SEVENTH MEETING OF THE ROLL BACK MALARIA PARTNERSHIP
MALARIA IN PREGNANCY WORKING GROUP

OCTOBER 10-12
BOLINGO HOTEL
ABUJA, NIGERIA

DRAFT MEETING MINUTES

Participants:

Chair: Juliana Yartey
Co-Chair: Claude Emile Rwagacondo

Meeting Objectives:

1. **Updates from RBM Global and Regional Partners**

2. **Discuss technical updates and country programming experiences related to the prevention and control of malaria during pregnancy and make appropriate recommendations.**

3. **Strengthening collaboration among sub-regional networks for the prevention and control of malaria in pregnancy (MIP).**

DAY 1: 10 October, 2006-10-12

Opening Ceremony
Facilitator: Gaudens Ntadom

Dr. Juliana Yartey welcomed the participants and provided a brief history of the working group and its purpose. She stressed that the role of the working group is to share best practices with partners to scale up programs in the field and to bring the MIP issues to the attention of the RBM partnership. Professor. F. Okonofua, President of FIGO, Nigeria provided a description of FIGO's role in safe motherhood and the recognized the growing need to address malaria in pregnancy in his welcoming remarks. He expressed strong support for malaria in pregnancy programs and stressed that to meet the Millennium Development Goals we need to focus on malaria because it is responsible for 11% of the maternal mortality in Nigeria. Dr. Wilson Were, Global Malaria Program, WHO, Geneva provided an

overview of the current burden of the disease in pregnancy and the extent of utilization of effective interventions. He highlighted the country level differentials in the coverage of the MIP interventions. Challenges highlighted in his overview included continued low coverage of IPT, especially IPT2 and ITNs; growing resistance of SP and the lack of a new drugs that are safe to use in pregnant women. He promoted developing comprehensive malaria in pregnancy prevention and treatment programs, monitoring SP resistance while continuing with IPT as a strategy for the African region. Dr. Soffola, introduced Honourable Minister of Health, Nigeria and Chairman of the RBM Partnership Board, Professor Eyitayo Lambo, Minister of Health graced the opening ceremony of the 7th MIP working group (MIPWG) meeting. In his key note address to the participants he highlighted……

Country Programming Experiences: Achievements, Challenges, Lessons Learnt and Scale-up Plan

Dr. Abdulai Tinorgah, UNICEF, Nigeria chaired this session and invited Nigerian participants to give an overview of the MIP situation in the country. Dr. Ntadom, National Malaria Control Program began by providing a summary of status of maternal mortality, contribution of malaria to maternal mortality and the achievements and challenges of the MIP situation in Nigeria. Four of the Six states (Plateau, Nasarawa, Ebonyi, and Lagos) in Nigeria were invited to provide an update to the participants.

Key findings: Maternal mortality in Nigeria is one of the highest in the world at 704/100,000 live births. Malaria is responsible for 11% of the maternal mortality in Nigeria. Nigeria uses a focused antenatal care (FANC) approach for IPT and SP is provided as DOTS. No SP is provided in the first trimester. Uncomplicated malaria in pregnancy is treated with Quinine in the first trimester and ACTs in the second and third trimester. Sever malaria is treated by IV/IM Quinine, IM Artemether, or IV/IM Artesunate. The NMCP has rolled out a coordinated response and achievements include provider training in FANC and MIP and production of IEC materials. One million doses of SP in GF round 2 and 73,000 doses of SP in Round 4 were procured. Over all 17% of pregnant women receive two doses of SP.

In Plateau State 70% of pregnant women were positive for malaria as opposed to the 23% in Nigeria. The State has trained 221 health workers and 3621 role model mothers trained in MIP. They are using community distributors for ITNs. In collaboration with the Filariasis Programs, in five out of the 12 LGAs they have achieved 60-80% coverage for ITNs. In Nasarawa State 206 health providers have been trained but they are still awaiting SP Supplies. Sate officials have mobilized communities and 90% pregnant women at Akwanga and Keana LGAs sleep under insecticide treated nets. Ebonyi State achieved a 25% coverage of IPT from August 2005 – September 2006. UNICEF provided ITNs and insecticides to three focal LGAs. They have invested in educational materials and developed radio jingle for community outreach. Around 120 health workers were trained in MIP/FANC during the same period. They still need to get more supplies of SP to achieve higher coverage. Lagos State has low ANC utilization: less than 40% access ANC services. The State officials have widely distributed the national malaria in pregnancy guidelines and over 50,000 women received IPT last year of which 70% was IPT1

and 30% was IPT2. Lagos State is expanding coverage by working with TBAs and the private sector facilities. ITNs are distributed free and through a voucher scheme.

