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**ROLL BACK MALARIA – MALARIA IN PREGNANCY (MiP)**

**19TH ANNUAL MEETING**

**SEPTEMBER 18-20, 2017**

**GENEVA, SWITZERLAND**

**Executive Summary:**

The 19th Roll Back Malaria- Malaria in Pregnancy (MIP) Working Group (WG) annual meeting was held from September 18-20, 2017 in Geneva, Switzerland. The meeting was organized in collaboration with the RBM Partnership, The Global Fund, PMI, Jhpiego and the USAID supported Maternal and Child Survival Program.

The **objectives** of the meeting were:

1. To review current working group priorities, structure and activities
2. To debrief on the dissemination and implementation of WHO’s new ANC recommendations
3. To share best practices in MiP programming from countries
4. To present and discuss key research in MiP programming
5. To present and discuss new opportunities for innovation in MiP programming
6. To identify future working group priorities, strategies and workplan for MiP prioritization

These objectives were achieved through a diverse series of presentations, panel discussions and group brainstorming sessions. Speakers included technical and programmatic leaders, donors, researchers and NMCP and MCH country representatives who shared their country experiences with MiP targets and interventions. A complete meeting agenda is available as Annex 1.

**Participants:**

The meeting included thirty-two participants representing the donor, academic and implementation communities. A complete list of participants is available as Annex 2.

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**Summary of Meeting Takeaways and Priorities:**

**Coordination & Collaboration-** Continued coordination and collaboration at global and country level is key to achieve our MiP WG priorities and propel MiP programming- focusing on increased IPTp uptake, use of LLINs and effective case management. The MiP WG will support efforts that:

* Strengthen partnerships to engender effective coordination and collaboration. This includes engagement with the RBM-- Country and Regional Support Committee, Social Behavior Change Communication (SBCC) MiP Sub Task Force and the Monitoring and Evaluation Working Group.
* Foster partnerships between national reproductive health programs and national malaria control programs as well as other key stakeholders (e.g. HIV, TB).

# Implementation- The [*WHO 2016* *Recommendations on antenatal care for a positive pregnancy*](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/) and the [*WHO 2013 Policy Brief for the Implementation of IPTp-SP*](http://www.who.int/malaria/publications/atoz/iptp-sp-updated-policy-brief-24jan2014.pdf?ua=1)provide key guidance to countries to support comprehensive care in pregnancy including implementing programs to prevent and effectively manage MiP. The MiP WG remains committed to:

# Supporting the dissemination of WHO policy documents, coupled with the MiP WG MiP ANC brief that provides further guidance on how countries can implement MiP programming in the context of the new ANC recommendations.

# Working with countries, through partners, to assist with the adoption of the recommendations and adaptation to the country context

# Implementation of SBCC strategies

# Documentation and dissemination of country best practices and lessons learned (e.g. program reviews, webinars)

**Tools & Products**- Effective tools and products are essential to strengthen quality care, increase demand among clients and providers and improve provider knowledge and skills. The MiP WG will support efforts to:

* Disseminate existing tools (e.g. Toolkit to Estimate Early Gestational Age, Malaria in Pregnancy Job Aid, Quality Assessments)
* Develop tools and products to support improved MiP implementation (e.g. community learning packages)

**Advocacy**- Prioritization of MiP programming remains highly important recognizing the vulnerability of pregnant women and as countries move from high to low malaria transmission. The MiP WG will continue to advocate for the most optimal care to ensure pregnant women will be protected from malaria. The MiP WG recognizes the importance of clear policy guidance for all malarious regions and will continue to advocate for guidance for all regions- especially as new evidence becomes available. The MiP WG will:

* Review and update (as needed) existing advocacy briefs and disseminate in collaboration with WHO (e.g. correct administration of folic acid, MiP in low transmission settings)
* Advocate for community based programming that has the potential to successfully expand coverage and reach the hardest to reach populations.
* Advocate for the inclusion of MiP in Global Fund grants
* Advocate for quality assured SP at point of care

# Research- Taking research to practice remains a core element of the MiP WG’s efforts. Moving forward, the MiP WG will support:

# Dissemination of key MiP research findings (e.g. to countries and partners) that include both clinical trials and operational research

**DAY 1**

**(1) WG Overview and Key Achievements**

***Viviana Mangiaterra, co-Chair***

**Shaping the global MiP agenda to ensure prioritization of MiP**

**(2) Malaria in Pregnancy (MiP) Update from WHO**

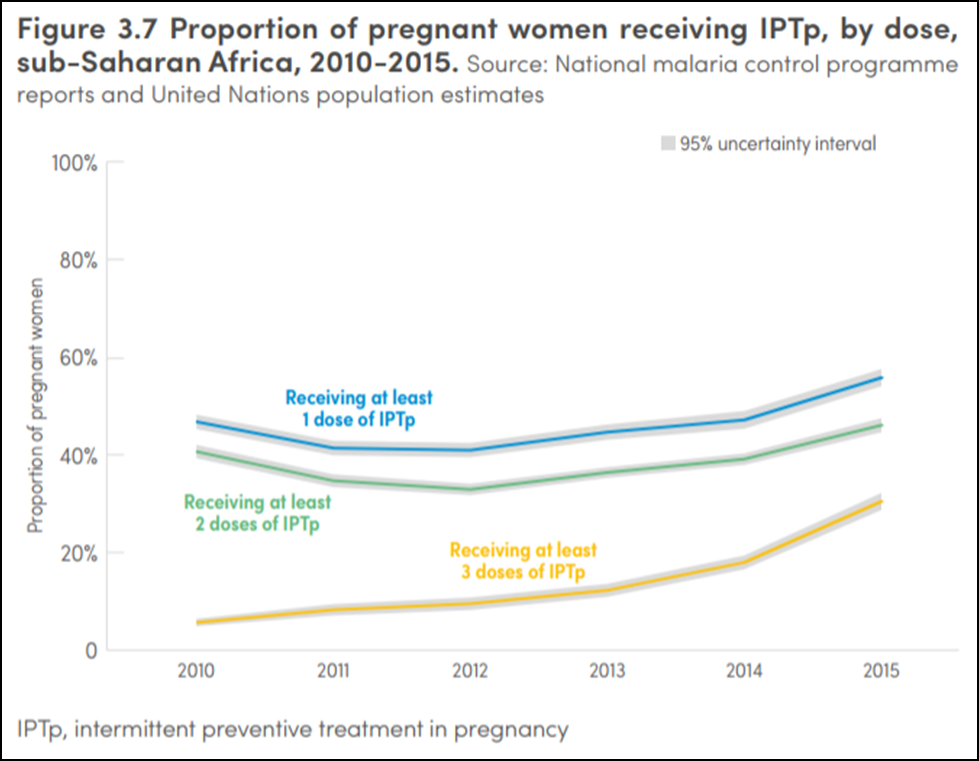
***Silvia Schwarte***

**Summary:**

**The WHO presentation covered the following areas:**

* WHO/UNITAID Enabler Grant, which covers the three diseases (malaria, TB and HIV). For the malaria sub-grant, two projects, i.e. TIPTOP and CARAMAL (formerly RAS) are included.
* IPTp-SP: New WHO Antenatal Care (ANC) guidelines and interagency briefing
* MIP Evidence Review Group (ERG) meeting July 2017
* ACT use in 1st trimester – Technical Expert Group (TEG) meeting planned for December 2017

World Malaria Report, 2016:



*It is estimated that, in 2015, among 20 countries that reported, 31% of eligible pregnant women (UI: 29–32%) received three or more doses of IPTp in 36 African countries that have adopted the policy –*

*a large increase from the 18% receiving three or more doses in 2014 and 6% in 2010*.

**Discussion:**

* The malaria enabler grant covers two UNITAID-funded projects: TIPTOP and CARAMAL (previously named RAS). Both projects focus on community-based delivery approaches of antimalarial commodities, namely intermittent preventive treatment during pregnancy with quality-assured SP (TIPTOP) and quality-assured rectal artesunate as pre-referral treatment for severe malaria in children under 6 years of age (CARAMAL). Over the duration of the enabler grant, WHO will provide technical input and course corrections for the two projects as needed, in order for the CHAI- and Jhpiego-led projects to generate quality evidence on community-based intervention delivery. Toward the end of each project, a comprehensive evidence compilation will take place to allow for a review by a WHO Evidence Review Group (ERG), and, if the evidence permits, a potential update of the current WHO recommendations.
* The question was raised whether rectal artesunate can be used for pregnant women. Based on the available evidence, current WHO recommendation are for children under 6 years of age only; the use of RAS in older children and adults is not recommended, guided by the findings of the trial that are the basis for this recommendation.
* In many studies in Asia there is a prevalence of vivax malaria and pregnant women are a reservoir for malaria. However,the current evidence base does not allow for any new recommendations for pregnant women in Asia. While IPTp-SP is only recommended for moderate-to-high transmission areas in Africa, the use of ITNs and prompt and proper case management applies to prevent malaria in pregnant women outside Africa. There is more evidence needed for asymptomatic malaria in Asia, particularly given the implications for newborns.
* The jump in IPTp3 coverage from 18% (2014) to 31% (2016), as documented in the World Malaria Report 2016 (see above graph), is significant. This is nicely reflecting the application of the updated guidance on IPTP-SP made in 2012: Usually, there is a time lag between the issuance of a policy by WHO, the adoption of the new WHO recommendations by a country and the actual deployment of the new recommendation.
* PMI data echoes this.
* There is a need to think about how to reduce the missed opportunities, particularly with IPTp1, when compared with the data on ANC visits.
* Availability of SP is still an issue impacting IPTp uptake.

