



**SIXTH MEETING OF  
THE RBM PARTNERSHIP  
MALARIA IN PREGNANCY  
WORKING GROUP**

**10-12 April 2006  
Dakar, Senegal  
Airport Hotel**

**DRAFT MEETING MINUTES**

**Participants: Juliana Yartey, (WHO/Geneva); Elaine Roman, (ACCESS/JHPIEGO); Jeremie Zoungrana (JHPIEGO Ghana); Joseph de Graft-Johnson (ACCESS/JHPIEGO); Thomas Teuscher (RBM Partnership Secretariat) Antoine Seruflira, (WHO/AFRO); Sename Baeta, (RAOPAG/WARN); Do Rego Nouratou (RAOPAG); Lalla Toure (UNICEF Regional Office, WCA); Holley Stewart, (Africa's Health in 2010/ AED); John Zoya, (Malawi Representative); Henry Dawo Effe-Akoto (MoH, Ghana); Kwame Asamoah (CDC, Atlanta); Rodio Diallo (PSI, Mali); Claude Emile Rwagacondo (RBM WARN hosted by UNICEF WCA); Pape Nousso Thior (MoH, Senegal)**

**Chair: Juliana Yartey  
Co-Chair: Claude Emile Rwagacondo**

**Meeting Objectives:**

- 1. Identify how the MPWG can support the RBM strategy for scaling up MIP interventions for sustainable impact**
- 2. Discuss technical updates and programming experiences related to the prevention and control of malaria during pregnancy in countries**
- 3. Review MPWG 2005-06 workplan, progress to date, future activities and support**

**DAY ONE: Monday, 10 April 2006**

**Facilitator: Juliana Yartey**

**Objectives:**

- 1. Review MPWGs' progress to date, linkages with other RBM Working Groups and updates from the RBM Secretariat and Partners.**
- 2. Updates on the Status of MIP prevention and control in the African region**
- 3. Review and discuss Senegal programming experiences**

Juliana Yartey, Chair of the Malaria in Pregnancy Working Group (MPWG) welcomed participants to the 6<sup>th</sup> meeting of the group. The co-Chair, Claude Rwagacondo, also welcomed participants to the meeting and to Senegal. This was followed by introduction of participants.

One key Objective of the meeting was to examine the achievements or progress of the MPWG and discuss how the Working Group can strengthen its relationship with the RBM regional networks such as the East Africa RBM Network (EARN) and West Africa RBM Network (WARN), and support the sub-regional coalitions for Malaria in Pregnancy in West Africa (RAOPAG) and the Eastern and Southern Africa Coalition for Malaria in Pregnancy (MIPESA).

Progress in the MPWGs activities were reviewed in the context of achievements since the last Working Group meeting in Ethiopia. The minutes of the 5<sup>th</sup> MPWG meeting in Ethiopia were reviewed, revised and adopted. The follow-up actions were simultaneously reviewed and discussed, and achievements and gaps noted. The English and French versions of the adopted minutes will be placed on the RBM (MPWG) website in the coming weeks.

*Note- All meeting presentations are available through the Secretariat at [pgichuhi@jhpiego.net](mailto:pgichuhi@jhpiego.net) or [eroman@jhpiego.net](mailto:eroman@jhpiego.net)*

**Agenda:** The agenda for the meeting was adopted after minor modifications.

**I. Update from the RBM Partnership Secretariat: Progress to date and linkages among RBM Working Groups - Thomas Teuscher**

The six RBM working groups (Insecticide Treated Nets (ITNs), MIP, Case Management, Communication, Finance & Resource Mobilization and Monitoring and Evaluation (M&E)) were established to provide guidance on the implementation and scale up of interventions for the prevention and treatment of malaria. These working groups are expected to work closely with each other and the regional networks for achieving sustainable scale up and impact. Harmonized planning and support at the global, regional and country level is necessary for countries to achieve the RBM goals and Millennium Development Goals.

The Global Funds is expected to issue a Call for Proposals in April or May 2006 for the 6<sup>th</sup> round of funding. For malaria in pregnancy, antenatal care (ANC) presents a unique opportunity to reach a high proportion of women accessing antenatal care with effective interventions for the prevention and control malaria during pregnancy and to scale-up for impact. Countries should have an antenatal care package within their global fund proposals that addresses MIP, and the MIP working group should support this effort.

Following the presentation from the RBM Secretariat, participants discussed issues related to the availability of commodities such as ITNs and antimalarials for case management and IPT in countries. It was suggested that the Global Fund set up its own procurement system in order to address current challenges and bottlenecks experienced by countries in obtaining commodities. It was recommended that the RBM Partnership secretariat should take on the issue and support this effort. There seems to have been previous discussions at various levels and RBM regarding the development of a central level procurement system, however, no consensus has been reached on this topic. The various RBM constituencies and NGO delegates should submit a concept note to the RBM Board on streamlining procurement mechanisms such as the “Global Drug Purchase Facility” that will help to address the current bottlenecks. Malaria endemic countries on the RBM Board can also advocate for this if this is something they see as a priority within their countries.