Summary of Federal Level Challenges and Recommendations

- There is definite political commitment to address MIP in Nigeria
- There are some gaps in putting policy into practice including logistics issues, SP availability and correct use
- ITN & IPT should be integrated in ANC as part of national comprehensive strategy
- Need to reach the whole population of pregnant women (scale up)
- Build a stronger partnership (currently fragmented) to reach all pregnant women
- Improve the M&E at Federal level to gauge program success
- Improve the involvement of states and LGAs in obtaining and disbursing MIP funding
- Improvement of collaboration between NMCP and MIP Researchers and harmonize usage of research results in MIP program implementation

Summary of State Level Challenges and Recommendations

- To standardize MIP policy implementation across States so impact measured is comparable across the States
- Scale up the MIP policy
- Mobilize more resources and advocate for MIP
- Enhance effective M&E and reporting
- Ensure that SP is utilized for MIP because sometimes it is available in existing state facilities and local pharmacy

Research findings on Malaria in Pregnancy Nigeria

Several local researchers presented recent research that was funded by USAID in Nigeria. These included:

- Clinical And Laboratory Features Of Congenital Malaria In Nigeria
- Peripartum Malaria In Nigeria: Current Status And Impact On Neonatal Outcome
- Epidemiology Of Congenital Malaria In Nigeria:
  A Multi-Center Study
- Use Of Malaria Preventive Measures In Pregnancy And Placental/Neonatal Parasitaemia

Key Findings:

Congenital malaria is not so rare

A twelve months of continuous study at four research sites found asexual stages of malaria parasitaemia in 5.1% (95/1875) of neonates of which 39% were symptomatic. This was associated with

- Shorter gestational age
- Longer labour
- Longer ruptured membranes
- Antepartem maternal parasitaemia and placental parasitaemia

Peripartum Malaria

In Nigeria 1 in 5 women have malaria parasitaemia at delivery. Maternal age less than 20 year was the most important predisposing factor. The major outcomes of peripartum malaria were

- reduction in mean birth weight,
- higher proportion of low birth weight babies
- reduction in maternal haematocrit

Conclusion of epidemiological Research findings

- Malaria detected all year round
- Commonest in primi- and second-gravida
- Malaria in pregnancy of asymptomatic
- Symptomatology is not related to parasite density
- The febrile pregnant woman runs 2-3 times risk of malaria
- Anemia strongly associated with malaria parasite even when no overt symptoms

IPT research findings

- The average knowledge IPT score of 63.7% was still low
- The application of this life-saving intervention (14.9%) falls far below acceptable levels even among medical practitioners in general, and obstetricians in particular
- There is therefore need to mount capacity building workshops on IPT and malaria control in the Cross River State to re-educate health care providers

MIP in Uganda

The final presentation of the day was a country presentation on MIP experience in Uganda. Sixty two percent of pregnant women carry parasites, 18% suffer from severe anaemia and there is increased incidence of low birth weight in babies. In Uganda, MIP is integrated into Reproductive Health and MIP implementation is going on all districts. Bottlenecks for scale up have been identified and mitigation is underway

Conclusion and Recommendations from Day 1

- MIP is more than IPT
- ITNs pose an integration challenge
- Case management is still not clear cut
- IPT challenged by low ANC utilization, beliefs and attitudes, and logistics leading to low adherence for IPT2
- M&E systems need improvement to document challenges and successes
- Research shows that MIP is a health burden on both mothers and newborns

Day 2

Dr. Juliana Yartey reviewed the meeting objectives and the agenda for the remainder of the meeting. Dr. Bill Brieger presented the summary of presentations and discussions from Day 1. Day 2 began with some presentations on country programs that were not covered on Day 1.

