ROLL BACK MALARIA PARTNERSHIP

FIFTH MEETING OF
THE RBM PARTNERSHIP
MALARIA IN PREGNANCY
WORKING GROUP

10-12 October 2005
Addis Ababa, Ethiopia
Hilton Hotel

MEETING MINUTES

Participants: Judith Robb-McCord, (USAID/Ethiopia); Elaine Roman, (ACCESS/JHPIEGO); Patricia Gomez, (ACCESS/ JHPIEGO); Solome Bakeera, (Malaria Consortium); Antoine Serufilira, (WHO/AFRO); Chilunga Puta, (RCQHC); Juliana Yartey, (WHO/Geneva); Sename Baeta, (RAOPAG/WARN); Lalla Toure (UNICEF/WCA); Mohammadou Kabir Cham, (RBM WIN/WHO); Holley Stewart, (SARA/AED); Stephane Duparc, (Glaxo Smith Kline); Solome Bakeera, (Malaria Consortium); Miriam Chipimo, (MIPESA); Deborah Armbruster, (PATH); Sodiomon Bienvenu Sirima, (Burkina Faso Representative); Sera Phiri Munthali, (Malawi Representative); Kidest Lulu, (USAID/ Ethiopia); Mulugetta Yohannes, (USAID/Ethiopia); Rory Nefdt, (UNICEF/Ethiopia); Dr. Afework Hailemariam, (MOH/Ethiopia); Dr. Ambachew Yohannes, (WHO/Ethiopia)

Chair: Judith Robb-McCord

Meeting Objectives:

1. **Identify how the RBM MPWG can support the RBM strategy and approach for scaling up programming for sustainable impact**
2. **Discuss technical updates and programming experiences related to the prevention and control of malaria during pregnancy**
3. **Review MPWG workplan, progress to date, and future support**

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DAY ONE: Facilitator: Judith Robb McCord
Monday, 10 September 2005

Objectives:
1. **Malaria in Pregnancy Working Group (MPWG) role within Roll Back Malaria (RBM) Structure**
2. **Review WHO/AFRO Strategic Framework and US President's Malaria Initiative and influence on country programming**
3. **Review and understand materials for country programming support**
4. **Review and discuss Ethiopia and Malawi country programming experiences**

Judith Robb-McCord welcomed participants to the meeting and reviewed the meeting agenda. Minor changes were made to the agenda. JRM emphasized the importance of the MPWG's role in supporting proven interventions for scale up through technical guidance to the RBM Secretariat and Board.

Review and Adoption & Matters Arising of Rwanda MPWG meeting minutes

Elaine Roman led representatives through the meeting minutes. The meeting minutes were officially adopted with the following feedback:

- RBM MIP M&E Framework (pg 7)- A consensus meeting was held with key stakeholders. The final report was sent out to key stakeholders for review and final feedback. The report will be published and disseminated by the end of 2005.
- RBM MPWG Support and Action (pg 10)- Second bullet should read 'MPWG statement to be reviewed and adopted'.
- General (Insecticide Treated Nets — ITN)- The ITN Working Group (WIN) has requested the MPWG's support in the dissemination of the revised RBM ITN Framework.

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Review of the 2004-2005 Workplan

Judith Robb-McCord led the discussion on the workplan review. Activities were updated per the discussions and will be reviewed throughout the meeting for revision. The final workplan is included as Annex 1.

Review of Global Strategies and Initiatives

A. Antoine Serifulira provided an update on the **WHO AFRO Strategic Framework**. A limited number of copies have been printed through CDC. Translation into French has been completed. Meeting representatives noted that the framework (e.g. Zambia) is being disseminated through national malaria control programs and is not being disseminated to national reproductive health programs, which makes it difficult to get to front line providers.

Actions: Antoine will follow up with Dr. Robalo (WHO/AFRO)

1. Distribution through networks/coalitions
2. Contact Dr. Robalo on future of document including printing and distribution
3. How has it been distributed? UNICEF could be used as a mechanism for distribution.
4. Portuguese translation?

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5. Followup with Chair of Communication Working Group (Comm WG) to find out what role they can play in dissemination.
6. Dissemination through Making Pregnancy Safer (MPS) and Child Survival Partners

B. Antoine Serifulira provided an update on the information note from WHO- "Sulfadoxine-pyrimethamine for IPT of malaria during pregnancy in areas of moderate to high-level SP resistance". This statement was developed in response to queries from the Global Fund looking for clarification on this issue and how to address it. It is expected that the document will be updated during the WHO Technical Consultative Meeting planned for 27-28 October 2005 in Harare. One key issue will be to define moderate to high transmission.