In response to a question on how the RBM Partnership ensures the usefulness of the working groups, it was stated that this is done through sharing of best practices and experiences. For example, if in round 6 of the GFATM, there is not one proposal that looks at strengthening ANC services, the MPWG has not done its job well.

RBM Working groups can ensure that at the country level there is dissemination of key guidance materials (e.g., consensus frameworks and statements, mechanisms for joint planning and harmonization such as the 3 ones approach, etc.). The usual approach has been placing documents on the RBM web site. But this approach is not adequate to ensure that key materials are made available and utilized at country level.

It was recommended that the RBM Partnership Secretariat should institute efforts to mobilize resources from multiple donors to support RBM activities and not just the major funding agencies. Participants were reminded that the broader RBM community including members of the MPWG has a collective responsibility and individual roles to play in achieving RBM goals.

## **II. Update on Major Global Funding Initiatives**

### **1. World Bank Booster Program:**

The Booster Program is a 10 year initiative (2005-2015) that will support national and regional strategies for prevention and treatment of malaria. The Booster Program directly supports country RBM Strategic Plans. Support for national strategies allows countries to apply for grants and loans. Phase I is supporting 17 countries in improving access to interventions including those for MIP prevention and control. Support for regional strategies could include targeted efforts through regional and sub-regional networks, monitoring and evaluation or targeted country level support. The focus here is for program implementation assistance including strengthening of health systems including antenatal care to support the delivery of MIP interventions and improving quality of care. This is captured through- Policy, planning, implementation and M&E.

### ***Discussion***

Questions were raised about how implementers/ technical support agencies can obtain Booster funds. The presenter noted that activities for which funding is being sought must be within country RBM strategic plans.

Further discussions evolved around how partners can support countries to strengthen their health information systems (HMIS). All GF proposals from Round 3 forward must provide specific support to M&E and strengthening existing HMIS systems. Malawi is receiving \$5 million through the Booster Program to strengthen its HMIS.

## **2. US President's Malaria Initiative (PMI): Status of Implementation**

The PMI is a 5-year, 1.2 billion initiative led by USAID in partnership with other US government agencies to reduce malaria related mortality by 50% in 12 to 15 selected countries. The PMI will work closely with international and in-country partners to ensure efforts are complementary and comprehensive. The PMI will fund commodities, technical support, and Monitoring and Evaluation. USAID has launched a new malaria data management system to report on all PMI and USAID malaria inputs, funding allocations, outcomes and results; USAID also makes available a detailed report on its malaria funding on [www.fightingmalaria.gov](http://www.fightingmalaria.gov).

The PMI Coordinator is responsible for approval of all malaria control activities and budgets. There will be a minimum program budget for non-PMI countries. Over two thirds of malaria spending is earmarked for commodities and indoor residual spraying; central and regional budgets will be reduced significantly as funding will be channeled to bilateral programs. With the advent of PMI, the US will continue to support 14 other countries in Africa and Cambodia and regional activities in the Mekong and Amazon, the Global Fund, malaria vaccine and drug discovery and development, the RBM Partnership and WHO.

PMI country selection criteria include: high burden of malaria, national malaria control policies and practices consistent with WHO recommendations, political will and commitment on the part of the host country, willingness to partner with the US government, and a Global Fund approved grant with performance on grant satisfactory to Global Fund, or demonstrated sponsorship by another malaria partner (Gates, World Bank, Bilaterals). Currently, Angola, Tanzania, and Uganda are designated PMI countries and have jump started programs in indoor residual spraying in Angola, ITN distribution in Tanzania, and free distribution of LLINs and ACTs in Uganda.

### ***Discussion***

Questions were raised regarding how the PMI funding will be managed? The State Department and Health and Human Services through CDC will work collaboratively in partnership with USAID. The funds will go to countries to support countries' needs. Two trips have already been made to countries to assess and plan respectively. The PMI will provide opportunities for all partners to be involved in planning and assessment through consultations.

Participants were interested in knowing the minimum program budget for non PMI countries. For FY06 1.5million; for FY07 the minimum will be raised to 2.5million. Countries receiving support from USAID's malaria program will need to increase their in-country contribution to the program to greater than \$200,000. The PMI program budget at country level is based on the country needs and funds available, most countries will be receiving 10-20m per year.

Participants also wondered why PMI is supporting countries that already have GFATM support. In response, the meeting was informed that no single funding organization can achieve scale up in a country and therefore the issue of complementarity of resources is key. Countries without GFATM grants can be part of PMI but there must be other financing partners involved in the

country to help scale-up – such as the Booster Program, Bilateral agencies and the Gates Foundation.

PMI is looking at how best to schedule resources across the duration of the scale-up effort in countries and to allocate available resources accordingly. PMI may revisit the schedule and get more countries on board earlier, or reduce scale up time to one year (because the initiative had so little funding in FY06, it really needed 2 years for the first 3 countries). It is hoped that the initiative will continue beyond the 5 years---this will depend on the success of the PMI in these five years and the will of the US Congress and the President.