Country Programming Experiences: Achievements, Challenges, Lessons Learnt and Scale-up Plan
Chair: Dr Kinde-Gazaard
Equatorial Guinea does not have an MIP policy yet but they have begun the implementation of IPT. The IPT is given out in 3 doses to women at 16, 20 and 27 weeks of pregnancy. Along with SP, Iron and Folic acid tablets are given out. The ITNs are given on the second or third visit to promote greater attendance of ANC. The challenges include obtaining information, stockouts of SP and low enrolment of primigravidae in the ANC

Benin has a population of 7 Million. Malaria is endemic and the incidence is 108/1000 in the general population. Of the 48,000 women who attended ANC, 8,000 had anaemia. The MOH introduced a kit that contains Iron, Folic Acid, 2 doses of IPT, and Mebendzole. The Kit is sold for 1000 CFA. SP is provided through a DOTS program. The IPT coverage is over 60% for IPT1 but up to less than 40% for IPT2 in some areas. The key challenges include the adherence of the providers, especially those from the private sector who do not always follow government policy. ANC attendance is still low. Tools are being revised and there is increasing resistance to IPT (22%) but there have been no adverse reactions. The main recommendations were to work more with the private sector, ensure pharmacovigilance to monitor development of resistance.

The discussion focused on why there was such a gap in IPT 1 and IPT2 coverage. Dr. Were wondered why there were still stockouts. SP is a cheap drug so why were the MOH not budgeting for this drug. However, Dr. Kwame mentioned that in most countries the drugs are in the country but there are problems of internal distribution. Another issue debated was withholding of the ITNs until later ANC visit. Some participants considered this to be unethical because we are trying to promote early ANC and early ITN use. SP resistance is less than 5% in adults. In addition, peripheral parasitemia is not as important as placental parasitemia. We need to do molecular mapping to see levels of placental parasitemia while on SP. In Benin the IPT2 problem is more of a documentation issue. Most women are receiving IPT2.

Session 3: Technical and programmatic updates on IRS, ITNs and antimalarials for MIP
Chair: Dr. T. O. Sofola, MOH, Nigeria

Indoor Residual Spraying (IRS): What does it entail & its impact on MIP – Dr. Birkines Ameneshewa, WHO/AFRO
The principle objective of vector control is to block transmission. Both, the ITNs and IRS, interventions of vector control, have mass effect and high population coverage. ITNs are highly effective and reduce childhood mortality by 17-63%, and maternal anemia by 47% but only 23% of households have an ITN and less than 20% of

children sleep under one. IRS is a method of spraying insecticide on walls to interrupt transmission and can achieve wide coverage. Cost of initial spraying is $2 per person and follow up implementation is $0.6 per person. Additional advantages of IRS for pregnant women include, equitable distribution – mostly free of charge for the population; can be useful in areas of unstable transmission where IPT cannot be used; reduces overall risk of transmission; and contributes to delay in appearance of parasite resistance to drugs. However, to implement an IRS program, we need full commitment for total coverage, timely and regular application, and community cooperation. In conclusion, if the structures in an operational areas have adequate sprayable surface and the vector is endophilic and susceptible to the insecticide, IRS can complement a comprehensive malaria prevention strategy. Malaria in pregnancy is a complex situation involving inter-related risk factors and no single measure can achieve full control of disease transmission, morbidity and mortality. IRS is one of the interventions that can significantly contribute to the prevention of malaria in pregnancy by:

- Reducing transmission risk factors among human and vector populations
- Addressing issues of equity, sustained & appropriate use, and ensuring prevention under all circumstances
- Contributing towards delaying appearance of drug resistance

Discussion: focused around the safety of IRS in pregnancy. In addition, participants wanted to clarify the use of ITNs vs. IRS coverage and when to use what. The cost for spraying seemed quite high for most countries to taken on a sustained program and countries represented were unsure that they would have the national capacity to undertake IRS for the whole country. South Africa was mentioned as a success story where malaria transmission has been reduced to very low levels because of IRS programs.

