



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

**28-30 April 2004
Accra, Ghana
Novotel Hotel**

MEETING MINUTES

Participants: Constance Marfo (Ghana MOH), Judith Robb-McCord (JHPIEGO/MNH Program), Seipati Mothebesoane-Anoh (WHO/AFRO), Elaine Roman (JHPIEGO/MNH Program), Juliana Yartey (WHO/HQ), Michelle Folsom (PATH/Kenya), Kwame Asamoah (CDC/MAC), Alison Bell (Malaria Consortium/EARN), Antoinette Ba (WHO/AFRO), Antoine Serufulira (WHO/AFRO), Mark Young (UNICEF), Peter Kezembe (MIPESA), Jackson Sillah (WHO/AFRO), Winnie Mwebesa (CORE Group), Joyce Ab (JHPIEGO), Joseph Akuamoah (USAID/WARP)

Chair: Judith Robb-McCord, JHPIEGO/Maternal and Neonatal Health Program
Co-Chair: Seipati Mothebesoane-Anoh, WHO/AFRO-Brazzaville

Overall Meeting Objectives:

- 1. To develop recommendations to the RBM Partnership regarding the prevention and management of malaria during pregnancy, including:**
 - a. Scale Up**
 - b. Integrated Reproductive Health Services**
 - c. Community distribution of IPT**
 - d. Use of SP for IPT in areas of increasing SP resistance for case management**
 - e. The integrated management of malaria in HIV+ pregnant women**
- 2. To outline next steps and actions for the Working Group in support of the RBM Partnership**

DAY ONE—28 April 2004

Objectives:

- 1. Understand the role of the Malaria in Pregnancy Working Group as per the evolution of expectations from the RBM Partnership;**
- 2. Update WG members on status and activities of the regional networks and coalitions;**
- 3. Discuss progress and/ or current status (and next steps) of MPWG identified workplan tasks;**
- 4. Identify program implementation issues raised from Coalition/Network and country updates.**

Judith Robb-McCord, Chair, welcomed participants to the third RBM Partnership Malaria In Pregnancy Working Group (MPWG) meeting and re-introduced Dr. Seipati Mothebesoane-Anoh, the Co-Chair. Ms. Robb-McCord reviewed the agenda with participants and emphasized that discussions during days 1 and 2 would support the development of key recommendations to the RBM Board that will support regional and country efforts for the prevention and control of malaria during pregnancy. The meeting minutes from the MPWG meeting held in Tanzania (1-2 October) were officially adopted with no revisions. The MPWG members introduced themselves.

Brief of RBM Partnership Board Meeting, 29 – 30 March, UNICEF/NY

Judith Robb-McCord updated the MPWG on the RBM Partnership meeting that was held 29-30 March 2004 at UNICEF in New York. The Board Chair announced the new Executive Secretary of the RBM Partnership, Dr. Awa Marie Coll-Seck. Dr. Fatoumata Nafo-Traore, the former Executive Secretary, is now the Director of WHO's Malaria Division. Discussions throughout Day 1 focused exclusively on improving access to effective case management using, primarily, Artemisinin-Combination Therapy (ACT). Highlights from the discussion included:

- A summary of recent discussions and presentations on the proposed Medicines and Supplies Services (MMSS) initiative as a roadmap to increase access to ACTs;
- RBM Partnership support for increased ACT production and the promotion of mechanisms that will reduce prices of pre-qualified ACTs;
- The recognition that “promise to buy” would provide assurance to markets and would need to take place prior to the development of a sustainable ACT market; and;
- Existing gaps between policy change, the training of health workers and the deployment of ACTs are areas that require more investments, particularly with respect to accelerating ACT use in decentralized systems.

Day 2 of the RBM Partnership Board Meeting looked at the progress of the RBM Secretariat. Representatives from the RBM Working Groups reported on activities undertaken or supported by their groups and related networks.

