Community IPTp Virtual Learning Meeting Setting the Stage for Success:

Lessons Learned to Move Malaria in Pregnancy to a New Level

Meeting Report
June 1–3, 2021

TIPTOP
ADVANCING PREVENTION OF MALARIA IN PREGNANCY

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MMV Medicines for Malaria Venture

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Abbreviations

ANC	Antenatal care
APEs	Agentes Polivalentes Elementares
BMGF	Bill & Melinda Gates Foundation
CDC	U.S. Centers for Disease Control and Prevention
CHW	Community health worker
C-IPTp	Community-based distribution of intermittent preventive treatment during pregnancy
CISM	Manhiça Health Research Centre
CSO	Civil society organization
DRC	Democratic Republic of the Congo
GDG	Guidelines Development Group
HAS	Health Surveillance Assistant
HCW	Health care worker
IPTp	Intermittent preventive treatment of malaria in pregnancy
ISGlobal	Barcelona Institute for Global Health
LCC	Lay community counselor
MIP	Malaria in pregnancy
MIPTWG	Malaria in pregnancy technical working group
MMV	Medicine for Malaria Ventures
MOH	Ministry of Health
NMCP	National Malaria Control Program
PMI	President's Malaria Initiative
PPE	Personal protective equipment
Q	Quarter
QA-SP	Quality-assured sulfadoxine-pyrimethamine
RPLM	Regional Program Learning Meeting
SP	Sulfadoxine-pyrimethamine
TBA	Traditional birth attendant
TIPTOP	Transforming Intermittent Preventive Treatment for Optimal Pregnancy
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

The Community Intermittent Preventive Treatment of Malaria in Pregnancy (C-IPTp) Virtual Learning Meeting was held June 1–3, 2021. A total of 175 participants from 17 countries joined the meeting. With funding support from Unitaid, through the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project, the meeting provided **an opportunity for sharing and learning, pivoting and building, and accelerating and optimizing C-IPTp**. Specifically, the meeting objectives were to:

- Present the preliminary C-IPTp TIPTOP project research findings.
- Present and discuss C-IPTp implementation lessons learned.
- Identify challenges and opportunities for countries to improve C-IPTp pilot implementation.

The opening session included remarks from Elaine Roman, TIPTOP Project Director; Philippe Duneton, Executive Director of Unitaid; Pedro L. Alonso, Director of the World Health Organization (WHO) Global Malaria Programme; and Raj Panjabi, United States Global Malaria Coordinator.

Day 1: Setting the Stage for C-IPTp

Day 1 started with an overview of the TIPTOP project, followed by a presentation from Pedro L. Alonso and David Schellenberg (WHO/Good Manufacturing Practices) on WHO's new Guideline Development Process. They identified three steps in the pathway to new recommendations by WHO. TIPTOP's research partner, Barcelona Institute for Global Health, presented a review of the preliminary findings from research studies of the TIPTOP project. These included baseline and midline household surveys and anthropological studies, cost-effectiveness studies, and sulfadoxine-pyrimethamine drug resistance monitoring studies. Routine monitoring data from each of TIPTOP country were also presented. The quote of the day:

> "We don't want countries to lose energy and steam. Anything that allows us to improve uptake of IPTp will be supported."
>
> – Dr. Pedro Alonso, Director, Global Malaria Programme, WHO

Day 1 Key Takeaways

- C-IPTp pilot implementation findings suggest this innovative approach has the potential to provide eligible pregnant women with more opportunities to get the right medicine, at the right time, in the right place in order to prevent malaria and its adverse consequences for themselves and their unborn babies.
- WHO has updated the Guidelines Development process—key steps are indicated in Session 1 below.
- Although the TIPTOP household surveys showed a significant increase in IPTp3-SP coverage in three of the four Phase I implementation areas (except Nhamatanda, Mozambique, due to Cyclone Idai and insecurity that led to the closure of three health facilities), antenatal care (ANC) 4 coverage showed mixed results, with marginal increases in Democratic Republic of the Congo and Nigeria, but decreases in Madagascar and Mozambique due to substantial contextual factors.
- Routine data monitoring, however, suggests that C-IPTp3 improves overall IPTp coverage without a negative impact on ANC utilization.
- Anthropological studies have shown that even though C-IPTp is widely accepted by its beneficiaries, barriers to further acceptance can be overcome through appropriate social and behavior change communication approaches.

Day 2: Exploring the Essentials of C-IPTp

Sessions on Day 2 provided opportunities to share lessons learned from access to and demand for C-IPTp, community health worker (CHW) experiences, role of civil society organizations, supervision systems as well as government partnerships and sustainability.

Day 2 Key Takeaways

- Increasing access to and demand for quality-assured sulfadoxine pyrimethamine, as a preventive medicine only, with user-friendly packaging, is expected to help increase uptake.
- CHWs are trusted members of their communities and are well positioned to reach pregnant women early in pregnancy and provide those eligible with quality-assured sulfadoxine pyrimethamine as well as refer them to ANC.
- Governments can ensure that CHWs are included in the health system and reimbursed appropriately. WHO advocates that CHWs should be recognized within the health systems where they work and receive remuneration for their support.
- As shown in Madagascar, peer CHW supervisors can play a key role in motivating, mentoring, and supervising CHWs
- Early engagement with civil society organizations lends to strong coordination, learning, and replication.
- Government-led partnerships foster collaboration and strong coordination of C-IPTp programs and contribute to setting the stage for sustainability.

Day 3: Reflecting on Lessons Learned in C-IPTp

On Day 3, focused discussions were held on generating demand creation for C-IPTp, maintaining continuity of services during the COVID-19 pandemic, reinforcing referral systems, and increasing private sector engagement.

Day 3 Key Takeaways

- Addressing the contextual factors and social norms that hinder uptake of IPTp and ANC utilization must be built into the C-IPTp program using multiple platforms.
- Engaging implementing partners from the beginning is critical for demand creation.
- Working with male partners is key to pregnant women's attendance of ANC.
- CHWs are instrumental to continuity of essential health services during health emergencies as was seen with the COVID-19 pandemic
- Provision of personal protective equipment from the beginning allowed health care providers (at facility and community levels) to feel safe while providing services.
- Remote platforms introduced as a result of the COVID-19 pandemic worked.
- Referring pregnant women and breaking down access barriers (e.g., cost, distance) go together.
- Pregnant women seek private care, therefore engaging the private sector in training, supervision, medicines supply, and routine monitoring will contribute to long-term success.
- WHO will assess the comprehensive evidence in 2022, which is expected to become available by April 2022 and will also include TIPTOP project endline analysis results. At this occasion, the preliminary baseline and mid-term observations suggesting C-IPTp adds value to increasing overall IPTp coverage, with mixed impact on ANC coverage, will be validated.
- Countries where the pilots have proven successful expressed an interest in continuing C-IPTp and scaling up the approach in other districts. They, however, anticipate support from other implementing partners in the short and medium term to do so.

Introduction

Globally, there were an estimated 229 million malaria cases in 2019 in 87 malaria-endemic countries, declining from 238 million in 2000. In 2019, in 33 moderate- to high-transmission countries in the World Health Organization (WHO) African Region, there were an estimated 33 million pregnancies, of which 35% (12 million) were exposed to malaria infection during pregnancy. It is estimated that malaria infection during pregnancy in these 33 countries resulted in 822,000 newborns with low birthweight. Although malaria is preventable and treatable, many women do not know that and/or cannot get safe, effective medicine or miss opportunities at antenatal care (ANC) to stay healthy. Using data from 33 African countries, the percentage of intermittent preventive treatment of malaria in pregnancy (IPTp) use by dose was computed. In 2019, 80% of pregnant women used ANC services at least once during their pregnancy. About 62% of pregnant women received IPTp1 and 49% received IPTp2. There was a slight increase in IPTp3 coverage, from 31% in 2018 to 34% in 2019. (WHO World Malaria Report 2020). Factors such as: 1) low demand for IPTp among providers and pregnant women; 2) perceptions that sulfadoxine-pyrimethamine (SP) for IPTp is a "failed drug;" 3) lack of availability of quality-assured sulfadoxine-pyrimethamine (QA-SP) for IPTp; and 4) insufficient evidence behind alternative service delivery innovations require solutions for countries to meet their malaria targets and relevant Sustainable Development Goals and underscore the need for innovation.

