomes:

1. Status of MIP implementation and bottle necks and towards the scale-up of interventions to achieve RBM goals reviewed.
2. Updates on relevant technical issues, research and tools in development provided.
3. Process of how the MIP WG and RBM sub-regional network for Central Africa (CARN) can effectively support the establishment of the Central African MIP discussed and subsequent follow up actions to support the creation of the CA MIP coalition RACPAG to scale up MIP interventions in the sub-region agreed upon and initiated.
4. Collaboration between malaria and DRH at AFRO strengthened and subsequent actions to support similar collaboration in countries agreed upon and initiated.

2.0 Opening

RBM MIP Chair – Dr Juliana Yartey:

The Chair welcomed participants to the meeting and gave a brief history of the establishment of the RBM MIP Working Group, its purpose and functions and the critical issues that needed to be addressed by partners to support countries in achieving the RBM Targets for 2010 and the MDGs. Of critical importance was the need to ensure that progress in MIP implementation and achievements of stated goals was being measured. She noted that there is a critical gap at this time in the operationalization of the MIP M&E framework in countries to ensure the adoption of uniform indicators and measures of progress in countries to reach agreed targets. She called the meeting's attention to the recently published guidelines for MIPM&E, and challenged partners, particularly WHO to discuss concrete follow up actions to support countries in the adoption and implementation of these M&E guidelines for MIP.

RBM Secretariat Representative - Dr Betty Udom

Reiterated the commitment of the RBM Partnership Secretariat to support the function of the RBM working groups. Highlighted the importance of MIP as an important issue in the fight against malaria and the achievement of the MDGs. Mentioned the development of the Global Malaria Business Plan which will highlight the steps required and the resources needed to scale up interventions. Stressed on the need for strengthening of and closer collaboration between regional bodies involved in MIP such MIPESA, RACPAG, RAOPAG. Emphasized on the need for strengthening monitoring and evaluation of MIP interventions that will contribute to regular reporting on implementation progress.

WHO AFRO Director Reproductive Health - Dr T Kesela

Highlighted on the need for strengthened collaboration between malaria and reproductive health programs to support the delivery of a basic integrated package of interventions for pregnant women. Given that MIP interventions are to be delivered through ANC by the same basic health provider in the ANC setting, Collaboration among programs becomes a critical aspect of Improved service delivery to ensure continuity of care and the delivery of a comprehensive package of interventions for women in various settings. In this regard, she alluded to the consideration of HIV as an important aspect of managing pregnant woman given the impact of HIV in pregnancy and the effect it has on malaria infection and pregnancy outcomes.

WHO AFRO Director Aids, TB, Malaria – Dr TY Sukwa ai

The Director ATM ai alluded to the importance of the Abuja and RBM Targets for 2010 and MDGs; 80% Abuja targets for IPT and ITN use, and the WHA resolution for scaling up IPT and ITN use. He reiterated WHO support for implementing MIP, the need for scale up and increase coverage with coordinated action through delivery point – ANC being the most critical platform for the delivery of MIP interventions. He acknowledged the level of commitment from the international community and the broader partnership for MIP and also stressed the importance of ensuring that country resources were made available to support MIP activities at the local level. He highlighted that priority research to inform policy decisions was critical for MIP at this time.

WHO AFRO Director Programme Management - Dr B Troure ai

He pointed out that malaria remains a major public health problem especially in pregnancy contributes greatly to low birth weight, still births and maternal anemia. He said the burden of malaria in pregnancy in Africa remains huge with he 42 endemic countries 35 countries have adopted MIP Strategy and of these 25 countries are implementing country wide the MIP strategy. He pointed out that meeting was milestone as it optimized the importance of a coordinated approach to dealing with the problem of MIP. He reiterated the importance that the ANC remains the entry point for pregnant women into the health service the provision of an integrated package of interventions. He said “this integrated package should be a product of coordinated efforts between different players involved in the provision of health for the pregnant woman”.

The meeting was declared formally opened by the Acting DPM, Dr. Toure.

3.0 Updates on MIP Status and Implementation

3.1 Update on progress in MIP implementation in the Africa region. Dr N Chisaka

AFRO presented the current status of malaria in pregnancy in the Africa region. The following points were highligted

- 35 Countries having adopted IPT and 27 fully implementing. Coverage varies in countries. IPT 2 ranges between 5%-68%. ITN coverage for pregnant women and women sleeping under a mosquito net the previous night stlli remain low, but are notably seen to be rising in countries such as Zambia, Malawia, Niger and Burkina Faso;
- Folic Acid: use in pregnancy is noted to to impact efficacy of SP for IPT;
- ITNs distibution for universal coverage recommended;
- Malaria case management in pregnancy remain an issue that requires further consideration and given the seriousness it deserves. Currently the actual burden of malaria in pregnancy not well known. Need to optimise the use of RDTs and Microscopy for pregnancy related fevers;
- Meeting was informed that Mauritania which was the last country in the region to adopt IPT had done so but was yet to implement.