The RBM Secretariat commissioned the Malaria Consortium (MC) to examine the role of the RBM WGs; specifically, to evaluate their purpose and their functionality under the RBM umbrella. The value added of the Working Group products was recognized but the need for greater guidance on issues of Working Groups scopes was noted. Issues raised for Board review include: strengthening linkages among and between Working Groups; reconfiguring the Working Groups to avoid fragmenting the overall RBM effort for the effective management and prevention of malaria; and how Working Groups can focus on defining practical solutions to bottlenecks identified at the country level. Based on the outcome of the Malaria Consortium review, the Secretariat will consider revising the terms of reference of the Working Group. It was agreed that the Secretariat's financial resources should not be the primary source of funding for Working Group plans and that participating members needed to help mobilize additional resources for activities. Additionally, it was agreed that the primary users of Working Group products should be the global RBM Partnership in order to build consensus on policies for scaling-up.

From this discussion the MPWG agreed to spend time on Day 2 providing additional input to the Malaria Consortium as per the Secretariat's review of the Working Groups.

Coalition and Network Updates

Updates from the East Africa RBM Network (EARN) and the Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition were presented. Unfortunately, participants from Réseau d'Afrique de l'Ouest contre le Paludisme pendant la Grossesse (RAOPAG)/Malaria in Pregnancy West Africa Coalition and the West Africa RBM Network (WARN) were not available to give updates. Dr. Seipati Mothebesoane-Anoh asked presenters to focus on achievements, challenges and country needs from the WG.

Malaria in Pregnancy East and Southern Africa (MIPESA) Coalition— Dr. Peter Kezembe, Chairman of the MIPESA Coalition, updated the MPWG on the Coalition. Briefly, the MIPESA Coalition was founded in 2002 and is made up of representatives from five countries (Kenya, Uganda, Tanzania, Malawi and Zambia) and international partners to accelerate country efforts targeting the scale up of the prevention and management of malaria during pregnancy through the sharing and dissemination of best practices and lessons learned. The MIPESA Coalition is designed to share lessons learned, best practices, state of the art technical and programmatic approaches within the region and more broadly in Africa. The Regional Centre for the Quality of Health Care (RCQHC) serves as the Secretariat for the MIPESA Coalition. MIPESA's TOR are written so that the Chair and Vice-Chair represent Malaria Control and Reproductive Health programs.

The MIPESA countries are linked through high burdens of malaria and high ANC coverage. Although all countries were at different stages of implementation when the Coalition was formed, the countries recognize they can support each other in their efforts to address malaria during pregnancy. Key successes include collaboration between malaria control and reproductive health partners. The MIPESA Coalition recently published the first MIPESA Newsletter that highlights some of the recent achievements in the sub-region. The MIPESA Coalition also developed a proposal for the GFATM for

Round 3, which was not funded. However, based on the positive feedback from the Global Fund Review Committee, the proposal was re-submitted in Round 4 with revisions made to address the TRP comments.

East Africa RBM Network (EARN)— Alison Bell, Malaria Consortium, updated the MPWG on EARN. Briefly, EARN covers seven countries and includes members from participating countries. EARN has five objectives: 1) provide countries with programmatic support for malaria control; 2) support for scale up based on evidence based practices; 3) support countries in RBM partnership management; 4) support Global Fund proposal development at the country level; and 5) coordinate the REAPING missions for East Africa. EARN is a virtual network with a coordinating committee with regular meetings and one annual country meeting including workplanning. Countries feed into the workplan based on assistance needed. Partners work through the EARN coordinating committee to support countries to meet their goals. A joint workplan was developed in 2003 with over 20 partners providing input to meet countries' needs. The 2003 EARN workplan 'Malaria during Pregnancy' section includes: a) Strengthening advocacy efforts; b) Development of Strategic Plans for Rwanda, Burundi, and Zanzibar; and c) Implementation of IPT.

EARN has supported REAPING (RBM Essential Actions Product Investments Needs and Gaps) missions and all category 1 countries are complete. The purpose of the REAPING missions was to see what is happening at the country level and how countries are working towards reaching Abuja targets. Through consultative country meetings, country gaps and key barriers to reaching Abuja targets were identified. Based on country need, EARN issued a statement on the use of DDT and Indoor Residual Spraying. Rwanda, Burundi and Somalia have requested REAPING missions.