**(3) Global Fund: Malaria in Pregnancy Perspectives**

***Roopal Patel, The Global Fund***

**Summary:**

* Clear articulation of MIP strategy (e.g., needs, costs, and financing gaps) will give countries the potential to leverage various funding streams to ensure delivery of a comprehensive, integrated intervention package
* A functioning health system is essential to decrease maternal and neonatal morbidity and mortality due to malaria in pregnancy and global malaria targets overall
  + Programs must address both supply and demand challenges
  + Derive clear lessons from assessment of new approaches to the delivery of preventive and treatment strategies

**Discussion:**

There is a need to address and continue to support the systems/platforms in place for pregnant women to receive the comprehensive care they need.

* No organization can achieve this alone so it is very important we are working together in partnership.

The role of community is important for linking in and creating stronger partnerships with communities.

* The launch of the call to action for IPTp that included community engagement helped to propel discussion of how to bring in communities.

Country adaptation to Global Fund strategy: It has been very challenging.

* The Global Fund has seen a lot of efforts in trying to look how the discussion can be carried out across diseases, particularly from a funding perspective and systems approach.
* There are a lot of commonalities across malaria, TB and HIV.
  + Countries that have applied simultaneously had better chances to address the underlying issues, such as procurement and supplies, workforce, data collection, etc.
  + Countries in which there is strong government leadership have much better chances to address the underlying approaches as well.

CCM: coordinating process for funding through The Global Fund

* The Global Fund has been promoting proactivity to have cross-cutting approaches.
  + There needs to be a champion in-country to push this forward and roll out interventions at the country level.
* MiP is usually part of the national program so it is usually covered by the Global Fund country grants, but aspects of quality of care are a dimension that is very important to prioritize.
* The Global Fund is tracking the investments of some of the key interventions.
  + They cannot track case management, but they are tracking IPTp and nets distributed at ANC.
  + The Global Fund is happy to share this information with others.
* Integrated data collection systems and their capacity for focusing on MiP and should be revamped to make them more functional.
  + The Global Fund is promoting HMIS and DHIS2 everywhere, but this needs more work by partners.
  + The Global Fund is also supporting the stratification of data by age, sex and location in DHIS.

Suggestion: It would be helpful to take a few successes from countries using the RMNCH approach and document them to help support other countries.

**Global Technical Updates: Updated WHO ANC recommendations & Implications for MiP Programming**

**(4) WHO Guideline on Antenatal Care (2016)**

***Özge Tunçalp, WHO***

**Summary:**

* Background
* Development of the WHO ANC guideline
* Recommendations
* What's new – Malaria in the context of ANC

Overarching aim: to provide pregnant women with respectful, individualized, person-centered care at every contact, with implementation of effective clinical practices (interventions and tests), and provision of relevant and timely information, and psychosocial and emotional support, by practitioners with good clinical and interpersonal skills within a well-functioning health system.

Relevant Links:

About the guidelines:

[www.who.int/reproductivehealth/news/antenatal-care/en/index.html](http://www.who.int/reproductivehealth/news/antenatal-care/en/index.html)

The guideline

[www.who.int/reproductivehealth/publications/maternal\_perinatal\_health/anc-positive-pregnancy-experience/en/](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/)

**Discussion:**

* Thus far, WHO hasn’t received feedback on the use of the word “positive” which usually associated with HIV.
* The concerns raised during the MiP WG meeting last year were addressed in the new guidelines with a lot of input from our partners.
* The most confusing part of the guidelines is what is meant as a contact. As an implementer it is very dififcult to determine who can do what at which contact, what counts as a contact and how we know we have put together a correct package to achieve our objectives.
* WHO is working on a contextual tool of the guideline to make it easier on policy makers to determine which of the 49 recommendations are most applicable to their countries and there are tools to help countries operationalize the term ‘contact’.
* There have been issues in East Africa with women being told to come back a different week for their IPTp.
* Providers need clarity on the week of contact and that translates into the measuring of gestational age.
  + One of the new things about the guidelines is that WHO is recommending early ultrasound and the reasoning behind this is the determination of gestational age. It will take time to see what’s feasible in countries.
* There is evidence that shows when we are too prescriptive on the weeks, it causes confusion among providers.
  + The table the MiP WG adapted in the MiP ANC brief outlines when women can receive IPTp. What is advocated is that a pregnant women receives SP at every ANC contact when she is eligible. This is particularly important to clarify when countries are training providers and the guidelines are being rolled out.

**Panel Discussion: Applying the recommendations & Accelerating MiP Programming**

* Susan Youll, PMI
* Houssy Diallo, The Global Fund
* Gladys Brew, Ghana Health Service
* Claude Arsène Ratsimbasoa, Ministry of Health (MOH), Madagascar
* Aline Uwimana, Rwanda Biomedical Center
* Nombré Yacouba, National Malaria Control Program, Burkina Faso

Aim of panel: The purpose of this panel discussion was to highlight how countries and donors are using the updated WHO ANC recommendations to accelerate MiP programming

**(5) PMI Update, *Susan Youll***

* PMI provides support to national programs, both Reproductive Health and NMCP, in terms of ensuring consistent coordination between the two programs and establishing national working groups to help roll out the ANC guidelines and to ensure there is consistency across the two programs.
* The recommendation of increased dosing has taken some time to roll out and so the data is just starting to reflect these new guidelines.
  + It’s important to ensure delivery of IPTp starts at 13 weeks so may need include a potential “9th contact”.
  + Four ANC visits continues to be low in countries so we need to continue to work towards this.
  + The potential for community engagement and using community health workers as a provider of SP could be an important strategy for increasing IPTp uptake and ANC attendance.
* Data quality and the use of quality data is a huge component of MiP programming.
  + There has been an increase in reporting of IPTp3, but there’s also been the use of different denominators for ANC and IPTp so it’s important to look at harmonizing this across countries.

**The Global Fund update, *Houssey Diallo***

3 things for countries to keep in mind

1. Collaboration---between RH and NMCP programs, but also among other departments, for example The Ministry of Education to encourage school aged women to attend ANC early when they become pregnant.
2. Better understanding about barriers---barriers such as preventing women from attending ANC early or preventing health care workers from providing SP, etc.
3. Measurement---this is key to management. Although there is increased reporting on IPTp3, there are significant discrepancies with the data in terms of what is meant as a third dose, etc.

**Insights from the Ghana Health Service, *Gladys Brew***

* Free maternity care has allowed Ghana to preform quite well with services for pregnant women.
  + It is not only about women wanting to come or not being able to come, but also about the system the country has in place.
  + It is not just cultural barriers keeping ANC numbers low.
    - For example, now that the financial barrier has been removed in Ghana, there is significant improvement in ANC attendance.
  + It’s important for countries to provide some type of intervention that helps to increase coverage of ANC.
  + Likewise, it’s important that the supplies are available.
* There are challenges in the facilities in the metro regions where they are not listening to the advice of the NMCP and are not providing SP to their elite clients of higher socio-economic status.

**Insights from the Madagascar Ministry of Health, *Claude Arsène Ratsimbasoa***

* There are 113 districts in Madagascar and IPTp is being used in 93.
* There is no reporting data for IPTp for pregnant women so the challenge is to introduce this into their system.

**Insights from the Burkina Faso National Malaria Control Program, *Nombré Yacouba***

* There is a big drop between IPTp1 and IPTp4 in Burkina Faso.
* There is an effort in Burkina to distribute IPTp at the community level through community health workers in order to overcome obstacles to women attending ANC.

**Insights from the Rwanda Biomedical Center, *Aline Uwimana***

* IPTp was stopped in 2008 due to a high level of resistance to SP. Since then they have prioritized the strengthening of case management and ANC promotion.
* Each village has 3 CHWs with two focusing on case management and one focusing on education and promotion.
* Rwanda is looking into an alternative to IPTp, such as screen and treat but the efficacy of this approach needs to be further researched.

**Discussion:**

HMIS doesn’t show when women are beginning ANC attendance. When are women starting ANC and how are you getting that information?

* + Ghana:
    - They list 1st, 2nd and 3rd trimester registration.

DHIS collects this and is showing an increase in the number of women attending ANC during the 1st trimester.

* + - Most of the women who did not get IPTp1 were women who were identified as being G6 deficient. There is no reason women who are G6 deficient to not receive SP. They shouldn’t receive primaquine, but there is a misconception about SP in Ghana.
    - Sometimes women are receiving more than 4 doses of SP because they are coming to ANC early.
  + Rwanda:
    - They capture the number of women attending ANC during the 1st trimester.
    - They are also piloting a project in which they are using a urine pregnancy test to try to identify pregnancies early to increase early ANC attendance.

The CHWs are able to do this pregnancy test. Women tend to hide they are pregnant, but the CHWs are from the same communities as the women they help so the women trust them to have the knowledge that they are pregnant when the testing is done.

* If a pregnant woman can attend all four ANC visits, then delivery at the health clinic is free.
* Countries could try to establish systems to maintain privacy for women who are attending ANC to overcome any cultural barriers with not wanting other community members to know they are pregnant.
  + For example, in Sierra Leone, MSF had separate areas for men and women seeking treatment at the health center.

What are the key elements for The Global Fund and PMI to be able to finance an integrated platform in a way which can be functional?

* + For The Global Fund a significant component of funding should go to health systems strengthening and sustainability. The Global Fund is more open now to ideas on how to do this.
  + PMI funds are specifically for malaria and they report to Congress on how those monies are spent.
    - PMI looks at how to contribute to filling any gaps/needs around MiP. Integrated programming is supported, such as FANC, and PMI wants to complement other USAID funding streams.

In Ghana are there politicians or elite women who can help champion SP so that the women of higher socio-economic status are willing to take SP?