C. Judith Robb-McCord provided an update on the **U.S. President's Malaria Initiative.** This initiative has pledged to increase funding for malaria prevention and treatment by more than $1.2 billion over five years. Year 1 target countries are Uganda, Tanzania, and Angola. This initiative is supporting efforts to scale up proven interventions with a focus on ITNs, treatment and addressing malaria in pregnancy. The United States White House Press Release and funding allocations over the five years were disseminated to MPWG representatives.

D. Debbie Armbruster provided an update on the Malaria Control and Evaluation Partnership and Africa (MACEPA). MACEPA is a 9-year initiative supporting national scale-up for malaria prevention and control; MIP is a key component of this support. MACEPA core principles include a) rapid national scale-up; b) focus on a few countries to assure national success for scale-up; c) strong evaluation to support performance management, impact assessment and advocacy based on success; and d) effective partner leveraging and collaboration. MACEPA will target cost-effective interventions including ITNs, especially for children under five and pregnant women, Indoor Residual Spraying (IRS), Malaria case management, prompt access to effective antimalarial drugs and IPTp and possibly IPTi in the future.

MACEPA's **goal** is: to evaluate the impact of the malaria burden on national scale-up of malaria control coverage, exceeding the Abuja targets in the African region, and to advocate regionally and globally for rapid program scale-up of program coverage and burden reduction.

This presentation is available through the MPWG Secretariat.

Discussion

Miriam Chipimo provided additional information on Zambia's efforts to prevent and control malaria during pregnancy. With support from MACEPA, Zambia has developed its five-year "Malaria Prevention and Control Road Map" (RM), which prioritizes malaria as an important health issue to address, aiming to meet the Millennium Development Goals for maternal and child health. The RM developed by central, provincial and district level stakeholders outlines roles for reproductive health (RH), focused ANC and child health programs for implementation. After its launch in Zambia the RM was presented in a global meeting in Paris focusing on the World Bank Booster program.

Prevention and Management of Malaria in Pregnancy in Ethiopia— Dr. Afework Hailemariam, Ministry of Health

Dr. Afework presented an overview of Ethiopia's national program including demographic data with a presentation entitled, "Malaria during pregnancy in Ethiopia: Introduction, Strategy, Progress and Challenges." Ethiopia is a country of 71 million people with 85% of the population living in rural areas. Malaria is the leading cause of morbidity and mortality. Ethiopia has all four species of Falciparum, however, *P. Falciparum* – 60% and *P. Vivax* – 40% are the two targeted in programming efforts. Malaria in Pregnancy is addressed through: a) chemoprophylaxis, b) case management, and c) ITN distribution.

Results were presented from ANC facilities (peripheral parasitemia, anemia in pregnancy, ownership of a mosquito net) and from delivery units (peripheral and placental parasitemia, low birth weight and prematurity). The study looked at the effect of peripheral and placental parasitemia on newborn outcomes. A third study presented was hospital-based, showing rates of admission among pregnant women in stable and unstable areas.

This presentation is available through the MPWG Secretariat

Discussion
Some of the representatives within the RBM MPWG asked for clarification on the use of IPT in areas of stable transmission in Ethiopia; specifically, why it was not included as a component of the national strategy? Dr. Afework said that reports of declining SP efficacy and the prevalence of *P. Vivax* led to a decision not to adopt and implement IPT. CDC will support a follow up study to the one described by Dr. Afework to revisit the issue of effectiveness and efficiency of IPT.

There was quite a bit of interest from the MPWG representatives to better understand ITN use among pregnant women and how ITNs reach pregnant women, especially through ANC. Ethiopia is implementing a strategy to address low ANC coverage (approx. 40%) through the placement of Health Extension Workers who will promote and distribute ITNs and possible treatment of cases.

NetMark conducted a household survey in 5000 households. The majority of respondents were not knowledgeable about ITNs. Eleven percent of households owned an ITN and ownership declined with low socio-economic status and living in rural areas. ITN distribution through ANC and use among pregnant women will be discussed more on Day 2.

Country Programming Experiences: What have we learned?

A. Chilunga Puta presented, "**Improving MIP Services: A Quality Improvement Approach."** In collaboration with the Zambia MOH, the Regional Centre for the Quality of Health Care conducted a study in Zambia. Study objectives were: a) to assess the quality of prevention and control of malaria in pregnancy through ANC, b) examine knowledge, attitudes and practices of MIP among health workers, c) assess health provider compliance with WHO guidelines, and d) introduce the performance improvement approach as a quality

improvement tool and introduction to malaria in pregnancy. The performance improvement approach (PIA) is a quality improvement approach that allows health providers to define actual performance and a plan of action to meet desired performance. Introduction of this tool engendered dramatic change, including the practice of focused ANC, uptake of IPT, use of ITNs, counseling at ANC for malaria, recognition of danger signs and birth preparedness to name a few.