Ms. Bell reported on behalf of EARN that the Global Fund process at the country level has been long and arduous. Countries that are promised funding under the Global Fund are noticing a reduction in donor funding due to the expectation of Global Funds. However, the process for receiving and disbursing the funds is somewhat complicated and slower than expected. This is having a detrimental impact on country budgets and the process of planning. Countries are economically fragile and Ministries of Finance are trying to balance funding and support with promised funds from Global Fund. National programs are under enormous pressure to implement, however, their resources are being depleted elsewhere and Global Funds are delayed.

The Networks want technical advice and guidance from the WGs. The WGs should use the Networks as an avenue to focus information to countries. The information provided from MIPESA and EARN should serve to focus discussions and policy advice coming from the RBM MPWG.

A consolidated list of issues and challenges confronting EARN and the MIPESA Coalition countries follows:

- Strengthened monitoring and evaluation at the country level to more adequately measure impact
- Alternatives for IPT in areas of unstable transmission
- Pharmacovigilance- ACTs and CTs in pregnant and lactating women
- For countries that have adopted CTs first line, what are alternatives for IPT?
- Community-based distribution of IPT
- GF-Impact at country level partnership funding
- Scaling up IPT and ITNs
- Optimal number of IPT doses in HIV prevalent settings
- Alternative drugs for IPT in areas of increasing SP resistance
- Promotion of OR at the country level
- Advocacy and behavior change communication
- Quality of Care

West Africa RBM Network (WARN) and Réseau d’Afrique de l’Ouest contre le Paludisme pendant la Grossesse (RAOPAG)/Malaria in Pregnancy West Africa Coalition—Professeur Sename Baeta was scheduled to update the MPWG on the West Africa RBM Network (WARN) and RAOPAG, however, he did not attend the meeting. A RAOPAG presentation was provided prior to the meeting that outlined RAOPAG’s structure and support for regional efforts to prevent and control malaria during pregnancy. Briefly, RAOPAG is a Network of countries in West Africa founded to “share experiences and best practices for the prevention and treatment of malaria during pregnancy.” RAOPAG’s founding country members include Benin, Burkina Faso, Cote d’Ivoire, Mali, Senegal and Togo. The Network includes international and incountry partners with a Steering Committee, Secretariat, and country teams. RAOPAG’s priorities include accelerating programs targeting malaria during pregnancy, advocacy efforts to revise policies as needed, dissemination of information, collaboration between malaria control and reproductive health and development of sub-regional structures that will support country programs. RAOPAG is now a functioning Network and has applied to the Global Fund for AIDS, TB and Malaria in Round 4 to support sub regional goals.

Update from the RBM Partnership Board—Dr. George Amofah, Chair of the RBM Partnership Board and the Director of Public Health Division, Ministry of Health in Ghana, attended the morning session of the meeting and spoke briefly about the Partnership Board, the Secretariat and expectations about the RBM Networks and Working Groups. The Secretariat has links to countries and the Networks which are made up of implementing partners. There is a regional focal person between the Secretariat and the Networks to promote linkages between the Networks. The Networks are really there to support the countries. The WGs are set up to provide technical information and guidance to the RBM Partnership Board. The WGs can address technical issues and questions through technical advice and dissemination of information. The WG is not a technical support implementing body. WGs should be advising on emerging issues.

WHO/AFRO Clinical Guidelines for the Prevention and Management of Malaria in Pregnancy— Dr. Antoinette Ba presented the *Guidelines for the Management and*

Prevention of Malaria in Pregnancy. These guidelines are linked to the WHO AFRO Strategic Framework for the Prevention and Management of Malaria in Pregnancy, which is a policy document. The Strategic Framework has gone through the review committee and is with the final editor and is expected to be available for distribution soon.