### **III. Status of MIP Strategy Implementation in the Africa Region - WHO/AFRO:**

The MIP strategy aims at improving pregnancy outcomes for both mother and developing baby. To date, 30 malaria endemic countries in the Africa region have already changed their policy and adopted the current WHO recommended IPT strategy. IPT implementation is ongoing in 17 countries (implementation includes advocacy, dissemination of the new policy, training of health workers, distribution of ITNs and IEC materials, etc. Large scale implementation is ongoing in eight countries, meaning that a large part of the country or the whole country is implementing the IPT policy. To date, only a few countries in the African region (Equatorial Guinea and Mauritania) are yet to adopt IPT MIP prevention and control policy. The coverage of other preventive measures such as ITN use remain very low in almost all countries. There is a need to strengthen operational research in alternative drugs for IPT to replace SP, in the use of ACTs during pregnancy, in the effectiveness of SP for IPT in areas with high resistance to SP, and in the strategies to increase the availability and use of ITNs/LLINs by pregnant women and babies.

#### ***Discussion***

Key issues emanating from discussions after this presentation were as follows: Among countries implementing IPT, very few (about 6 countries) have revised their ANC cards and register to accommodate IPT monitoring. With a strong global advocacy and trend towards integration of services, perhaps key global health agencies such as WHO should be encouraging donors to be flexible in their resource allocation and accountability mechanisms. Integration of services needs to begin with collaboration among programs so that strengthened systems, particularly for M&E can support integrated service delivery at all levels.

In countries where resistance to SP is over 20%, participants wanted to know WHO's recommendation on the use of SP for IPT in such situations. According to a recent Technical consultation on the effectiveness of IPT with SP in areas of moderate-to-high SP resistance, SP can be recommended up to an efficacy of 50% parasitological failure as measured in children. (Refer to WHO recommendation on use of IPT with SP.) WHO recommends that ACTs can be used in the 2<sup>nd</sup> and 3<sup>rd</sup> trimesters of pregnancy; ACT use in 1<sup>st</sup> trimester is not recommended but can be used when no other alternative is available. Pharmacovigilance systems are fragile and need to be established and supported to monitor use of ACTs and other antimalarials in pregnancy. In Zambia, a pregnancy register is in place that captures antimalarial (including ACT use) by pregnant women. Ghana indicated that it has a pharmacovigilance system in place also.

### **IV. Status of MIP Implementation in Senegal: Achievements, Challenges and Lessons Learned**

In 2001, Senegal participated in a meeting with 6 francophone countries to share experiences in malaria prevention and control. The meeting focused on the adoption of IPT with SP. In 2003, a follow on meeting occurred to look at specific country experiences in the implementation of IPT with SP.

Resistance to chloroquine ranges between 20%-37%. In 2003, a national consensus meeting was held to adopt SP+AQ as first line treatment and IPT with SP for MIP. Stocks of chloroquine have since been destroyed and replaced with SP. Training on the new strategy was supported throughout the country. Involvement of the national midwives association at the beginning of IPT adoption and implementation has had a positive impact on implementation. Challenges encountered by the malaria control program include data collection at health facilities for routine monitoring; incomplete data on IPT1 and IPT2, provider resistance to new protocol and limited support supervision. Scale-up is expected to occur with a community based approach, reinforcing supervision, addressing provider concerns and standardized forms for data collection. A key lesson learnt was the engagement of the national midwives and the national reproductive health (RH) program in the implementation of the national MIP control policy.

### ***Discussion***

IPT coverage is not yet known due to the lack of data collection and monitoring tools. IPT2 uptake is low. The reasons for low IPT2 uptake include late booking for ANC; low turnout among pregnant women for repeat ANC visits; poor quality of ANC which needs to be improved and the costs of ANC services despite the provision of free IPT/SP.

Senegal is using multiple channels to distribute ITNs to pregnant women. The private sector is selling ITNs through market channels. In the public sector ITNs are subsidized for pregnant women (CFA 2000; \$3.70) and provided at the first ANC visit. A major limitation is that Senegal does not have enough ITNs in the country to reach its target population. Funding was secured in the Global Fund Round 4 to procure ITNs; Senegal placed its order in October 05 and is still waiting for the order to be filled.

### **DAY TWO: Tuesday 11 April 2006**

**Facilitator: Claude Rwagacondo**

#### **Objectives:**

- 1. Updates on ITNs delivery through ANC**
- 2. Share country programming experiences: Ghana, Burkina Faso, and Malawi and Mali**

#### **I. Updates on ITN Delivery through ANC**

##### **1. PSI: ITN delivery through ANC- Rodio Diallo**

The presentation highlighted the importance of ITN delivery through ANC. Key reasons ANC is the optimal venue for ITN delivery for pregnant women include: a) access for pregnant women; b) the majority of pregnant women attend at least one ANC visit; c) ITNs can be stored in a secure place within the facility; d) the existing relationship between the provider and the client is strengthened; e) targeting subsidies; and f) accountability of stock. PSI is supporting ITN

distribution through ANC in 17 countries in Africa, however, only in Kenya and Malawi has this been achieved successfully on a national scale.