* + It’s very likely that the numbers in Ghana for IPTp uptake are higher, but these elite women do not want to swallow the SP in front of providers so DOT is not possible.

In Burkina, how are the CHWs identifying pregnant women at the community level?

* + They are identifying pregnant women through female CHWs who receive a small stipend. The pregnant women are then referred to ANC.

SPAQ is being used for SMC, but it only lasts in the body for a short period of time. Why are we not using a longer lasting drug?

In Rwanda the screen and treat study is for all women, not just suspected pregnant women.

* + In every transmission strata in both Africa and Asia, giving IPTp at each visit has been determined as being superior to screen and treat.
  + Rwanda is not interested in going back to IPTp so they are studying screen and treat vs. not doing anything at all.
  + Burundi also does not do IPTp as SP was removed from the country when it was shown to be ineffective for treatment. Chloroquine was also removed for the country . It would be good to know how this has affected the incidence of low birthweight and malaria in pregnancy
  + Indonesia is in a unique situation because since 2012 Indonesia is using a screen and treat policy with microscopy or mRDT at first ANC visit. It doesn’t matter which trimester the women visits ANC, if they are positive for malaria during their first ANC visit, they are being treated.

**Roundtable Discussions: Learning from countries**

Aim of roundtable discussions: To learn from countries about the following topics:

• Successful strategies for early ANC attendance- Ghana

• Prioritizing MiP in the national agenda- Madagascar

• Implications for MiP Programming in the context of elimination –Rwanda

• Road map for adoption of new WHO ANC guidelines – Uganda *(Please note that Dr. Jane Nabakooza of the Uganda MOH was unable to attend the meeting, but she has shared her road map which is available in Annex 3.)*

**RWANDA**

**Summary:**

Since 2011 there has been a resurgence in malaria and the system of active case detention in the 9 pre-elimination districts became overwhelmed and had to be stopped. Possible reasons for the increase in malaria include: insecticide resistance (to permethrin, increase in rice farming, and increase in temperature due to climate change. The loss of acquired semi-immunity can also be a factor in the resurgences of malaria. Now the focus is on malaria control in all areas and they have seen a positive change starting this year.

**Key Takeaways:**

1. Rwanda has had to shift from elimination to control efforts
2. IPTp is still not used in Rwanda
3. Current malaria control efforts are starting to show a positive impact

**Discussion:**

* In areas that are previously high transmission, even once the transmission is brought down substantially, there is always a risk of resurgence. This is why WHO does not provide a threshold at which IPTp should be discontinued.
  + Countries might also want to think about continuing IPTp at a sub-national level only for areas of medium to high transmission since stopping and then restarting IPTp is very difficult.
    - Zimbabwe just had to reimplement IPTp in several areas where a resurgence was observed.
  + There are 3 CHWs in each community, 2 for treatment and 1 for education. CHWs receive an SMS message alerting them to when a pregnant woman needs to go to ANC.
    - This is a good system with potential for application in other countries.

**GHANA**

**Summary:**

Universal health coverage efforts are underway with approximately 70% coverage although facility reimbursement challenges persist and coverage is not as high in rural areas as compared to urban areas.

The health private sector (~20% of health services) presents some unique challenges. For example, the private sector does not always go through same procurement systems. In addition, private providers are not routinely doing provider-initiated HIV testing and counseling for fear of alienating clients.

In the public sector, below the health center level, there is now an additional level referred to as Community Health-based Planning and Services (CHPS), staffed by Community Health Officers (CHOs). The goal is to provide a midwife for every CHPS compound so that the first visit can be with a skilled midwife for gestational age estimation, prescriptions, vital signs, etc. However, it is hard to get midwifery coverage in all regions of Ghana so CHOs do a big job to help fill gaps in midwifery coverage.

There are 2 CHOs are in each electoral area and they are key for registering pregnant women. CHOs do home visits in their catchment area and it is easy for women to disclose pregnancy status to the CHOs since they tend to be women with a long history in their own communities. CHOs get two-year training for basic health services and are trained to follow up with pregnant women at home after first ANC visit. CHOs can provide ITNs, and case management, with some CHOs providing SP to clients reporting quickening. CHOs are salaried and are supervised by a Medical Assistant in the health center. There is a separate CHW program in which CHWs are not salaried government employees and have a higher turnover.

**Key Takeaways:**

1. Ghana has increased access to ANC in rural areas by introducing the CHO model

2. MiP services are integrated in the new CHPs model

3. Linkage between the CHPS program and facility-based care has improved both the experience and the content of ANC in Ghana

**MADAGASCAR**

**Summary:**

There is a new Malaria Strategic Plan in development that will incorporate the new ANC guidelines, moving from 4 visits to 8 contacts. Madagascar is C-IPT/TIPTOP country so this is in alignment with the new guidelines. A lot of the population is remote and doesn’t have good access to formal health facilities so Madagascar needs more programs to reach remote populations, but many challenges persist including: security problems, accessibility of facilities, preferences for TBAs, financial problems, education levels of pregnant women, insufficient staff (some places have 1/per post), lack of availability of commodities. Other challenges include SP stock outs, areas without electronic data collection systems, SP stock outs and the supervision and motivation of CHWs who are not salaried.

**Key Takeaways:**

1. Whole health system and stakeholders must be working to deliver interventions

2. Need to have and use good data to monitor and support program and make good decisions

3. Need community interventions, but also to monitor resistance

**Discussion:**

* A lot of the population is very remote with poor infrastructure so there are challenges to reach health centers.
* CHWs are volunteers and get incentives, but they are not salaried. The government would like the CHWs to remain unsalaried, but this sometimes detracts from their motivation to do their duties.
* Madagascar has already introduced C-IPTp through the TIPTOP project in Mananjary district, Vatovavy Fitovinany region, in the south-east of the country. This may help with the location barrier preventing people from attending ANC.
* There are still problems with stock outs of SP. National quantification exercises are taking place to address this issue.
* Human resources issues exist as well. Some facilities only have one person on staff.
* The system and stakeholders really need to be engaged and work together to implement interventions.
* Use of data to monitor programming and use for decision-making is very important.
* Community interventions, including C-IPTp, need to be implemented with an eye towards monitoring resistance.
* It’s important to understand the differences between titles of various health workers in the communities, especially in light of the task shifting recommendations included in the updated WHO ANC guidelines. These titles, workloads, compensation and training vary drastically across countries.

**MiP Country Profiles Development and Dissemination**

***Kate Wolf, MCSP/Jhpiego***

***Summary:***

Last year at the WG meeting we talked about trying to get a better sense of where countries are post-2012 WHO ANC guideline update, for example: who has updated their policy, what the policies say, how they are being implemented. The MiP profiles were developed to address this need. Two draft profiles for Benin and Senegal were shared to get feedback from the group on the utility, and any suggested changes based on the national, regional and global perspectives.

**Discussion:**

Recommendations from the group were discussed and documented for incorporation into the further development of the MiP profiles.

**Update on MiP Activities**

***Lisa Nichols, Abt Associates***

**Summary:**

Abt Associates is working with public sector, private sector, health financing actors, governance actors (local to promote Community Based access/health insurance) and Governments/NMCPs from:

Senegal, Zimbabwe, Ghana, Nigeria, and Uganda through the following projects: IRS and ANC vouchers, SHOPS Plus, Health financing governance (HFG), and AIRS (Abt is the lead partner on the Africa Indoor Spraying project). The focus is on the following:

• Updating case management of MIP

• Increasing access to RDT; referral

• Promotion of ANC, IPTp, net use

• Improving quality of ANC and IPTp in public and private sector facilities

The SHOPS Associate Award in Ghana continues to work with private sector providers. The latest data from the previous year showed that 46% of pregnant women who are presenting symptoms for treatment at a private pharmacy are testing positive and are referred. Those testing negative are also encouraged to attend ANC.

HFG supports Ghana’s National Health Insurance Scheme (NHIS) in strengthening financial incentives and ensuring access to essential malaria services; providing access to the uninsured; and leveraging the purchasing power of the NHIS for diagnosis and treatment. Capitation for Primary Health Care has been scaled up to 4 regions, 600+ NHIA staff trained, nearly 100% of active members enrolled with preferred primary care provider. Capitation is good for malaria because it helps with NHIS sustainability; providers benefit from keeping the population healthy; financial incentives promote prevention, early detection, and efficient treatment; patients are linked to provider for a period of time so there is more chance for health promotion and behavior change; it promotes fairness and equity.

HFG also supports better use of claims data for NHIS management and malaria service delivery improvement. In addition, HFG is examining the economic impact of malaria investments and using contextual data on malaria to influence health financing actors.

**Discussion:**

These are really important activities and need to be considered as priorities for the WG workplan.

**DAY 2**

**Optimal delivery and continued challenges with MiP programming**

**(6) Low Dose Folic Acid Policy**

***Clara Menéndez, ISGlobal***

**Summary:**

In sub-Saharan Africa anaemia is among the principal causes of mortality and morbidity. In low income settings, its etiology is often multifactorial: poor nutrition, infections, menstruation, pregnancy, etc. Depending on the level of prevalence in the area, folic acid is recommended in low doses for prevention of anemia:

* + Where anaemia prevalence in pregnancy is less than 40%: give 30-60mg of elemental iron and 0.4 mg of folic acid
  + Where anaemia prevalence in pregnancy is 40% or more: give 60 mg of elemental iron and 0.4 mg of folic acid
    - WHO recommends a low dose of folic acid (0.4mg daily) because it does not reduce SP efficacy
    - Higher doses of folic acid (5mg daily) significantly reduce SP efficacy and should not be given at the same time.