ITN Experiences and Lessons Learnt in Social Marketing (SM) – Dr. Uzo Gilpin, PSI/Nigeria

Social marketing is the application of techniques and resources of commercial marketing to achieve social objectives. For ITNs, SM seeks to increase coverage by increasing consumer demand, willingness to pay (WTP), use and increasing physical and financial access. The process includes taking a product, for example, ITNs, branding it and promoting it through mass media and interpersonal communication. In addition, the product is distributed to several different outlets and is sold at a subsidized or commercial price.

PSI has programs in Angola, Benin, Burkina Faso, DRC, Guinea, Kenya, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, São Tomé, Zambia, and Zimbabwe through which they have distributed 7.7 Million nets in 2005 of which 4.4 Million were distributed through ANC programs. The process in Kenya and Malawi, where nets are distributed at national scale included, securing national level public sector support for initiative, hosting a one day district level malaria partner meeting , District Health Management Team (DHMT) training by PSI/MOH for one day, nurse training by DHMT , ITN delivery for one month supply (100-300 ITNs/clinic). One net is distributed to each child under age 5 Years and to pregnant woman on showing card/ health passport – which is stamped. The cost of the net is approximately $0.5 per net PSI and DHMTs conduct monthly supervisory/supply visits. Safes may be

installed at facilities to collect cash and increase accountability. The program in Kenya saw a huge jump in ITN distribution when the program was integrated into ANC.
In Nigeria, there is increased uptake due to perceived mosquito nuisance in the Northern states. There are program synergies in distribution of Long lasting Insecticide Net (LLIN) with IPT program using SP and integration into PMTCT programs. Effective partnership developed with government, RH program and community led to reduced leakages and theft Use of WaterGuard to provide safe drinking water for IPT was demonstrated to be beneficial and the program achieved rapid implementation because of strong distribution mechanism
In conclusion, PSI experience suggests that tried and tested models can be adapted, programs should use existing structures, consider sustainability, develop true partnership at planning stage, promote distribution and use and remain flexible.

Discussion: Some of the questions from the participants included why would we want to replacement of public sector with commercial models. PSI programs have demonstrated increased use of nets. They work in partnership with MOH to fulfill demand for nets and negotiate lower prices from net manufacturers. Packaged ITNs should include ropes because in some countries, people do not have ropes to tie the bed net to the posts. Long lasting net manufacturers have the capacity to produce more but they do not get orders on time. In Rwanda, PSI distributed nets through a measles campaign but it is a challenge because Rwanda is very rural and decentralized.

Antimalarials for MIP - Availability, Procurement and Pharmacovigilance
Dr. Thidaine Ndoye, RPM+

MIP should be considered as a comprehensive package that includes: IPT/SP, at least 2 doses (ANC attendance); ITNs provided to pregnant women as early in pregnancy as possible; effective case management of malaria illness and anemia; and communication for behavior change. SP is the most effective single-dose antimalarial preventive therapy currently. Artemisinin drugs are not recommended in the first trimester of pregnancy. For treatment of malaria during the first trimester pregnancy, Quinine I/V or I/M is used. For uncomplicated malaria in second and third trimester, treatment guidelines of the country should be followed and for complicated malaria, Quinine is the drug of choice.

Framework for implementing of a new MIP policy included consensus building, resource mobilization, drug procurement and regulation and pharmacovigilance. SP and Quinine or Artemether are produced by many manufactures, but there are limited suppliers of ACTs. National budgets and donor funding can ensure supplies of SP. Quality issues are a big concern for SP and Quinine in terms of storage, stability and efficacy are some of the key challenges. Some export quality drugs do not measure up to standard and many countries have weak regulation and enforcement systems. In addition, the supply chain systems is not functioning well and many facilities are unable to accurately forecast and quantify drugs needed. Subsidies are improving the availability and accessibility of SP.