Discusion Points:

1. DHS to be inclisive of approapriate malaria modules to ensure that MIP/iPT daa is welll captured
2. AFROM&E participation in MIP important to strengthen M&E component of MIP programs. AFRO and Partners has to support countries to move towards the collection and utilization of data
3. CDC to share tool on assessing malaria burden
4. Operational guidelines for MIPM&E is to be distributed to countries thorught WHO AFRO ICT's and the MIP Coalitions.

3.2 Update on status of MIP Implementation (Countries)

DR Congo:

Has Strategic Plan for Malaria Control. This has contributed towards a positive effect at country level. Coverage of MIP interventions was through GFATM support. Most data obtained from surveys. Currently covering only 49% of the health zones. They have a routine Health Management Information System (HMIS) but this is weak. The issueof consumables remain critical. The RH division has been invited to participate in MIP activities and will be included in surveys on MIP. Collaboration remains critical with WHO being the main partner. Malaria consortium now on board.

Gabon:

Have MIP strategy nd are implementing countrywide. Currently there is an MCH service. The health informton system remains inadequate. It was pointed out that the ITN distribution strategy was not comensurrate with current strategy..

Congo Brazaville:

Adopted policy for MIP in 2006 and started implementation in 2007. ITNs are distributed to all in campaigns free of charge. Coverage of nets , 64% have ordinary nets and 15% have ITNs. Quickening remains the criteria for determining eligibility for SP provision.

Cameroon:

Has adopted and statrted to implement MIP interventions betwwen 2004-2006. Initially, pregnmanct women had to buy SP for IPT but since 2006, SP is now provided free to all pregnant women through antenatal care. Data for baseline on MIP obtained from routine registers. Malaria data collecting systems mostly vertical due to weakness of horizontal systems. Wanted to find out about the effcetiveness of CBI for IPT. Malaria case management at 29%??. Diagnosis for malaria in pregnancy remains a challenge. Requested AFRO to provide guidance on RDTs use.

Summary of key issues from Counties in Central Africa:

- MIP remains a major public health problem in countries.
- Avaialbility of commodities impacts on the ability to scale up.
- Collaboration and coordination of partners are critical and needs to be strengthned

- On-going problems with ITNs disribution.
- M&E for MIP remains weak and needss to be strengtend in Central African countries
- Malaria case management in pregnancy and issues related to diagnosis need to be fully embraced addressed.
- Important that actual need is brought forward for MIP, planning, M&E and coordination.

Ghana

Implementing MIP including IPT, ITN and Case management. Using an number of methods to scale up ITNs. These include: Voucher scheme. But it was noted that the voucher scheme is expensive and difficult to implement. The issue of when to start and stop IPT dosing for pregnant women was raised as there seems to be some conflicting messaging in countries. i.e 20 to 36 weeks gestation. It was clarified that IPT should start after quickening (first notable movement of the foetus) at about 16 weeks and continued throughout pregnancy at a minimum of four weeks intervals. Concerns about Kernictus due to SP were thought to be less of an issue based on current available data. Hence it was emphasied that all documents reflecting 18/19 weeks of pregnancy through to 36 weeks should be updated. With regards to M&E of MIP, the importance of including MIP indicators into routine HMIS was empahasized as this was necessary for monitoring coverage. Despite efforts to scale up IPT, uptake was still low. The issue of potential interactions between folic acid and SP was also discussed and remains controversial with inadequate data to support reported assertions and concerns. WHO currently recommends 0.4 mg per day which is not likely to affect uptake of SP. However, higher doses of 4.0mg or more remain avvailable on the market and are sometimes given to pregnant women in ANC which may affect SP bioavailability..

Nigeria

Implementing MIP interventions. Nigeria has attempted to assess the magnitude of the problem and the burden is high. The needs are equally graet due to weak health system and low ANC attendance. A critical issue of the positioning on MIP within RH. This is important to ensure success with implementation. Currently, MIP continues to be part of Malaria and not RH program. There is no comprehensive plan for MIP. Nigeria expressed a need for.concrete support such as strenghtnening the WHO office to be able to respond to the huge needs of the country, with at least a Malaria Professional Officer in each State. There is also a need to advocate for increased political will. Partnership is critical in filling

the GAP for MIP. As regards, implementation of IPTp, at least two doses was the optimal. The issues of decentalisation was seen a having both advantageses and disadvantages.