Multiple countries have and are taking steps to test an innovative community-based approach that offers pregnant women the opportunity to receive IPTp at the community level. This approach—called community-based distribution of intermittent preventive treatment during pregnancy (C-IPTp)—complements the currently recommended administration of IPTp-SP at ANC clinics (see WHO consolidated Guidelines for Malaria (launched in July 2021 and available via the following link: Guideline WHO Guidelines for malaria - 13 July 2021 (magicapp.org). With support from Unitaid, four countries (Democratic Republic of the Congo [DRC], Madagascar, Mozambique, and Nigeria) are testing the introduction and expansion of C-IPTp. Independently from the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project, Burkina Faso and Malawi, with support from the President's Malaria Initiative (PMI), as well as Senegal are in various stages of piloting C-IPTp. Sierra Leone has adopted C-IPTp as national policy and is rolling it out nationwide. The findings from each of these countries are contributing to building an evidence base that will be reviewed by WHO in 2022 in consideration of a potential update of recommendations, as the evidence permits.

If proven a successful strategy contributing to an increase in IPTp-SP coverage without a negative impact on ANC attendance, C-IPTp could support countries to prevent malaria in pregnancy (MIP), which would minimize missed opportunities.

Meeting organizers

Unitaid funded the Virtual C-IPTp Learning Meeting. Jhpiego, in collaboration with the Barcelona Institute for Global Health (ISGlobal), Medicine for Malaria Ventures (MMV), WHO, PMI, and the Bill & Melinda Gates Foundation (BMGF) conceptualized and organized the meeting.

Meeting purpose and objectives

The meeting objectives were to:

- Present the preliminary C-IPTp project research findings.
- Present and discuss C-IPTp implementation lessons learned.
- Identify challenges and opportunities for countries to improve C-IPTp pilot implementation.

Meeting format and attendance

The 3-day meeting, from June 1–3 2021, brought together 175 participants including ministry representatives, researchers, partners, and donors from Benin, Burkina Faso, Burundi, Cameroon, DRC, Madagascar, Malawi, Mali, Mozambique, Nigeria, Senegal, Sierra Leone, Spain, Switzerland, Uganda, the United States, and Zimbabwe, for a total of 17 countries (see Annex 1). There were seven Plenary Sessions with two to four speakers per session. Each speaker was given 10–25 minutes to make their presentations, followed by group discussions. In addition, there were two breakout room sessions to discuss the critical lessons learned in implementing C-IPTp (see attached Meeting Agenda for details).

The meeting was structured to have discussions around some core themes, namely: setting the stage for C-IPTp implementation; reviewing C-IPTp research findings as part of evidence generation for policy formulation; and reflecting on lessons learned from C-IPTp implementation and from working with governments.

Key takeaways from sessions

Day 1

Opening remarks

Elaine Roman, TIPTOP Project Director, provided welcome remarks. She noted that participants' presence underscored the collective commitment to meet the needs of all women in halting the scourge of MIP. She added that approaches like community delivery of IPTp offer great potential: to afford pregnant women more **opportunities** in their community, including the prevention of malaria and referral to ANC, through a community health worker (CHW), who lives within reach—reaching the most vulnerable, improving access to quality-assured medicine, and strengthening critical links between communities where women live and the health facilities supporting those communities.

Dr Philippe Duneton, Executive Director of Unitaid, thanked the TIPTOP consortium and partners for the work that they are doing in advancing the prevention of MIP through community engagement, especially during the COVID-19 pandemic. He expressed his hope that the outcome of the pilot projects will confirm the value of the approach.

In his goodwill message, Pedro L. Alonso, Director of the WHO Global Malaria Programme, noted that WHO attaches importance to the meeting and any work that aims to reduce morbidity and mortality in African pregnant women due to malaria, in turn reducing low birthweight, prematurity, and neonatal mortality in these particularly vulnerable populations. Dr. Alonso indicated the need for immediate action and recognized that IPTp with SP is the oldest policy recommendation in the WHO toolkit (from 1997—almost 25 years ago!), yet only about one-third of women receive at least 3 doses of SP. He acknowledged the support of Unitaid and partners in looking for means to increase the uptake, access, and impact of IPTp. Finally, Dr. Alonso called for the malaria community to integrate interventions into existing delivery platforms for maternal and child health, reproductive health, etc.

Dr Raj Panjabi, United States Global Malaria Coordinator, stated that *"to end malaria, we need to reach the unreached."* He advised participants to explore how to maximize opportunities for eligible women to receive preventive treatment for MIP. He lauded Unitaid for supporting the C-IPTp project saying that *'It is smarter to bring care to the pregnant woman than waiting for the pregnant woman to come in for care."* He also made the case for a fair and just remuneration for CHWs and other health workers for the work they do in caring for the population.

Session 1: What is TIPTOP and C-IPTp all about?

Koki Agarwal (Jhpiego), Global Director of the MOMENTUM Country and Global Leadership, facilitated the two presentations in this session.

In the first presentation, Emmanuel Otolorin (Jhpiego) gave an overview of the TIPTOP project. He noted the numerous missed opportunities for IPTp coverage in areas of moderate to high malaria transmission, with only 34% of pregnant women receiving WHO's recommended minimum of 3 doses of monthly SP during pregnancy in 2019. He described the role of trained CHWs in the TIPTOP project to seek out pregnant women in the community, map them on a register, conduct household visits to educate them on the benefits of comprehensive ANC and IPTp in order to minimize the adverse effects of MIP, screen them for their eligibility to receive SP doses, and provide the doses by directly observed therapy to those eligible and/or refer them for ANC (as applicable, differs by country and dose).

Key Takeaways

- C-IPTp is a novel approach that has the potential to provide eligible pregnant women with more opportunities to protect themselves and their unborn babies from malaria, in addition to receiving comprehensive care through the antenatal clinic.
- TIPTOP's initial success up to May 2021 has been grounded on the engagement of civil society organizations (CSOs), CHWs, and community leaders through government-led partnerships providing a well-rounded approach to encouraging pregnant women to receive comprehensive ANC including IPTp-SP doses.
- Community engagement, adaptability, creativity, and innovation are key elements that can help in achieving short- and long-term public health gains for MIP and maternal and newborn health and toward achieving the Sustainable Development Goals.

Pedro Alonso and David Schellenberg of the WHO Global Malaria Programme made the second presentation on the new WHO Guideline Development Process. They identified three steps in the pathway to new recommendations by WHO that can be viewed in the text box below. Focus of the new pathway is to deliver timely, high-quality recommendations for malaria-endemic countries through processes that are transparent, consistent, efficient, and predictable.

The three steps in the pathway to new recommendations:

1. **Better anticipate** products or strategies that are likely to be key in future efforts to control and eliminate malaria.
2. **Develop recommendations** for countries on "what to do' and what malaria control products to use based on the best available evidence.
3. **Optimize uptake** of the recommendations by improving the way they are shared and updated.

The following definitions and taxonomy should be well distinguished and considered:

- **Guideline.** Any document developed by WHO that contains ***recommendations*** for clinical practice or public health policy.
- **Recommendation.** Tells the intended end-user what he or she can or should do in specific situations to achieve the best health outcomes possible, individually or collectively. ***Recommendations are based on systematically reviewed evidence.***
- **Policy.** Decisions, plans, and actions undertaken to achieve specific health goals within a society—**established and implemented by countries based on** WHO recommendations contained within guidelines.