This presentation is available through the MPWG Secretariat.

Discussion
It was pointed out that a key ingredient of the performance improvement initiative and approach is to have champions to support change. This includes strengthening district capacity among key stakeholders. As a result of this study, Zambia implemented a number of systematic changes including correction of ANC register and mothers' cards to record IPT and provision of iron accurately. It was also noted that PIA will not address major systemic gaps and hence needs to be one component of a holistic comprehensive approach.

B. Sodiomon Bienvenu Sirima presented, **"Malaria burden during pregnancy, before and after an implementation of IPT program in a pilot district of Koupela in Burkina Faso."** Although Burkina Faso had high compliance with chloroquine chemoprophylaxis (62-93%), rates of peripheral and placental parasitemia were high (2001). As a result, Burkina Faso implemented a pilot study in the Koupéla district to introduce focused ANC and IPT and assess the rates of IPT uptake, peripheral and placental parasitemia. The pilot included interventions at the facility, community and individual level. Results of the study conclude: IPT reduces: a) peripheral malaria; b) placental malaria; c) maternal anemia (mild and severe); and d) low birth weght (with 3 doses of SP). As a result of this study, Burkina Faso adopted a strategy for pregnant women that included IPT.

This presentation is available through the MPWG Secretariat.

Day One Follow-On and Recommendations:

- MIP Research Group to develop a list of current, major research studies in Africa on malaria in pregnancy. Who will follow up?
- Follow up with Magda Robalo, WHO/AFRO, on the use of the Strategic Framework for the Prevention and Control of Malaria in Pregnancy in Africa (Antoine Serufilira)
- Follow up with MERG to find out where the final document for the indicators is (Julianna Yartey)
- Follow up with the Malaria Consortium on the "Policy to Strategy to Implementation Brief" (Solome Bakeera)
- Follow up with the RBM Executive Secretariat on more effectively linking Working Group chairpersons to share information. The Chair of the Working Group will send a letter to the RBM Executive Secretariat for followup.

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DAY TWO: Facilitator: Dr. Kabir Cham
Tuesday, 11 October 2005

Objectives:
1. Review and discuss regional support and country experiences affecting MIP
2. Review and discuss one country's experience linking focused ANC with ITN delivery
3. Determine the MPWG's role in supporting sustainable scale-up
4. Elect Chair, Co-Chair and Secretariat

Judith Robb McCord provided an overview of the agenda and welcomed Dr. Kabir Cham as the Chair for Day Two.

Supporting Country Implementation

A. Rory Nefdt presented, "**ITN Delivery in the Antenatal Period."** Rory presented multiple ITN targeting schemes for pregnant women, drawing on experiences from Zambia and Ethiopia. In Zambia, there has been a voucher scheme for the past three years targeting pregnant women. This is a partnership between the Central Board of Health, UNICEF and USAID. Exxon-Mobil joined the partnership and paid for the vouchers. Other ITN distribution channels in Zambia include the commercial sector, PSI/Society for Health using net subsidization and the Community-Based Malaria Prevention and Control Program (that trained thousands of malaria volunteers at the community level and increased net distribution at that level). They also used the measles campaign for ITN distribution.

In Ethiopia, malaria is much more complicated and unpredictable than in Zambia. NetMark is the only group targeting pregnant women. The RBM program in the country is targeting all vulnerable families with a strategy of two nets per household by 2010. In Ethiopia, there is a commercial sector, which is actually quite vibrant, that subsidized programs, NGOs with direct subsidies and distribution of free nets. There have also been free nets distributed through emergency response. The Ethiopian RBM policy now gives priority to pregnant women and children through health centers, health extension workers (for the future) and the Enhanced Outreach Strategy (EOS) as supported by UNICEF. The EOS targets vulnerable districts that include the 5-8 million chronically vulnerable communities. This provides an opportunity to provide ITNs to people who could not afford an ITN (or possibly reach health services).

To reach 100% coverage Ethiopia needs 1,971,402 ITNs. There are approximately 3 million nets in the country that must be distributed by December 2005. Funds are available to purchase about 2 million nets but a decision needs to be made regarding using long-lasting (LLITN) or regular nets. The State Minister wants only long-lasting nets. However, there is a global shortage and the waiting period for LLITNs is very long. For 2006, there is a 2.1 million net gap (over the 2.9 million available nets). In 2007, 5 million nets will be needed and 6 million will be needed in 2008.

