MALARIA IN PREGNANCY WORKING GROUP (MIP)
Minutes of the Strategic Planning (8th) Meeting
19-20 March 2007
Geneva, Switzerland

Day 1: 19th March
Session 1: Opening

Dr. Rick Steketee chaired the session and led the group in making self-introductions. Dr. Monir Islam of WHO/MPS gave the following key message during his opening remarks: ANC is not just an opportunity to deliver nets and IPT, but also an opportunity for socialization for pregnant women. A new partnership between Maternal Health and Malaria is developing and needed to achieve MDG6. The MPS Department has a Partnership Unit that promises support to the RBM MIP Working Group. A review of the meeting objectives and agenda followed.

Dr. Thomas Teuscher presented the mission of the RBM Partnership. Key issues include promoting sustainable delivery and use of most effective prevention and treatment technologies, and involvement of all sectors that have potential to contribute to the attainment of RBM goals. Special focus is on receipt of Global Fund Grants where the success of the RBM partnership can be measured in the number of successful grants approved, phase 2 applications renewed and excellent performance ratings achieved.

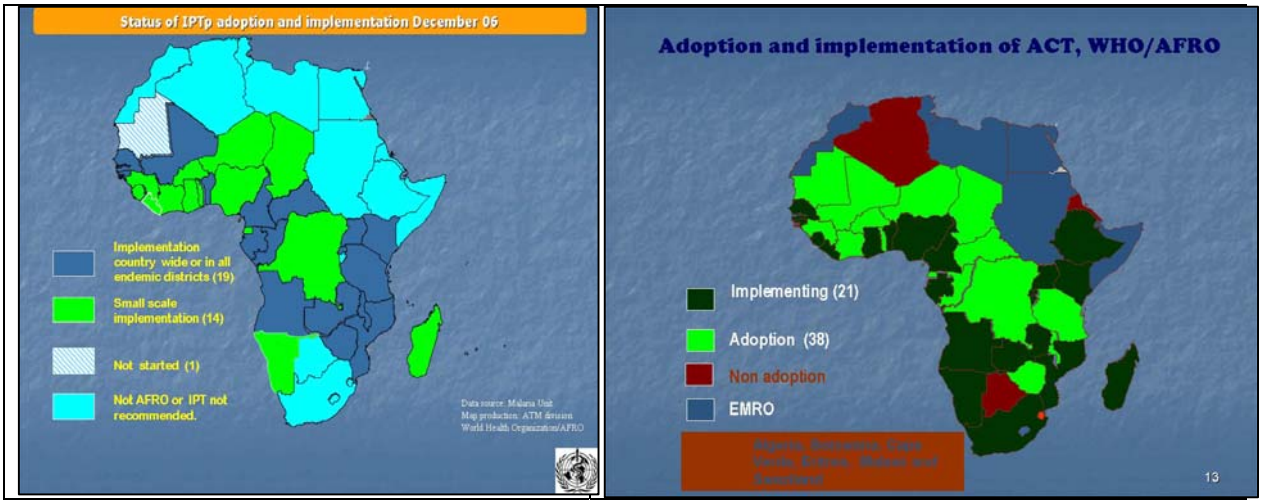
Dr. A.B. Diallo provided an overview of the status of MIP. He provided information on progress on the uptake of the following interventions and related activities in the African Region:

- Intermittent Preventive Treatment (IPTp)
- Insecticides Treated Nets (ITNs)
- Case Management (CM)
- Research/Evaluation on MIP activities (2004-6)
- Models Of Collaboration Between Malaria and Reproductive Health Programs for MIP, and
- Partnerships for MIP

Status of IPTp and ACT adoption and implementation in Africa are summarized in the figures below.
Dr Diallo suggested the following next steps and way forward.

- Supporting countries to scale up IPTp implementation.
- Supporting countries to scale up other preventive measures for malaria (ITNs and IRS);
- Supporting countries to strengthen health information systems for monitoring and evaluation purposes.