Tanzania

Has been implementing MIP interventions for several years with coordinated planning since 2000. Most implementation related activities contracated out to ACCESS/JHPIEGO. Strong collaboration between RH and malaria programs has been key to the success of implementing MIP in Tanzania. Other factors contributing to success iin MIp implementation is the MIPESA coalition. MIPESA provided a great forum for exchange of experiences and best practices among countries The Tanzania programme has been undertaking periodic surveys to assess MIP progress, due to weak HMIS for MIP. The surveys are conduted in 21 districts. This is complemented by sentinel surveillance. Drug management is done with the support of MSH.

Summary of discussion points from Countries

- Programme support and partnership remain critical in the effort to scale up MIP interventions.
- There is need for sustained political support, strong programme management and planning for MIP at local, national and regional levels.
- Voucher scheme for ITN distribution are a challenging approcah to scale-up. They are also expensive
- The initiation of SP for ITP should be done after quickeing through to delivery with four weeks intervals. Current guidance in countries indicating otherwise should be revised.
- The WHO recommended 0.4 mg folic acid should be implemented in countries to prevent anaemia in pregnant women and reduce the chance of reduced SP effectiveness.
- M&E remains a challenge. Integrated HMIS is important as it can support data collection to assess national coverages. Where this is lacking, it can be complemented by vertical infomaton systems.
- In large countries such as Nigeria, a deliberate policy and effort to strengthen health system capacity is crical to improve implementation and measuring progress.

- Community distribution of IPT through integrated outreach MNCH services could contribute to increased uptake of MIP interventions.

4.0 Sharing Best Practices and Experiences - Scaling up IPT and ITNs: Achieving RBM Goals: Success Stories – Zanzibar

Zanzibar is implementing all MIP interventions and is a full member of MIPESA. LLINs are being provided by PMI. ITNs are also being provided to the general population. There's high political commitment and the Partnership working very well and supporting the three ones approach. Integrated approach is adopted and being practiced for all malaria interventions. Zanzibar is now moving towards universal access. With increased coverage of effective interventions, reduced transmission has resulted in a changing epidemiological disease pattern. Diagnosis is increasingly becoming an important component of MIPwith the changing epidemiological profile of the diseases in the country.. All suspected cases now require laboratory confirmation. All facilities have therefore been equipped with diagnostic capacity. Where there is no microscopy, RDTs are being used. RDTs and microscopy QA/QC in place. Efforts on strengthening surveillance system ongoing in view of noted reduction in transmission.

Discussion points

- Implications on continued use of IPTp in areas with reducing transmission: Need to continue IPT until carefull assessment establishes extent of transmission reduction and the continued usefulness/benefit of IPT.
- Need for new drugs for IPT in light of increasing resistance to SP.
- Data on birth outcomes important as part of HMIS and MIP M&E to demonstrate the impact of increased coverage on maternal and child health outcomes. Current Zanzibar success story could benefit from birth outcomes data to demonstrate impact of MIP interventions (IPT, ITN and CM).

5.0 Update on Technical Issues, Research and Tools in Development

5.1 WHO MIP M&E Guidelines (French and English) - Dr Nathan Bakyaita

The MIP M&E guidelines had been finalized and printed in French and English. The guidelines are to be disseminated through the RBM MIP working group website, the MIP coalitions, directly to countries through WHO and through other Partner agencies.

The MIP M&E guidelines were presented and the issue of the denominator for IPT 1 and 2 was raised again. This issue has been

discussed in previous meetings that arrived at a concensus that the denominator in question should be first ANC attendance. However it was pointed out that the denominators in question - i) number of first ANC attendees and ii) total estimated number of pregnant women provide different measures and could be used on they type of coverage data desired. Operational coverage would use number of first ANC attendees and programatic coverage would use the total estimated number of pregnant women as denominator.

GFATM M&E guidelines and indicators are identical with the malaria monitoring and evauation guidelines. HMIS important in determining national coverages. Role of CSO in determining sample size and samling for MIS critical. Importance for coordination among key players. National malaria control programme must lead the process as the data obtained is primarily national data. HMIS important in generating routine data and MIP indicators should be integrated and supported to ensure smooth data collection and management and effective utlization at local level. Important for capacity to be established for data use at local level.

Discussion points:

- Need to ensure the adoption of correct methodologies when conducting surveys,otherwise data becomes useless.
- WHO to provide training in data base management and methodologies for strengthening data management to ensure comparability
- TBA's have a role to play in MNCH programs. Their role is in encouraging and bringing pregnant women to facilities for skilled care (ANC, delivery, postnatal care). They can be motivated to play this role effectively with incentives.
- Proportion of women delivering in facilities with skilled care remains low in the Africa region. Efforts should be made to promote skilled for pregnant women at every opportunity.