This presentation is available through the Secretariat.

B. Rory Nfedt was joined by **Shoa Girma, Country Director for NetMark/Ethiopia**. Shoa presented NetMark's targeted subsidy net program for pregnant women in Amhara region. They are working with two brands in Ethiopia through two major distributors. NetMark provides subsidies for pregnant women beginning in April 2005. The program was launched in April 2005 in 21 antenatal sites in western and eastern Amhara providing subsidies-through vouchers for pregnant women. Women who attend ANC clinics receive a voucher worth 40 Birr towards the purchase of an ITN. Providers at the health center have guides for counseling on malaria that include information on ITNs. At the retail level there is a selection of four different nets of varying prices, size, color, etc. The cost to the pregnant woman, depending on the ITN she purchases, is between 5 and 12 Birr (65 cents to $3.50). The retailer removes the proof of purchase sticker and places it on the voucher. Typically, the retailer uses the voucher reimbursement to purchase more ITNs from the distributor. NetMark is adding 14 sites in two weeks for a total of 36 sites. They also expect to expand to two more regions in the coming months. Thus far, they have a 60-70% redemption of 10,000 vouchers distributed. They have two different products—factory pre-treated and nets bundled with KO tabs. The factory pre-treated nets are green.

Dr. Cham explained that the factory pre-treated nets must be white as there are questions about the effectiveness of the colored insecticide-treated nets. There is a question regarding the effect of the insecticide on the color as well as the effect of the heat process used to color the nets. Dr. Cham highlighted the role of scale-up in Ethiopia and emphasized that the Ethiopia approach is promoting rapid scale-up for malaria prevention and control.

C. Dr. Sera Munthali presented, "**The Malawi Experience with ITNs and IPT/SP."** Malaria in pregnancy is a major public health problem in Malawi. Malawi also has a very high maternal malaria rate (MMR) at 1100/100,000 live births. Malawi was the first country to adopt IPT/SP; the country also has high ANC attendance and enjoys sound collaboration between malaria control and RH. Two doses of SP are advocated in ANC centers. All health facilities have additional SP as well as cups, buckets and safe water for IPT through directly observed therapy (DOTS). There is an intensified IEC and advocacy effort in the country. In a nationwide malaria coverage survey, it was found that IPT coverage for first dose was 93% and second dose was 60%.

A study done last year looked at the use of a monthly dose of IPT and impact on placental parasitemia and other health indicators. Eligibility criteria included at least 15 years of age, first or second pregnancy, and fetal movement. Enrollment totaled 486 pregnant women. Among HIV+ women treated with monthly doses, 7% had placental parasitemia. Of HIV+ women treated with two doses, 25% had placental parasitemia. The study conclusion is that for HIV + pregnant women, monthly IPT is more efficacious than 2 doses.

Malawi introduced ITNs in 1995. In June 2002, ITN guidelines were established including procurement, logistics, standardized pricing, etc. In November 2002, ITNS were heavily subsidized and scale-up began. The three channels of distribution are community-based distributors, the commercial sector and health facilities (targeting pregnant women and children). Since November 2002, 2.5 million nets have been distributed. A national survey

found that there is one net in 43% of households (up from only 13% previously) and use by pregnant women increased from 6% to 31%.

Challenges include increasing the number of women who take the second dose of IPT; implementing DOTS in all facilities; dealing with increasing SP resistance; health worker confusion regarding IPT doses and timing and drug stock outs. There is a high demand for ITNS with a limited supply of nets. The program is looking at how to increase net coverage and use, especially in rural areas. They are also looking at how to reach to poorest of the poor for free distribution.

Discussion
The issue of HIV+ women who are taking cotramoxizol and who should not be taking SP needs to be managed at the clinic level. In Zambia, when designing the PMTCT program, they couldn't find any guidelines on this issue.

ACTION: WHO/AFRO to share their recommendation on the use of SP in HIV+ pregnant women who are using cotramoxizol. This information should also be included in any updated MIP resource materials and should be shared with HIV colleagues. MPWG to look at how country programs are dealing with this issue for the development of program implementation guidelines/recommendations.

There was also some discussion about using IPT after 36 weeks. The WHO guidelines confirm that IPT can be used up to delivery. Country guidelines should be checked for this in an effort to increase uptake of the 2nd dose.

Dr. Cham urged the MPWG to emphasize all aspects of prevention efforts for malaria in pregnancy and not to look solely at IPT/SP. He stated that malaria in Africa is diverse and requires a broad perspective that includes the use of ITNs, IPT/SP and effective case management.

