



Policies and actions for improved Malaria in Pregnancy efforts in communities

Malaria in Pregnancy Stakeholders Forum Report

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POLICIES AND ACTIONS FOR IMPROVED MALARIA IN PREGNANCY EFFORTS IN COMMUNITIES

Malaria in Pregnancy Stakeholders Forum Report

EXECUTIVE SUMMARY

For many pregnant women across sub-Saharan Africa, the danger of contracting malaria during pregnancy remains unnecessarily high, causing life-threatening risks for the mother and her baby.

According to World Health Organization (WHO) guidelines, intermittent preventive treatment of malaria in pregnancy using sulfadoxine-pyrimethamine (IPTp-SP), an antimalarial medicine given to expectant mothers, is an effective intervention to safeguard against the risks of malaria in pregnancy (MiP), which include maternal anemia, miscarriage, premature delivery, stillbirth, and low birth weight.¹ Due to inconsistencies in global recommendations and national policy, many countries have seen a lagging uptake of this medicine; although WHO now recommends one dose of IPTp-SP every month beginning in the second trimester, a majority of women fail to receive even two doses.²

In Kenya, IPTp-SP is administered during antenatal care (ANC) visits. Unfortunately, long distances to health facilities, perceived poor quality of care, and other deterring factors mean that expectant women often do not attend the recommended four ANC visits, therefore receiving too few IPTp-SP doses during their pregnancy.³

Throughout the region and in Kenya, however, there is emerging evidence suggesting that community-based approaches for delivering IPTp-SP could increase the number of pregnant women able to access preventive malaria care.⁴ In light of this new evidence, it is critical that members of the malaria and reproductive and maternal health communities consider new and innovative ways in which the health care system can work with community structures to protect as many women as possible from malaria in pregnancy.

In October 2014, PATH convened government officials, leading experts, and civil society representatives from Kenya, Nigeria, Tanzania, and Uganda at a Malaria in Pregnancy Stakeholders Forum in Nairobi, Kenya. Colleagues shared a range of global and regional evidence supporting enhanced community-based distribution of IPTp-SP:

- In 2012, WHO published guidelines endorsing the use of lay health workers to deliver IPTp-SP to pregnant women living in malaria-endemic areas. Further, in 2013, WHO released a policy brief on the implementation of IPTp-SP, which recommends administration of the drug once a month, beginning as early as possible in the second trimester to ensure pregnant women are fully protected against malaria.
- In Kenya, a study led by PATH found that community health workers (CHWs) can safely and effectively administer IPTp-SP without decreasing ANC attendance among pregnant women.⁵
- Additionally, the Kenya Medical Research Institute/US Centers for Disease Control and Prevention demonstrated that IPTp-SP uptake significantly increased as a result of a government memo clarifying the role of health care providers and CHWs in administering IPTp-SP and referring women to ANC, respectively.⁶
- Evidence from Nigeria supports the use of Community Directed Interventions, by which a community plans and implements delivery of a health service, promoting community ownership and bolstering IPTp-SP distribution.⁷
- In Uganda, coverage was improved by health education messaging and IPTp-SP delivery by community drug distributors.⁸

Participants agreed that emerging evidence supports the need for scaling up community-based approaches to complement IPTp-SP distribution by service providers during ANC visits. After identifying barriers and

challenges to scaling up these interventions, participants considered potential policy and programming solutions that could ensure all Kenyan women are able to access IPTp-SP, both during ANC visits and within the community. Participants offered recommendations for a path forward, in alignment with the upcoming review and evaluation of the Kenya National Malaria Strategy (NMS) in 2017. Recommendations include:

- PATH, in consultation with the MiP Technical Working Group, compiles an evidence dossier of research supporting community-based MiP interventions and WHO task-shifting guidance recommending IPTp-SP distribution by CHWs in malaria-endemic areas. The Ministry of Health (MOH) Malaria Control Unit (MCU) and Reproductive and Maternal Health Services Unit should review the dossier and consider recommendations for community-based approaches in the revised NMS.
- Based on the evidence dossier, the MCU updates national policies, including Standard Treatment Guidelines and the 2017 revision of the NMS, to reflect

the most current WHO recommendations related to IPTp-SP provision.