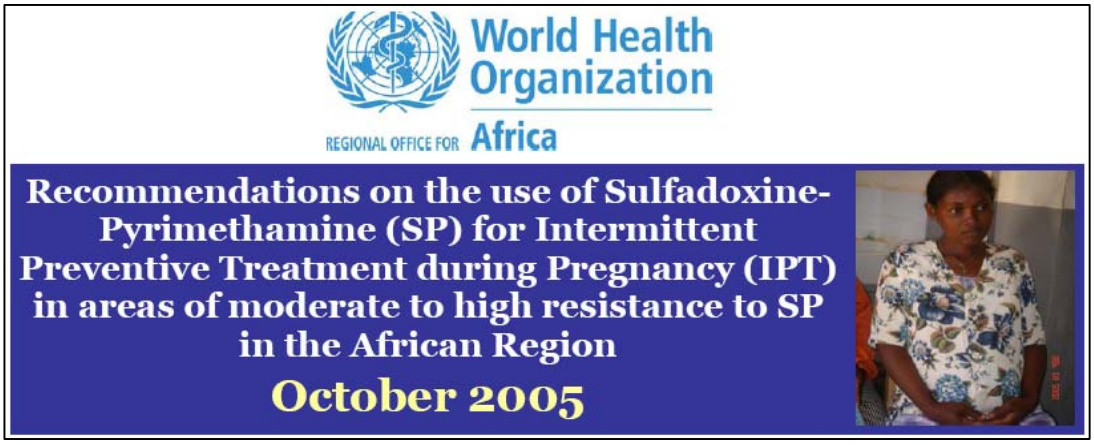
- Strengthening collaboration between Malaria, RH and other programmes to promote delivery of malaria interventions to vulnerable groups (U5, Pregnant women, HIV infected persons) within existing integrated service delivery mechanisms.
- Strengthening partnerships for malaria control including MIP Networks (MIPESA, RAOPAG) in countries and the region.
- Finding alternative drugs for IPTp.



Discussions following Dr. Diallo's presentation highlighted several issues and gaps influencing the uptake of MIP interventions including: safety of all combinations of antimalarial drugs, especially for pregnant women, need for policy guidelines on quinine and SP; and the need for relevant guidelines to reach health care workers at all levels. Participants stressed the importance of knowing extent of implementation of specific interventions in countries.

Session 2: Scaling up MIP Interventions

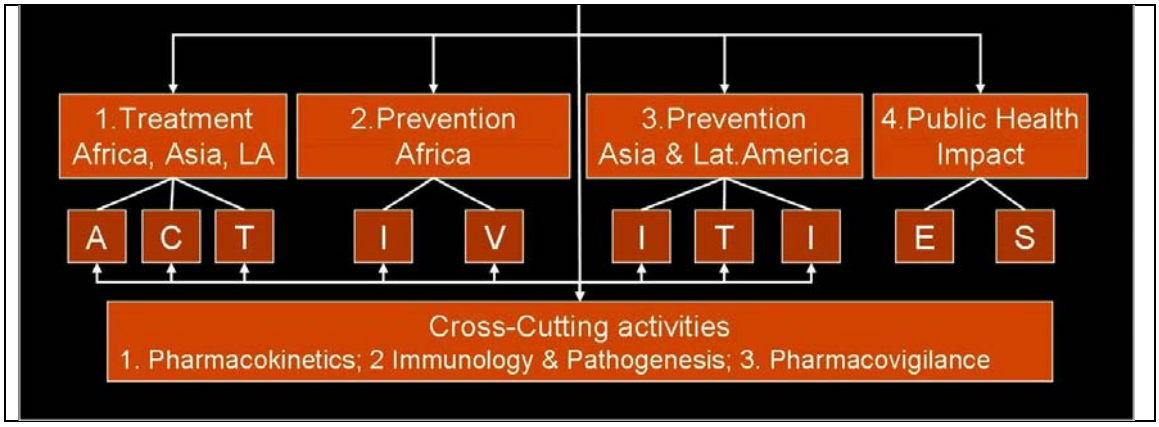
One of the key obstacles to scaling up MIP interventions is concern about the effectiveness of IPT with SP in the face of increasing resistance to SP. Dr. Feiko ter Kuile of the Liverpool School of Tropical Medicine presented the outcome of a WHO Technical Consultation on the effectiveness of IPTp-SP for IPT in areas of moderate-to-high resistance to SP. After reviewing the available evidence, the consultation concluded and recommended that two-dose SP for IPTp is still effective in areas with low to intermediate SP resistance (<30%). Protective Efficacy (PE) against placental malaria 57%; anaemia 17% (0.4 g/dL); LBW 37% (100g); all $P<0.05$. Efficacy declines with increasing SP resistance, but remains substantial. PE placental malaria 53% (vs 66% in low-moderate resistant areas), LBW 30% (vs 40%). No trend for effect on peripheral parasitaemia and anaemia. No data were available from very high transmission areas (>50%). Participants stressed the need to address community and health worker misconceptions about IPT/SP as obstacles to scaling up this intervention. There is also need for better communication between health workers and scientists to ensure timely and appropriate communication of research needs and findings.