***Discussion:***

Participants enquired about the coverage and utilization of ITNs among pregnant women in the countries supported by PMI. Targeting pregnant women, PSI has delivered a total 4.5 million nets in 15 countries through ANC. Data collected from Kenya reveals nearly 50% of pregnant women slept under a mosquito net the previous night (PSI national survey, 2005).

Regarding re-treatment of nets by pregnant women, PSI indicated that most of the ITNs used are long lasting nets (LLIN). However, PSI does support campaigns for re-treatment too. PSI also indicated that nets are often provided to women at their second or last visit as an incentive for adhering to the recommended ANC schedule. The meeting recommended that pregnant women should receive an ITN at the first ANC visit and not when they have completed a certain number of visits. This is to enable them begin ITN use early in pregnancy and obtain maximum benefit of the ITN. It was also proposed that pregnant women should be given ITNs for free since ITNs are public goods for the benefit of the mother, baby, family and society at large.

ITN coverage is currently very low- throughout Africa. To reach 100% coverage, including the poorest quintiles and pregnant women and children, there should be a balance among subsidized ITNs, market priming and free ITN distribution. It was noted that campaigns are not effective at reaching pregnant women; since they target children under five. A combination of approaches will help countries reach the most vulnerable.

## **II. Country Programming Experiences: What have we Learned?**

### **A. Malawi: ITN Delivery through ANC- John Zoya**

Health services in Malawi are provided for free to the client. In 1998, with support from UNICEF, Malawi started distribution of ITNs in three districts. In 2002, ITN guidelines were developed. At this time ITNs were heavily subsidized. The first free mass net re-treatment campaign was in 2003. In 2005, approximately, 1.9 million ITNs were re-treated.

Malawi has four distribution models: 1) health facility distribution with subsidy; 2) community based distribution through village health committees, which is also subsidized; 3) free distribution in emergency situations; and 4) commercial sector distribution. High risk groups including pregnant women are targeted. Health workers are motivated through a 20% commission on each ITN sold. Distribution of ITNs in 2005 was 1,350,000 ITNs. Net use by pregnant women is 31.4%. National coverage is 43% (ownership) and 35.5% (usage- children under five). There is still a need to distribute nets to the poorest of the poor- for those who cannot afford to buy an ITN.

***Discussion***

Participants asked about the involvement of the Reproductive Health (RH) programs in the distribution of ITNs to pregnant women through ANC. The meeting was informed that the national Division of RH was actively involved and the district RH nurse is responsible for the ITNs at the ANC.

In response to a question on the methodology used to assess utilization (vs. coverage) by pregnant women, the group was informed that the University of Malawi carried out a national household survey with support from the University of Malawi. This survey asked individuals including pregnant women and children if they had slept under an ITN the night before. The survey team also checked to see if the ITNs were in the household. Although ITN distribution appears higher than actual use, four districts have achieved Abuja targets. It is recognized that some people own ITNs but do not necessarily use them. The importance of using the ITN during the dry season and not only the wet season is being addressed through educational campaigns.

The quality of subsidized ITNs appear to be different from non-subsidized ITNs. The subsidized ITNs are green and rectangular. These are distributed by PSI in all the facilities. There are also conical ITNs that are blue and are believed to have a better quality. Of 1 million ITNs distributed by PSI, none were distributed free. However 75,000 ITNs received through WHO were distributed at no cost to individuals. Through the GF proposal, Malawi will expand free ITN distribution. The private sector is an active contributor to ITN distribution. Twenty-seven percent of health services are provided through Christian Health Services (CHS). The MOH works closely with CHS to ensure they have the commodities for MIP including ITNs and SP.

There were discussions around the possibility of saturating household with nets in Malawi, given the size of the population (12 million ITNs). However, the response to this recommendation was that this is neither feasible nor a strategic option for long term viability and support.

## **B. Ghana: A comprehensive approach to MIP Prevention and Control- Ofei-Akoto**

Ghana has adopted a strategy of human resource capacity development and improved service delivery, and is targeting efforts at the community, facility and regional levels for comprehensive MIP program implementation in all districts. The first line drug for treatment of pregnant women in the 1<sup>st</sup> trimester is quinine. In the 2<sup>nd</sup> and 3<sup>rd</sup> trimesters AT+AQ is used as first line and quinine for severe malaria. In 2005, IPT 2 Coverage in the Tano district reached 50.1%. ITN use at first ANC visit 21.2%. This nearly doubled for the 2<sup>nd</sup> ANC visit. Supply of ITNs is the biggest challenge. Community Based Agents (CBAs) play an important role in MIP implementation. They support mothers at the community level and inform pregnant women when to go back for ANC follow up visits to receive the second IPT dose. They also serve as a link between the community and facility, especially when pregnant women experience adverse events in relation to medications taken. Pharmacovigilance systems are in place at the facility level to monitor adverse events. Ghana plans to move forward with community MIP implementation through CBAs. SP is produced locally.