The clinical guidelines were developed to support countries to implement malaria prevention and control efforts. The guidelines target trainers and health workers at the district level. The current version is still draft. The document is expected to be finalized by mid-June 2004. Once completed, the IPT fact sheet will be extracted as a job aid for providers. The guidelines are comprised of five sections: 1) Introduction; 2) Overview; 3) Management of Malaria During Pregnancy; 4) Prevention of Malaria During Pregnancy; and 5) Operational Research. The MPWG was asked to provide feedback and input prior to the close of the meeting 30 April 2004. MPWG participants agreed to read the clinical guidelines and provide input to Dr. Ba on Day 2 of the meeting.

ESA Regional Advocacy Training and Next Steps— Michelle Folsom, Africa Regional Representative for PATH provided this update. First she provided an update to the MPWG workplan that includes a list of advocacy materials now available on the RBM Web Page and linkage to the RBM Communication and Advocacy WG (CWG). The CWG has developed a draft Communication Strategic Framework that is available for review, an advocacy brochure also available for review and is in the process of developing a global RBM Advocacy proposal to the Gates Foundation. These linkages should continue to be strengthened.

Secondly, with funding from USAID, through the Maternal and Neonatal Health Program, PATH facilitated the MIPESA Advocacy workshop, which included malaria control, reproductive health and IEC specialists. The overall goal of the advocacy-training workshop was to strengthen the capacity of the five MIPESA member countries to carry out national and community level advocacy for malaria in pregnancy. Specific objectives were to increase knowledge and understanding of advocacy and how it can support MIPESA in meeting its objectives, introduce proven advocacy approaches, build basic skills in advocacy through participatory activities and sharing experiences, increase access of available data to inform the advocacy process, increase confidence to those embarking on advocacy efforts, and to develop an advocacy plan/strategy. To realize the full gains of this workshop follow on support is being given through JHPIEGO/MNH and the RCQHC. *A full workshop report is available through JHPIEGO.*

Overview of Malaria in Pregnancy in Ghana—Dr. Constance Marfo, MOH-Ghana, updated the MPWG on Ghana's experiences in the prevention and control of malaria during pregnancy. Malaria accounts for 13.8% of all OPD attendances by pregnant women, 10.6% of admission and 9.4% of deaths (approximately 2000). Ghana changed its anti-malaria policy for pregnant women from chloroquine chemoprophylaxis to IPT with SP in May 2003, based on international and national evidence. Ghana undertook a double-blind placebo control trial (Dr. Nii Larye Browne), which showed improved birth weight with multiple doses of SP (up to six). The trial also indicated that SP given earlier in pregnancy had higher benefit. Based on the study, Ghana adopted the IPT policy that

supports all pregnant women to receive three doses of IPT with SP. Of note, CDC pointed out that only when HIV prevalence is 10% or more it is more cost effective to give everyone 3 doses of IPT.

Lessons learned from Ghana include:

- Consensus at all levels;
- Involvement of all stakeholders from beginning- especially RH, procurement, NGOs, private sector;
- IEC sustained, repetitive- but don't start IEC when goods products are not ready;
- Scheduling of activities important; and
- Monitoring- establish system for monitoring.

Intermittent Preventive Treatment with SP and HIV OIs prophylaxis with Trimethoprim-Sulfamethoxazole—Kwame Asamoah presented the relationship between CTX and SP among pregnant women and the benefit of CTX to HIV positive women and the implications for those who are dually infected. CTX has antimalarial activity similar to SP. Additionally, CTX and SP are chemically similar with evidence of *P.falciparum* cross resistance between them. All pregnant women who are HIV positive should be receiving CTX. Simultaneous use of SP and CTX should be avoided since such combination results in a 10-fold increase of severe adverse drug effect. The emerging consensus is that the real benefit of CTX for HIV women outweighs the unknown risk of compromising efficacy of antifolate antimalarials.

This information has important programmatic implications that the MPWG agreed to discuss further on Day 2 and 3 of the meeting. Some of these include: a) addressing the integration of services; and, b) the development of case studies that address implementation issues.