Currently, folic acid supplements are commonly available in 5mg formulations in many international settings. The WHO Model Essential Medicinces List (EML) categorizes folic acid as an anti-anaemia medicine, with listed dosages for folic acid alone in 1 mg and 5 mg tablets.

Conclusions:

* There is a need to increase availability of lower-dose folic acid supplements in endemic malaria countries for anemia prevention in pregnant women and other groups receiving antifolates and exposed to malaria
* Evidence is needed on folic acid status in population groups besides pregnant women, receiving CTXp and being exposed to malaria

**Discussion:**

* There are two papers from Sierra Leone and Bangladesh showing that only 50% of anemia is due to iron deficiency.
* There is a need for the WG to prioritize getting out this key message regarding the 0.4 mg folic acid to countries as part of the WG work plan.
  + Guidance on folic acid and the range for elemental iron can be found in the MiP ANC brief produced by the WG with inputs from the Nutrition Group
* One of the major issues with folic acid is it’s not being procured by international donors. It’s one of the drugs commonly being manufactured in country and since they started producing 5mg, they are continuing with that.

Recommendations:

* + There needs to be substantial pressure from the MOH to change this to 0.4mg.
    - At MCSP the nutrition and malaria teams did a joint presentation for the anemia task force and there is no reason for 5mg to still be produced, aside from megablomastic anemia in children.
    - Folic acid is necessary for the reproduction of red blood cells and you often get severe anemia after using injectable artesunate. In such cases there might be a need to supplement with folic acid so we need to be careful about recommending to remove 5mg altogether.
  + The WG could also liaise with the Nutrition Group (and the Malaria Group) at WHO to ask them to remove 5mg from the EML.
    - The EML was just updated in March and will not be updated again for another two years. Given the time it takes to disseminate this to the national level it might be more important to create a brief or use the MiP ANC Brief to emphasize this message about folic acid.
  + If the WG makes a push to coordinate on the EML, maybe we can also consider advocacy for using SP for IPTp for chemoprevention.
    - It’s much more expensive to use DHA-PPQ which is $2.30 per pack. SP can be given as a single dose so there’s no issues of compliance/adherenece, but with DP it is three days worth of medicine and it’s not possible to have it directly observed so you have to expect women to take it at home for the following two days which may or may not happen.
    - It’s not entirely clear if the benefit of DP is equivalent to SP for low birth weight. This is why WHO has not made a recommendation of DP as an alternative to SP in countries with high resistance.
    - The focus should be on bed nets if DP/SP can’t be used and it’s important for women to come in for testing if they show any signs of symptoms.

**Group ANC: Lessons from the field and links to WHO ANC recommendations**

***Koki Agarwal, MCSP/Jhpiego***

*(Please note that we are unable to share the presentation slides at this time since results are still preliminary)*

**Summary:**

Jhpiego is carrying out the first cluster RCT of G-ANC in Kenya and Nigeria with the rationale that traditional ANC is a model that struggles to retain women and there is low return on investment.

G-ANC has three key elements: clinical assessment, participatory facilitated learning, and peer support. Women are placed in groups of 8-12 women with similar gestational ages.

Initial findings suggest that G-ANC Improves MiP related quality of care. Providers reported IPTp was more likely to be given at G-ANC visits and that they felt better about the care they were giving and the improved relationships with patients. G-ANC clients were more likely to report when provider asked about fever at every visit. 95% of intervention groups would choose G-ANC in a subsequent pregnancy.

And all 10 intervention sites in Nigeria continue to offer G-ANC outside of the study with no financial support.

**Discussion:**

* *Ghana:* the physical environment of the ANC clinics is such that it’s not possible to group women like this.
  + The ANC clinics are very crowded so they have started doing pregnancy schools with the midwives and pregnant women in the peri-urban areas.
    - They are finding that this is helping, but it is not as participatory as the G-ANC.
    - This research can help to empower governments to make the physical environment of ANC clinics more supportive of such activities, especially in the cities where this is lacking.
  + Labor wards are also getting more crowded and this is a real challenge.
* One of the persistent barriers to ANC is the poor attitude that providers convey and the G-ANC might help diminish this since the providers might be less likely to talk down to a group of women. This would be interesting to look into during the study.
  + Initial qualitative research shows that both the client and the provider are happy with the G-ANC.
* To what extent are the providers less burdened because this is a study? We need to be a little careful to extrapolate that this reduces the burden on providers.
  + There is a difficulty because women have seen the G-ANC taking place and want to join the classes, but first human resource issues need to be addressed.
  + In terms of task shifting, CHWs could perform most of the facilitation and then have the providers come in for specific elements so this is something to look into more.
  + There may not be a reduction of workload for the providers, but there may be a more productive use of their time, helping them to feel more motivated.
    - The G-ANC did take a slightly longer amount of time, but not when compared to how much time it would take given how many women were in the class.
    - One provider mentioned how G-ANC helped to really get to know the clients better and that might also help with motivation.
* The most interesting result is the empowerment of the pregnant woman, understanding why she needs to take action during pregnancy and all the elements of comprehensive care.
  + There was an additional component of male engagement in which women as a group could decide if they wanted to invite their male partners to join them for G-ANC.
* One of the difficulties is forming groups of women with similar gestational ages so there is still individual ANC occurring simultaneously.

Suggestion: The last G-ANC class could be moved up as right now it says between 36-40 weeks, but at 38 weeks many women will have already delivered.

**Diagnostics for MiP**

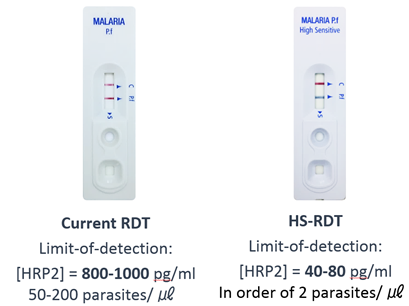
**(7) Highly sensitive mRDT and relevance to MiP**

***Iveth Gonzalez, FIND***

**Summary:**

Improved diagnostics for malaria in pregnancy:

Microscopy and standard RDTs continue to be the recommended diagnostic tools to confirm malaria infection in febrile patients. In the frame of malaria elimination, the development of more sensitive tests to support screen and treat campaigns has been supported. A new highly sensitive RDT (HS-RDT) for the detection of P. falciparum infections is currently in the market. Clinical studies to demonstrate its usefulness to detect sub-microscopy malaria infections during pregnancy are ongoing. Similarly, a nucleic acid amplification assay similar to PCR (LAMP) has also been evaluate for malaria screening and treatment during pregnancy in Colombia and Indonesia. While the usefulness and impact of current diagnostic tests for ISTp is controversial, studies are needed to demonstrate if highly sensitive diagnostic tools could be useful to detect and treat malaria during pregnancy in areas where IPTp is not recommended. A roadmap of required studies is in development.



* A new highly sensitive HRP2 RDT for screening-and-treatment is currently in field evaluation:
* Conclusion: HRP2 HS RDT detect more sub-microscopic infections than conventional RDTs, but are still missing infections detected through qPCR
* A study of the performance of HS-RDT with samples from pregnant women is taking place in Colombia and will soon be expanded to Papua New Guinea and Benin

**Discussion:**

* A highly sensitive RDT is $1 which is more expensive than regular RDTs. LAMP is $5 each.
* Will there be more false positives when using the highly sensitive RDTs?
  + In the study in Colombia they found 1 or 2 false positives and those women had had malaria in the 1-2 weeks prior.
  + This is one of the limitations of these tests.
    - This is contributing to WHO’s decision to not recommend the PCR, LAMP or any type of high sensitivity test for detecting malaria in pregnancy.

**(8)** **Pregnant women and children as sentinel populations for monitoring malaria prevalence**

***Julie Gutman, CDC***

**Summary:**

Data on household prevalence of malaria is generally obtained from cross sectional household surveys, such as DHS and MIS (malaria indicator surveys).  However, pregnant women and infants attending health facilities for routine (non-sick) care can serve as sentinel populations for monitoring malaria prevalence.

Pregnant women and children under five visit health facilities frequently for routine care and can thus be easily accessed for malaria testing.  Monthly attendance to routine care is relatively stable over time.  In most countries, a large proportion (>90%) of pregnant women visit antenatal care (ANC) at least once, so women attending ANC1 can thus be considered representative of the general population of pregnant women. In addition, children visit Expanded Programme on Immunization (EPI) clinics several times in the first year of life. The majority of those attending ANC/ EPI clinics are healthy. As compared to test positivity rates among febrile patients, which will fluctuate depending on the prevalent cause of fever, the proportion malaria positive among pregnant women attending ANC1 and children under five presenting for vaccination will more closely reflect population level prevalence.

Pilot Study in Lake Zone of Tanzania: December 2012 to November 2013: Pregnant women attending first ANC and infants 9-12 months old presenting for measles vaccination were screened for malaria infection using a malaria rapid diagnostic test (RDT), regardless of symptoms.

Conclusions:

* Populations accessible through health facilities may be used as a surrogate marker to monitor malaria prevalence continuously
* Pregnant women attending 1st antenatal care, particularly primigravidae, can serve as a useful indicator of malaria prevalence in the community
* Prevalence of malaria among primigravidae is similar to children under 5
* Need to weigh the feasibility, acceptability, and cost of testing all patients versus the utility of this data

**Discussion:**

* How would you ensure the pregnant women who come to the facility are representative of pregnant women if the ANC attendance isn’t as high as 90%?
  + The idea behind using pregnant women who come for their first visit is that hopefully the ANC attendance is high and if that’s not the case, then this would need to be considered before using them as a sentinel population.
  + This data is not to replace HMIS/DHIS2. This could be used as another source of data, particularly in areas where malaria prevalence is low.
* In Tanzania they are testing for malaria at the first visit.
  + This is not a policy endorsed by WHO, but this is Tanzania policy.
* Pregnant women have been used for HIV prevalence data and in some cases the correlation between facility and community was not as strong.