## **Discussion**

Participants were informed that Ghana was able to maintain community-based Agents (health workers) for outreach activities with support from the Global Fund, which provides funding for CBA activities. Incentives provided to CBAs motivate them to support health programming efforts. For example, CBAs receive personal identification cards, which allow them to open bank accounts. They were also provided with raincoats and boots, and some have received bicycles. Hence, attrition has been very low.

In response to a question on how long there has been a shortage of ITNs and what are the strategies to address this shortage, the meeting was informed that this has been a long-standing problem. The demand is great but supply remains a problem. There are national efforts to ensure

the availability of SP for IPT in health facilities at all times however, stock-outs do occur from time to time.

With regards to improving early ANC attendance, this was recognized as a challenge. However, CBAs play a pivotal role in promoting early attendance to ANC and also deliver ITNs to pregnant women. It was emphasized that CBAs are not trained to treat cases at home with ACTs. The role of CBAs is to educate and refer.

### **C. Burkina Faso: From pilot study to implementation- Jeremie Zougrana**

Based on the results of the pilot implemented in Koupela district, Burkina Faso adopted an MIP strategy with IPT in 2003, and expanded implementation efforts, though on a relatively small scale. Burkina Faso's strategy for implementation targeted community sensitization and facility level care simultaneously. Burkina Faso is lacking funding to support scale-up. Thirteen of 53 districts have received training on Focused Antenatal Care (FANC) which includes MIP. MIP training materials have been revised to include treatment aspects and provider training is ongoing. However, more support is required to scale-up to national level. Challenges beyond funding include lack of political will, a weak monitoring and evaluation system, lack of a strategic plan for community interventions and the need for printing of updated training materials.

### **Discussion**

ANC attendance in Burkina Faso is currently low. With regards to increasing IPT2 uptake, it was noted that an increase in ANC utilization will help to increase the uptake of IPT. Providers need to be educated on the correct timing and dosing of IPT in order to avoid missed opportunities for IPT delivery. Districts have asked for training on focused ANC. There is a national strategy to scale up FANC. However, there is not enough funding to support this scale up.

One of the challenges faced by the National Malaria Control Program was that it tried to implement the program independently and did not engage partners adequately. Consequently, Burkina Faso missed opportunities for GF support. There is a realization that collaboration is necessary at all levels. Increased global support is needed to support Burkina Faso to scale-up its MIP implementation efforts. However, it needs to strengthen its political will in this effort.

### **D. Mali: Community Based Distribution of IPT- Joseph de Graft Johnson**

Mali has low ANC coverage (1 visit- 41% and 2+ visits 28%). With the goal of improving newborn survival, community-based distribution of IPT was implemented in one district (Kolondieba) in Mali. Bougouni was designated as the comparison district. The study was designed to examine how to reach women who do not come to ANC with IPT. Key questions for this quasi-experimental study included: a) can community health workers dispense IPT/SP appropriately to pregnant women, b) will community based distribution increase IPT uptake among pregnant women; and c) will community based distribution of IPT prevent women from attending ANC. First dose of IPT was 49% and 42% respectively.

The majority of IPT delivered to pregnant women in both districts was through the health facility. A conclusion from the study is community health workers can safely provide IPT when

appropriately trained and support services to pregnant women where routine ANC do not reach. There is a place for community-based distribution of IPT when women cannot access ANC.

## **Discussion**

Mali does not have a policy for community-based distribution of IPT. There is an ongoing debate as to whether community-based distribution of IPT is appropriate and should be implemented in Mali. The outcome of the recent studies are being discussed and next steps for implementation are on hold.

Participants were curious to know the involvement of other stakeholders, especially the Division of Reproductive Health (DRH). It was noted that DRH was involved from the beginning and the design of the study was supported by DRH.

It was also noted that TBAs role should be able to promote ANC. In areas where there is no ANC, outreach can be used for holistic care. There was a plea to recognize that care is not easily accessible by all pregnant women and therefore, there is a need to be able to reach pregnant women with services as best as possible. Participants suggested that if Mali wants to increase ANC coverage, the cost of SP should be eliminated.

## **III. Achieving Scale up**

Based on the country presentations and ensuing discussions, the WG discussed challenges affecting scale-up of MIP interventions and recommendations to address those challenges.