- The MOH disseminates revised national guidelines and policies to health facilities to ensure that facility-based health care workers administer IPTp-SP to pregnant women during ANC as soon as possible in the second trimester.

This agenda for action builds on new evidence for community-based MiP treatment and prevention in Kenya and the region, and seeks to bring national guidelines and policies into alignment with global recommendations. It supports service providers in delivering IPTp-SP through increased ANC visits, while enhancing the ability of CHWs to offer an additional channel of distribution that ensures pregnant women receive the care they need to prevent malaria during pregnancy. PATH is committed to ensuring that new evidence is shared with decision-makers and will work with its partners to propel this shared agenda forward, advocating for policies and action to more fully protect expectant mothers from malaria.



PATH/ERIC BECKER

Community-based approaches for delivering IPTp-SP could increase the number of pregnant women able to access preventive malaria care.



Clockwise from left: Women receive insecticide-treated nets during antenatal care visits; a woman gets tested for malaria using a rapid diagnostic test; a woman from Kisumu West makes her way to a health facility for antenatal care.

INTRODUCTION

While the global health community has made great progress in the fight against malaria in the last decade, the risk of contracting malaria remains high for many expectant mothers. Malaria in pregnancy (MiP) continues to contribute to high maternal and newborn morbidity and mortality rates; each year, malaria accounts for more than 10,000 maternal deaths and between 75,000 and 200,000 infant deaths.⁹ Additionally, a single malarial episode during pregnancy increases the risk of maternal anemia, miscarriage, premature delivery, stillbirth, and low birth weight.¹⁰ In malaria-endemic regions of sub-Saharan Africa, many expectant mothers lack access to malaria prevention and treatment, threatening their health and the health of their newborns.

The World Health Organization (WHO) currently recommends a multi-pronged approach for malaria prevention and control during pregnancy, which includes three critical measures:

- Use of insecticide-treated nets (ITNs) beginning as soon as possible during pregnancy.
- Distribution of intermittent preventive treatment of malaria in pregnancy using sulfadoxine-pyrimethamine (IPTp-SP).
- Prompt diagnosis and effective case management of malaria.¹¹

Many malaria-endemic countries have made strong progress in ITN coverage and case management, but the vast majority of pregnant women still do not complete the full recommended schedule of IPTp-SP, an antimalarial medicine that is safe for use during pregnancy.¹²

Based on recent evidence, the frequency at which IPTp-SP should be administered has been revised since WHO released *A Strategic Framework for Malaria Prevention and Control During Pregnancy in the African Region* in 2004. According to a 2013 WHO policy brief on the implementation of IPTp-SP, administration of the

drug is now recommended once a month, beginning as early as possible in the second trimester,^a to ensure that an expectant mother is fully protected from MiP.¹³ Additionally, 2012 WHO guidance—*Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*—recommends the use of lay health workers to deliver IPTp-SP to pregnant women living in malaria-endemic areas.¹⁴

In Kenya, current policy supports a minimum of two doses of IPTp-SP after quickening, which falls short of WHO recommendations, in terms of timing of the first treatment and dosage. Even under Kenya's current recommendations, data show that just 25 percent of women are receiving two doses of IPTp-SP throughout their pregnancy.¹⁵ A contributing factor to lagging uptake in Kenya is that IPTp-SP is administered solely during antenatal care (ANC) visits; because of long distances to health facilities, perceived poor quality of care, and other deterring factors, expectant mothers often do not attend the recommended four ANC visits, meaning that many women receive too few IPTp-SP doses during their pregnancy. Throughout the region and in Kenya, however, there is emerging evidence suggesting that community-based approaches for delivering IPTp-SP could increase the number of pregnant women able to access preventive malaria care while not compromising ANC visits.¹⁶

On October 7, 2014, PATH hosted a Malaria in Pregnancy Stakeholders Forum in Nairobi, Kenya, to ensure that the malaria and reproductive and maternal health communities joined together to review implications of new research and data underscoring the importance of community-level distribution in reaching all pregnant women. Leading experts shared evidence and lessons learned from pilot studies seeking to increase access to IPTp-SP through community channels. National and county government officials, experts, and civil society representatives then discussed potential policies and programs to support the scale-up of successful approaches.