**(9) Unitaid strategy and malaria projects**

***Alexandra Cameron, Unitaid***

**Summary:**

Unitaid plays a role in trying to bring innovations to the global forefront. Unitiad has a new strategy endorsed in December 2016 that reaffirms the commitment to addressing HIV, TB and malaria and highlights Unitaid’s role in more integrated approaches to health, in particularly in RMNCH, but always thinking of the three diseases as the entry points. Unitaid plays a role at three critical moments in a product’s lifecycle: scale-up, adoption, availability. The mission statement is to maximize the effectiveness of the global health response by catalyzing equitable access to better health products.

Unitaid’s areas for interventions are as follows:

* Accelerate adoption of innovative vector control tools
* Optimize introduction of tools for the treatment of severe malaria
* Expand access to preventive chemotherapy in pregnant women
* Opportunity for a malaria vaccine (RTSS)

**(10) TIPTOP Project & Burkina Faso Study**

***Elaine Roman, MCSP/Jhpiego***

**Summary:**

TIPTOP is Transforming IPTp for Optimal Pregnancy. The goal of the project is to contribute to reduced maternal and neonatal mortality in project areas by expanding access to QA SP for IPTp. This is a landmark project that aims at generating evidence for WHO to review in view of a potential update of policy recommendations based on the project findings, introduce and set stage for scale up of community-based IPTp (C-IPTp) and introduce and increase demand for QA SP.

TIPTOP will be implemented in Nigeria, Madagascar, DRC and Mozambique in partnership with ISGlobal as the research partner. These two organizations will be collaborating with MMV (Medicines for Malaria Venture) and WHO which have enabler grants. Key stakeholders such as PMI and The Global Fund have been involved since the strategy development. This highlights the value that Unitaid and the partnership places in setting the stage for long-term sustainability. TIPTOP is also working very closely with country governments to drive this project.

The C-IPTp study in Burkina Faso Study is supported by PMI. The study is now in the data collection and implementation phase. It is a small pilot study, but the aim is similar to that of TIPTOP, looking at IPTp uptake and ANC utilization.

**Discussion:**

* TIPTOP will be addressing gap areas, for example providers who are not confident in assessing gestational age. TIPTOP will work with partners to address health systems.
  + It is expected that that national curriculum will include the comprehensive knowledge for CHWs, but Jhpiego is in the process of producing a training package that will address some of the known gaps that exist.
  + The mandate of the project is not to provide technical assistance on the adaptation and review of the new regulations, but the mandate does include working with partners to help countries adapt these, with the TIPTOP model fitting into that. TIPTOP will work very closely with MiP TWGs and WHO in countries to support this.
* Suggestion to merge the MiP community-based activities with iCCM activities.
  + It is not clear that this is possible. The target population is very different so this really should be tested.
* The economic study is to analyze the cost for adding another approach to the system. It is to provide the MOH with a value of the intervention that can be related to the effectiveness of the intervention.

**(11) PQE Initiative (Program Quality & Efficiency Initiative for Integrated Service delivery at ANC)**

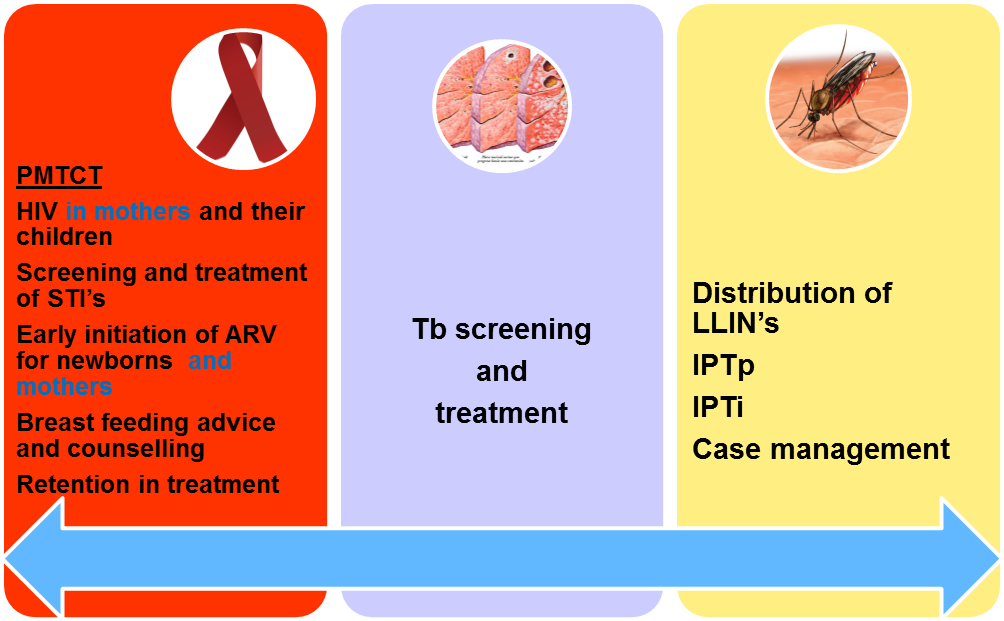
***Nicholas Furtado, The Global Fund***

**Summary:**

The importance of quality in health care delivery

The Global Fund and program quality

Demonstration of quality improvement of integrated antenatal and postnatal care in countries.



There are missed opportunities across the continuum of care.

The ANC/PNC platforms are a unique entry point that integrates evidence-based interventions critical for eliminating all 3 diseases, HIV, TB and Malaria, all along the continuum of care for mothers and babies. By improving quality will we also increase efficiency. The three aspects to look at with quality of care are: structure, process, outcome.

Demonstration of quality improvement of integrated antenatal and postnatal care in countries: Current status and next steps:

* Core tools for assessment, increasing coverage of integrated ANC/PNC, standards and QI methodology have been developed and adapted
* Project activities have begun in Togo and in early stages in Ghana
* Next wave of countries are Niger, Tanzania, Afghanistan and Pakistan
* Framework for cost effective/efficiency analysis

**Discussion:**

* The core group for quality/efficacy is focused on 9 countries and TGF is in constant collaboration with them.
* It is very important the ANC and PNC pieces are looked at together with mortality and morbidity.
* There is an issue with sustainability of higher standards outside an intervention. The question is how to keep those good results without the intervention itself.
  + This is a very calculated process, working with government departments on quality of care. It involves not changing resources in a big way, but rather improving processes.
  + There are a lot of research questions that are internal for TGF, but are also for the larger community about why investing money in RMNCH can still impact.
    - In some countries there is a very large sampling and in such cases, national entities such as academic institutions will be used for implementation.
    - The idea is that it can be a demonstration project that will be adopted at the national level and scaled up.
* In South Sudan the Malaria Consortium did an audit of maternal services in hospitals in Juba.
  + Audit vs. supervision:
    - The quality improvement during supervision might be more effective than an audit based approach because supervision and on the job mentoring help to improve provider performance more than the audit approach.
      * Break down the tasks that a health worker has to do into steps and then conduct supervision every month to see how they improved over time.
    - The Audit approach engages everyone in the system. The Global Fund intention is to do both of these in countries as there will be a lot of work going into mentoring and supervision.
* Ghana is happy to see efforts looking at processes and outcomes as well as inputs which are very important.
  + The hope in Ghana is that TGF will be covering areas right in the city of Accra.
    - A lot of the blame for low quality maternity care can be systems issues, such as workload.
  + TGF will be using a systems approach to determine where bottlenecks are. If workload comes up as an issue in consultations, then it will be addressed.
* It is the decision of the government about whether to scale up
* TGF is seeking to start a small advisory group for the quality of care across HIV, TB and malaria.

**Research Updates:**

**(12) Results from clinical trials on IST, SST, IPTp with DP in Indonesia and sub-studies on acceptability, feasibility, cost effectiveness**

***Rukhsana Ahmed, Liverpool School of Tropical Medicine***

**Summary:**

There are many challenges for MIP prevention in Asia-Pacific region including: diverse exposure risks ranging from very low to intense transmission; need to target both P.falciparum and P.vivax; P. Vivax relapse, and multi-drug resistance.

Two studies undertaken:

1. Intermittent screening and treatment or intermittent preventive therapy for the control of malaria in pregnancy in Indonesia: an open label randomised control trial
2. Evaluation of the Implementation of SST for the Control of Malaria in Pregnancy in Eastern Indonesia (quantitative study)

**Discussion:**

* The choice of the drug for IPTp in Indonesia is interesting. Were they any molecular studies to look at resistance markers, particularly for artemisin? In SMC there was a long debate about using DHA-PPQ for SMC, because the DHA is only in the body for a short time so the question is why not just use PPQ, then you would avoid resistance to ACTs which need to be used for treatment. PPQ has a half-life that is longer than SP.
  + There is a separate project through the Eijkman Institute looking at resistance markers
  + The CDC has done a review looking at all available data and there is no increase in adverse effects with each course of DHA-PPQ. The results don’t suggest accumulation of the drug is pushing into higher toxic levels.
* The STOPMIP trial used DP which is the same drug being used for treatment in Indonesia, as per national policy since 2010.
* The study found the cost of delivering IPTp-DP was higher compared to SSTp-DP. Howver it might be an efficacious strategy for MiP prevention in moderatre-high transmission settings as found in Papua, needing further studies.
  + Therefore to suggest further implementation studies are needed to determine feasibility of strategy as monthly prophylaxis to asymptomatic women does not seem consistent with the results presented.
  + However, it does seem necessary to do a verification study with implementation to see if it can be an efficacious strategy for the prevention of adverse outcomes of malaria in pregnancy in the context of malaria transmission.
  + The alternative strategies for SST with IST and IPTp were looked at because there was a burden assessment previously conducted in which we found sub-microscopic asymptomatic infections were high and they are not picked up by SST and during late pregnancy.
    - With SST, screening is at the first ANC visit, possibly at around 20 weeks when women first present, so asymptomatic cases occurring late in pregnancy would not be detected. This was why we looked at IST and IPTp as alternative strategies.