5.2 MIP Implementation Guide/ Resource Package JHPIEGO/ACCESS – Ms. E. Roman

Ms. Roman provided an update on two new products to support MIP program implementation and scale up in Africa. The first, developed jointly with WHO, CDC and RPM Plus, *Prevention and Control of Malaria in Pregnancy in the Africa Region: A Program Implementation Guide* details a step-by-step process for MIP programming targeting policy makers, program managers and healthcare providers. The guide was inspired by the *WHO/AFRO Strategic Framework for Malaria in Pregnancy in the Africa Region*.

It outlines seven essential programming components that are needed to put Malaria in Pregnancy policy into practice at the health facility level and draws on existing country experiences, best practices and lessons learned for practical implementation. The Guide comprises the following sections: (1) Introduction; (2) Essential Components for Implementing MIP Programs;
(3) Practical Solutions to Frequently Seen Problems: (a) Women do not come early in their pregnancies for antenatal care (ANC);
(b) Women are not given anti-malarial drugs recommended per national guidelines or do not use them if they are available; and (c) Women are unable to obtain insecticide-treated nets (ITNs) ordo not use them if they are available. Finalization of the guide is pending WHO approval.

The second, developed by Jhpiego is an updated version of the *Malaria during Pregnancy Resource Package: Tools to Facilitate Policy Change and Implementation* (available on CD). The updated Malaria Resource Package is a compilation of tools and resources for countries to adapt to their context as they work toward the prevention and control of malaria in pregnancy. It includes training and programming materials as well as reference materials. The Resource Package will be made available in the near future.

tool that had information on the the different interventions for MIP. This was almost ready for distribution. It was requested that information on its finaliztaion be provided to the WG to ensure countries had it.

5.3 Focused Antnatal Care – Dr A. Serufurila/Dr T Nkurunzina

FANC an advanced system for RH management of the pregnant woman. Important to collaborate between different players. FANC data management has to include MIP data. It is important that modalities for this are developed. Training and change in attitude very important for success. Examples of Ghana show that midwives accepted FANC but experienced a number of challenges which included; space, fewer staff, institutional information and other operational challenges such as patients' preferences, availability of equipment and commodities at the right time. It was stressed that FANC goes beyond ANC to communities' reduction of MMR; burden of work is heavy as focuses on individual attention. It is important that FANC implementation involves the communities and partners.

Discussion points

- Need to strengthen FANC data management to collect MIP data

- Important that commodities are available to ensure patient provider confidence.
- Distance from home remains a challenge and hence every village has to have a dispensary
- Community outreach programs to deliver comprehensive services must be encouraged.
- Need to look at the schedule of visits for FANC. Is the timing recommended at specific gestational ages e.g 21 weeks, 28 weeks , 32 weeks etc, or fist vist, 2nd visit and third vist with specified time intervals as it obtains with IPT e.g. 1st dose at visit after quickening and subsequent doses at 4 week intervals.
- Need to ensure DOT is practised within FANC

6.0 Updates from RBM Partners

6.1 Update from PMI/CDC – USAID; Dr Kwame Asamoah

PMI supports national malaria control programmes to rapidly scale up known and proven effective malaria interventions. PMI collaborates with all malaria stakeholders in a country to move the malaria agenda forward. Over 40% of PMI funding for a country is used to purchase commodities such as antimalarials and LLIns . There is a strong monitoring and evaluation component in PMI to keep track of activities and measure progress and the achievement of targets. Tanzania' reported having a very good experience with PMI. Concerns were expressed about the difficulty of working with PMI at country level to ensure processes are as stipulated. CDC to follow up on concerns.

6.2 MIP Research Consortium – Dr J Yartey

The Gates funded MIP Research Consortium held its first Annual General Meeting (AGM) in Geneva in February 2008. Participants were encouraged to visit the website, discuss the relevant research issues and provide input to the development of the research agenda in terms of identifying and highlighting gaps in knowledge and engaging in relevant research where possible.

6.3 PSI – Congo - ITN Distribution

PSI DR Congo works in partnership with NMCP. Planning for ITN distribution is often done jointly with the programme. Training of nurses, organization of logistics and related activities are all done together and involves the provincial level and distribution points staff. ITNs are provided at a nominal cost of CF 250. Distribution is through ANC clinics as well as through the private sector.

Discussion points:

- Mechanism for reaching all pregnant women should be established especially given the cost implication which hinders equitable access.
- Women in the first trimester should be encouraged to obtain nets as they are most susceptible to the effects of malaria.
- Adolescents should also be encouraged to develop the habit of sleeping under ITNs to prevent adverse consequences of MIp associated with first pregnancies.
- Need to ensure there is increased information and advocacy on the need for skilled care at every delivery.