Dr. Feiko ter Kuile and Jenny Hill shared information about the Malaria in Pregnancy Consortium which is in the process of being established with funds from the Gates foundation, and related activities. These included the following:

- Case-Management (3 Multicentre trials)
- Prevention: Africa (2 trials)
- Prevention Non-Africa (3 trials)
- Pharmacovigilance: Trial data (2nd/3rd trimester), Pregnancy Exposure Register (1st trimester)
- Burden, Immunology and Pathogenesis
- Public Health Impact: Up-scaling; economics; anthropology

She outlined the overall strategy as presented in the figure below.



Participants entered into a discussion about the role of the community in improving ANC utilization and delivering MIP interventions at the community level, if ANC attendance is sub-optimal?" Case Studies to look at different implementation strategies should help answer related questions such as: How can we sustain community systems? Which community interventions are feasible and effective: Health promotion; Service Delivery? how should they be delivered and by whom? Concerns were expressed about focusing too narrowly on the delivery of malaria

interventions in terms of community response, rather than engaging the community in a comprehensive approach to maternal care as obtains in ANC settings.

Dr Peter Kazembe presented the key issues influencing uptake of IPTp. At present almost all sub-Saharan African countries have a national MIP policy that includes the adoption of IPTp. However, IPTp coverage remains low. Experience from countries with ANC attendance of about 94% with 16% IPT2 uptake, for example, demonstrates that high ANC attendance alone is not sufficient to ensure high IPT coverage. Important contributory factors include inadequate drug supply, staff shortages, poor health worker knowledge and practices, and poor ANC access. Success scale-up of IPT scale up will require close collaboration between national malaria control and Reproductive Health programmes.

Discussion around IPTp uptake ensued and raised more discussions about the role of the community. Some concerns and misconceptions about IPT prevent its promotion by communities and uptake by pregnant women. For example, communities may wonder why SP is being given to mothers, if it is not good for children, and the national policy has changed in favour of ACTs? There are also questions about the potential role of TBAs in promoting or delivering MIP interventions. A joint statement issued by WHO and UNICEF clarifies the role of TBA in maternal and newborn health care. TBAs have a role in supporting women at the community level and providing timely referral to healthcare workers and facilities with appropriate skills and resources for maternity care to save women's lives. They can also advise women to use various effective interventions such as ITN and IPT and provide psychosocial support. They can also serve to effectively mobilize communities to engage in appropriate health promotion activities. Service quality and logistics issues must be addressed.