- **Guidance.** A broader term encompassing advice ranging from specific guidelines to operational considerations. Guidance is not necessarily based on a systematic review of evidence.

Five groups are involved in developing WHO Guidelines. These consist of **two internal groups,** namely the Guideline Review Committee and the Steering Group, as well as **three external groups,** namely the Guidelines Development Group (GDG), External Review Group, and the Evidence Review Group. The eight steps in the Guidelines Development process and roles of the different groups are summarized in Table 1 below.

Table 1: Overview of the process of guideline development

Step	Activity	Group(s) responsible
1	Scope the guideline	Steering Group with stakeholder input
2	Set up the GDG and External Review Group	
3	Formulate patient/population, intervention, comparison, and outcomes questions and select outcomes	GDG
4	Retrieve evidence, assess quality, and synthesize	Evidence Review Group
5	Grade the certainty of evidence	
6	Formulate recommendations using Evidence to Decision Framework	GDG
7	External review	Evidence Review Group
8	Disseminate, implement, and evaluate impact	WHO

With respect to development of IPTp guidelines, the GDG met in November 2020 to review and finalize the questions related to **p**atient/population, **i**ntervention, **c**omparison and **o**utcomes on IPTp, IPTp in HIV, seasonal malaria chemoprophylaxis, intermittent preventive treatment in infants, mass drug administration (burden reduction), and IPT in schoolchildren. Evidence review meetings are planned for June, July, and August.

Session 2: TIPTOP data to date (Part 1)

Clara Menendez, (ISGlobal), Research Professor, facilitated this session that included presentations on the TIPTOP household survey findings and the findings from routine monitoring data. Franco Pagnoni (ISGlobal), TIPTOP Technical Director, presented on *Household surveys to measure TIPTOP indicators: Results from Surveys 2018–2020*. These are the results of household surveys performed in 2018, 2019, and 2020 in 12 study sites across the three TIPTOP countries (baseline/repeat baseline/midline). He noted that an important increase of IPTp3-SP coverage estimates was observed in all Phase 1 implementation areas except in Nhamatanda, Mozambique, which was ravaged by Cyclone Idai and insecurity that led to the closure of three health facilities. ANC4+ coverage also marginally increased in Phase 1 implementation areas in DRC and Nigeria, but not in Nhamatanda, Mozambique, where a 17% decrease was noted, or in Mananjary, Madagascar, where a decrease of 25.5% was also observed. He attributed these decreases to a variety of contextual factors.

Christina Maly, (Jhpiego), Senior Technical Advisor, Measurement and Learning, reviewed *Routine Monitoring of TIPTOP Project Data*. She described the TIPTOP approach to collection and use of routine monitoring data utilizing existing data systems and standardizing across all four countries. The data reviewed showed that C-IPTp has increased IPTp distribution, including doses distributed through ANC. She also showed that C-IPTp has strengthened IPTp cascades across all TIPTOP districts

even though gaps between doses persist in some districts. Concerning ANC attendance, the data review showed that C-IPTp has not had a negative impact on early ANC initiation.

Key Takeaways

1. Although the household surveys showed a significant increase in IPTp3-SP coverage in three of the four Phase 1 implementation areas (except Nhamatanda, Mozambique, due to Cyclone Idai and insecurity leading to three facility closures), ANC4 coverage showed mixed results with marginal increases in DRC and Nigeria; however, due to substantial contextual factors, there were decreases in Madagascar and Mozambique.
2. Routine data monitoring, however, suggests that C-IPTp improves overall IPTp3 coverage without a negative impact on ANC utilization.

Session 3: TIPTOP data to date (Part 2)

Koki Agarwal, (Jhpiego), the Global Director of MOMENTUM Country and Global Leadership, facilitated this session. Cristina Enguita-Fernàndez and Yara Alonso, Social Scientists, (ISGlobal), presented on *Assessing barriers and opportunities for a community-based distribution of IPTp as part of the TIPTOP project: Preliminary findings.* The presentation covered the study design, study tools, and activities in the 12 project districts across the four countries. The study concluded that although cases of refusal—both refusal of treatment and project participation—have been reported, it is possible to conclude that C-IPTp is widely accepted by its beneficiaries in project areas. The authors also concluded that the identified barriers to C-IPTp could be overcome by addressing beneficiaries' concerns over SP side effects, ensuring the involvement of key actors related to maternal health issues, such as engaging traditional birth attendants (TBAs); strengthening continuous engagement strategies among CHWs, facility-based health workers and the communities they serve, and reframing sensitization strategies to address context-specific barriers.

Clara Pons and Laia Cirera Crivillé, (ISGlobal), presented on the progress of the drug resistance and cost-effectiveness studies. The objective of the drug resistance study was to assess the impact of C-IPTp-SP on the prevalence of genetic markers related to *Plasmodium falciparum* resistance to SP. They described the study areas, study population (children with uncomplicated clinical malaria), and study design, which is a health-facility-based, cross-sectional survey in intervention and control areas. The key markers that will be assessed are dihydrofolate reductase triple mutation (codon 108, 51, and 59) and the triple P. falciparum dihydropteorate synthetase mutations at codons 431, 437, 540, 581, and 613. The study (i.e., sample collection in the four project countries) is expected to be completed by September 2021, while analysis results are planned to be available by end of 2021. The objective of the *Cost-Effectiveness Study* is to estimate and compare the incremental costs and health gains (cost-effectiveness) associated with C-IPTp. The study aims to compare the cost of SP delivered at the health facilities versus the cost of SP delivered at the community level (in addition to health facilities). Pregnant women leaving the ANC visit and health professionals from randomly selected health facilities make up the study population. Data collection has been completed in all project districts except in Vohipeno, Madagascar, where completion is expected in a few weeks.

Key Takeaways

1. C-IPTp is widely accepted by its beneficiaries in all four countries but there are barriers to full implementation such as fear of SP side effects and lack of spousal consent.
2. To overcome the barriers to C-IPTp, implementers should allay beneficiaries' fears of side effects, ensure the engagement of relevant stakeholders including TBAs, strengthen linkages between the health facility and community, and focus demand creation on specific identified barriers such as lack of spousal consent for antenatal clinic attendance.
3. Any decision on whether to expand C-IPTp to other countries in sub-Saharan Africa needs to be guided not only by the effectiveness of the strategy, but also by its additional costs.

4. The cost-effectiveness study compares the incremental costs and health gains (effectiveness) associated with a) SP delivery exclusively at the ANC visits versus b) SP delivery at the community level in addition to routine delivery at the health facilities.

Day 2

Session 4: Update on availability of QA-SP and IPTp-specific packaging

Maud Majeres Lugand (MMV) facilitated the session and Pierre Hugo (MMV) presented the *Update on Quality-Assured SP and IPTp-specific packaging*. They outlined the objectives of the MMV/Unitaid Supply Grant, which includes obtaining WHO prequalification for SP at a commercial-scale manufacturing plant compliant with Good Manufacturing Procedures, along with ensuring manufacturer support to facilitate drug development, bioequivalence studies, and submission of dossiers for WHO prequalification. A second objective is to develop a user-friendly primary and secondary packaging of SP specific to IPTp, supporting the correct use and administration of the preventive medicine in the context of a community health delivery system. This approach shall help to position SP as an IPTp preventive treatment, also while trying to address the negative perception of SP. There is an expectation that improved acceptance and use of IPTp will increase overall IPTp uptake and generate demand for QA-SP. So far, MMV has been providing support to three pharmaceutical companies: Universal Corporate Limited in Kenya as well as SWIPHA and EMZOR pharmaceutical companies in Nigeria. MMV estimates that Kenya's Universal Corporate Limited may receive WHO approval by Quarter (Q) 4 of 2021, while SWIPHA and EMZOR dossier reviews are expected to span the period from Q4 of 2021 to Q4 of 2022.