DAY 2

29 APRIL 2004

Objectives:

- 1. Identify program implications for scale up, recommendations and action steps from the regional and technical updates**
- 2. Discuss technical updates related to the prevention and control of malaria during pregnancy;**
- 3. Initiate process of developing consensus statements around key themes/issues**
- 4. Provide technical guidance and input for the WHO/AFRO Clinical Guidelines for the Management and Prevention of Malaria in Pregnancy**
- 5. Review the findings of the Malaria Consortium review of the RBM Working Groups and provide further insight and recommendations**

Judith Robb-McCord welcomed participants to the second day of the MPWG meeting with a brief review of Day 1. Elaine Roman went through the Day 2 agenda, which was

revised based on Day 1 discussions. Two agenda items were added: 1) Input to the Clinical Guidelines and 2) Function of the MPWG.

Community-based Delivery of IPT— This session was chaired by Dr. Peter Kezembe. Dr. Antoinette Ba presented—the *Role of CHWs and TBAs to prevent and control malaria during pregnancy*. This session laid the foundation for discussion around community service delivery with particular focus on community-based and household distribution of IPT. Dr. Kazembe presented key issues:

- Guidelines and policies on the distribution of drugs varies among countries;
- We are promoting IPT through ANC as an integrated package of services— household distribution would need to maintain the full package of care;
- There are issues around the properly trained CHWs and ensuring their competence and skill to effectively manage community/household level distribution; and
- For this to be effective in the long-term, mechanisms for sustained support for community and household distribution need to be put in place.

Dr. Ba's presentation highlighted the rationale for community distribution of IPT; key to this is reaching women who do not have access to ANC. Kenya and Uganda are piloting community distribution of IPT. In Uganda the project includes MIP counseling, IPT delivery, and ANC referral. Some of the major issues include: a) the need to fit the project appropriately to the context and environment; b) delivery of drugs by CHWs and TBAs; c) can the TBA and/or CHW have the capacity to deliver services without compromising quality of services; d) ensuring the CHW and TBA will be able to refer women with complications to the appropriate level of care; and, e) linking community based providers with facility-based care. The TBA and/or CHW are not substitutes for a dysfunctional health care delivery system.

Community involvement in the healthcare is not questionable- it is essential. When defining the health care system the household level is very much a part of this. There is a continuum of care from household to hospital. We need to reach into pockets of the population that are not receiving quality care while continuing to strengthen facility based care. We need to have more answers as to how to do this effectively and with good quality. The recommendation from WHO still stands that IPT should be delivered through ANC, however, in malaria endemic areas, where ANC attendance is low- programs will need to assess the most cost-effective strategies for controlling malaria during pregnancy.- this includes community based program delivery. (WHO-AFRO Strategic Framework, 2004 in press). There was some discussion about including malaria prevention and control in complex emergency and refugee settings. The WHO-AFRO Strategic Framework for the Management and Prevention of Malaria in Pregnancy provides guidance and recommendations around community distribution of IPT that should be used to advise countries who are dealing with these issues.

Input to Clinical Guidelines-- Dr. Kazembe facilitated this session. Feedback was provided to WHO-AFRO and is available from JHPIEGO in a separate attachment upon request. The input was given to Dr. Ba for her consideration and input.

Malaria, Pregnancy and HIV Infection—Dr. Kwame Asomoa presented to the MPWG the effect of HIV on malaria during pregnancy. Based on a recent study conducted in Kisumu, Kenya- HIV positive pregnant women had a higher relative risk of developing peripheral, placental and clinical malaria. Malaria infection among pregnant women stimulates reproduction of HIV viral load. Co-infection with malaria and HIV in pregnant women contributes to maternal anemia, LBW and increased risk for poor infant survival. The MPWG agreed that this presentation has important programmatic implications. Additional studies are being conducted that are looking at the relationship between HIV and malaria and MTCT. Data from these studies will hopefully answer the outstanding question re: the relationship between malaria in HIV+ women and increased risk of MTCT.

Juliana Yartey updated the MPWG on WHO's position on HIV/malaria interaction. A task force has convened at WHO to review the evidence, outstanding questions and issues and will develop a WHO statement prior to the global HIV/AIDS conference to be held in Bangkok, Thailand 2004. The Director of the HIV 3x5 task force sits on this team. Another ongoing effort at WHO is between the RH and HIV units and the Malaria unit. This team is trying to set up country learning sites to learn how to implement integrated programs. There is an existing framework (presented at MPWG meeting in Tanzania 2003); a position paper has been developed and there are ongoing assessments looking at integrated service delivery (Mozambique and Uganda) that will be completed in the next month. There were updates specific to Tanzania and Uganda given around PMTCT implementation.