Dr. Desmond Chavasse's presentation on “ITN Delivery Through ANC” was delivered by Dr. Juliana Yartey. PSI’s experience shows that delivery of ITNs though ANC is beneficial in terms of Access, Attendance, Distribution, Promotion, Targeting Subsidies, and Accountability. While subsidies are thought to be sustainable, arguments over free versus cost should not prevent ITNs from being distributed in ANC. Lessons learned include the fact that ITN distribution through ANC can be scaled up. In Malawi, demand outstripped supply at subsidized cost of $0.50.
The ITN presentation generated much discussion and a variety of viewpoints. Market issues may not be relevant where LLINs are used and are not available commercially. ITNs/LLINs should be considered as public goods and should be free. PSI, though known for subsidized nets also sells to other programs that distribute free. There's need for a comprehensive ‘package’ of interventions and not just a one-commodity promotional activity. Package would include not only malaria commodities and services but all relevant maternal health services. When an

intervention or a commodity such as ITN is not part of a package, there could be high uptake but poor utilization. Ultimately, coverage is the main issue.

An observation was made regarding ITN coverage for pregnant women which appears to track with ITN coverage in the general population regardless of whether IPTp coverage is high or low. Apparently this is a supply problem and implies that ITN distribution is not well linked with ANC where IPTp is given. It was suggested that ITNs be linked with routine immunization programs as well. Participants observed, that sometimes health workers do not want to be burdened with the responsibility of cost-recovery.

Dr. Peter Olumese addressed current issues related to Case Management during pregnancy. Artemisinin-based combination therapies (ACT) are recommended for the treatment of all cases of uncomplicated falciparum malaria including: in infants, in people living with HIV/AIDS, for home-based management of malaria, and pregnant women in the 2nd and 3rd trimesters. An exception is during the first trimester of pregnancy - only use ACTs when there are no alternative effective antimalarials. Peter also outlined diagnosis and research issues. One challenge is parasitological confirmation (microscopy or RDT) before treatment. Exceptions to diagnosis preceding treatment include children under 5 years of age, from areas of high transmission and suspected cases of severe malaria. The following high priority research areas were identified:

- malaria diagnosis in < 5 year-olds in high transmission areas
- treatment of uncomplicated and severe malaria in pregnancy
- treatment of *P. vivax*
- rectal artemisinin in the management of severe malaria
- management of HIV/AIDS and malaria, etc…

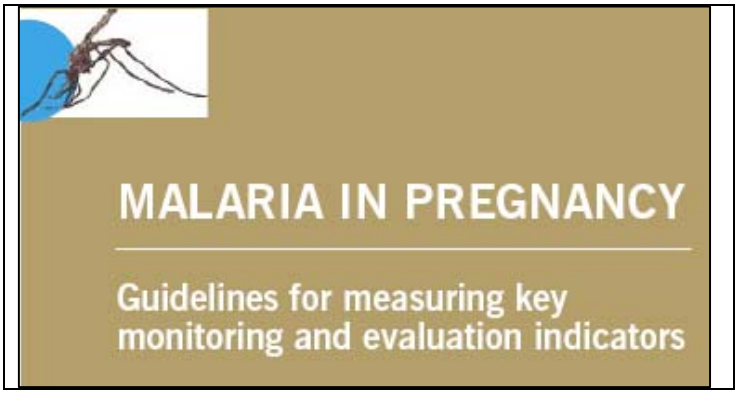
One issue discussed was effectiveness and sensitivity of RDTs – when to use them? Participants felt it was important to recognize that not all fevers are malaria. The issue of asymptomatic malaria was raised and questions were asked about the role of RDTs in diagnosis of asymptomatic malaria infection in pregnant women. Concerning the WHO malaria treatment guidelines the need to include IPT and clarify the difference between the concept of IPT, treatment and chemoprophylaxis for travelers in the next issue of the guidelines was stressed. It was also noted that placental malaria does not cause fever.