Pharmacovigilance is the "the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem." We need a pharmacovigilance system because there is

- Limited post-marketing studies for ACTs
- Limited data on efficacy and tolerance of SP in vulnerable groups
- Limited investigations on interactions with other molecules
- Pregnant women may receive ACTs; it's important to monitor adverse drug reactions (ADR)

The drug regulation authority (DRA) in supervising the response to adverse drug reaction and coordinating all the partners. Examples of ADR with antimalarials:
Quinine: Cutaneous allergy (pruritus), Hypoglycaemia, Cinchonism: headache, dizziness, and tinnitus. With SP there can be exceptionally severe cutaneous allergic reactions: pruritus, photosensitivity reactions, exfoliative dermatitis, toxic epidermal necrolysis and Stevens Johnson's syndrome; and crystalluria.

Discussion: Some participants mentioned that there was a need for standard protocol for measuring efficacy of SP. For best outcome, IPT should be implemented as part of ANC programs. Several groups expressed the need to research for a new drug to be used in pregnant women. This was expressed as an urgent need because there was increasing resistance to SP. However, the participants also acknowledged the difficulty of testing new drugs for pregnant women because of potential foetal impacts.

Malaria in Pregnancy Research Working Group
Dr. Jenny Hill
This presentation outlined the rationale for the research. Pregnant women are biologically susceptible and may have asymptomatic malaria. Prevention of MIP relies heavily on drugs bit here is emerging resistance and not much research going on. This program is funded by Bill and Melinda Gates Foundation and its purpose is to devise an *integrated and prioritized global research agenda* to support the control of MIP for the next 5 years. The activities will include

- develop a public access Web based MIP resource
- conduct 7 State-of-the-art reviews covering full research spectrum
- develop a research strategy

Overall research priorities include developing

- Next 3 drugs for treatment (Africa, Asia, LA)
- Next 3 drugs for prevention
- Optimal combinations of preventive interventions in different epidemiological settings (Africa, Asia, LA)
- Improved delivery of existing intervention strategies to achieve high coverage

Discussion
Participants agreed to identify areas for operations research in MIP and pass on to the secretariat. In addition, the group disseminate its results through the WHO library annual publication. Some participants requested that Nigerian studies be considered for inclusion on the research consortium's agenda and or can the scientists be collaborators. There can be capacity building, possibility for North-south collaboration, through visiting scientists, fellowships and grants.

Strengthening partnership for MIP
Chair: Dr Sofola

Status of MIPESA Coalition: Dr Patrobas for Dr. Marero Mufungo
The MIPESA Started in 2001, for five countries *(Kenya, Tanzania, Malawi, Zambia and Uganda)*. The secretariat is housed in Uganda at the Makrere University. All five countries adopted IPT, ITN use in pregnancy, case management, monitoring, prevention and management of anemia, and focused antenatal care (FANC). Some of the challenges faced by the countries in rolling out MIP programs include, late attendance at ANC, stock outs of SP, Iron, folic acid and ITNs, shortages of human resources, water for SP intake, reluctance of service providers to give SP in pregnancy (Tanzania and Malawi), fear of allergic reactions to SP (Tanzania) , and lack of supervision.

The added value of the MIPESA coalition is to promote country collaboration & partnerships, provide a forum for discussion, promote technical support and documentation , share experiences and lessons learnt, and coordinate activities. The achievements of the coalition include intra-country collaboration between the MCP & RH; documentation of best practices across member countries; accelerated IPT coverage in the region; building capacity of member & non-member countries; multilevel advocacy for MIP; technical assistance to member & non-member countries; mobilized resources for in-country activities; coordinated regional activities to pilot tools such as - M&E, PIA.
Key challenges for MIPESA include ffinancial sustenance; competition with other coalitions/networks for same resources; Increasing SP resistance & issues of alternative drugs; global policies that constrict investment in health; scaling up MIP interventions among member countries especially ITNs. The next steps: review goals and objectives, address issues beyond MIP, expand countries within the coalition, collaboration with other networks

RAOPAG II: Update on Activities, Achievements and Challenges
Prof. Dorothée Kinde Gazard

Started in 2003 with 9 member countries. The goal is to accelerate the prevention, treatment and control of MIP. The partners include; USAID/MAC, JHPIEGO, CDC and WHO. The main activities have included strategy development for 6-10 of the countries, situational analysis for MIP in nine countries, meeting between network's documentation of best practices in pregnancy and development of a database in the region for MIP, and strengthening of partner capacity to address MIP.