Session 5: Breakout rooms on lessons learned from C-IPTp implementation

Room 1

Kristen Vibbert, (Jhpiego), Senior Program Officer of TIPTOP, facilitated the two presentations in Room 1. Chibinda Deogratias, (Jhpiego), TIPTOP's Country Manager in the DRC, presented on *Community Health Worker Selection, Training, Supervision, SP Supply and Incentives*. He concluded that motivated and incentivized CHWs are key to the success of any C-IPTp project and that close collaboration with key partners at all levels of the Ministry of Health (MOH) and engagement CSOs are key to increasing demand for C-IPTp. However, the low level of education of most CHWs in DRC has necessitated changes to the training materials and presentations to accommodate lower literacy levels in addition to investment in close follow-up through supervision visits and monitoring.

In his own contribution on the same topic, Ousmane Badolo, (Jhpiego) Malaria Technical Director in Burkina Faso, noted that CHWs are selected and trusted by their communities. CHWs undergo 3 days of training and monthly supervision to deliver C-IPTp. They also conduct sensitization activities to encourage pregnant women to attend ANC early at the health center where they could receive the first dose of SP, if deemed eligible. Thereafter, they deliver follow-up SP doses at the community level as needed. The major challenges encountered during implementation included insufficient number of female CHWs and irregular payment of CHW stipends by the Burkina Faso government.

These presentations were followed by a discussion that included the importance of country adaptation of the *2018 WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes,*[1] especially Recommendation No. 7, which deals with remuneration of CHWs:

- **Recommendation 7A.** WHO recommends remunerating practicing CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training,

[1] WHO guideline on health policy and system support to optimize community health worker programmes. Geneva: World Health Organization; 2018.
http://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf

and roles that they undertake. Certainty of the evidence—very low. Strength of the recommendation—strong.

- **Recommendation 7B.** WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives. Certainty of the evidence—very low. Strength of the recommendation—conditional.

Key Takeaways

- CHWs who are selected, trained, and incentivized by their communities are key to the success of C-IPTp programs.
- Uninterrupted availability of QA-SP among trained CHWs for end-user distribution is essential for a successful C-IPTp program.
- Monthly meetings between CHWs and their supervising facility-based health care workers (HCWs) has been shown to be critical for quality data reporting and SP replenishment.
- In Burkina Faso, CHWs' sensitization activities encourage pregnant women to attend ANC early at the health center.
- CHWs can be trained to competently screen pregnant women for eligibility to receive follow-up SP doses and to provide the needed dose of SP to those eligible.

Room 2

> "The needs of the supervisee are more important than the needs of the system."
>
> – Jean Pierre Rakotovao (Jhpiego)

Kathrine Wolf (Jhpiego), Senior Malaria Technical Advisor II, facilitated the session in Room 2 where presentations on Lessons Learned from Supervision Systems were made in English and French. Jean Pierre Rakotovao (Jhpiego), TIPTOP's Malaria Technical Advisor in Madagascar, described four different types of supervision, namely external supervision (from the MOH to HCWs and from HCWs to CHWs), internal supervision (by the facility line manager to the supervisee), community supervision (led by a village chief), and remote supervision, which became necessary during the COVID-19 pandemic (mobile mentoring, use of WhatsApp, Skype, Messenger, and SMS messaging). He also talked about the innovative CHW Peer Supervision System introduced in Madagascar, which entails identifying high-performing CHWs and special training to become peer supervisors. Thereafter, they provide mentorship and supervision of other CHWs in their communities. In addition to peer supervision, these peer CHWs also assist the Head of the Basic Health Centre during monthly meetings with CHWs to ensure quality community-level data collection.

Seynabou Gaye of Programme National de Lutte contre le Paludisme (PNLP) in the MOH in Senegal presented on Lessons learned from the community IPT supervision system in Senegal. She concluded that the involvement of village chiefs and female leaders made it possible to reach a large number of women with IPTp through the ANC platform and that the empowerment of community actors strengthens the acceptability and adherence of women to the IPTp schedule. She also noted that the payment of a small sum for the CHW is a crucial incentive.

Key Takeaways

- Respecting the steps of the supervision process contributes to its quality.
- Supervision by the peer CHW strengthens the link between the health system and the CHWs.
- It is important to adapt supervision to the realities in the field for supervisees' buy-in and creativity.
- Involvement of community leaders contributes to the reach and acceptability of IPTp.

Room 3: Role of Civil Society Organizations

Gloria Sebikaari (U.S. Agency for International Development [USAID]/PMI), Malaria Program Management Specialist in Uganda, facilitated the session in Room 3. In the first presentation, Bartholomew Odio (Jhpiego), TIPTOP's Malaria Technical Advisor in Nigeria, presented on the *Role of Civil Society Organizations in Community IPTp Implementation*. He described the types of CSOs involved in C-IPTp in Nigeria and their roles in the implementation of C-IPTp, which include dissemination of culturally appropriate messages and information, education, and communications materials on MIP, as well as mobilization and education of women of childbearing age on the burden and prevention of MIP.

In a similar presentation on the same topic, Hery Harimanitra Andriamanjato (Jhpiego), TIPTOP's Senior Program Officer in Madagascar, identified two types of CSOs in Madagascar, namely women's groups, which conduct mass sensitization and hold group discussions on MIP, and the association of puppet players who use their skills in mass sensitization and promotion of community health through puppet performances. Both of these groups give gifts to pregnant women and refer them for ANC as needed. He noted that the initial experience of Madagascar's work with the CSOs was not as effective as expected. Changes to the CSO strategy included short-term contracts, the development of action plans, and activity verification, thus resulting in improved coordination with CSOs. Finally, he noted that COVID-19 disrupted community sensitization activities because of a ban on large gatherings. However, the team was able to maintain services by changing from mass sensitization to group discussions, while puppet players were transformed into motorcycle educators (TAM-TAM). He noted that sustainability of CSO activities is dependent on a number of factors including development of a strong alliance with all project stakeholders facilitating field activities; the integration of CSOs into the health system so that they will be under the regular monitoring of the Basic Health Centre and Health local committee; participation of CSOs in each monthly CHW review meetings at the health facility level; and involvement in the local social development committee, which is a platform of discussion for decision-makers.

Key Takeaways

- Early engagement with CSOs provided impetus for strong coordination and learning agenda across programs.
- Government leadership and active community involvement through the CSOs are crucial to project ownership and sustainability.
- Sustained community mobilization and engagement activities working through the CSOs is key for meeting critical project performance indicators.
- Sustainability of CSO activities is dependent on a variety of factors including a strong alliance developed with the various actors in the project; integration of CSOs into the health system; participation of CSOs in monthly CHW review meetings at the health facility level; and involvement in the local social development committee.

Session 6: Panel discussion in plenary on lessons learned working with government and partners including planning for sustainability

Julie Gutman (CDC), Strategic Applied Science Team Lead, facilitated this session of two presentations. In the first presentation, Odete Cossa (Jhpiego), TIPTOP Country Manager in Mozambique, identified the different government ministries, departments, and agencies as well as implementing partners that collaborated on the C-IPTp project in Mozambique. She noted the importance of the MIP technical working group (MIPTWG) which provided the umbrella for partners to make recommendations on the implementation of national malaria policies and to act as an advisory body for the National Malaria Control Program (NMCP) in the field of malaria case management and specifically on MIP.

Of particular importance is the role of the MIPTWG in administering the TIPTOP-developed sustainability matrix in Mozambique. The use of the matrix for biannual sustainability assessments helped to identify progress and gaps on the sustainability pathway. Members of the MIPTWG use the assessment tool to develop action plans to set the stage for eventual MOH ownership of the C-IPTp approach. She noted that after three assessments, it would appear that the country was on track to meet the requirements for some indicators such as MIP capacity-building, availability of QA-SP, and integration of MIP with other essential health services. However, areas needing additional action for sustainability of C-IPTp included financing and a conducive policy environment for C-IPTp that was being subjected to WHO's policy recommendations after assessment of the evidence.