In the absence of Dr. Moji Odeku for MOH Nigeria, Dr. Bill Brieger presented experiences on collaboration between NMCP and Reproductive Health in implementing MIP programs in Nigeria. In 2004, the Malaria Action Coalition (MAC) brought the National Malaria Control Program and Reproductive Health programmes together to develop national MIP Guidelines and to adapt Focused Antenatal Care (FANC) training materials. Challenges to MIP implementation and scale-up in Nigeria include -

- Dissemination of guidelines
- Improvement of public sector ANC attendance
- Dedication of SP for IPT including better procurement and supply management
- Incorporating MIP indicators to M&E system
- delivering LLINs through ANC

Malaria Action Coalition partners provided technical assistance to address these issues. Subsequently, in 2006, MAC worked with the MoH to overcome bottlenecks in Nigeria's GFATM malaria grant, a key component of which was MIP. NMCP and RH programmes were brought together to identify problems and set priorities for MIP. MAC sponsored a national MIP strategy development workshop in 2007. The next step is to observe RH participation in grant implementation.

Ensuing discussions stressed the need to get RH programs more involved in GFATM proposal writing and not just implementation. Participants expressed concern about MIP being subsumed under case management in some country proposals. This results in budgeting only for SP for IPT within the proposal as the MIP component, which is clearly inadequate. They expressed a need to look at whole RH systems strengthening, not just MIP. A guidance document for GFATM proposal development prepared for countries and consultants by WHO was shared with the group for input and feedback.



Issues of monitoring and evaluation were addressed by Dr. Rick Steketee in a presentation entitled "Measuring Progress". He introduced the MIP Monitoring and Evaluation guidelines which has been finalized and is in the process of being printing by WHO. He stressed the need for a link between 1) strategy, 2) measurement, and 3) response. For example the strategy may be IPTp coverage and use (DOT with 2+ doses). Measurement on IPTp coverage and use can be obtained through population-based household surveys (DHS, MICS, MIS). If results show inadequate IPTp coverage, responses might be aim at improvements in procurement, ANC supplies, staff distribution, procedures, and/or acceptance.

The following indicators and sources of information were outlined:

- Impact indicators
  - % LBW singleton live births & by parity (Household [HH] survey; Health Facility [HF] registry?)
  - % of screened pregnant women with severe anaemia (HH survey)
- Outcome indicators
  - % of pregnant women receiving IPTp as DOT (HF survey/registry)
  - % of pregnant women who slept under an ITN last night (HH survey)
- Output indicators
  - % ANC staff trained in the last 12 months (HF survey/registry)
  - % ANCs reporting drug stock-out (HF survey/registry)

Discussion followed. One question was "Why is there no case management indicator?" in response it was noted that in RBM's previous external review it was criticized for having 75-100

indicators. There is need to keep indicators few and simple – ones to which the health system can actually respond. MIS has been done in Zambia, Angola and Senegal. UNICEF has MICS data.

Session 3: MIP Networks

Dr Dorothee Kinde-Gazard described network experiences in East/Southern and West Africa. RAOPAG is based in 9 countries in West Africa. MIPESA includes 5 countries in East and Southern Africa. Examples of Network Activity include efforts 1) to support countries for scaling up MIP interventions, 2) to establish a monitoring and evaluation system, 3) to follow up MIP research and sharing experience and lessons learnt and 4) to identify funding and resources for supporting networks. She concluded that RBM is the main hope for supporting the networks and advocacy is needed in the Board meeting to have resources to sustain the networks.

In the ensuing discussion, efforts were made to help networks focus their terms of reference on activities that would be compatible with the overall RBM MIP Working Group and give added value. This would put the networks in a better position to source support through RBM, either directly from the Board or jointly from other sources. Network Terms of Reference will be reviewed and suggestions made for their consideration and adoption in order to streamline them into the Working Group. Networks are unique subregional and country coalition mechanisms that the MPWG can work with to achieve the RBM Partnership goals.

Day 2: Session 4: RBM Functions and Change Initiative

Dr. Boi-Betty Udom briefed the group on the RBM Change initiative. This resulted from a 2005 meeting in Yaoundé where the strengths and weaknesses of the RBM partnership were discussed. A consulting group led the RBM Partnership through an assessment process from January-November 2006. A new organogram was developed and roles and responsibilities were more clearly defined, particularly the roles of the RBM secretariat.