A health worker by many names

In many countries, selected community members are trained to perform discrete functions related to health care delivery—from delivering oral rehydration solution and zinc to children with diarrhea to referring pregnant women to health care facilities. Though they do not have a professional degree, these trained community health workers (CHWs) are critical to improving their community's access to basic health services. CHWs are also referred to as lay health workers, volunteer health workers, community health agents, and traditional midwives, among other names.

The forum served as a unique moment for county and national officials to learn about and discuss innovative ways to build on community structures to reach all pregnant women with IPTp-SP. As a result of the forum, participants agreed on concrete next steps and recommendations to ensure that Kenya leads the way for MiP programs and policy solutions in East Africa.

MEETING OVERVIEW

PATH organized the Malaria in Pregnancy Stakeholders Forum to review MiP program data and research from Kenya, learn about regional evidence for community-based approaches, and identify next steps and action items to ensure the prioritization of preventive MiP activities in Kenya. A total of 35 participants from across the government and health sectors attended, including individuals from the national Malaria Control Unit (MCU) and the Reproductive and Maternal Health Services Unit (RMHSU), both within the Ministry of Health (MOH). Also present were Kisumu West sub-county health officials, who voiced their support for community-based MiP interventions following a successful pilot in their county that engaged community health workers (CHWs) to reach pregnant women with IPTp-SP.

“Community health workers are our neighbors, and they can be our messengers; they have much more interaction with the community outside the hours of 9 and 5.” -Dr. Waqo Ejersa, Kenya Ministry of Health Malaria Control Unit

a. The 2013 WHO policy brief on the implementation of IPTp-SP determines the second trimester to begin at 13 weeks of pregnancy. Though “quickening,” or first detection of fetal movement, “is used in many countries to determine if a woman is in her second trimester...it is not a marker of the beginning of the second trimester. While some pregnant women experience quickening as early as 16 weeks, others may not do so until 20 weeks of gestation.”

WELCOME AND OPENING REMARKS

Rosemarie Muganda-Onyando, deputy director of PATH's Kenya Country Program, opened the day-long meeting by encouraging participants to learn from the work and research of technical experts, share experiences and best practices for reaching expectant mothers, and discuss how Kenya can move forward to ensure that programs and policies provide an enabling environment for reaching women in low-resource settings.

Dr. Waqo Ejersa, the head of Kenya's MCU, welcomed participants and stressed the importance of considering innovative approaches to fight MiP. He indicated that despite Kenya's significant headway in distributing ITNs

and increasing prompt case management of MiP, malaria still constitutes a major challenge for safe pregnancy. Dr. Waqo set the tone for the day's meeting, calling on participants to consider the value of allowing trained community members to distribute appropriate medicines and encourage ANC for pregnant women.

While health officials and technical experts have in-depth knowledge of MiP prevention and treatment, Dr. Waqo emphasized the need to rely on CHWs to be messengers. Because of their respected role in the community, as well as their accessibility, strengthening the role of CHWs will mean more personal interactions and an increased number of women able to access preventive malaria care.



Jacqueline Acheng

Dr. Waqo Ejersa, head of Kenya's Malaria Control Unit, addressing the MiP forum participants.