In the second presentation, Bright Orji (Jhpiego), TIPTOP Country Manager in Nigeria, highlighted the importance of strong collaboration and coordination by a government-led partnership as evidenced by joint planning, training activities, supervision, and advocacy visits. He also noted that embedding TIPTOP project staff in the MOH offices in project States translated into a common goal, strong commitment, and clearly defined roles. Examples of positive lessons learned included a strengthened private/public sector initiative that led to a private sector donation of 18,000 doses of SP plus 8,000 additional donated doses from PMI to mitigate the risk of SP stock-outs in project health facilities. The partnership with the Nigerian Government also led to the approval of import duty waiver for the QA-SP procured by TIPTOP for C-IPTp. Nigeria's experience on sustainability readiness tracking was quite similar to that of Mozambique. The results of the baseline and three follow-up assessments have shown that Nigeria is on track in its readiness to sustain the C-IPTp approach.

Some of the challenges faced while working with governments included some level of bureaucracy and frequent rescheduling of meetings because of competing or emergency programs, for example, Cyclone Idai in Mozambique, communal clashes in Nigeria, and the COVID-19 pandemic.

Key Takeaways

- Having a collaborative platform, such as an MIPTWG, is critical for collective strategy development and assessing country readiness for C-IPTp scale-up.
- Early engagement with key national agencies reduced bottlenecks in the importation of QA-SP and helps prioritize C-IPTp support, even in unstable or emergency contexts.
- Embedding staff in the MOH builds synergy among government ministries, departments, and agencies (e.g., Mass Drug Administrations), which led to an integrated team approach for a common goal, with defined roles and harmonized outputs, such as an Integrated Health Data Management Team.
- Integration of C-IPTp with other existing MOH programs, such as the NMCP, reproductive, maternal and newborn health, TB, HIV/AIDS, and CHW programs, will increase access to essential health services.
- Scalability and sustainability must be supported by the government within the parameters of existing MOH programs and institutions.
- Strengthening of monitoring and evaluation in facilities and in the community helps to assure the quality of data management and use.

Day 3

Session 7: Breakout rooms on challenges and opportunities for C-IPTp implementation

Room 1: Challenges and opportunities with demand creation

Jackson Sillah of WHO's Africa Regional Office facilitated the session in Room 1. There was only one presentation focused on *Challenges and Opportunities for Demand Creation for C-IPTp*. In his presentation, Chibinda Deogratias (Jhpiego), TIPTOP Country Manager in DRC, outlined the strategies and platforms adopted to create demand for C-IPTp in the country. The communication channels used included radio jingles, community health talks, distribution of patient educational leaflets and posters, counseling of pregnant women and their families during home visits, implementation of antenatal outreaches to the hard-to-reach pregnant women, and branding of trained CHWs with T-shirts, caps, and backpacks. The activities were implemented in partnership with the MOH, CSOs, the Global Fund's SANRU project and PMI's Integrated Health Program.

Some of the positive lessons learned from demand creation activities are as follows:

- Involving male partners helped in bringing pregnant women to ANC and in getting them to take SP.
- Strengthening of communication/sensitization **improved early ANC initiation** (ANC1 before 16 weeks) and ANC4 coverage.
- Re-energizing the community participation system through the TIPTOP project led to an improvement in all the health facility indicators.
- The new SP packaging with clear messages appealed to pregnant women.
- Engaging implementing partners in discussions about the importance of uninterrupted supply of medicines, and specifically SP, reduced the risk of SP stock-outs.

Some of the challenges encountered include frequent personnel changes in the MOH at all levels leading to a need for regular orientation of new staff to the project recurrent epidemics and pandemics (e.g., Ebola, Cholera, malaria, COVID-19) as well as long-held traditional beliefs and customs. The presentation was followed by a question-and-answer session (see key takeaways in the textbox below).

Key Takeaways

- Ignorance, culture, and traditional beliefs are known barriers to increasing C-IPTp demand in the DRC.
- Multiple channels are needed to educate pregnant woman and the community on the burden of MIP, as well as available inexpensive interventions that can be delivered on the ANC platform.
- Community mobilization through health talks at large gatherings, counseling during home visits, distribution of patient education leaflets, and airing of radio jingles have been associated with an improved health-seeking behavior.
- Insecurity and natural disasters have impeded project progress.

Room 2: Challenges and opportunities of C-IPTp implementation during the COVID-19 pandemic

Franco Pagnoni, (ISGlobal), TIPTOP's Technical Director, facilitated the session in Room 2. Andritahina Razafiarijaona, (Jhpiego), TIPTOP's Country Manager in Madagascar, presented on the *Challenges and Opportunities of C-IPTp Implementation during the COVID-19 Pandemic*. He drew attention to the disruption of essential services caused by the COVID-19 pandemic and the resultant

restrictions imposed by the government. Of particular importance were the travel restrictions to regions, suspension of public transportation, closure of project offices after some staff were infected, cancellation of some activities, and reduction in the number of participants in community mobilization activities to under 20 at a time.

Other COVID-19 mitigation measures introduced included the development and broadcasting of special radio jingles on the importance of continuing to seek health care during COVID-19, switching the activities of puppet players to mobile vehicle educators (TAM-TAM), reducing discussion group sizes for CSO activities to a maximum of 20 people per session, and complying with all other national COVID-19 guidelines during CHW review meetings. Unitaid's approval for TIPTOP to procure and distribute personal protective equipment (PPE) during this period was applauded. These measures helped to maintain C-IPTp implementation with minor disruptions.

In her own presentation, Seynabou Gaye from the NMCP in Senegal confirmed that the COVID-19 pandemic led to temporary cessation of monitoring and coordination of activities, suspension of health promotion and prevention activities, stoppage of awareness and communication activities through visites à domicile and social mobilizations, as well as the implementation of the travel ban. In response, CHWs were trained on COVID-19 prevention measures while PPE (e.g., masks and hand-rub gels) was provided. She concluded her presentation by making recommendations for emergency preparedness. These include strengthening the capacity of community actors on epidemics and emergency surveillance and response; strengthening community engagement through the establishment of a rapid community response mechanism; communicating with the population about epidemic diseases and emergencies in order to avoid the fear of the unknown, and prioritizing the integration of activities at the community level.

Key Takeaways

- Collaboration between government and partners during epidemics or pandemics such as COVID-19 can help to build trust for dealing with future challenges.
- Training in infection prevention and control and PPE distribution improved the sanitary habits of HCWs and CHWs.
- Tools developed and/or adapted and used for remote trainings and meetings are available for use in similar situations.

Room 3: Challenges and opportunities of CHW referral systems

Khatia Munguambe, Senior Research Fellow at Eduardo Mondlane University and Manhiça Health Research Centre (CISM) in Mozambique, facilitated presentations in Room 3. In the first presentation, Baltazar Neves Candrinho, Director, NMCP in Mozambique, outlined the importance of the *CHW referral system to the ANC in Mozambique,* given the fact that the national policy requires that all pregnant women must receive their first dose of IPTp from an HCW in a health facility. Subsequent doses can be provided through a community delivery system such as the TIPTOP project. However, given the shortage of CHWs, called "Agentes Polivalentes Elementares" (APEs), in the project districts, Mozambique approved the recruitment, training, and deployment of lay community counselors (LCCs) to assist the APEs. The LCCs conducted home visits, identified pregnant women, and referred them to the health facilities or to APEs. Referral completion rates by pregnant women fluctuated between 50% and 70%.

Sosten Lankhulani, Deputy Director, NMCP in Malawi, shared the *Preliminary Results of a Cluster Randomized Trial of Community-Based IPTp Delivery in Malawi*. These results showed that the overall IPTp coverage levels increased over time but the intervention did not lead to substantially greater improvements in IPTp3+ coverage. Furthermore, improvements in ANC retention and early ANC initiation were seen. Among the challenges encountered in implementation was the infrequent

home visits by the Health Surveillance Assistants (HSAs) due to the very low HSA population ratio (1 HSA: 1,000 population).