7.0 Interactions between SRNs, MIP Coalitions, WHO & PARTNERS

7.1 Update from MIPESA – Dr Chilunga Puta

MIPESA initially consisted of five countries but has since been expanded to include six more countries bringing the tolal to 11. MIPESA is a country-led (and not partner-led) coalition established to strengthen country MIP implementation. No regular funding for MIPESA but countries rely on in-country partnerships, Key Partners such as WHO and USAID and Governmemnt support to fund MIPESA Secretariat and MIP related activities. Through MIPESA conferences and country visits for sharing best practices, MIPESA has contributed to strengthned malaria and RH collaboration with most countries now offering a complete and integrated package of MIP interventions within ANC. MIPESA's added value is seen as a strong advocacy coalition that contributed to refinement of the WHO MIP strategy,capacity building for MIP, RH and malaria coordination, Advocacy and collaboration, and documentation of country best practices. However, it was noted that MIPESA countries needs to strengthen their monitoring and evaluation capability and the Coalition Secretariat could be supported by partners to build capacity in this regard and for the sub-region. It was noted that WHO MPS/DRH and Malaria departments have demonstrated commitment at all levels and supported the coalition from its inception until now.

Discussion points

- MIPESA commended for adopting MIP M&E indicators in countries.

- Of particular note is the low LLIN coverage in countries, which was attributed to in adequate availability and poor distribution mechanisms. This has since changed in view of efforts towards universal access and achievement of the 2010 RBM targets.

- Added value of MIPESA is the ability to encourage and support member countries to adopt MIP policies and strategies and providing a forum for dialogue, sharing of best practices and partnership harmonization and support for advocacy and resource mobilization.

7.2 Update from RAOPAG - Dr Do-Rego

- Following the presentaton from RAOPAG, the following key issues were raised:were not adequately engaged in the coalition or convinced on the way forward.

- RAOPAG Executive would have to re-engage and mobilize countries to chart a way forward including the strengthening of the Secretariat.

- It was discussed that with time, all countries might have to contribute sorme funds to support the functioning of the network.

- The issue of English countries being sidelined in communication was discussed and agreement from the chair was that the coalition would now proceed and provide invitation and notices in two langueges to accommodate the English speaking countries instead of limiting all communications to French as had been the case previously.

- Changing of indicators when other countries are using them

As the presentation and discussions pertaining to the two coalitions was to pave the way for a discussion on the possible creation of a Central Africa Coalition, the meeting agreed to the need for a Central African MIP coalition. However, Representatives of the Central African countries fellt there was need to report back to their constituencies and obtain concensus on the topic before proceeding with the process of convenning a meeting to initiate the formation of the coalition. WHO was requested by countries to support the provcess and the MIPESA Coalition secretariat provided a synopsis of the process of formation of MIPESA. MIPESA was requested to provide a framework or some form of written guidance to RAOPAG to adapt that will also support RACTAP.

7.3 RBM partnership Update - Dr B Udom

The RBM Partnership works through sub-regional networks through the guidance of thematic Working Groups. Currently, the four existing networks exist only in Africa. These are: SARN in the south, WARN in the West, EARN in the East and CARN in the Central regions. The role of the networks is to foster partnership and coordination of partners efforts in the implementation of malaria interventions. The MIP coalitions are also part of RBM partnerships and are expected to work no only with the MIP but with the SRNs as well. SRN are supported by a coordinator who functions as a liason for the RBM at the regional level.

7.4 WHO-IST

WHO ISTs are the implementational arms of the WHO Regional Office for Africa. They are intended to to be as near to the countries as possible to ensure timely support. WHO AFRO remains committed to the RBM sub-regional networks and the MIP Coalitions. The committment is demonstrated by the joint hosting of this MIPWG meeting by the two divisions of ATM and DRH. In addition, there is clear demonstrated commitment and support from WHO at all levels including HQ in supporting the coalitions to achieve their goals and being part of the broader RBM Partnership.

8.0 Work Planning and Global Malaria Business Plan Review

8.1 Work Plan and Minutes of previous meeting -Dr J Yartey

The meeting reviewed the minutes of the previous meeting. Following discussion, the minutes were then adopted as a true reflection of what transpired in the Lusaka MIP WG meeting. The MIPWG work plan was also adopted but concern was raised as regards the unavailability of funds to ensure the MIP activities are implemented as planned. It was noted though that the RBM Secretariat was making submissions to ensure that all working groups had some resources to implement their plans for the year. It was important therefore that the Working Group's needs as regards finances be transmitted to RBM secretariat for consideration. The discussion also reflected on the following:

- National Malaria Control programmes receiving support from GFATM or other sources should ensure that MIP package is included

- Need to encourage and strengthen SRN and MIP Coalitions collaboration
- Include FANC in GFATM proposals
- Donors and Partners should have the same targets
- MIP coalitions play an important role and should therefore be funded
- Need for evidence-based decisions to support MIP, hence importance of good documentation and research
- Implementation should be geared towards making impact

8.2 Global Malaria Business Plan

This session was led by The MIPWG chair. She briefed the WG on the outcome of the meeting held in New York to discuss the progress made in the development of the GMBP. She highlighted the challenges associated with the development of the plan. Concerns raised by partners regarding the transparency of the whole process. It was pointed out that it was important to appreciate the nuances and complex nature of the global momentum associated with the GMBP development. In this regard, it was suggested that the MIPWG should contribute sections on the MIP component to ensure that MIP issues are adequately reflected in the document. WHO Country offices should also be involved in the development of Country business plans.