Malaria during Pregnancy in Low Transmission Setting—CDC is conducting a literature review on appropriate treatment strategies for low malaria transmission areas. There needs to be consensus on what is "low" and further study on when it is beneficial to adopt IPT or case management or both where relevant.

Feedback to the RBM Board on the Functionality of the MPWG—Alison Bell presented the scope of the Malaria Consortium review of the RBM Working Groups. For now, continuation of the Working Groups (WGs) will proceed. Findings of the review to date include:

- Development of indicators has been suggested to measure success and to ensure WGs are product-oriented.
- Working Groups are made up of representatives from various organizations. Many of the products listed by Working Groups are the responsibility of participating organizations and not the Working Group, per se. This has implications regarding the sustainability of the Working Groups and their ability to support product development when resources—both human and financial—are limited.
- Membership needs to be reviewed with a balance of operational and research expertise to include adequate African representation.

Recommendations include: a) WG activities should be time-limited; b) appoint person within RBM Secretariat to coordinate with the WGs.

MPWG Recommendations:

Functionality

- Current recommendations are positive and will support the accountability of the MPWG.
- The RBM Board needs to clearly lay out their expectations for the MPWG; specifically, what is their recommendation on how the MPWG will support program efforts at the sub-regional and country level. Currently, the MPWG is working to support efforts at the sub-regional level by interacting with the Networks and Coalitions. Is there an expectation to expand this interaction and what is the Secretariat's position on how the Working Groups will disseminate information and recommendations? Will this happen through the RBM Partnership?
- The term product needs to be defined- the MPWG sees the product as not something the MPWG develops in a vacuum; rather, the MPWG facilitates technical guidance and input to these RBM partner products.
- There needs to be accountability from the RBM Board with communication between the Board and the WGs. This includes not only laying out expectations and facilitating the responsibility of moving advice and products through the proper channels.
- The RBM Secretariat needs to have financial support in place to support the Working Groups including participant travel of those who do not have resources.

Indicators

- These can be pulled out of the MPWG TOR.

Developing Consensus and Recommendations Around Key Issues—The MPWG is issues central to effective scale up of implementation of malaria during pregnancy programs. After reviewing discussions from days 1 and 2, the Working Group agreed to break into three separate groups on Day 3 and develop recommendation statements for malaria case management during pregnancy; community-based distribution of IPT and use of IPT according to transmission setting and use in areas of increasing resistance; and, HIV and malaria and the integration of services.

Group One- Malaria Case Management during Pregnancy—the MPWG will make recommendations (draft out issues and questions) to the Case Management WG for further discussion. (Antoine Serufulira, Jackson Sillah, Alison Bell)

Group Two- IPT including community-based distribution, use according to transmission setting and use in areas of increasing resistance. (Winnie Mwebesa, Seipati Mothebesoane-Anoh, Antoinette Ba, Peter Kazembe)

Group Three- HIV and Malaria- Integration of Services (Elaine Roman, Michele Folsom, Mark Young, Kwame Asamoah, Juliana Yartey, Joyce Ablordeppey)

RBM Working Group for Scaling up ITNs (WIN) Statement Regarding Use of ITNs in Pregnancy for the RBM Malaria in Pregnancy Working Group

The RBM WIN submitted a statement of recommendation to the MPWG for review and adoption. As submitted, the statement read:

There is substantial evidence of benefit to mothers and their newborns from the use of ITNs during pregnancy and the postnatal period in areas of medium to high malaria transmission. Although there remain some gaps in the evidence for areas of low, highly seasonal or unstable transmission such as southern Africa, the Horn of Africa, and parts of Asia, it is likely that ITNs also help to protect against malaria in pregnancy in such settings. For this reason, the RBM Working Group for Scaling up ITNs recommends to the RBM Working Group for Malaria in Pregnancy that ITN use should be promoted in all malarious areas as a universal component of all malaria in pregnancy programs along with effective case management and IPT where recommended.