Materials for Country Programming

WHO/AFRO Strategic Orientations and Technical Guidance for Malaria in Pregnancy WHO/AFRO—Antoinette Ba: Dr. Ba's presentation was an update on the different tools developed or under development in AFRO for malaria control during pregnancy.

A. **The Strategic Framework—**WHO has been distributing the document at the global and country level (through WHO countries office and upon request by partners). If any partners at the country level need the document, they can request copies from WHO/AFRO. There is an electronic version. It has been used in two workshops and has built awareness and created demand where used. It is available in French. They ordered 2000 copies and had support from CDC for production. A Portuguese version is being proofread and will be sent for printing soon. They are expecting the Portuguese version to be ready in early 2006.

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a. The presentation stated that to date 29 countries in Africa have adopted IPT with SP. The majority of these countries (21) have initiated implementation and are at varying levels of program maturity. In West Africa, IPT is being widely implemented in Ghana and Senegal. Implementation has not yet started in countries such as Burkina Faso, Benin, Namibia and Niger.

b. **Malaria in Pregnancy Clinical Guidelines**—The document has been widely reviewed. Comments were received from the WHO Publication Committee in February 2005. Revisions were suggested to focus on *the management of the prevention of malaria during pregnancy* to harmonize this document with guidelines already available entitled: *Treatment Guidelines for Malaria* and *Guidelines for the Diagnosis and Treatment of Malaria in the Africa Region.* Both of these documents have sections covering malaria in pregnancy. The new document will be entitled *The management of the prevention of malaria during pregnancy* and will be reviewed after revisions have been made. It is expected that it will be finalized by the first quarter of 2006.

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c. **Framework for the Collaboration Between the Malaria Control and the RH Programs to Control Malaria in Pregnancy**—The first draft of the document has been circulated. It will be shared at upcoming partner meetings for input.

d. **Clarification was given regarding the point raised on Day 1 as Dr. BA was not there, re**: the dissemination of the strategic framework, the WHO statement on the use of SP for IPT in case of SP resistance and the forthcoming meeting in Harare

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This presentation is available through the Secretariat.

B. Malaria Resource Package—Elaine Roman

The USAID-funded Maternal and Neonatal Health (MNH) Program developed the Malaria Resource Package to respond to country needs for information regarding the appropriate prevention and management of malaria in pregnancy. The CD has been widely distributed throughout Africa and in some Asian countries through a variety of networks. It is available in English, French and Portuguese. The package contains a variety of tools that can be adapted at the country level. Tools include: training materials, job aids, key articles and abstracts, information on the safety of SP, two country case studies, a starter press kit and communication strategy, provider job aids, etc. Feedback from countries shows that the package is useful; however, computer access is difficult so it is important to also deliver the tools in hard copy, when resources permit.

Discussion

ACCESS, the follow on to the MNH Program, would like to update the Resource Package to include new materials and information. This would be done with broad participation from partners working in malaria. Dr. Cham would like to include the newly developed ITN strategy in the updated resource package.

Miriam Chipimo, Zambia MOH, feels that the CD is valuable but maybe isn't being used as much as possible because it is not being demonstrated at the country level. She explained that

providers and managers are very busy with many materials and it is very helpful if orientations for materials such as the Resource Package are provided to the appropriate people at the country level. Miriam emphasized that the orientations don't need to be large, but could even be given to a few people and led by JHPIEGO country offices. (JHPIEGO is the prime on the MNH and ACCESS Programs and took the lead in developing the resource package.)

C. Integration of Malaria In Pregnancy Into Maternal and Child Health Services: Implementation Guidelines—Antoine Serufilira

This is a tool to be used at the country level to support countries as they move forward with the prevention and management of malaria in pregnancy. The goal of the document is "to orient policy makers, managers and service providers and stakeholders on the process of integration." The objectives are to: improve access of pregnant women to malaria services; respond to RH needs of pregnant women who have malaria; and maximize the use of limited resources and services. The layout of the document has been designed and includes: implementation framework, strategies and stages, roles and responsibilities and monitoring and evaluation (M&E). The tool emphasizes the three-pronged approach: IPT, ITNs and case management and promotes integration of the prevention/management of malaria in pregnancy with maternal and child health services.

Discussion

The need to build input from a variety of partners into the design and development phase of document production was discussed. This ensures that partners are at the table from the beginning and all relevant information is available early on, as opposed to later during review of a draft. It was further expressed that the MPWG is an excellent forum for the discussion of materials, tools, guidelines that are needed rather than an assortment of materials being designed and developed. The MPWG has a responsibility and opportunity to provide that type of input with an eye especially for what will be value added. It was stated that the materials presented earlier in the day are very useful but suggested that we consider a compilation of these materials. The updated Malaria Resource Package is intended as a compilation of all technically relevant and available resources.