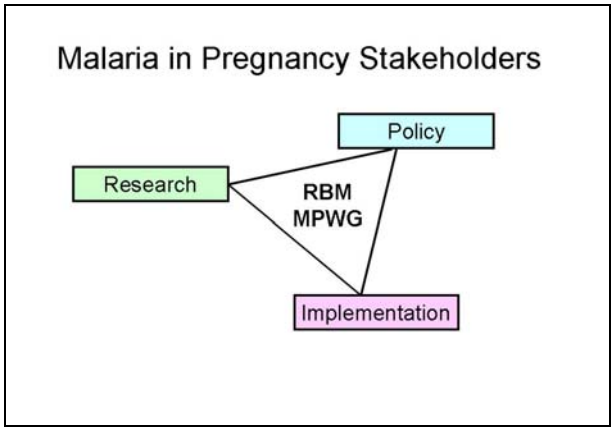
The last RBM Board meeting decided that the main challenge was to support countries and therefore they created the Harmonization Working Group to coordinate input/support from all partners. The Global Fund application process was identified as an opportunity to work towards more successful malaria grant applications and coordinate partners efforts.

The decision on hosting of RBM is embodied in a MOU with WHO, in which RBM is within the HIV, TB, Malaria (HTM) Cluster of WHO under the Assistant Director General (ADG) HTM, and no longer under the Global Malaria Program (GMP). This hosting arrangement will be tried for one year.

Partners wanted to see a clear strategy for malaria control to be addressed by each working group. Each working group will make suggestions to the Board about future roles and directions. The Board would like to see best practices coming out of each working group so that informed decisions can be made and communicated to each country. In short, working groups would define best practices and provide implementation support to countries using these best practices as guidance. Each working group must now identify how it can contribute to the partnership and what products it can deliver.

The RBM Secretariat should broker efforts at coordination, harmonization, consensus and reduction of fragmentation. WHO on the other hand will focus on policy, norms, standards but not on implementation. Other partners will have implementation roles and the RBM Partnership brings them all together with their various skills. As a broker the Secretariat can help mobilize additional recourses to ensure the success of countries with a good performance record and channel help to those with poor performance.

Effort was made to distinguish between GMP's TEGs and RBM's WGs. There is concern about duplication. Some do not have clear boundaries. Process WGs like the Harmonization WG may have a less ambiguous role in RBM. The technical groups like MIP, ITNs and Case Management groups may find overlap. To survive a WG must have a clear product in mind and provide help to countries. The MIP WG especially has a unique role in terms of bridging the gap between Malaria and Reproductive Health programs and is not a sub-group of either.



Stakeholders with interest in MIP were identified and came from the realms of research, policy and implementation. Each brings different strengths and efforts which must be coordinated. Stakeholders must also represent both malaria and reproductive health.

RBM has been receiving requests to expand into Latin America and Asia. The original focus was on Africa due to the seriousness of the problem. Now others want in. The implication of this for MIP must be studied.

Concerning the Workplan, participants talked about the potential unique contribution of regional networks, but recognized the need to be quite clear on the tangible products and results expected from supporting networks. Networks can address the complexity of MIP which spans both malaria and reproductive health and thus provide an opportunity for collaboration between these two groups. Reasons for difficulties in implementing MIP programs can result from the fact that these two programmes often do not work together efectively. Networks fostering collaboration therefore, would be a valuable outcome not just for malaria and reproductive health programmes but for promoting and supporting maternal and child health and survival in general. It is important to document and share the experiences of the 14 countries already involved in the two sub-regional networks for MIP, and this is ongoing.

Session 5: Terms of Reference and Workplan

Participants worked in two groups to develop drafts of a revised TOR for the MPWG and an annual Workplan. A first suggestion by the Workplan group was to focus on two years instead of one. Concerning input to this years GFATM proposals, the group conceded that it might be too late for to make any significant contribution this year, as the MIP working group does not have resources to support countries in this effort at this time. Once resources are allocated by the

Board, it should be possible to organize substantial support to countries for the inclusion of MIP concerns adequately in their GFATM proposals, and subsequent support for implementation. The RBM Board does not meet until May 2007 and the GF proposals are due in July 2007. This informed the need to have a 2-year workplan for submission to the Board.