### **Challenges Affecting Scale-Up**

1. Commodity Supply
  - SP stockouts and availability within ANC settings
  - ITNs (LLINs) demand exceeding supply
  - ACTs
2. Distribution of ITNs through ANC
  - Methods of distribution to ensure appropriate targeting of pregnant women
  - How the MPWG can help countries promote ITN distribution through ANC
3. Improving Quality of ANC
  - Improving early attendance at ANC
  - Increasing IPT2 uptake
  - Ensuring comprehensive ANC including PMTCT and integrated services for MNCH
  - Adoption of WHO 4-visit schedule for ANC (Focused ANC) and use of existing guidelines at the country level.
4. Strengthening monitoring and evaluation (M&E) for MIP within existing National Health Information systems.
5. Improving collaboration between the malaria control and RH programs
6. How to involve communities effectively in MIP prevention and control
7. Advocacy for MIP in particular, and maternal health issues in general, at national, regional and global levels.

**DAY THREE: Facilitator: Juliana Yartey**  
**Wednesday, 12 April 2006**

**Objectives:**

1. Review and discuss support for sub-regional networks and coalitions
2. Review and discuss MPWG workplan
3. Review and discuss existing tools and advocacy materials
4. Review and discuss Partner's representation in the MPWG and Identity of MPWG
4. Determine next steps and meeting dates

**I. Support for Sub-Regional Coalitions and Networks**

**A. RAOPAG Network-** RAOPAG has 10 member countries (Benin, Burkina Faso, Cote d'Ivoire, Nigeria, Senegal, Mali, Niger, Guinée Conakry, Togo) and 7 observer countries. Coverage of ITNs among pregnant women has increased in most countries. In Benin, ITNs are now included in dowries. ITNs are also being targeted to pregnant women. However, there are problems with re-treatment of ITNs and supply of long-lasting ITNs (LLINs). All countries are supportive of IPT, however, some countries are piloting while others are implementing. Challenges include scaling up the delivery of IPT/SP through ANC, lack of resources, weak sharing of information among countries, engagement with the private sector, integration of programs and services (e.g., HIV, Malaria and RH), and Monitoring and Evaluation. RAOPAG will continue to foster collaboration among countries. This will include facilitating sharing of information, advocacy to raise the profile of RAOPAG, advocacy to engage the private sector, support for integration of MIP into training curricula and pre-service education.

**Discussion**

The RAOPAG organigram was presented and explained. Every quarter the President goes to Benin to meet with the Secretariat to discuss implementation and way forward. There is one general assembly each year, which includes country focal persons and global, regional and country partners. A new Technical Assistant, Dr. Do Rego who has just been recruited was introduced to the meeting. RAOPAG recognizes the need to revise its current organigram in the light of this development.

RAOPAG has sent questionnaires to countries to assess their expectations from RAOPAG and the support that is needed at the country level. Now with the Technical Assistant, Dr. Do Rego on board, countries can receive support through RAOPAG.

Meeting participants were interested in knowing what insecticide is being used in the sub-region for ITN re-treatment and what RAOPAG was doing to address this issue at the sub-regional level. The meeting was informed that RAOPAG has been linking up with the WANMAT to examine this further. This is a drug resistance network that will look at this issue more closely.

**B. MIPESA Coalition-** The MIPESA Coalition representative was unable to attend the meeting. A brief update on the MIPESA Coalition, including current status and next steps were given by Elaine Roman. The Chair of MIPESA recently resigned to take up a position with UNICEF and the new Acting Chair is Dr. Marero (Tanzania). It is expected that MIPESA will have a Steering Committee meeting in the coming months to discuss its strategic plan including regional activities and collaboration with RAOPAG, EARN and the

MPWG. The MIPESA documentation- ‘Assessment of MIPESA Country Experiences in the Adoption and Implementation of Malaria in Pregnancy Policies’ has been finalized. Copies will be printed and disseminated.

## **Discussion**

Discussion ensued around countries participation in MIPESA. The MIPESA countries were the first five countries to adopt the WHO 3-pronged strategy for the prevention and control of MIP. MIPESA is now open to new country membership and has taken steps in this direction. The MIPESA Secretariat can be contacted for further information.

For effective prevention and control of MIP, there is need for a strong collaboration between malaria control and RH programs. RAOPAG and MIPESA foster this relationship among programs and among countries within their coalition. The uniqueness of MIPESA and RAOPAG are that these are country driven coalitions and link to the sub regional networks as the MIP ‘arm’.

## **Recommendations for MIP Sub-Regional Networks**

1. The MPWG should raise these issues formally to RAOPAG and MIPESA so that the networks can define a plan to address the issues below.
  - For RAOPAG to be a West African network it needs to go beyond Francophone representation and strategize to include all West African countries. This should involve a restructuring of the organization.
  - The RAOPAG Steering Committee should be reviewed and revised to include Anglophone representation. The Secretariat must position itself to be functional. This means being the link between the Steering Committee and the countries. The Secretariat should be bi-lingual with the ability to communicate effectively with all parties involved.
  - RAOPAG and MIPESA need to demonstrate their added value, in order to sustain donor and Partner support.
  - RAOPAG and MIPESA should bring data to such fora and regional meetings to showcase where countries are with MIP strategy implementation.
  - There is need for intense advocacy to partners so that RAOPAG and MIPESA activities are recognized and supported.
  - RAOPAG and MIPESA should document the status of MIP implementation in collaboration with WARN/EARN.
  - The MIP M&E Framework should be disseminated to countries through the RAOPAG and MIPESA networks with technical assistance from partners for M&E support. The Framework should also be made available at the MPWG web page on the RBM website.
  - MIPESA should develop a dissemination plan for its ‘Best Practices’ document that outlines the number of copies needed, target audience and how the document will be used. This will inform the number of copies required for printing.
  - MIPESA should develop a two page brief that outlines the best practices and lessons learned from country experiences. This should be disseminated widely.