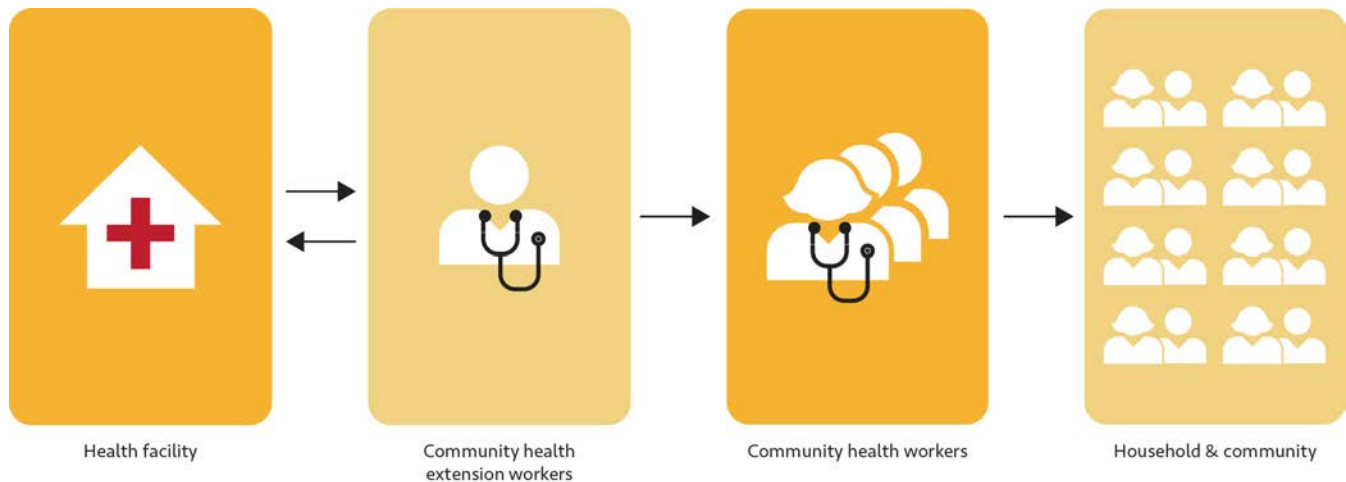
EMERGING EVIDENCE AND EVIDENCE-BASED APPROACHES

The first half of the MiP Stakeholders Forum focused on sharing emerging evidence from Kenya and the region. As Dr. Waqo expressed in his opening remarks, neighboring countries with similar public health concerns must learn from one another in order to address the burden of malaria in sub-Saharan Africa, where 90 percent of malaria occurs. Presenters from Nigeria, Tanzania, and Uganda joined Kenyan colleagues in discussing a variety of community-based approaches that have successfully increased the number of women accessing IPTp-SP.



Map of Kisumu West sub-county, where the community-based MiP interventions pilot study took place.

Community health care structure in Kenya



Community-based approaches for IPTp-SP distribution in Kisumu, Kenya

Dr. Samwel Onditi, technical advisor on malaria and child survival for PATH Kenya, presented on community-based approaches to strengthening ANC and improving coverage for MiP interventions. As part of his presentation, he stressed that providing MiP interventions solely through ANC has not enabled Kenya to reach its goal of 80 percent coverage by 2016. Currently, only 25 percent of women receive the minimum recommended two doses,¹⁷ which falls short of global recommendations. In partnership with the US Agency for International Development (USAID)-funded AIDS, Population and Health Integrated Assistance Plus program, and with support from the Bill & Melinda Gates Foundation, PATH sought to close this gap in Kisumu West sub-county by piloting a community-based approach to increase uptake of IPTp-SP.

In October 2013, a series of key informant interviews with Sub-county Health Management Teams, nurses, health facility leaders, and community health extension workers (CHEWs), as well as focus group discussions with pregnant women, CHWs, and community leaders, helped PATH to identify many factors that influence ANC attendance and IPTp-SP compliance. Some pregnant women, for example, stated that they delayed or did not