Key Takeaways

- The CHW referral system in Mozambique is critical for the implementation of the national policy that requires pregnant women to receive the first dose of IPTp in the health facility.
- APEs identified and screened pregnant women for eligibility to receive follow-up doses of SP and refer them to ANC.
- LCCs identified and referred pregnant women to health facilities for comprehensive care and to APEs for C-IPTp.
- Only about half of pregnant women referred by CHWs completed the referral. The most common reason women did not follow through on the referral was distance to and/or transport costs to the health facility.
- In Malawi, IPTp3+ coverage was high overall, and increased from baseline to endline, while improvements in ANC retention and early ANC initiation were also seen.

Room 4: Challenges and opportunities of private sector engagement for C-IPTp

Abigail Pratt (BMGF), Program Officer, facilitated the session in Room 4. Herbert Enyeribe Onuoha (Jhpiego), Monitoring and Evaluation Advisor in TIPTOP Nigeria, made a presentation on *How private sector engagement can help to accelerate C-IPTp as part of comprehensive care for pregnant women*. He noted that providers in the private sector are important contributors to public health service delivery but are oftentimes not recognized and supported. He added that the consequences of their non-engagement could include inadequate supervision, unverifiable quality of private sector health care provision, under-reporting of health data, and incomplete health facility listing in the DHIS2 platform. He listed interventions implemented to include baseline health facility assessments, capacity-building of HCWs on MIP as well as record keeping/data management, supply of National Health Management Information System tools and provision of QA-SP.

Wani Kumba Lahai, Principal Public Health Sister in the Ministry of Health and Sanitation in Sierra Leone, also made a presentation on *C-IPTp Implementation in Sierra Leone and the Potential Role for the Private Sector*. She gave an overview of C-IPTp implementation in Sierra Leone and listed lessons learned during implementation as follows:

- Delivery of C-IPTp by TBAs facilitated access to IPTp 1, 2, and 3 in hard-to-reach communities.
- Integration of IPTp into the basic ANC package improved the quality of ANC services.
- Community engagement yielded participation and commitment.
- The emergence of COVID-19 pandemic is undermining the gains of malaria programming in Sierra Leone.

She identified potential roles for the private health sector to include education/sensitization initiatives (volunteer community champions to educate the community); provision of IPTp and other preventive malaria services to pregnant women; onsite testing and treatment of clinical malaria; in–kind contributions (e.g., mass commodity purchases of bed nets, anti-malarial medicines, mass communications materials); and financial contributions to C-IPTp (e.g., community champion program).

Key Takeaways

- Private sector engagement is key to expanding care for pregnant women including MIP and ensuring no missed opportunities for pregnant women.
- If supplied with National Health Management and Information System tools, private facilities will record and report service statistics to the national database.
- Involving private facilities in monthly data review meetings will improve the quality of data reporting.

Gladys Tetteh (Jhpiego), Malaria Director, facilitated the report-back session in the plenary, during which the breakout room facilitators presented key takeaways from their different sessions. She also facilitated the subsequent group discussion on the themes of the breakout room presentations.

Closing

Koki Agarwal (Jhpiego), Director of the MOMENTUM Country and Global Leadership, facilitated the closing session. Participants discussed lessons learned and shared during the meeting as well as the challenges and opportunities of replicating and/or scaling up C-IPTp in countries. The importance of WHO's Guidance for C-IPTp in the future was considered critical by some countries, while inadequate government commitment to funding of C-IPTp activities and procurement of QA-SP were identified as potential challenges. The need to have implementing partners step forward to support C-IPTp was also noted.

Elaine Roman announced the proposal to host a face-to-face Regional Program Learning Meeting (RPLM) in Mozambique in the first quarter of 2022 and asked participants to stay tuned for more information in the near future. The meeting ended with an educative video on MIP.

Key Takeaways

- WHO will assess the comprehensive evidence in 2022, which is expected to become available by April 2022 and will also include TIPTOP project endline analysis results. At this occasion, the preliminary baseline/mid-term observations suggesting C-IPTp adds value to increasing overall IPTp coverage, with mixed impact on ANC coverage, will be validated.
- Countries where the pilots have proven successful expressed an interest in continuing C-IPTp and to scale up the approach in other districts. They, however, anticipate support from other implementing partners in the short and medium term to do so.

(See Annexes below)

Annex 1: List of Participants

*Many participants joined as part of a group, so this list is not exhaustive.

Name (Original Name)	Country	Affiliation
Abdisalan Noor	Switzerland	Not specified
Abdrahamane Diallo	Not specified	Not specified
Abigail Pratt	US	BMGF
Aderito Melembe	Mozambique	Not specified
Abonyi Ambrose	Nigeria	Not specified
Ashley Garley	US	USAID
Agnes Efeti Nganje	Nigeria	Jhpiego
Aishatu Gubio	Nigeria	Federal MOH
Albert Rasolofomanana	Madagascar	MOH
Akinola Shonde	Nigeria	Catholic Relief Services
Alessandra Trianni	Switzerland	Unitaid
Alicia Esther Carbonell	Mozambique	WHO
Aline Maliwani	DRC	NMCP
Ambachew Yohannes	Switzerland	Unitaid
Victor Ameh	Nigeria	Federal MOH/NMCP
Andriamananjara Mauricette	Madagascar	Not specified
André Koné	Burkina Faso	Jhpiego
Andre Lamina	Mozambique	Jhpiego
André Tchouatieu	Switzerland	MMV
Andritahina Razafiarijaona	Madagascar	Jhpiego
“Anganje”	Not specified	Not specified
Anne Linn	US	USAID
Antía Figueroa	Spain	ISGlobal
Arooj Yousaf	US	Jhpiego
Aurore Ogouyemi-Hounto	Benin	NMCP
Bakary Sambou	DRC	WHO
Baltazar Candrinho	Mozambique	MOH
Bartholomew Odio	Nigeria	Jhpiego
Beatriz Galatas Andrade	Switzerland	WHO
Benedict Abore	Nigeria	Not specified
Bourama Kamate	Mali	Not specified
Bolatito Aiyenigba	Nigeria	Breakthrough Action

Name (Original Name)	Country	Affiliation
Andrea Bosman	Switzerland	WHO
Bright Orji Clement	Nigeria	Jhpiego
Camille Bignon	Benin	NMCP
Cecile Walton	US	Jhpiego
Célestin Razafinjato	Madagascar	MOH
Celia Woodfill	Mali	U.S. Centers for Disease Control and Prevention (CDC)
Chantee Geigan	US	Jhpiego
Charity Ifeyinwa	Nigeria	Not specified
Charlene Kabongo	DRC	NMCP
Chinyere Nwani	Nigeria	Jhpiego
Chinyere Obieje	Nigeria	Jhpiego
Christina Maly	US	Jhpiego
Clara Menendez	Spain	ISGlobal
Clara Pons	Spain	ISGlobal
Cristina Enguita	Spain	ISGlobal
Dale Halliday	Switzerland	Unitaid
Denis Okethwangu	Uganda	Not specified
Deogratias Cibinda Ntale	DRC	Jhpiego
Dina Randriamiarinjatovo	Madagascar	Pasteur Institute of Madagascar
Dominique Bomba	Benin	NMCP
Dorothy Achu	Cameroon	NMCP
“EAbuh”	Not specified	Not specified
Emmanuel Alabi	Nigeria	Jhpiego
Edima Akpan	Nigeria	Federal MOH
Eladio Muianga	Mozambique	Jhpiego
Elaine Roman	US	Jhpiego
Elizabeth Njoku	Nigeria	Jhpiego
Elmard Rabotovao	Madagascar	Jhpiego
Elsa Nhantumbo	Madagascar	Jhpiego
Emmanuel Ogharu	Nigeria	Jhpiego
Emmanuel Otolorin	Nigeria	Jhpiego
Enobong Ndekhedehe	Nigeria	Not specified
Erasmus Odima	Nigeria	Jhpiego
Estevao Mucavele	Mozambique	Not specified
Estrella Lasry	Switzerland	Global Fund