After review and discussion, the MPWG agreed to amend the statement to read:

There is substantial evidence of benefit to pregnant women and their newborns from the use of ITNs during pregnancy and the postnatal period in areas of medium to high malaria transmission. There remain some gaps in the evidence for areas of low, highly seasonal or unstable transmission; however, it is likely that ITNs also help to protect against malaria in pregnancy in such settings. For this reason, the RBM Working Group for MIP recommends that ITN use be promoted along with effective case management and IPT (where recommended) as essential components of reproductive health services for pregnant women in all malarious areas.

The MPWG endorsed this statement and will now send on to the RBM Secretariat for the Board's review and endorsement.

DAY 3
30 APRIL 2004

Day 3 focused on developing recommendations as per the groups listed above for submission to the RBM Secretariat and RBM Partnership Board. The ‘Community Based Distribution of IPT’ and ‘HIV and Malaria- Integration of Services’ groups developed final recommendations for submission to the RBM Secretariat and Board. Once endorsed, the MPWG would like to see recommendations developed by the Working Group disseminated by the RBM Board and Secretariat to global and country level partners working in reproductive health, maternal and child health, malaria and HIV/AIDS.

Group One—Case Management

The Case Management team decided that it needed additional time to review the pending issues and questions to be presented to the Case Management Working Group. This is expected to be completed by July 2004 and will be an amendment to the meeting minutes at that time.

Group Two—Community-based Distribution of IPT

A general recommendation was made regarding the WHO/AFRO Strategic Framework for the Management of Malaria in Pregnancy and the section on “Opportunities for Community-based Programming.” It was suggested that in paragraph two, that traditional birth attendant should be changed to community health worker. WHO/AFRO representatives will take this recommendation back for inclusion in the Strategic Framework.

Community-distribution (CBD) of IPT.

As a component of comprehensive reproductive health services the antenatal clinic is the appropriate point of service for IPT in areas where women attend antenatal care (ANC) at least once during their pregnancy. However in areas where ANC services are not well developed and/or attendance is low, other opportunities including community-based distribution of IPT should be explored. In the meanwhile, strengthening health systems and establishing linkages with the formal health system should be carried out to ensure CBD of IPT is not a stand-alone activity.

Issues to be considered in the implementation of CBD programs include:

1. Human resources:
 - Training and supervision of Community Health Workers (CHWs)
 - Skills: capacity to identify pregnancy and determine gestational age
 - Retention of CHWs through compensation/ incentives packages.
2. Drug management
 - Drug distribution and quality
 - Policy should be in place to ensure procurement/ distribution of drugs is controlled

- How the health system will manage the distribution of drugs to the CHWs?
 - How to ensure quality of drugs? (Limited capacity to test quality of drugs in certain countries especially when procurement is not obtained through central medical stores)
 - Management of Over the Counter (OTC) access to drugs (formal and informal sectors).
 - Costing issues
 - Revolving Drug Funds
 - Subsidized
 - Partnership between private-public sector should be considered
3. Service delivery
- Policy and management support to link communities to facility-based service delivery
 - CBD of IPT should be part of an integrated package of ANC services
 - Referral of pregnant women for ANC and skilled delivery
4. M & E
- Indicators need to be defined and integrated into the Health Management Information System (HMIS).
 - Monthly reports by CHWs
 - Data collection during DHS and community survey on IPT delivery at household level

Group Three— Integrated Reproductive Health Services: Malaria and HIV in pregnant women

Interaction between HIV and Malaria

Studies have demonstrated interactions between malaria and HIV. Malaria infection contributes to increased HIV viral load, and HIV infection increases the incidence and severity of clinical malaria. Increase in HIV viral load is associated with increased transmission and possible disease progression. In non-pregnant adults, HIV infection has been found to roughly double the risk of clinical malaria. Pregnant women infected with both HIV and malaria are at higher risk of developing anaemia, delivering prematurely, and delivering a low birthweight infant. As a result, infants born to co-infected mothers are at much greater risk of dying during the post-neonatal period than those infants born to mothers infected with either malaria or HIV alone.