The group also discussed the value added of this type of document. It is recognized that we need to translate the WHO Strategic Framework into implementation guides. The Strategic Framework represents an integrated approach. At the same time, we have country experiences that have been shared. We need to think through how to take the principles and approaches of the Strategic Framework to develop an implementation guide based on country experiences and lessons learned.

In Accra, Ghana, the MPWG clearly identified the need for an implementation guide. At that time, the Clinical Guidelines were being developed and the Malaria Consortium was developing the Policy to Practice document. In Rwanda, it was agreed to look at these documents to inform further thinking. One recommendation was to merge the framework for collaboration with the implementation guide.

The interventions are carried out in ANC, which requires integrated care. There are methodologies and approaches available to assist clinicians to deliver a package of focused antenatal care (FANC) services. Should the MPWG consider developing a modular guide that would include the pieces of FANC? In Zambia, when they were updating guides for PMTCT, they updated the guides for FANC as the entry point for these services. The notion of a modular guide was seconded. It was recognized that ANC is only one avenue for the prevention and management of malaria in pregnancy. Other avenues would need to be included.

Finally, participants agreed to task a "satellite" group to think about the design of the guidelines and to report back to the main group decisions and next steps. A small group will meet on Wednesday morning (10/12) to discuss the way forward in the development of an implementation guide and country-level tools. It was agreed that JHPIEGO would proceed with the development of the implementation guide in collaboration with WHO and CDC.

Regional Coalitions and Network Support: Documenting Best Practices and Lessons Learned

A. Assessment of MIPESA Country Experiences in the Adoption and Implementation of Malaria In Pregnancy—Miriam Chipimo

The assessment targeted Malawi, Zambia, Tanzania, Kenya and Uganda and was conducted from May to July 2005. Terms of reference included documenting successes in implementation, added value of MIPESA, identify factors contributing to MIPESA's successes and limitations, identify how RBM and other partners have contributed to MIPESA's achievements; and, to identify MIPESA's role vis a vis other coalitions.

Miriam briefly reviewed briefly MIPESA's history and discussed MIPESA's mission as "the provision of support for inter-country program collaboration in accelerating the prevention and control of malaria in pregnancy in east and southern Africa." All countries include IPT and ITNs and case management for malaria in pregnancy. MIP is endemic in the majority of districts in each country, excepting Kenya, where it is endemic in only 45 of 78 districts. ANC attendance at least once in the five countries is very high ranging from 90 – 95%. Strengthening MIP programs has been through the development and use of guidelines, performance improvement, supervision, on-the-job training, refresher training, community involvement and M&E. Challenges include late ANC attendance, stockouts of supplies, resistance to SP and lack of alternative drugs for pregnancy, reluctance of service providers to use SP in pregnancy, and shortage of human resources for health, including weak laboratory services for case management.

ITN coverage in the five countries was quite low when compared to IPT coverage. On documentation of best practices the consultancy team identified ITN distribution in ANC sites and private sector involvement (e.g. Tanzania and Zambia), community involvement to identify priorities and assist in service delivery, staff retention schemes, and establishment and coordination of partners.

MIPESA has succeeded in supporting intra-country collaboration between MCP and RH programs; promotion of information sharing between countries; accelerated IPT coverage in

the region; advocacy for MIP recognition on national, regional and global agendas; facilitated technical assistance to MIPESA and non-MIPESA countries; facilitated piloting of MIP tools and mobilized and shared resources for country implementation. When considering the added value of MIPESA, it was also found that MIPESA has promoted country partnerships, has provided a forum for discussing technical and programmatic issues, stimulates countries to achieve results through positive competition and coordination of regional activities.

Recommendations included defining the vision and mandate of MIPESA; strengthening country focal points to support coalition activities, strengthening the secretariat; streamlining and strengthening MIP monitoring in the region; fostering complementarity of MIPESA with other regional networks; ensuring broader representation at the global and regional level, etc.

Discussion

Looking at the uptake of IPT 2 due to late arrival at ANC, we should consider the use of Traditional Birth Attendants and other community-based health providers for distribution of IPTs and/or health messages that mobilize women and families for care. This is a discussion that has been underway within the MPWG. The Strategic Framework states "To accelerate the delivery of services to pregnant women….national programmes should explore…community-based health providers to deliver some components of the proposed malaria prevention and control package. Community health workers may be effective at promoting the use of ANC services and ITNs and, with appropriate training and logistic support, could deliver IPT." (p. 13) It was agreed that the TBAs should mobilize women to care and not detract from facility-based care.