**(13) Text messaging to increase IPTp coverage**

***Prudence Hamade, Malaria Consortium***

**Summary:**

Health worker training in low and middle income countries typically follows a cascade model, where a selected number of health workers attend classroom training and cascade relevant information to their colleagues. This approach is often ineffective as important information does not reach those who need it.

Sending education text messages to health workers in order to reinforce classroom training content and share information with those who were not trained is a feasible and acceptable alternative to providing classroom training only. Text messaging is simple to implement, inexpensive and does not disrupt service provision. In this study, text messaging improved health worker knowledge of IPTp and increased IPTp coverage.

**Conclusion:**

The increase of mobile phone networks in recent years has transformed communications in sub-Saharan Africa, with mobile phone use becoming more affordable and accessible, even among the poorest populations and in rural areas. Seeking to capitalize on this trend, mobile health (mHealth) interventions have seen a rapid increase in the popularity of recent years. mHealth is broadly defined as the “use of mobile and wireless technologies to support the achievement of health objectives” Common examples include the use of text message reminders to encourage follow-up appointments, health behaviors and data gathering.

**Discussion:**

* How is Uganda applying this approach since the results are finalized?
  + DFID is talking about doing a randomized trial to confirm these results. There are other studies for example, the Kenya case management study, showing the benefit of using SMS message to improve health outcomes.
* This seems like a really good tool for behavior maintenance.
  + Maintaining a behavior is difficult so it would be great to see that angle on this.
  + Reminding people what they are supposed to do is very important, in addition to supervision activities.
* The cheap cost of this ($20) is great, but it’s important to do a full study.
  + While knowledge might have been improved, it might not mean behavior has changed.
  + It could not replace supervision, but could help to complement it.
    - Part of supervision is reminding of the messages, but also looking at the registers, etc. so it’s important to have both.
* The data shows that only 45% were getting IPTp. Do we know how many women were getting their blood pressure taken each time, etc.?
  + Maybe it would be better if service providers are reminded on things that they have to do every time as part of the essential service package, rather than focusing just on IPTp, and also making sure that supplies exist for providing these services (ie: SP).
  + For a quality service, all of those things need to be in place.

**(14) The protective effect of IPTp-SP against the dual burden of malaria and STIs/RTIs in pregnancy**

***Matthew Chico, London School of Hygiene and Tropical Medicine***

**Summary:**

**Key points:**

* Curable sexually transmitted and reproductive tract infections (STIs/RTIs) – syphilis, *Neisseria gonorrhoeae, Chlamydia trachomatis*, *Trichomonas vaginalis,* and bacterial vaginosis – are associated with adverse birth outcomes that range from stillbirth, intrauterine growth retardation, preterm birth, and low birthweight. The consequences of curable STIs/RTIs on birth outcomes are comparable to malaria infection. When considered collectively, curable STIs/RTIs are as prevalent amongst pregnant women in sub-Saharan Africa – and potentially more so – than malaria infection.
* The World Health Organization recommends screening of all pregnant women for syphilis during their first antenatal care visit, whereas other curable STIs/RTIs are to be addressed using diagnostic and treatment algorithms referred to as the [Syndromic Management of Curable STIs/RTIs](http://www.who.int/reproductivehealth/publications/rtis/9789241593407index/en/). Syndromic management was developed by the World Health Organization in the late 1990s for use in low-resource settings that lack basic laboratory capacity and skilled staff. It is an effective tool for diagnosing and treating men. However, because women are most commonly asymptomatic, curable STIs/RTIs amongst pregnant women are often unattended.
* A systematic review and meta-analysis of curable STIs/RTIs and malaria infection in sub-Saharan Africa amongst pregnant women at antenatal care facilities published in the [*Journal of the American Medical Association*](https://jamanetwork.com/journals/jama/article-abstract/1157494)suggests that – when considered collectively – curable STIs/RTIs are as common as malaria in pregnancy, and possibly more prevalent.
* Results from a cohort study in Zambia published *in* [*American Journal of Tropical Medicine and Hygiene*](http://www.ajtmh.org/content/journals/10.4269/ajtmh.16-0370)  showed an alarmingly high prevalence of malaria infection and curable STIs/RTIs. Amongst HIV-uninfected pregnant women at booking, 18.1% (± 2.5%) had neither malaria nor a curable STI/RTI; 19.5% (± 2.5%) had malaria only; 25.4% (± 2.8%) had at least one STI/RTI only, and 37.0% (± 3.1%) had malaria and curable STI/RTI co-infection. Amongst HIV-infected pregnant women at booking, 5.8% (± 3.9%) had neither malaria nor a curable STI/RTI; 14.5% (± 5.8%) had malaria only; 29.7% (± 7.5%) had at least one STI/RTI only, and 50.0% (± 8.2%) had malaria and curable STI/RTI co-infection.
* Sub-analysis of this cohort data and published in the [*Journal of Clinical Infectious Diseases*](https://academic.oup.com/cid/article-lookup/doi/10.1093/cid/cix026) suggests that intermittent preventive treatment of malaria in pregnancy (IPTp) using sulphadoxine pyrimethamine (SP) is protective against adverse birth outcomes attributable to malaria and curable STIs/RTIs. Why might this be? One possible reason is that sulphadoxine is derived from sulphonamide, the world’s first mass produced antibiotic that was first synthesised in the 1930s. Sulphonamides have been used for decades to treat curable STIs/RTIs: [*N gonorrhoeae*](https://www.ncbi.nlm.nih.gov/pubmed/6362039)*,* [*C. trachomatis*](https://www.ncbi.nlm.nih.gov/pubmed/7055176), [*T. vaginalis*](http://www.ajog.org/article/S0002-9378(16)40086-4/abstract)*,* and [*Gardnerella vaginalis*](https://www.ncbi.nlm.nih.gov/pubmed/6153721)(common bacteria associated with bacterial vaginosis; formerly categorised as *Haemophilus vaginalis*).
* The use of azithromycin as part of IPTp may confer greater protection against adverse birth outcomes than IPTp-SP. Clinical trials are underway to compare IPTp-SP versus IPTp with dihydroartemisinin-piperaquine versus IPTp with dihydroartemisinin-piperaquine plus azithromycin.

**Discussion:**

* Inflammation as a cause of pre-term delivery: did any of the studies look at markers?
  + Relatively few MIP studies have investigated inflammatory markers and their relation to preterm birth. This is planned in the forthcoming IPTp trials of East and Southern Africa.
* Have you done any studies looking at giving SP to people with potential for high incidence of STIs, but without malaria?
  + I am unaware of any studies that have done this.

**DAY 3**

**(15) Harmonization Across RBM: Improving Collaboration with other Working Groups**

***Peter Olunese, WHO***

**Summary:**

The architecture agreed at the RBM Board’s 29th meeting is designed to ensure efficient governance. Key Partner Mechanisms include: the Partnership Board; a Management Team, led by a Chief Executive Officer (CEO); and Partner Committees. Collaboration across the RBM spectrum and the harmonization is crucial in sustaining current gains and moving forward to achieve the goals and targets of the Malaria Global Technical Strategy. However, challenges and missed opportunities remain, including effectively integrating RBM WGs into the Partner Committees; maximizing delivery of malaria interventions within the broader framework of reproductive health and child health programs at country level and; addressing gender and human rights issues in malaria.

**Discussion:**

* The big challenge in this round of the Global Fund funding is implementation.
  + If the countries don’t implement well there will be no carryover of the money, but the problem of not getting results will influence the application of the next cycle.
  + This also offers opportunity because the reprogramming process will put the money in a pool so if countries need additional money they will be the first ones to receive additional resources.
  + This is something we need to keep in mind as implementers—the opportunity to use resources in countries. UNGA just launched the GFF replenishment.
* This WG has successfully produced a number of products and supported dissemination with WHO over the years. Now we need to flip the dialogue or support countries to flip the dialogue and figure out where MiP is prioritized in malaria control efforts.
  + With RMNCH we are talking about integration and the importance of bringing MCH and malaria control together, but we know that doesn’t always happen.
  + How can we better influence the use of the tools, how can we work with WHO to make sure that countries working on the TPRs are putting MiP at the forefront of the discussions?

CRSPC: The objective of the CRSPC is to harness the people within the CRSPC to help countries deliver better by harnessing the potential of each individual and reharnessing the loss of constituency base.

* + It would be good if the CRSPC had monthly calls and have thematic discussions around what to do. People can bring in their individual experiences and their country experiences to have targeted discussions.
    - Even in the dissonance we might find a better solution.
  + A WG is bigger than a workstream as there are things WGs do that are outside delivery, implementation, etc. of CRSPC.
* At the last count there are more than 500 members of the CRSPC and only recently did they receive support from the Secretariat.
* In the Harmonization Working Group all of the co-Chairs presented their workplans, products, etc. Hopefully they can be disseminated through the RBM mechanism.