Moving Forward: Programming Recommendations

Interactions between HIV and malaria will have significant implications for programming in areas with high prevalence of both conditions. The high co-burden of HIV and malaria in areas such as Africa, highlights the need for simultaneous prevention and control measures. Prevention of HIV/AIDS should be an important component of malaria control, and malaria prevention and control should be an important element of HIV/AIDS control programmes. This requires effective partnership and collaboration between these

two programmes. For the pregnant women, effective delivery of interventions for the prevention and control of both malaria and HIV, including PMTCT, is vital.

For these reasons, the RBM Working Group for Malaria in Pregnancy recommends that there should be strong collaboration between HIV/AIDS and malaria programmes for the delivery of interventions through reproductive health services, in order to achieve optimal health outcomes.

RBM recognizes antenatal services (ANC) as the appropriate entry point for delivery of interventions for the prevention and control of malaria during pregnancy, and has developed partnership with reproductive health for this purpose. Effective service delivery to meet the demands of the HIV/AIDS and malaria disease burdens requires the strengthening of antenatal care for delivery of an integrated package of interventions. This integrated package should include intermittent preventive treatment (IPT), insecticide treated nets (ITNs), and effective malaria case management, as well as interventions for prevention and control of HIV (VCT and PMTCT).

It is important to highlight that pregnant women who are HIV positive who are receiving CTX prophylaxis for opportunistic infections, should not receive IPT with SP, since adverse drug reaction in HIV+ persons using the two drugs increases by 10 fold as per the WHO UNAIDS recommendations.

OVERALL RECOMMENDATIONS FROM MEETING:

Based on discussions over the three-day period, the MPWG agreed to the following list of recommendations for future action:

- Include representation from lead partners in HIV and newborn health in the MPWG (include representation from lead partners at the policy level—not to exceed 2 representatives for each technical area)
- Establish formal linkages between and among RBM Working Groups beginning with a meeting of Chairs and Co-Chairs in Geneva in the next 3-6 months
- Encourage an Africa-regional meeting to share the evidence-base on the interaction of malaria and HIV in pregnant women
- Endorsement by the RBM Secretariat and Partnership Board of the MPWG TOR needs to be communicated to the MPWG

ACTIONS

- Develop a portfolio of abstracts on HIV and malaria interaction for distribution to regional networks, coalitions, partners and countries
- Development of a list (a review of the research) of what studies are ongoing or being planned around the interaction of malaria and HIV in pregnant women and the risk of MTCT. The WG decided to set up a task force that will look at all the questions and issues to come up with a comprehensive list of questions and that represent country needs

- Discuss with key members (e.g. CDC, MIPESA, WHO) the possibility of developing presentations for the upcoming WHO International Best Practices in RH Conference to be held in Uganda in June 2004
- The MPWG should read the initial draft of the MC Working Group assessment report and provide feedback to Judith Robb-McCord on the MPWG's achievements.
- Look for other opportunities for MPWG participants to participate in global, regional and sub-regional conferences.
- PATH representative to follow up with Communications WG on their strategy and advocacy brochure for review by the MPWG.
- Determine why colleagues from various groups including SAMC, WARN and RAOPAG did not attend the meeting and determine what needs to be done to ensure participation in the future.

NEXT STEPS

The minutes will be finalized and forwarded to the RBM Secretariat by the end of May. The recommendation statements will be forwarded to the RBM Secretariat by the end of May. The Chair of the WG will forward the revised ITN statement to the WIN and will send the recommendations on case management for malaria in pregnancy to the Working Group for Case Management.

The next meeting will be in early October 2004. The WG secretariat will look into holding the meeting in Madagascar, Rwanda or Zanzibar.

Suggestions for the next agenda include:

- Review of an MIP Fact Sheet that incorporates the IPT Dose Fact –WHO;
- Review of the M&E Pilot Indicators for malaria in pregnancy;
- Malaria prevention and control in emergency situations, including refugee settings, internally displaced populations, etc.