The TOR group addressed the existing document and worked on updating it. Key suggestions for the core TOR elements included the following:

- Facilitate development of consensus among partners on strategic issues related to implementation of interventions for the prevention and control of Malaria During Pregnancy (Intermittent preventive treatment, Insecticide treated nets and effective case management of malaria and anaemia) in the WHO Africa Region and relevant strategies for other regions.
- Analytic role: Track progress in countries, Synthesize experiences and disseminate best practices related to the implementation of interventions for MIP
- Identify emerging programmatic and implementation research questions and bring these to the attention of relevant partners.
- Keep MIP working group partners informed of relevant developments within partner institutions and other working groups
- Identify critical strategic and programmatic issues arising from implementation of malaria in pregnancy interventions and activities and ensure responsibility is taken up by working group members, sub-regional networks and other RBM Partnership groups for follow up action
- Assist to coordinate partner resources targeted to control of malaria during pregnancy through the Harmonization working group
- Advocate for increased attention to and resources targeted to control of malaria during pregnancy through the Advocacy working group.
- Recommend strategies for addressing the capacity gaps for scaling up for impact
- Promote collaboration and bridging between malaria and reproductive health partners at all levels and between national programs at country level

A full draft of the TOR will be circulated.

The draft Workplan addressed the following focus areas and activities, and like the TOR will be circulated in draft form.

1. Documentation of Best Practices

- Synthesize and disseminate country level best practices and lessons learned including RH-Malaria collaboration experiences
- Role of Community in MIP implementation: Synthesize and disseminate country level community-based activities and interventions that support and promote MIP within context of RH
- Synthesize and disseminate information on the various models of ITN delivery and benefits of ITN delivery through ANC.

2. Situation and Gap Analysis and Response to MIP
   - Conduct desk review of MIP components of donor programs (e.g. GFATM) and coverage data in sub-regional network countries

- Orient sub-regional networks on conducting country-based situation analysis to identify MIP program implementation bottlenecks
- Sub-regional teams conduct country-based situation analysis

3. Sub-Regional Networks and Resource Centers
   - Develop capacity of sub-regional networks to provide technical assistance for overcoming MIP bottlenecks and support scale-up of MIP interventions.
   - MIP Networks to provide technical assistance to overcome implementation Bottlenecks.

   - Equip MIP networks to provide support to countries to incorporate MIP indicators into their maternal health cards and registers and establish a common regional understanding and methodology for data collection and reporting for monitoring and evaluation purposes.
   - Provide technical assistance through sub-regional networks in global fund proposal development to include MIP (Mal and RH programs to be involved in this process)
   - Strengthen sub-regional network secretariats to provide MIP implementation support in countries
     a. MIP Network Secretariats to establish sub-regional list-serves for disseminating updates in MIP
     b. Establish MIP Expert and Consultant database
     c. MIP Secretariats to collate country-based MIP implementation concerns to feed into MIP research agenda.

3. Disseminate MIP related materials and tools through RBM subregional networks:
   - M&E guidelines for MIP.
   - Recommendations from WHO Technical Consultation on Effectiveness of IPT/SP in areas of moderate-to-high resistance to SP.
   - WHO/UNICEF Statement of the role of Traditional Birth Attendants (TBAs) in maternal Health Care.
   - Technical Brief clarifying concept of IPT and distinction from case management e.g. why SP is no longer recommended for case management but recommended for IPT. -
   - Statement addressing concerns about IRS and pregnancy,

4. Advocacy
   - In collaboration with Advocacy working group, identify MIP champion organizations (NGOs, donors) who will commit to advocacy efforts, and work together in advocacy efforts.

5. Resource Mobilization
   - Identify organization willing to commit resources to MIP activities and support for country level operations research and scale-up.

6. Responding to a Global Need
   - Commence development of a Global Framework for MIP.