Questions to consider as the MiP WG moves forward:

* How to continue using the RBM website as a platform for disseminating products through the MiP WG.
* The idea of having co-Chairs of the WG being members of the CRSPC would be helpful so that they are part of the CRSPC workplan development. There are other opportunities, for example with proposal development,
* The CRSPC has an ethical mandate to be the entry point to help countries contact people/group who can help them.
  + The CRSPC needs to link back to the WGs when countries need support and connect people appropriately.
  + The CRSPC is also the exit point to get information out.
* It seems that in trying to work across institutions and diseases, we ought to have colleagues who are working on HIV in pregnancy participating in WG discussions. There really isn’t a good option for pregnant women living with HIV.
  + It would be good if the MiP WG routinely had evidence/presentations from people working on HIV/TB in pregnancy and for them to hear what we are doing.
  + Certain agencies are doing that and have integrated across health systems strengthening and community systems strengthening. It’s important to look into those entry points.
* Regions other than Africa are missing. How can regions other than African regions become more prominent in WGs?
  + Most of the work providing support to countries comes through the WHO regional offices. When deciding what support goes to what country it is done through those regional offices.
* Some of the reorganization of RBM was to help encourage more country participation so a lot of the implementation is happening at the country level.
  + What do countries think about how we can strengthen the WG and get more country representation in the WG?
  + How do we translate these WG discussions into implementation at the country level?
* If we are talking about integration, then need go beyond the NMCPs to include the MCH system. Countries have knowledge to bring to the table so the group should be widened.
  + The RBM partnership is in each country and focuses specifically on malaria. If we take funds for malaria for HSS, who takes charge?
  + We need a health system in the country that cuts across all of the diseases, health systems.
    - There is not always the support needed to do such types of programming in countries. The real partnership has to function at the country level.
  + Suggestion: Maybe the MiP WG could reach out to countries to have an MiP focal point to update both the NMCP and MCH and share technical updates with both.
* The Global Fund is reforming the CCMs to be more
  + In the last 10 months all efforts have been focused on The Global Fund grants.
  + Implementation support has always been a challenge.
    - There was a structured way to provide support for grant development and now it’s important to have a structured way to support implementation.

**(16) Social Behavior Change Communication Working Group**

***Mike Toso, CCP***

**Summary:**

The RBM Social Behavior Change Communication (SBCC) WG is tasked with the implementation of the Strategic Framework for Malaria Social and Behavior Change Communication 2017-2030.  The strategic framework is currently being approved by Dr. Kesete, RBM CEO.

The key outputs of the SBCC WG are: collection, presentation, and discussion of each year’s most innovative, thoroughly evaluated SBC interventions on group calls throughout the year; annual meetings (which include skills building sessions, panel discussions, and sharing of promising practices), and global guidance.

The SBCC WG has 4 task forces including an MiP task force.  Opportunities to collaborate with other RBM WGs include: attending WG calls & annual meetings, sharing SOWs, contributing to GF concept notes, and assisting with dissemination of products/resources.

**Discussion:**

* Task forces within the RBM SBCC WG develop activities that compliment to corresponding RBM Working Groups.  If you have any specific resources for ANC & PNC that you would like to disseminate please send them to [miketoso@jhu.edu](mailto:miketoso@jhu.edu).
* As we think one of our task force priorities, we should look at opportunities where we can collaborate better to reach a wider audience through the dissemination of our WG products.
  + We’ve used standard channels, but there are opportunities to make a further imprint.

**(17) Applying the ANC recommendations & Accelerating MiP programming**

***Valentina Buj, UNICEF***

**Summary:**

A core underlying principle of UNICEF’s support to maternal, newborn and child health programs is the continuum of care. UNICEF is focusing on how to scale up full packages across the continuum of care including: 4-visit focused ANC package; IPTp and bednets for malaria; prevention and management of STIs and HIV; calcium supplementation and; diagnosis and treatment of maternal chronic conditions. There are a lot of gaps across that continuum of care and UNICEF thinks through the last mile of how to reach the poorest, rural, hard to reach woman.

**Discussion:**

U-Report is a crowd-sourced information platform.

* It’s a free SMS system so if you attend a health facility that doesn’t have a commodity in stock, then UNICEF gets pinged and if they get more than three pings they will go visit the health facility.
* There are also questions sent via SMS to get community-based information.

Equity profiles:

* UNICEF use situation analyses to determine target populations based on disparities. These country profiles are used to create a country response.
* There is peer to peer learning so countries with best practices can share with each other.
* UNICEF has malaria in children equity profiles tracking delivery of services for children.

The Global Fund: the strategy is for countries to take over the programming in the short-term or long-term.

* There is a strong focus on high burden countries.
* If money is not spent it will go back to the pool and be redistributed.
  + If the efforts to accelerate MiP in a critical country are not successful the money will be redistributed to countries performing well.
  + A big concern at the moment is countries that are trying to spend are putting the money all into commodities.
    - It’s a vicious cycle because sometimes they have lots of commodities in the warehouses, but not the money to circulate it.
    - There is a large difference between a metric of how many bed nets were purchased vs. how many bednets were delivered.
* There is a new indicator called the use-access ratio for bednets.
  + Ghana does not have a bednet use problem. The problem is not that behavior change efforts aren’t working, it’s that evidence is needed to show the importance of getting the nets out to houses.
* PMI: is trying to complement and fill gaps and recognizes that TGF grants UNICEF are buying commodities.
  + For example, if there are nets being brought into countries, PMI is open to work with the resident advisors in-country to get those nets out to the communities.
  + Likewise, if countries are getting TGF grants for health systems strengthening, PMI can help support getting the commodities to complement that.
  + There is a USAID Resident Advisor in every country and it would be good to engage them in discussions.
* Rwanda is facing a critical issue with the resurgence of MiP so as a community we need to think through how we can respond collectively to this urgent situation.
* Rectal artesunate:

WHO is allowing only for children under 6. Is this available in the communities?

* + There is a Unitaid sponsored project to look at operational necessities to ensure it is available. There is a big focus on the referral pathway.
  + It’s important to put together the entire supply chain pathway for rectal artesunate to ensure it is at the health facilities.

WHO would need further studies to provide evidence for giving rectal artesunate to pregnant women with severe malaria.

**MiP M&E Brief**

***Elaine Roman, MCSP/Jhpiego***

**Summary:**

The development of a brief for M&E specifically focused on MiP has been drafted in coordination with Elaine and Viviana and the MERG. There is also a team of collaborating partners who are going to be involved in the development of this. If there are others who are interested in joining, please let Elaine and Viviana know.

**MiP Implementation Kit**

***Mike Toso, JHUCCP***

**Summary:**

This is a kit to help country staff developing a behavior change strategy include MiP. The majority of the guidance has to do with the service providers and it is divided into 4 sections. The toolkit can be accessed online: <https://sbccimplementationkits.org/malaria-in-pregnancy/> The website contains a step-by-step walk through how to create a strategy. You can also see on the map which countries have up to date strategies and click on the countries to read their BCC strategies.

**Discussion:**

* If you’re developing your own strategy, you can send it to Mike and he will have the task force review it.
  + The task force is made up of NMCP representatives who can provide useful feedback.
  + This is how they are tracking the use of this tool.

**Other Partner tools/products**

Toolkit to Improve Early and Sustained Uptake of Intermittent Preventive Treatment of Malaria in Pregnancy:

MCSP, in conjunction with PMI, developed a tool to help health providers estimate early gestational age in the absence of ultrasound.

IPTp Quality Assurance Checklist: <http://www.africanstrategies4health.org/uploads/1/3/5/3/13538666/iptp_technical_brief_final.pdf>

African Strategies 4 Health, through MSH, reviewed IPTp service delivery in Uganda and came out with an IPTp quality assurance checklist.

Injectable Artesunate Toolkit:

<https://www.mmv.org/access/tool-kits/injectable-artesunate-tool-kit>

MMV and Malaria Consortium produced a job aid on how to use injectable artesunate.

Case Management Job Aid: <http://www.mcsprogram.org/resource/treatment-uncomplicated-malaria-among-women-reproductive-age-2/>

MCSP, with support from PMI, developed an algorithm to remind providers to test for pregnancy when treating for malaria.

**Workplan**

Groups were asked to brainstorm work plan activities in the following 5 areas: Advocacy, Research, Coordination, Implementation, Tools/Products. The ideas presented below reflect key themes that will be further refined in the coming months resulting in the development of a final MiP WG work plan for 2017-18.

***Next Steps:***

A first draft of the workplan will be drafted based on inputs from the group and then will be circulated for feedback.