The synergies that link MIPESA and EARN were discussed briefly. It was said that MIPESA is a country-driven coalition addressing country needs through advocacy and capacity development, while EARN is a partner-driven coalition supporting countries' technical needs.

B. RAOPAG: Affecting Policy Change in West Africa—Dr. Baeta

Founded in 2003 with Benin, Burkina Faso, Ivory Coast, Mali, Senegal and Togo. All these countries have adopted IPT/SP through ANC services as well as the distribution of ITNs to pregnant women and children under age 5. Short pilot studies were conducted to document P.Falciparum resistance to CQ and to measure the efficacy of IPT/SP to support policy change towards IPT/SP. Workshops were held in countries to discuss and adopt the new policy for IPT/SP. Implementation of IPT/SP was initiated in Senegal and Togo after training of trainers and health providers. The promotion of ITNs is also supported at all levels in member countries. RAOPAG also organized two workshops on advocacy and submitted two proposals to the Global Fund.

The aim of RAOPAG is to provide technical support and share experiences with country members to accelerate the prevention and control of malaria in pregnancy. Their goal is to harmonize in all 16 countries of the West African Epidemiological Bloc to standardize protocols, policies, training curricula, information systems, M&E systems and research protocols and to document best practices to enable information exchanges. RAOPAG and

country members have succeeded, in a very short time, to accelerate policy change for prevention and control of malaria in pregnancy in many West African countries.

Discussion
There was a question about the malaria transmission pattern in the region and across countries as RAOPAG is trying to standardize guidelines, protocols, etc. It was agreed that it is important to take into consideration the epidemiological profile of countries while shaping protocols, curricula, monitoring and evaluation frameworks, etc. RAOPAG is working to mobilize funding as evidenced by their application to the Global Fund. It was suggested that countries in the coalitions include funding support for RAOPAG and MIPESA in their Global Fund proposals.

C. WARN—the focal person for WARN is supposed to be with UNICEF-WACARO. They are hiring for this position and expect someone to be on board very soon. It was agreed that since there were no official steering committee members from WARN and EARN at the meeting, updates from these networks would be tabled.

Added Value of the RBM MPWG- A discussion commenced on the added value of the MPWG. Judith Robb-McCord reminded representatives that the RBM Secretariat commissioned a review of all the Working Groups over one year ago. A summary of this report says that, "Working Groups need to achieve consensus on scale up and documentation and dissemination of best practices. Working groups should not duplicate efforts of technical committees or country activities." The MPWG has been able to disseminate guidance at the country level by the nature of the representatives work effort. While this report summarizes working group progress and roles, it is not the definitive guidance for the working groups.

How do countries get information and technical guidance? This meeting is an opportunity to examine the larger issues and challenges so that we as a working group can identify what guidance should go to the RBM board and to countries. The NGOs that sit at the table provide an important added value in the work that they do and share. The MPWG has been successful in promoting a number of issues that relate to MIP programming. In some ways the MPWG has gone beyond the expectation of the RBM Secretariat. The MPWG is working directly with regional networks and coalitions for rapid scale-up and working to resolve issues on the ground.

Elections
Judith Robb-McCord reviewed the TOR for the MPWG. She also recommended that the Secretariat does not move from ACCESS/JHPIEGO since ACCESS/JHPIEGO has funding support for the Secretariat role through the Malaria Action Coalition. There was discussion to postpone the elections until the current Chair is able to follow up with the RBM Secretariat. It was decided to go ahead and make nominations. Holley Stewart from SARA/AED was nominated to be the Chair. Holley declined as her project is in transition and she thought that it might be more appropriate to nominate someone from an organization that is focused more on implementation. Juliana Yartey was also nominated and voted in as the new Chair of the MPWG. The WARN representative and Kwame Asamoa (CDC) were nominated to be Co-Chair. There were six votes for the WARN representative and six votes for Kwame Asamoa. There was then a suggestion to take a second vote or have the current Chair (Judith Robb-

McCord) make the deciding decision. The Chair went with Dr. Claude because he is working in the region; he will be able to bridge the link between the regional networks and the MPWG; and he will have this position in his SOW. Juliana Yartey thanked everyone for the opportunity to support the mandate of the MPWG. She looks forward to working with the MPWG representatives to continue the agenda.

DAY THREE: Facilitator: Juliana Yartey
Wednesday, 12 October 2005

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Objective:
1. **Review and discuss country experiences affecting MIP**
2. **Determine MPWG future support affecting sustainable scale up**

Juliana Yartey provided and overview of the Day 3 Agenda.