## **Recommendations Specific to GFATM Proposal Development**

1. Proposals must show the added value of the regional networks and clearly reflect how (through regional support) the network augment existing country implementation efforts.

2. Proposals should be complementary to country initiated efforts and focus on how the regional networks can help strengthen ANC for MIP.
  3. Proposals should also ensure countries HMIS are strengthened, standardized and the MIP M&E indicators adopted.
  4. MIPESA and RAOPAG should begin the process of proposal development, outlining objectives, key areas for support, and how they can help strengthen ANC services. This work should begin prior to the Call for Proposals.
  5. If possible, MIPESA and RAOPAG should consider the development of a joint proposal.
- C. West Africa Regional Network (WARN)** - The role of the sub-regional networks is to coordinate partner support for country level action. A joint workplan is developed among all partners at Annual general meetings to support countries. WARN also has a role in supporting sub-regional networks such as RAOPAG. This support includes active engagement and participation in RAOPAG activities to support its mandate. WARN also provides key strategic guidance to countries for strategic planning, focused technical assistance and monitoring. There is no duplication between RAOPAG and WARN. Their roles are different but complementary.

The EARN focal person was unable to attend the meeting. However, it was noted that the role of EARN and WARN are similar per their respective regions.

## **II. Review of Tools and Advocacy Materials**

- 1. Future's Advocacy Manual** - This tool was presented by Elaine Roman on behalf of the Future's Group.

### **Discussion**

General Feedback included:

- a. The MIP working group recognizes that this is an important tool and hopes that the Futures Group will work towards finalizing it as an important tool for country use.
  - b. The title is confusing. It appears that the tool goes beyond issues of advocacy (e.g., social and community mobilization). This should be reflected in the title if this is the case. Also, is the tool part of a series- 'Networking for Policy Change'? If yes, then that should be indicated as this is not explicit.
  - c. In general, the tool appears very dense and daunting. While the content may be very useful for countries and can/should be an important tool for MIP advocacy, the tool is not very user friendly the way it is currently laid out.
- 2. MIP Implementation Guide**- An outline of the MIP Implementation Guide was presented by Elaine Roman. The MIP working group will review the document, and provide input during the process of development.
  - 3. Malaria Resource Package Update**- The Malaria Resource Package is to be updated. Elaine Roman will send communication to partners with more details asking for input and information on relevant new documents.
  - 4. MIP M&E Framework**- This document will be disseminated electronically and will be reviewed through the WHO publication committee for finalization and publication. It will also be placed on the WHO Global Malaria Program (GMP) website and the MPWG web page of the RBM website.

### **III. Recommendations of the MPWG Meeting and Annual Workplan**

#### **A. Recommendations of the MIP Working Group Meeting**

##### **I. Make package of tools to support scale-up of MIP interventions available to countries**

1. Define the tools package that is necessary for scaling up MIP intervention (*available in English and French*)
  - i. MIP Strategic framework (WHO/AFRO)
  - ii. IMPAC Guidelines (Integrated Management of Pregnancy and Childbirth)
  - iii. MIP M&E Framework
  - iv. MIP Implementation Guide (*in preparation*)
  - v. Training materials and consensus statements:
    - a. SP for IPT in areas of high SP resistance,
    - b. Interactions between HIV and malaria and implications for service delivery
    - c. ITN delivery within ANC
    - d. FANC training materials
    - e. Community involvement in MIP control (*The Futures Group??*)
2. Submit toolkit to GFATM for inclusion in the GFATM Round 6<sup>th</sup> RFPs and make package available to other donors (PMI, Booster, Gates, other Bilateral agencies)
3. Make toolkit available on WHO, RBM MIP website and other Partners' websites.