8.3 RBM Needs Assessments

The meeting was informed that so far three countries had completed the needs assessments. Those completed included Ethiopia, Ghana and Nigeria. DRC assessment was in the pipeline. The meeting observed that:

- There was need for involvement of the MIP coalitions in the needs assessments.
- There was an implication for countries that postpone the NA.
- Why was Ghana not included in the first four countries as earlier proposed?
- There was need for being more consultative in the implementation of the needs assessments.

9.0 Recommendations and Way Forward

Following the deliberations of the meeting the following recommendations

1. Sub regional networks should have representatives from Reproductive Health

2. M&E personnel should be represented at coalition meetings to support M&E issues and related activities
3. The process of collaboration between malaria and RH should be reciprocal and not one sided. Either program could lead the initive at any time.
4. There is need to involve more WHO National Professional Officers in MIP activities to ensure they are on board on issues dealing with MIP
5. WHO Annual Review and Planning meetings to be used as opportunity for advocating and planning for MIP
6. As a way forward for the formation of RACPAG, relevant levels of WHO should convene a meeting of Central African countries in collaboration with RBM CARN to initiate the process.
7. Countries to ensure importance of the sub-regional body (RACPAG) is communicated to enable appropriate advocacy at country level for local buy in.
8. WHO AFRO and HQ to ensure appropriate technical details on MIP implementation is circulated to countries.
9. Guidance on harmonious work between ISTs and RBM networks developed to ensure optimization of resources.
10. Other technical units in WHO such IMCI and HIV to be represented in MIP meetings and relevant activities.

Next Steps

1. Next meeting, October 2008 - Manila, The Philippines. Working Group is flexible and would consider other venues in the region if necessary: WPRO; SEARO. Therefore, need to communicate to WPRO, SEARO ASAP
2. MIPESA requesting learning session in June, WHO/AFRO and HQ to support. Other partners JHPIEGO, MACEPA and UNICEF to support as well
3. MIP coalitions to link up with SRN and incorporate their coalition work plans in the SRNs' for funding considerations.

Final Remarks – Chair/ MIPWG

Acknowledged and thanked the WHO Regional Office Senior Management for hosting the meeting at the Regional office. She noted that this showed the commitment of WHO at the highest level on addressing the issue of MIP. She especially thanked the Directors of ATM and DRH for their unwavering support in this regard.

She also thanked the participants for their generosity in sharing the wealth of information and experiences related to MIP implementation, the SRN networks and MIP coalitions for the excellent activities in countries and at sub-regional level and the

partners for their commitment and support in moving MIP agenda forward**.**

10.0 Conclusion

MIP remains a critical condition with adverse effects on both the mother and developing foetus. In this regard, it continues to be an important public health issue in countries with high malaria transmission.

Given that cost effective interventions for implementing MIP are known, the onus is on national malaria control and reproductive health programmes to ensure that these available effective tools are used. The SRN and MIP coalitions should work together in ensuring that these tools are collectively adopted, implemented and scaled up within the broader context of the country health sector actions. WHO technical support in addition to other agencies providing similar support should be timely and available when needed to ensure the overall technical content of programme implementation is strengthened.

The opening ceremony saw the Directors of the two programs allude to the need for an integrated package of malaria in pregnancy interventions at the ANC. Focused ANC should be seen as a platform and avenue for effective delivery of pregnancy-specific interventions that will reduce the burden from quasi vertical programmes that target the same pregnant woman and ANC workers.

The fact that Central African countries are lagging behind in MIP intervention coverage is of great concern as this a region were a huge burden of MIP also exists. Undoubtedly the lack of a coalition to support country MIP implementation contributes greatly to the current situation. However, countries have the responsibility to ensure that the region moves forward to achieve shared success. WHO should take a strong lead in supporting the process of strengthening central African countries and ensuring that the necessary support for MIP is carried out.

The RBM partnership is committed to supporting efforts to move the MIP agenda forward. The formation of the MIP Research Cobnsortium highlights the commitment the research community and other global Partners such as the Gates Foundation has towards this area. It is important for the MIP Research Consortium to work very closely with the MIP Working Group to ensure that the research agenda also focuses on some of the critical operational issues for MIP

One of the challenging bottlenecks of fully opeartionalising the MIP agenda and annual work plan is the lack of funds. It is hoped though that the RBM Secretariat and SRNs funding will complement the MIP Working Group and coalition activities.