Technical Update

A. Stephane Duparc, presented **'Drug Development and Pregnancy'.** This presentation focused on efforts to develop safe and efficacious drugs for malaria in pregnancy. The focus is to look at drugs that are safe during the 2nd and 3rd trimester and then look at development for IPT; only when the drug has first been proven safe.

Stephane described the multiple phases of clinical development. Phase I uses male volunteers. Phase II and III studies drugs in non-pregnant women but of childbearing age. Phase IV programs- examples include Lapdap (chlorproquanil/dapsone). A two-year study supported through the London school in Tanzania, Muheza district 4-arm study (SP, SP+amodiaquine, chlorproquanil+dapsone, amodiaquine+artesunate) is in progress. Although SP resistance is prevalent in Muheza it was included in the arm of the study. The WHO website contains the most up to date information on Lapdap for use in pregnancy.

A WHO Technical Diseases Research (TDR) Lapdap in Pregnancy Group exists. This group is starting (2006) a 2-year study in West Africa. This study will look at pharmokinetics of chloroproquanil dapsone and safety and efficacy of chloroproquanil dapsone compared to SP. There is also planned collaboration between Glaxo Smith Kline (GSK) and the London School for Health and Tropical Medicine (LSHTM) to develop a pregnancy register.

Glaxo Smith Kline has done some studies looking at Artesunate with rats and rabbits. In both cases, malformation in association with embryolethality was detected. Further studies are continuing; greatest concern is for the first trimester. There seems to be no reaction between iron folate and artemisinins.

This presentation is available through the MPWG Secretariat.

Discussion
A concern was raised for ethical considerations for pregnant women and exposure to drugs during pregnancy that are still being tested. It was stressed that providers need to be aware of

these ethical issues for pregnant women and make sure that the women are not inadvertently exposed to drugs.

Drugs for first trimester are not being tested since the research focus is still trying to identify drugs for 2nd and 3rd trimester. It is difficult to know the effect of artemisinin combination therapy (ACTs) in women prior to conception. If women take the drugs just prior to conception and are monitored for adverse outcomes, this could provide insight to the effect of these drugs.

B. Patricia Gomez presented, **'Standards for performance and quality improvement'.** This presentation further described performance and quality improvement to assess the services being provided. Patricia presented the "Standards based management tool for Madagascar" as one example of a tool for standards. Each country can identify what should be used, based on standards and country policy. Standards are defined by evidence-based practices and should not be compromised. Standards give guidance on what we need to do on a daily basis to perform our jobs; this is extremely important for providers and managers. Recognizing that providers are being asked to provide a myriad of services, the standards become an important guide and tool for them to measure and track their performance. Standards can set parameters around: infrastructure, equipment and supplies, skills/competencies, information/ education/communication. They can obtain input from clients, facility and village health services.

For the prevention of malaria in pregnancy, the standards focused on ANC as a comprehensive approach. ANC services are the platform for care and all aspects of this care must be monitored and followed so that key aspects of care, including malaria in pregnancy (MIP), can be addressed appropriately. This approach engenders quality and comprehensive care. With the written standards in place the Performance Improvmeent Approach (PIA) process can be used to identify gaps in performance (based on standards) and develop a plan to address those gaps.

This presentation is available through the MPWG Secretariat.

Discussion

A WHO document, Standards for Maternal and Newborn Health, will be published soon. This document identifies standards at the clinical and community level. A question was asked: how do countries merge their national guidelines/norms/protocols with the 'standards' developed and how are standards measured since there are a number of criteria? Typically, a group of stakeholders who are experts in the field are oriented to the standards-based management process/ PIA. When these trainers have been oriented they use this approach in their process. The tools are adapted through a process with local experts and stakeholders. The Essential Health Technology Package is being developed through WHO; this is tool that helps you to identify the resource needs.

Because there are multiple criteria there may be a need to identify priority critical interventions because a provider may only perform 9 out of 10 criteria and will then not be meeting performance standards. One representative noted that a similar standards-based tool would be

useful for campaigns for malaria, or any other focus. In addition to assessment, the tool can also be used for advocacy to address gaps and issues in programming.

Workplan Review
The 2005-2006 workplan was developed through review, updating and revision of the 2004-2005 workplan. *See Annex 1*.

Closing
The Dr. Jimma from the MOH wrapped up the meeting emphasizing the importance of the MPWG's role. Malaria continues to be a heavy burden in Ethiopia, which is why it is a top priority for the MOH.

Vote of Thanks
Juliana Yartey gave a vote of thanks to the MPWG members and said she looks forward to continuing to work with this group to affect positive change and scale up for the prevention and control of malaria in pregnancy. A vote of thanks to Seipati Anoh who was unable to attend the meeting but who has been the Vice Chair since the inception of the MPWG.