##### **II. Support countries to develop their GFATM Round 6 proposals**

1. Ensure that countries recognize ANC as the platform for MIP implementation in their GFATM applications
2. Engage consultant to review/analyze past GFATM plans to identify elements of success related to MIP implementation
3. Develop generic template that can be used by countries to adequately develop MIP components in their GFATM proposals for Round 6 (MPWG in collaboration with RAOPAG and MIPESA)
4. Identify TA needs and qualified neutral brokers/individuals for such support to countries and to regional networks (RAOPAG & MIPESA)—for developing Rd 6 proposals, assuring that proposals are comprehensive, and mentoring of implementation, monitoring and evaluation (WARN, EARN)

##### **III. Strengthen ANC**

1. Support countries to adopt and implement the WHO recommended four-visit ANC schedule (IMPAC Guidelines-FANC)
2. Get potential donors to support implementation and scale-up in countries
  - i. Adaptation
  - ii. Adoption
  - iii. Printing and dissemination
  - iv. Training (pre-service & in-service)
  - v. Support implementation at district level (supervision, etc.)
  - vi. Strengthening Monitoring and evaluation systems
  - vii. Documentation and sharing of country experiences and lessons learnt
3. Ensure community's involvement in the planning and implementation of MIP in-country (RAOPAG, MIPESA)
4. Foster collaboration between national Malaria Control and Reproductive Health/Making Pregnancy Safer (MPS) Programs to strengthen MIP implementation

- i. Define modalities for collaboration between the NMC and RH/MPS programmes for implementation of MIP at country level (joint responsibility of MPWG, RAOPAG, MIPESA, EARN, WARN)
  - ii. Advocate for collaboration between the NMC and RH/MPS programmes to support effective MIP implementation at national level
- 5. Strengthen monitoring and evaluation systems for MIP within HMIS:
  - i. Support countries to revise maternity registers and ANC cards

#### **IV. Advocacy**

1. Develop advocacy materials and consensus statements for ITN distribution through ANC in collaboration with ITN WG
2. Advocate for the inclusion of ITNs as an RH commodity
3. Advocate for maintaining SP on the essential drug list for IPT
4. Advocate for ensuring availability of and access to ITNs in countries through simplified procurement mechanisms, e.g. pooled procurement of commodities
5. MPWG to review the Futures Group MIP advocacy manual and provide direct feedback to Nancy Russell and/or Michelle Prosser.

#### **V. Research**

1. Identify alternative drugs for IPT (MIP Research Group)
2. Identify drugs for case management for MIP (MIP Research Group)
3. OR to support scale up of MIP interventions in countries
  - i. Models of ITN delivery
  - ii. Expanding access to hard-to-reach areas
4. Identify alternative insecticides for ITNs in areas of vector resistance (MIP Research Group)

#### **VI. Strengthen MIP Networks**

1. RAOPAG should review organizational structure including country representation.
  - i. Steering committee should include language blocks representation
  - ii. Role and structure of secretariat should be reviewed to make it functional, able to effectively serve as a link between steering committee and countries (the focal points)
2. Building capacity of MIP networks to support countries in attaining their own mandates, and providing technical assistance for implementation and scale of MIP interventions in countries including strengthening of antenatal care and Health Management Information Systems (HMIS) for M & E.
3. RAOPAG should document status of MIP implementation in countries.
4. Networks should disseminate, and provide TA to operationalize, M&E framework in countries
5. Country and partner support for network country representative to participate in network regional meetings and activities.
6. Summarize MIPESA best practices document into a 2-page brief of key issues and disseminate to RH program managers, and national malaria control programs.
7. MIPESA should expand and invite prospective countries to join it, e.g. Madagascar.
8. MPWG to facilitate exchange between RAOPAG and MIPESA
  - ii. Proposal for a joint Annual General Meeting

## **B. MPWG 2006/07 Annual WorkPlan**

The MPWG 2005/06 workplan was discussed with relevant updates. The revised workplan is available through the Secretariat and/or on the RBM MIP working group website. <http://www.rbm.who.int/mpwg.html>

### **Key revisions to the workplan in addition to the recommendations above include:**

1. Research is ongoing to explore alternative drugs for IPT and case management. The MIP Research Working Group is engaged in this effort. It was noted that this research should not be limited to Africa.
2. Although an update on community-based distribution of IPT was not presented by AFRO, a country study in Mali was presented by ACCESS/JHPIEGO.
3. The Chair of the MIP working group reported on her participation in the ITN working group's meeting in Basel in March 2006. The ITN working group fully advocates for distribution of ITNs through ANC.
4. Further collaboration with other RBM Working groups should be explored.

## **V. MIP Working Group Representation and Identity of the MIP Working Group**

MIP working group participants decided that the working group's representation should be expanded to include the private sector, drug manufacturing groups, ITN manufactures, and leading experts in RH, Malaria and HIV, including representatives from Professional Associations such as FIGO and ICN and ICM.

The current acronym for the RBM Partnership Working Group for Malaria in Pregnancy is "MPWG". The group decided that the acronym for the Working Group should change from "MPWG" to "MIP", which is simpler.

**Next Meeting:** Meeting participants discussed country choices for the next meeting. These included Nigeria, Congo-Brazzaville and Equatorial Guinea. Meeting participants voted by majority for Equatorial Guinea to be the venue for the next meeting.

**Proposed Dates:** Week of Oct. 9-13, 2006.

**Closing:** The meeting ended at 7:00 pm on Friday, April 12, 2006 with closing remarks by the chair who thanked participants for their enthusiasm, commitment and active participation in this meeting.