11.0 Annexure

11.1 Agenda of Meeting

Tenth Meeting of the RBM Malaria In Pregnancy
Working Group (MIP)
21st - 23rd April 2008,
WHO Regional Office for Africa
Congo, Brazzaville.

Day One: Monday 21 April, 2007

8:30-9:00 REGISTRATION

OPENING:

Chairperson - ATM

Master of Ceremonies - DRH

9:00 - 10:00

- Security Briefing	- UN Security
- Remarks by RBM MIP Working Group	- WG Chair
- Remarks by RBM Secreteriat	- RBM Secret.
- Welcome Remarks and Introduction of Participants	- DRH
- Review of meeting Objectives and Agenda	- MPS
- Welcome Remarks	- ATM
- Opening Remarks	- DPM

*******GROUP PHOTOGRAPH*******

10:00 - 10:30 TEA BREAK

Session 1: Updates on MIP Status and Implementation

Chair: Dr. Juliana Yartey

10:30 - 12:30 **-** Update on progress in MIP implementation in the Africa region - AFRO/MAL

- Update on status of MIP Implementation in Countries of Central African Region (DRC, Gabon, Congo Brazzaville, Cameroun)

- Scaling up: Discussion of technical issues and bottle-necks

12:30 - 2:00 **LUNCH**

Session 2: Sharing Best Practices and Experiences: Scaling up IPT and ITNs

Chair: Dr. Josephine Namboze

2:00 - 4:00 - Ghana, Tanzania, Nigeria

4:00 - 4:30 **TEA BREAK**

4:30 - 5:30 Achieving RBM Goals: Success Stories - Zanzibar

Day Two: Tuesday 22 April, 2008

Session 3: Update on Technical Issues, Research and Tools in Development

Chair: Dr. Kwame Asamoah

9:00 - 9:30	Summary of previous day's deliberations	-
9:30 - 10:00	Focused Antenatal Care (FANC)	- AFRO/MPS
10:00 - 10:30	**TEA BREAK**	
10:30- 11:30	MIP M&E Guidelines (French and English)	- AFRO/MAL
11:30 - 11:45	MIP Implementation Guide/ Resource Package	- JHPIEGO/ACCESS
11:45 - 12:00	MIP Research - MIP Research Consortium	- J. Hill
12:00 - 12:30	RBM Needs Assessment and GFATM Support tools	- RBM

12:30 - 2:00 **LUNCH**

Session 4: - Updates from RBM Partners

Chair: Dr. Chilunga Puta

2:00 - 2:30	- Update from the RBM Partnership Secretariat Board Decisions, HWG/MIST, Global Malaria Business Plan	- RBM
2:30 - 2:45	- Update from PMI	- PMI
2:45 - 3:00	- ITN delivery through ANC	- PSI

3:00 - 3:30 **TEA BREAK**

Session 5 **Interactions between SRNs, MIP Coalitions, WHO & PARTNERS**

Chair: Dr. Mufungo Marero

3:30 - 4:00	Update from MIPESA	- MIPESA
4:00 - 4:30	Update from RAOPAG	- RAOPAG
4:30 - 5:30	**-** Discussion of the interaction between CARN, RACPAG, WHO ICTs & Partners - Summary of proprosed actions and way forward or next steps.	

Day Three: Wednesday 23 April, 2008

Session 6 **Next Steps**

Chair: Dr. Chisaka Noel

9:00 - 9:30	Summary of previous day's delibrerations	-
9:30 - 10:00	Review and adoption of Minutes of the last meeting	-
10:00 - 10:30	**TEA BREAK**	
10:30 - 12:30	Action points from previous minutes for further action	
12:30 - 2:00	**LUNCH**	

Session 7 **Work Planning and RBM Business Plan Review**

2:00 - 3:30	RBM Global Malaria Business Plan - Presentation and Discussion	
3:30 - 4:00	**TEA BREAK**	
4:00 - 4:30	Review of MIP WG Work Plan and Budget (2008)	
4:30 - 5:00	AOB/Closing	