The key challenges include the legal status of RAOPAG – for some types of donors, European Union, RAOPAG needs to be registered as a legal entity. meeting between the 3 networks. Resource mobilization remains a challenge especially with the end of the Malaria Action Coalition, motivation of technical assistance for RAOPAG, involving countries in proposal development for global fund.

Discussion: There was much discussion around the two presentations on the MIP networks. For MIPESA it focused on how they were working with other partners like WHO, NMCPs, ESAMC and what was their added value. In addition, participants raised issues of standardization of approaches for MIP across the five countries. The issue of dependence on external funding was raised by several participants and there were issues about the added value of MIPESA. Some suggestions came from the floor on innovative ways for MIPESA to seek resource mobilization especially with regards to Global Fund.

For RAOPAG the discussion centered around the need for the secretary to meet members of NMCPs and RH. As with MIPESA, the issues of "added value" were raised for RAOPAG. Most participants considered this was strategically important for resource mobilization for these networks. One possibly discussed included developing a joint proposal with MIPESA. There were some suggestions that these networks could benefit from the successful existence of other networks in the region such as the RS network. The participants left the discussion with an assignment to think about the issues overnight and to come prepared to develop recommendations for these networks on the last day.

Roll Back Malaria (RBM) Partnership Coordination
John Chimubwa

RBM is a social movement supported by many partners and is owned by all the partners. The decisions are made by consensus and country priorities drive Roll Back Malaria activities. The RBM partnership comprises of 20 voting members and has a chair, vice-, member and alternate member. The Board provides policy guidance to the partnership and coordinates engagement of wider partnership and supervises the the RBM Secretariat. The Secretariat is organised at three levels: Global, subregional, at country level. The Secretariat supports country partnership to overcome implementation bottle necks and coordinates timely, quality support to countries Supports acceleration in scaling up effective interventions
It is also responsible for conducting global advocacy for malaria control and mobilizing resources. There are different working groups set up under RBM. These include Malaria in Pregnancy, WIN, MERG and there role is to collate and disseminate relevant technical information, seek agreement on specific subjects in policy and best practices, and address gaps in partners' capacity to respond to country and global needs. All countries and partners strive toward harmonization of program impact by subscribing to one national malaria plan, one coordination mechanism for implementation of the plan, and one M&E plan system.

Discussion: There was discussion around whether the RBM networks can help the MIP networks and if they could help link up with global fund staff and portfolio manager. There was general discussion that there is limited capacity at country level in all areas and poorly developed health systems. One major point discussed was that NMCPs are not implementers so they should strive to integrate malaria into reproductive and child health programs. In addition, managers should utilize available data or look for management information data for decision making and provide feedback to lower levels. Participants mentioned that there was no transparency between global fund and RBM partners. Global fund money should be utilized to strengthen health system to improve malaria management. More of the

global fund proposals should include MIP and the RH people should be involved in the Global fund application.

In summary, the key points were how malaria programs can better integrate with RH, how subregional networks can contribute and benefit from global fund proposals, how can the weaknesses in the implementation of global fund application be improved upon – since 60% of the malaria grants are in jeopardy, and that there needs to be a greater effort to build capacity of the implements.

Long Lasting Insecticide Treated Nets Technology
Mr. Naji Nandi

The last presentation of the Day 2 was a brief talk by Mr.. Nandi, on of the manufacturers of the Long lasting Nets (LLN). This company was set up as a collaboration for producing LLIN in Nigeria with a British company. The initial capacity will be for the production of 3m nets. Up till now they have been importing from India. The nets are 12 mm polyethelene yarn, 100 dinnier, monofilament net that are impregnated with deltamethrin.

Day 3
John Chimubwa provided a summary of Day 2 discussions and presentations. Some clarifications were made regarding the summary

Discussion: How can the Networks work together.