**ANNEX 1: MEETING AGENDA**

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| **DAY ONE: September 18, 2017**  **Daily Objective:**   * To review working group priorities, structure and activities * To debrief on the dissemination and implementation of WHO’s new ANC recommendations * To share best practices in MiP programming from countries | | |
| **Time** | **Session** | **Responsible/Chair** |
| 8:00-8:30 | **Registration & Coffee** |  |
| 8:30-9:10 | **Opening Session:** |  |
|  | * Welcome and Introductions * Review of agenda and meeting objectives and expected outcomes * WG overview and key achievements | Elaine Roman & Viviana Mangiaterra,  WG co-Chairs |
| 9:10-9:45 | **Shaping the global MiP agenda to ensure prioritization of MiP** |  |
|  | * WHO * The Global Fund | Silvia Schwarte, WHO  Dr. Roopal Patel, The Global Fund |
| 9:45-10:30  10:30-11:00 | **Global Technical Updates:**  **Updated WHO ANC recommendations & Implications for MiP Programming**  **COFFEE/TEA BREAK** | Özge Tunçalp, WHO |
| 11:00-12:00 | **Panel Discussion: Applying the recommendations & Accelerating MiP Programming**   * Susan Youll, PMI * Houssy Diallo, The Global Fund * Gladys Brew, Ghana Health Service * Claude Arsène Ratsimbasoa, Ministry of Health (MOH), Madagascar * Aline Uwimana, Rwanda Biomedical Center | Lisa Nichols, Abt Associates |
| 12:00-1:00 | **LUNCH** |  |
| 1:00-2:30 | **Roundtable Discussions: Learning from countries**   * Successful strategies for early ANC attendance- Ghana * Prioritizing MiP in the national agenda- Madagascar * Implications for MiP Programming in the context of elimination –Rwanda | Gladys Brew, Ghana Health Service  Claude Arsène Ratsimbasoa, MOH  Nivonirina Rajoelina Raveloaritrema, MOH  Aline Uwimana, Rwanda Biomedical Center  Felix Sayinzoga, Rwanda Biomedical Center |
| 2:30-3:00 | **TEA/COFFEE BREAK** |  |
| 3:00-4:00 | **Partner Updates**   * MiP country profiles development and application * Update on Abt’s MiP activities | Katherine Wolf, MCSP/Jhpiego  Lisa Nichols, Abt Associates |
| 4:00-4:30 | **Day One Wrap-up and Close** | Elaine Roman & Viviana Mangiaterra |
| **DAY TWO: September 19, 2017**  **Day Objectives:**  To present and discuss key research in MiP programming; to present and discuss new opportunities for innovation in MiP programming | | |
| **Time** | **Session** | **Responsible/Chair** |
| 8:00-8:30 | **Welcome Coffee** |  |
| 8:30-8:45 | **Overview of Day 1** | Viviana Mangiaterra, The Global Fund |
| 8:45-9:30 | **Optimal delivery and continued challenges with MiP programming :**   * Low Dose Folic Acid Policy * Group ANC: Lessons from the field and links to WHO ANC recommendations | Clara Menéndez, ISGlobal  Koki Agarwal, MCSP/Jhpiego |
| 9:30-10:15 | **Diagnostics for MiP**   * Highly sensitive mRDT and relevance to MiP * Pregnant women and children as sentinel populations for monitoring malaria prevalence | Iveth Gonzalez, FIND  Julie Gutman, CDC |
| 10:15-10:45 | **TEA/COFFEE BREAK** |  |
| 10:45-11:30 | **C-IPTp**   * Unitaid Strategy & Malaria Projects * TIPTOP Project & Burkina Faso Study | Alexandra Cameron, Unitaid  Elaine Roman, Jhpiego |
| 11:30-12:00 | **PQE Initiative (Program Quality & Efficiency Initiative for Integrated Service delivery at ANC)** | Nicholas Furtado, The Global Fund |
| 12:00-1:00 | **LUNCH** |  |
| 1:00-2:30 | **Research Updates**   * Results from clinical trials on IST, SST, IPTp with DP in Indonesia and sub-studies on acceptability, feasibility, cost effectiveness * Text messaging to increase IPTp coverage | Rukhsana Ahmed, LSTM  Prudence Hamade, Malaria Consortium |
| 2:30-3:00 | **TEA/COFFEE BREAK** |  |
| 3:00-3:45 | **Research Updates**, continued   * The protective effect of IPTp-SP against the dual burden of malaria and STIs/RTIs in pregnancy | Matthew Chico, LSHTM |
| 3:45-4:15 | **Day Two Wrap-up** | Elaine Roman & Viviana Mangiaterra |
| 5:00-6:30 | **Evening Reception in the 10th floor lobby of The Global Fund Building** |  |

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| **DAY THREE: September 20, 2017**  **Daily Objective:**  To identify future working group priorities and strategies for MiP prioritization | | |
| **Time** | **Session** | **Responsible/Chair** |
| 8:00-8:30 | **Welcome Coffee** |  |
| 8:30-8:45 | **Applying the ANC recommendations & Accelerating MiP programming** | Valentina Buj, UNICEF |
| 8:45-9:30 | **Products & Tools to Support MiP Implementation**  MiP M&E Brief  MiP Implementation Kit | Elaine Roman, MCSP/Jhpiego  Mike Toso, JHU CCP |
| 9:30-10:15 | **Harmonization Across RBM: Improving Collaboration with other Working Groups** | Peter Olunese, WHO  Mike Toso, JHU CCP |
| 10:15-10:45 | **TEA/COFFEE BREAK** |  |
| 10:45-12:15 | **Moving Forward & Next Steps for RBMMiPWG**  Update on changes within Roll Back Malaria. Identification of priority activities needing MiP WG support. Review of workplan priorities and how to move the RBMMiPWG agenda forward in the coming year | Elaine Roman & Viviana Mangiaterra,  WG co-Chairs |
|  |  |  |
| 12:15-12:30  12:30-1:30 | **Meeting Wrap-up**  **LUNCH** | Elaine Roman & Viviana Mangiaterra,  WG co-Chairs |
|  |  |  |

**ANNEX 2: PARTICIPANT LIST**

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| --- | --- | --- |
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**ANNEX 3: UGANDA ROAD MAP FOR ADOPTION OF NEW WHO ANC GUIDELINES**

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**THE UGANDA ROAD MAP FOR ADOPTION OF NEW WHO ANC GUIDELINES-2016**

**INTRODUCTION/BACKGROUND:** In 2015, about 303.000 of women 90% of which were from low income countries like Uganda including adolescents died due to childbirth related complications. 2.6M still births were reported in the same year and 60% of these are mainly due infections e.g Malaria and Hypertensive disorders. Note that over 90% of Uganda population is at risk for Malaria, but the same population is also at risk of other infectious diseases that can greatly affect the outcome of Pregnancy, and rate of teenage Pregnancy is at 33%(UDHS2011).However these can be averted through delivery of curative, prevention and Health promotion services and the new ANC WHO guidelines provide this opportunity. As is the recommendation, Uganda will prioritize universal but critically review the current epidemiological situation for adoption of contextual recommendations. Below is the proposed roadmap for adoption of the new WHO ANC guidelines:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Milestones** | **Targeted audience** | **Activities** | **Timeline & Technical lead** | **Expected out come** |
| 1. | National Policy level | MOH top Management | * Review country epidemiological context * Review ANC delivery platforms and Health systems. * Update policy guidelines and standards * Review the RMNCH strategy to include new recommendations | April 2018 | * Contextual recommendations to prioritize. * Guidelines on task shifting. * Strong systems and platforms that can accommodate the new ANC guidelines. * Costed plan that is aligned to the general MOH plan |
| Reproductive Health Division |
| 2. | Consultation and engagement of Key stakeholders | * Other Key contextual Ministries, Implementing * And developmental Pateners etc * Regional /District Managers * Health Facility in charges * Community leaders * Health workers and community workers. | * Leadership ,involvement and engagement * Of key actors at different levels of the Health system. * Holding meetings to share the new recommendations and get feedback. | September 2018 | * Partners/Stake holders buy in, ownership and leadership. * Expert and context specific opinion/reviews/adjustments * Consensus building. |
| Reproductive Health Division, Other Relevant MOH programs National Malaria Control Program, AIDs Control Program |
| 3. | Implementation | * Health workers Training Institutions. * Practicing Health workers * Data Managers * Logistics Managers * Community Health workers | * Support Human resource capacity to implement the new WHO ANC guidelines. * Strengthen commodities and logistics supply chain management system to accommodate those that will be introduced with the new guidelines. * Improve the information system and align it to the new WHO ANC guidelines | June 2020 | * Reviewed and updated in service and pre-service curriculum that include new ANC guidelines. * Updated protocols, standards and job aids. * Updated scope of work for providers. * ANC task shifting plan where other ordinary service providers, community Health workers and others can provide basic ANC services. * Strong midwifery deployment, training and mentorship plan * Reliable well financed procurement and distribution plan with new commodities fully included and no stock outs. * Indicators and data collection tools reviewed to support effective monitoring of new ANC WHO recommendations * Updated client/patient communication materials |
|  |
| 4 | Coordination | * Leaders at different levels implementation including Community | * Organize the delivery of ANC services for effective implementation of new WHO ANC recommendations | June 2017 | * Sustainable ANC delivery model * Mechanism of coordination of ANC service delivery at all levels * Reorganized ANC services and client flow. * Quality improvement plans and teams. |
| Reproductive Health Division |
| 5. | Monitoring ,Evaluation and Operational Research | * Resource Centre, * Research Institutions * Academia | * Define and monitor the implementation of the different milestone of the Road Map. * Strengthen collection and use of ANC data programming and decision making. * Support implementation research to inform introduction and scale up of new complex recommendations. | May 2017 | * Availability of a well articulated road map for adopting new WHO guidelines. * Use of data for programming and decision making. * Use research findings to effectively introduce and scale complex recommendations. |
| Reproductive Health Division |

**Opportunities:**

1. The on-going review process of the sexual reproductive Health Policy guideline from the 2012 version to the 2016 version.
2. The upcoming review of data collection tools /HMIS, indicators (September 2017) by the resource centre of Ministry of Health.
3. Key programs that depend on the ANC platform to implement intervention that are instrumental to their performance like the AIDs Control Program and National Malaria control Program are undergoing evaluation and review(Mid –term review of the 2014 to 2020 Uganda Malaria Reduction strategy) respectively.
4. There are number of other new WHO policy updates that should be aligned to the new WHO ANC guidelines; like IPTp.
5. The Anemia prevention and Control Strategy-2015 to 2021 a multi-sectoral document is being finalized and these changes can be included using anemia in Pregnancy as an entry point.

**Conclusion:** Since there is need to improve the quality of ANC services and yet the new WHO ANC guidelines provide an opportunity for this to be achieved, Uganda is willing to adopt the guidelines but for effective and sustainable implementation the above proposed roadmap is very key.