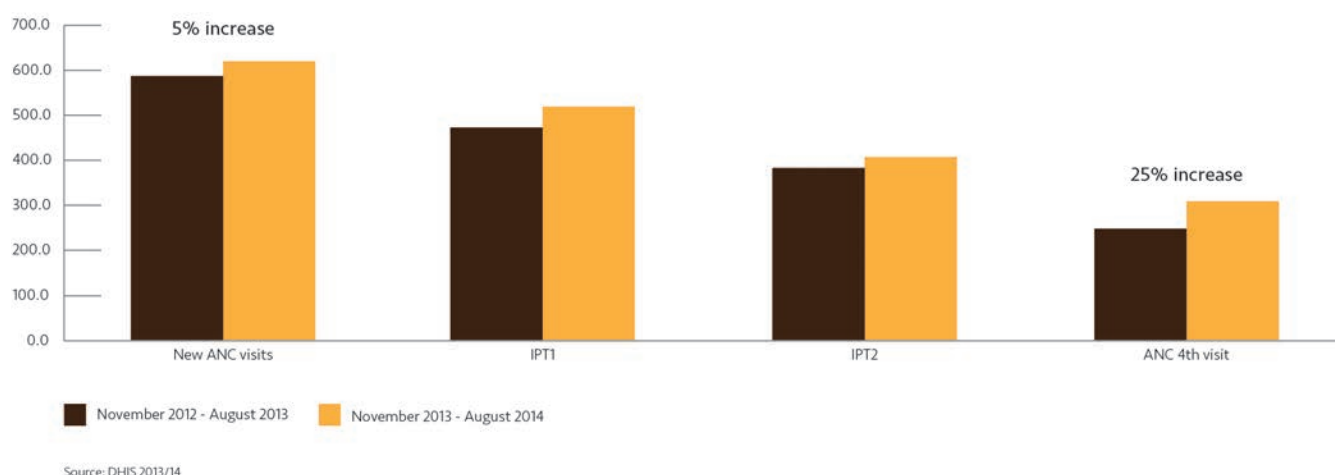
attend ANC because of previous negative interactions with health facility staff. Other women reported sympathy toward overburdened service providers and delayed ANC to avoid crowding the clinic. The majority of women were not aware of IPTp-SP recommendations until their first clinic visit, often during their fifth or sixth month of pregnancy—by which time they had already missed multiple recommended doses. Discussions with pregnant women also revealed that household visits by CHWs encouraged women to adhere to ANC schedules. Additionally, many of the women indicated that they would prefer to take IPTp-SP from a CHW at home using their own cups and drinking water.

Building on these findings, in November 2013, PATH mobilized Sub-county Health Management Teams in Kisumu West to train CHEWs and CHWs to safely and effectively administer IPTp-SP to pregnant women. In Kenya, one CHEW is based at each primary care facility and oversees a community unit of approximately 1,000 nearby households. CHEWs supervise the team of CHWs who serve the households in the community unit.¹⁸

Working in four community units, CHWs conducted their regular monthly visits to households, placing a greater emphasis on identifying pregnant women. CHWs encouraged women to seek care at the nearest facility, where they would receive their first dose of IPTp-SP. If a

“In Kenya, malaria in pregnancy is on the platform of antenatal care, but this hasn’t given us enough results. We need to look more broadly at other available options.” -Dr. Samwel Onditi, PATH

Pregnant women accessing ANC and IPTp-SP in pilot health facilities



woman was not up to date on subsequent doses, CHWs administered the medicine through directly observed therapy and recorded the completed dose in the woman's Mother and Child Health Booklet. This booklet is an MOH-developed tool given to mothers during ANC visits to track key health data for mother and child during pregnancy and early childhood. Because women bring their booklet to each ANC visit, health workers at the facility level were able to see when treatment had been given at the community level, and vice versa, therefore avoiding duplicative treatments and connecting the community and facility levels.



A community health worker leads celebrations during the closeout ceremony of the community-based interventions pilot study in Kisumu West sub-county.

By explaining the importance of seeking care at a health facility, CHWs had a positive impact on ANC attendance. In pilot health facilities where CHWs administered IPTp-SP, there was a five percent increase in the number of women who attended ANC at least one time. Attendance was 25 percent higher for the fourth ANC visit. Additionally, the pilot found that pregnant women who were likely to miss later doses of IPTp-SP because of inadequate ANC attendance were instead reached in their homes by CHWs. According to CHWs, this added task was not burdensome, but empowering. Overall, the pilot demonstrated that CHWs can effectively distribute IPTp-SP while having a positive influence on ANC visits and IPTp-SP uptake.¹⁹

Reducing missed opportunities at ANC in Western Kenya

Dr. Peter Ouma, senior research officer at the Kenya Medical Research Institute/US Centers for Disease Control and Prevention (KEMRI/CDC), presented on the status of MiP prevention strategies in Western Kenya. Dr. Ouma emphasized the significant burden of malaria in sub-Saharan Africa; 30 million pregnancies are exposed to the risk of malaria each year, and in the former Nyanza Province,^b 20 percent of pregnant women have malaria parasitemia (malaria parasites in the blood) when presenting for their first ANC visit. Furthermore, Dr. Ouma pointed to a gap between ANC visits and IPTp-SP coverage; many women who attend ANC do not receive preventive malaria treatment during their visit.²⁰

To address this gap in coverage, in April 2011, the MOH released a memo to orient health management teams in the former Nyanza, Coast, and Western Provinces on

b. March 2013 marked the official launch of decentralization as 47 new county governors and county assemblies were elected in Kenya. Functions and funds have been transferred to the new counties; however, as new county institutions are gradually taking shape, county-specific health data are not yet measured or available.