Name (Original Name)	Country	Affiliation
Eva de Carvalho	Mozambique	WHO
Fabrice Witanday	DRC	Jhpiego
Fady Toure	Mali	NMCP
Felana Nafindra Andrianirina	Madagascar	Jhpiego
Fernand Katembwe	DRC	Jhpiego
Fatoumata Sidibe	Mali	Not specified
Firima Augustine	Nigeria	Not specified
Flavio Wate	Mozambique	PMI/USAID
Florence Rondozai	Zimbabwe	SCI
Franco Pagnoni	Spain	ISGlobal
George Jagoe	Switzerland	MMV
Geraldina Duarte	Mozambique	Jhpiego
Gladys Tetteh	US	Jhpiego
Gloria Sebikaari	Uganda	PMI/USAID
Gregory Andriamanoarisoa	Madagascar	Jhpiego
Hailey Cox	US	Jhpiego
Hasina Randrianandrasana	Madagascar	Jhpiego
Helio Mucavele	Mozambique	PMI
Henintsoa Rabarijaona	Madagascar	WHO
Herbert Onuoha	Nigeria	Jhpiego
Hery Njaka Randrianalison	Madagascar	Jhpiego
Hery Harimanitra Andriamanjato	Madagascar	Jhpiego
Ibrahim Kabo	Nigeria	Palladium International Ltd./Integrated Health Program
Idowu Akanmu	Nigeria	Breakthrough Action
Ifeanyi Ume	Nigeria	Integrated Health Program
Inès Tshika	Not specified	Not specified
Irina Fomenko	Spain	Unitaid
Jackson Sillah	DRC	WHO
Jane Irene Nabakooza	Uganda	MOH
Jean Pierre Rakotovao	Madagascar	Jhpiego
Jean Marie Edengue Ekani	Not specified	Unicef
Jessica Butts	US	CDC
Jim William Wirngo	Cameroon	NMCP
John Munthali	Malawi	PMI/Impact Malaria

Name (Original Name)	Country	Affiliation
John Muyaya	DRC	Jhpiego
Joseph Ekandji Telonga	DRC	Jhpiego
Joseph Ngwanza	DRC	National Reproductive Health Program
Jules Ilaka Nakamukwikila	DRC	Ministry of Public Health, Hygiene, and Prevention
Julie Tsiriarivelo	Madagascar	Jhpiego
Julie Gutman	US	Malaria Branch, CDC
Katherine Wolf	US	Jhpiego
Khatia Munguambe	Mozambique	CISM
Koki Agarwal	US	Jhpiego
Kristen Vibbert	US	Jhpiego
Laia Cirera	Spain	ISGlobal
Laura Anderson	Not specified	WHO
Lee Pyne-Mercier	US	BMGF
Lenjary Rasetralimanga	Madagascar	MOH
Linda Mavungu	DRC	Jhpiego
Lolade Oseni	US	Jhpiego
Louise Mahan	Burundi	USAID
Luwei Pearson	US	Unicef
Madeleine Howard	US	Jhpiego
Manitra Raveloarimanana	Madagascar	Jhpiego
Marc Bañuls	Spain	ISGlobal
Marcel Goupil	Not specified	Unspecified
Maud Majeres	Switzerland	MMV
Maurice Randriarison	Madagascar	MOH
Mauricette Andriamananjara Nambiniosoa	Madagascar	Unspecified
Maximo Ramirez	Spain	ISGlobal
Mialiseheno Andriamasinoro	Madagascar	Jhpiego
Milijaona Fitesa	Madagascar	University of Toliary
Mireia LLach Berne	Spain	ISGlobal
Montserrat Pi	Spain	Unspecified
Moumouni Bonkoungou	Burkina Faso	Jhpiego
Munira Ismail	Nigeria	PMI
Mwalenga Nghipumbwa	Not specified	WHO
“Nadia”	Not specified	Not specified

Name (Original Name)	Country	Affiliation
Neusa F. Torres	Not specified	CISM
Odete Cossa	Mozambique	Jhpiego
Olatayo Abikoye	Not specified	Not specified
Olugbenga Mokuolu	Nigeria	National Malaria Elimination Programme
Oluseyi Akintola	Nigeria	Centers for Communication and Social Impact
Ombeni Mwerinde	Switzerland	Unitaid
Osvaldo Garrine	Mozambique	FHI360
Ousmane Badolo	Burkina Faso	Jhpiego
Patrick Jiomague	Cameroon	Plan International
Patricia Razafimandimby	Madagascar	Jhpiego
Paulo Bulule	Mozambique	Jhpiego
Pedro Luis Alonso	Switzerland	WHO
Peter Olumese	Switzerland	WHO
Pierre Hugo	Not specified	MMV
Philip Ukemezia	Nigeria	Jhpiego
Pilar Fontsere	Spain	ISGlobal
Ramatu Salifu	Nigeria	National Malaria Elimination Programme
Regis Magauzi	Zimbabwe	PMI/USAID
“Rigot”	Not specified	Not specified
Saad Hassan	Not specified	USAID
Samuel Mabunda	Mozambique	Jhpiego
Sarah Nsiangani	DRC	Jhpiego
“Scossa”	Not specified	Not specified
Senyabou Gaye	Senegal	NMCP
Silvia Schwarte	Switzerland	WHO
Simon Fozo Kwake	Not specified	Plan International
Solofo Razakamiadana	Madagascar	PMI/USAID
Sosten Lankhulani	Malawi	NMCP
Susan Youll	Not specified	PMI
Temitope Ipinmoye	Nigeria	Catholic Relief Services
Thierry Ouedraogo	Burkina Faso	Jhpiego
Tito Aiyenigba	Nigeria	Breakthrough Action
Tyson Volkmann	Malawi	PMI
Victor Adebayo	Nigeria	Catholic Relief Services
Victoria Taiwo	Nigeria	National Malaria Elimination Programme

Name (Original Name)	Country	Affiliation
Wani Lahai	Sierra Leone	NMCP
Winifred Imoyera	Nigeria	National Malaria Elimination Programme
Yara Alonso	Spain	ISGlobal
Youssouf Sawadogo	Madagascar	Jhpiego

Annex 2: Agenda

AGENDA	
C-IPTp VIRTUAL LEARNING MEETING Setting the Stage for Success: Lessons learned to move MIP to a new level.	**Date** **June 1–3, 2021** **08.00–11.00am EST daily**

Backgund	Globally, there were an estimated 229 million malaria cases in 2019 in 87 malaria-endemic countries, declining from 238 million in 2000. In 2019, in 33 moderate- to high-transmission countries in the WHO African Region, there were an estimated 33 million pregnancies, of which 35% (12 million) were exposed to malaria infection during pregnancy. It is estimated that malaria infection during pregnancy in these 33 countries resulted in 822,000 children with low birthweight. Although malaria is preventable and treatable, many women do not know that and cannot get safe, effective medicine or miss opportunities at ANC to stay healthy. Using data from 33 African countries, the percentage of IPTp use by dose was computed. In 2019, 80% of pregnant women used ANC services at least once during their pregnancy. About 62% of pregnant women received IPTp1 and 49% received IPTp2. There was a slight increase in IPTp3 coverage, from 31% in 2018 to 34% in 2019. (WHO's World Malaria Report, 2020). Factors such as: 1) low demand for IPTp among providers and pregnant women; 2) perceptions that SP for IPTp is a "failed drug;" 3) lack of availability of QA-SP for IPTp; and 4) insufficient evidence behind alternative service delivery innovations require solutions for countries to meet their malaria targets and relevant Sustainable Development Goals and underscore the need for innovation. Multiple countries have and are taking steps to test an innovative community-based approach that offers pregnant women the opportunity to receive IPTp at the community level, to complement the currently recommended administration of IPTp-SP at ANC clinics (see WHO consolidated Guidelines for Malaria (launched in February 2021 and available via the following link: Guideline WHO Guidelines for malaria - 13 July 2021 (magicapp.org). This approach is called C-IPTp. With support from Unitaid, four countries (DRC, Madagascar, Mozambique, and Nigeria) are testing the introduction and expansion of C-IPTp. Independently from the TIPTOP project, Burkina Faso and Malawi, with support from PMI, as well as Senegal are in various stages of piloting C-IPTp. Sierra Leone has adopted C-IPTp as national policy and is rolling it out nationwide. The findings from each of these pilots in the different countries and implementation experience in Sierra Leone will contribute to building an evidence base that will be reviewed by WHO in 2022 in view of a potential update of recommendations as the evidence permits.