One major issue that was debated was whether MIPESA and RAOPAG can work within the RBM Subregional Networks (SRNs), EARN and WARN. Could they participate as special working groups within these subregional networks. However, some participants felt strongly that they would lose their mandate within the wider SRNs. According to Dr. Chimubwa mentioned that the SRNs are given a small amount of resources to bring together the members of the SRNs.

Another issue highlighted was the lack of involvement of RH in the MIP activities. Tanzania and Zambia were mentioned as examples where the RH Division is fully engaged in rolling out MIP as a component of FANC. The NMCP is working closely with the RCH Division. One of the participants mentioned that if the RCH people do not demonstrate interest then the malaria staff should interact with them and support them to roll out training and implementation.

MIPESA membership is included within EARN so they could form a subgroup within EARN. RAOPAG needs recognition by WHO regional office and legal status before approaching EU for funding. MIPESA has approached MACEPA and will explore possibility of resource mobilisation from JICA & UNICEF.

RAOPAG will hold annual meeting to decide on legal status & organigram. But proposals are already developed and they need a partner to fund it
MIPESA steering committee will meet in November to either define end points or re-strategise beyond MIP to be funded by WHO. Possibly by MACEPA after they define their added value.

Recommendations

RH and Malaria collaboration

- Resource mobilisation for MIP should involve both Mal & RH. Resources for MIP implementation should be made available to RH
- NMCP should work with RH to develop proposals for MIP to GFATM & other resource mobilisation (for GF ensure RH is listed as a recipient)
- NMCP and RH to advocate for MIP and ensure malaria is included in country RH plans and the country roadmap for RH and vice versa
- NMCP and RH to share the key findings of research in this area with relevant partners.
- Malaria and RH managers to be involved in each other's meetings: RH to be involved in WHO malaria inter-country, regional program managers and malaria staff to be involved in annual RH task force (partners') meeting, Program Managers meeting/regional advisers' meetings; annual RH task force meetings to involve malaria staff. For example Malaria managers should get involved with global partners of RH such as Partnership for Maternal New born and Child Health, White Ribbon Alliance, ACCESS, and Africa 2010
- Partnership forum at country level should have a sub-committee for MIP chaired by RH,
- Hold regular meeting, for example, quarterly or annually to review joint plans etc.
- NMCP managers to advocate for increased RH responsibility for MIP activities in countries
- RBM secretariat to facilitate partnership building at country level for MIP & other interventions

Collaboration of the MIP networks with Regional networks

- Include MIP networks as a specialized group within SRN (opportunity for advocacy from within)
- Partners should support one meeting as a joint meeting between MIPESA & RAOPAG before the next MIPWG meeting. The expected outcome of this meeting would be for advocacy, sustainability, funding (added value of the meeting). Tentatively scheduled for April 2007
- WHO to provide guidance and guidelines on protocols for monitoring SP resistance in Pregnant women and to report to the next meeting
- The IP Secretariat should ensure that WHO recommendation on SP resistance and IPT implementation should be disseminated to all countries through SRNs

MIPWG role and meetings

- Dissemination widely to all stakeholders including countries beyond EARN and WARN
- Finalize guidelines and tools. Comments on various documents and forwarded to relevant focal points
- In pregnancy (for instance children under five and people living with HIV (PLWAs) malaria should be considered serious and managed promptly. ACTs should be given in 2nd and 3rd trimesters

- In the light of limited resources, the meeting urges partners to chip into supporting some partner's participation and running the next WG meeting (Communicate early enough concerning the next meeting)
- Chairmanship and secretariat will lie with WHO RH & Malaria programs shifting from ACCESS Program in accordance with the constitution

Involving professional associations in MIP
Dr. Friday Okonofua

World Bank Booster program
Anne Pierre-Louis

PMI

Briefing on the last RBM Board meeting

Update on tools
Koki Agarwal

Next Steps
The venue and timing for the next meeting was considered. Participants voted that April 2007 would be a good time. The timing will be worked around Easter. The Benin team recommended having the next meeting in Benin. Several participants mentioned that the last three meetings have been in West Africa and the WG meeting should be held in an East or Southern African country. Also it was decided that WHO will now serve as the secretariat and JHIPEGO will not have the resources to continue in that role