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11.2 List of participants

PARTICIPANT	TITLE	ORGANIZATION	E-mail address	Contact address	COUNTRY	Telophone
Dr Kwame Asamoa	CDC/PMI	CDC/PMI	kasamoa@cdc.gov	CDC/PMI	USA	
Dr Chilunga Puta	RCQHC	RCQHC	cputa@rcqhc.org	RCQHC Makerere University	Zambia	
Dr. Antoine Serufilira	WHO/AFRO/MPS/CA	WHO/AFRO/MPS/CA	serufiliraa@ga.afro.who.int	BP 820 Libreville, Gabon	Gabon	
Dr Chisaka Noel	WHO/AFRO/MAL	WHO/AFRO/MAL	chisakan@afro.who.int	WHO,RO	Congo	
Ms. Elaine Roman	ACCESS/JHPIEGO	ACCESS/JHPIEGO	eroman@jhpiego.net	2478 Vine Place 2478 CO 80304	USA	
Dr Triphonie Nkurunziza	WHO/AFRO/MPS	WHO/AFRO/MPS	nkurunzizat@afro.who.int	WHO, RO.		
Dr Josephine Namboze	MCM/DP/SA	WHO	Nambozej@afro.who.int	BE 777 BELVEDERE Harare	Harare	4724138165
Dr Nathan Bakyaita	WHO/AFRO/SME	WHO/AFRO/SME	bakyaitan@afro.who.int	WHO, RO	Congo	
Dr Boi-Betty Udom	RBM Secretariat	RBM Secretariat	udomb@who.int	WHO/HQ	SUISSE	
Dr Charles Katureebe	WHO/Uganda	WHO/Uganda	katureebec@ug.afro.who.int	WHO/Uganda	Uganda	2.56783E+11
Dr. Felicia Owusu Antwi	WHO/Ghana	WHO/Ghana	Owusu-Antwif@gh.afro.who.int	Residential Area, Accra, Ghana	Ghana	23321763920
Dr Mufungo Wanjara Marero	MIPESA/NMCP	Tanzania	marerom@yahoo.com	PO box 9083	Tanzania	
Dr. Salhiya Muhsi	C/PNLP	Ministry of Health & Social Welfar, Zanzibar	salhiya75@yahoo.com	Ministry of Health & S.W Box 236	Zanzibar	
Dr. Juliana Yartey	Yes	WHO/HQ/MPS	yarteyj@who.int	WHO,HQ	Switzerland	

Dr Nouratou do Rego	RAOPAG	RAOPAG/BENIN	nourange@yahoo.fr		BENIN	
Dr LIBAMA François	PNLP	Congo	libama_francois@yahoo.fr	BP 286 Brazzaville	Congo	
Ms Naa-Korkor Allotey	NMCP	Ghana	korkorallotey@yahoo.com	Po box KN 267 ACCRA	Ghana	23321661484
Dr Godwin Ntadom	NMCP	Nigeria	ntadomg@yahoo.com	NMCP Emoh Yobe House Abuja	Nigeria	2.34803E+12
Mrs. Bamigbe Osuntogun	RH	Nigeria	modeku@yahoo.com bamigbeosuntogun@yahoo.com	Rm 1017 Family Health Div	Nigeria	2.34805E+12
SAID AZZAHA	RCH-MOHSW	Tanzanian	azzahnogy@yahoo.fr	Po box 2179 RCH Mohso Zanzibar		
DICKO ALLAYE	Interpreter	Malienne	Allayedicko@hotmail.com	BP 1806 Bamako	Mali	6747327
BOUSOMOG Antoine	Interpreter	Cameroon	bousomog@hotmail.com	BP 284 Poste centrale	Cameroun	237 99910582
Guintran Jean Olivier	WHO/ISTWT/MAL	WHO/AFRO/ISTC	guintranjo@bf.afro.who.int	WHO Burkina -Faso	Burkina	
Gandzien P. Constant	MSR	Congo	pierre-gandzien@yahoo.fr	MOH Brazzaville	Congo	
NOFLY, AZZA	RSH -MOHSW	ZANZIBAR	azzahnofly@yahoo.fr	Po Box 2179 RCH Mohso Zanzibar		
NDOMBI Annas Isabelle	MSR	Gabon	ndombigloire@yahoo.fr	BP: 16026 tél 0024106241018	Gabon	24106241018
Prof. SIMPSON Ekundayo	Interpreter	INTERLINGUA LIMITED	profsimpson2003@yahoo.com	22 Gnassigbe Eyadema St Asokoro Abuja Nigeria	Nigeria	234-9-3141986
Dr ACHU Dorothy	PNLP	Ministry of Health Cameroun	dollykah@yahoo,com	Po Box 14386 Yaounde Cameroun	Cameroun	237 22223917
TETTY Steve	Interpreter	Freelance	Stevettty@yahoo.com	BP 15 705 ACCRA North	Ghana	
Dr Colette Losso	PNSR	RDC	losacolette@yahoo;fr	1252 av bangale Kinshasa	RDC	
Dr Angbalu Jean	PNSR	RDC	jean_angvalu@yahoo.fr	MOH Kinshasa	RDC	
Nanga Jean	PSI	RDC	Jnangacpsicongo.org	PSI Kinshasa	RDC	999920213