	If proven a successful strategy, C-IPTp could help support an increase in IPTp-SP coverage as well as ANC attendance, minimizing missed opportunities and support countries to prevent MIP.	
Meeting Objectives:	• Present preliminary C-IPTp project research findings. • Present and discuss C-IPTp implementation lessons learned. • Identify challenges and opportunities for countries to improve C-IPTp pilot implementation.	
Suggested pre- reading:	• Health Facility Assessment Reports • ISGlobal Household Survey and Qualitative study reports • TIPTOP Brief	
Day 1		
08.00 – 08.15 (15 mins)	**Opening** Welcome remarks | Elaine Roman, Jhpiego Goodwill message | Philippe Duneton, Unitaid Goodwill message | Pedro L. Alonso, WHO, Global Malaria Programme Goodwill message | Raj Panjabi, PMI Meeting purpose, objectives and norms | Hailey Cox, Jhpiego	**Plenary**
08.15 – 08.55 (40 mins)	**What is TIPTOP and C-IPTp all about?** **Facilitator:** Koki Agarwal, Jhpiego • Implementation overview of TIPTOP study components, generation of evidence and learning (15 mins) | Emmanuel 'Dipo Otolorin, Jhpiego • WHO guideline development: IPTp (15 mins) | Pedro Alonso, David Schellenberg, WHO **Discussion** (10 mins)	**Plenary**
08.55 – 10.05 (70 mins)	**TIPTOP Data to Date (Part 1)** **Facilitator:** Clara Menendez, ISGlobal, Manhiça Health Research Centre • Household surveys (25 mins) | Franco Pagnoni, ISGlobal • Routine Monitoring (25 mins) |Christina Maly, Jhpiego **Discussion** (20 mins)	**Plenary**
10.05 – 10.55 (50 mins)	**TIPTOP Data to Date (Part 2)** **Facilitator:** Koki Agarwal, Jhpiego • Anthropological Study (20 mins) |Cristina Enguita-Fernàndez and Yara Alonso, ISGlobal • Other studies (e.g., Drug Resistance Study, Cost-effectiveness study) (10 mins) | Clara Pons and Laia Cirera Crivillé, ISGlobal **Discussion** (20 mins)	
10.55 – 11.00	**Closing and Wrap-Up** **Facilitator:** Emmanuel Otolorin, Jhpiego	**Plenary**
Day 2		
08.00 – 08.10 (10 mins)	**Opening** Elaine Roman, Jhpiego	**Plenary**
08.10 – 08.30 (20 mins)	**Update: Quality-Assured SP and IPTp-specific packaging** **Facilitator:** Maud Majeres Lugand, MMV SP availability and access (15 mins) | Pierre Hugo, MMV **Discussion** (5 mins)	**Plenary**
08.30 – 09.50 (80 mins)	**BREAKOUT ROOMS** **Room 1: CHWs: Selection, training, supervision, SP supply and incentives (25 mins)**	**Breakout rooms**

	Facilitator | Katherine Wolf, Jhpiego • Presenter 1: Chibinda Deogratias, Jhpiego (10 mins) • Presenter 2: Gauthier Tougri, NMCP Burkina Faso (10 mins) **Discussion** (5 mins) **Room 2: Lessons Learned from Supervision Systems (25 mins)** **Facilitator** | Eric M. Sompwe, MOH/DRC • Presenter 1: Jean Pierre Rakotovao, Jhpiego (10 mins), • Presenter 2: Seynabou Gaye, NMCP Senegal (10 mins) **Discussion** (5 mins) **Room 3: Role of Civil Society Organizations (25 mins)** **Facilitator** | Gloria Sebikaari, PMI/Uganda • Presenter 1: Bartholomew Odio, Jhpiego (10 mins), • Presenter 2: Hery Harimanitra Andriamanjato, Jhpiego (10 mins) **Discussion** (5 mins) **Reports in Plenary:** Groups report back in plenary (5 mins each group (15 mins)) **Discussion** (40 mins) | **Facilitator**: Koki Agarwal, Jhpiego	French translation available French translation available Portuguese translation available
09.50 – 10.50 (60 mins)	**Panel Discussion on Lessons Learned Working with Government and Partners including Planning for Sustainability.** **Facilitator:** Julie Gutman, CDC • Presenter 1: Odete Cossa, Jhpiego (15 mins) • Presenter 2: Bright Orji, Jhpiego (15 mins) **Discussion** (30 mins)	**Plenary**
10.50 – 11.00	**Closing & Wrap-Up** **Facilitator:** Elaine Roman, Jhpiego	**Plenary**
Day 3		
08.00 – 08.10 (10 mins)	**Opening**	**Plenary**
08.10 - 9.50 (100 mins)	**BREAKOUT ROOMS: Discussions on Challenges and Opportunities (40 mins in breakout rooms)** **Room 1 Challenges and opportunities with demand creation** **Facilitator**: Jackson Sillah, WHO • Presenter 1: Chibinda Deogratias, Jhpiego (15 mins) **Discussion** (25 mins) **Room 2 Challenges and opportunities of C-IPTp implementation during the COVID-19 pandemic** **Facilitator:** Franco Pagnoni, ISGlobal • Presenter 1: Andritahina Razafiarijaona, Jhpiego (10 mins), • Presenter 2: Seynabou Gaye, NMCP Senegal (10 mins) **Discussion** (20 mins) **Room 3 Challenges and Opportunities of CHW referral systems** **Facilitator:** Khatia Munguambe, CISM Mozambique • Presenter 1: Baltazar Candrinho, NMCP Mozambique (10 mins), • Presenter 2: Sosten Lankhulani, NMCP Malawi (10 mins) **Discussion** (20 mins) **Room 4 Challenges and opportunities with private sector engagement.** **Facilitator:** Abigail Pratt, BMGF	**Breakout Rooms**

	• Presenter 1: Herbert Enyeribe Onuoha, Jhpiego (10 mins) • Presenter 2: Wani Lahai, NMCP Sierra Leone (10 mins) **Reports in Plenary:** **Facilitator:** Gladys Tetteh, Jhpiego **Groups report back** (20 mins, 5 mins each group) **Large Group Discussion** (40 mins)	
09.50 – 10.50 (60 mins)	**Panel Discussion: The Future of C-IPTp** **Facilitator:** Koki Agarwal, Jhpiego Panelists: Bright Orji, Jhpiego Nigeria Nnenna Ogbulafor, MOH Nigeria Ousmane Badolo, Jhpiego Burkina Faso Cibinda Deogratias, Jhpiego DRC Eric Sompwe, MOH DRC	**Plenary**
10.50 – 11.00 (10 mins)	**Closing, Announcement of 2022 RPLM** in Mozambique and C-IPTp **Video**| Elaine Roman, Jhpiego	**Plenary**