PATH/Cabe Blenczycki

Community health workers can play a critical role in guiding expectant mothers to antenatal care and ensuring they receive preventive malaria treatment during pregnancy.

current guidelines for IPTp-SP administration in Kenya. The memo clarified that the first IPTp-SP dose should be administered as directly observed therapy during ANC after the first felt movement of the fetus (quickening), and women should receive at least two doses spaced at least four weeks apart. The memo applied only to these provinces given the high levels of malaria transmission, yet even these revised recommendations fall short of the global best practices set by WHO.

Supported by Jhpiego and USAID's Maternal and Child Health Integrated Program, the County Health Management Teams in Bungoma County (part of former Western Province) disseminated the memo to all health facilities and trained service providers to ensure that health care staff had updated knowledge of appropriate IPTp-SP administration during ANC. In this instance, CHWs did not administer IPTp-SP, but they were trained to mobilize pregnant women to seek care at the facility level.

After the memo was disseminated, KEMRI/CDC used a cross-sectional household survey to assess whether IPTp-SP coverage had improved in areas where CHWs had

identified pregnant women and encouraged ANC visits. In all, 748 women who delivered in the previous four months answered questions about ANC attendance and IPTp-SP dosage. The survey found that 63 percent of these women received two or more doses during ANC visits, which represents the highest coverage reported in Kenya since IPTp-SP administration became policy in 2001.

Dr. Ouma concluded that a simple ministerial memo, combined with a refresher training for health providers and a community-centered approach, is effective to increase IPTp-SP uptake, but there is much more progress to be made to reach 80 percent coverage by 2016. Though the current National Malaria Strategy (NMS) supports the "promotion of IPTp-SP in the community," these guidelines need to be more comprehensively disseminated to service providers, who can then train CHEWs and CHWs for their critical role in encouraging ANC.²¹ By using CHWs to guide women to ANC, community-based health structures can ensure increased coverage of preventive malaria care in pregnant women.²²



PATH/Cabe Blenczycki

A pregnant woman's ability to access preventive malaria care leads to improved health outcomes for her and her newborn.

"We have had a long struggle to figure out how to increase IPTp-SP uptake in our country." -Dr. Peter Ouma, Kenya Medical Research Institute

Nigeria MiP community-clinic partnership intervention



Community Directed Interventions for MiP in Akwa Ibom State, Nigeria

Bright Orji, Jhpiego program manager in Nigeria, presented on adapting community interventions that support improved outcomes for MiP. As in Kenya, Nigeria's National Malaria Strategic Plan recommends two doses of IPTp-SP given during ANC visits. In Akwa Ibom State, a high-risk region with year-round malaria transmission, the 2008 Nigeria Demographic and Health Survey found that only 6.5 percent of pregnant women received two doses of IPTp-SP.²³ Jhpiego's approach to improving coverage varied slightly from other research presented in the forum; using Community Directed Interventions (CDI), through which the community plans and implements health interventions with minimal guidance from the health system, the Akwa Ibom State pilot sought to increase the uptake of MiP services.

Through partnerships with local clinics, communities were able to take charge of MiP interventions. Local clinics established performance standards, and health workers trained and supervised community-selected volunteers to administer the first two doses of IPTp-SP at the household level, ensuring that the volunteers were stocked with commodities. These volunteers referred

women to health facilities and recorded data from the pregnant women they reached.

Findings of this study demonstrated that CDI can lead to a substantial increase in administration of preventive malaria interventions; the number of women receiving at least two doses of IPTp-SP through CDI was 35 percent higher than the control group without CDI. Mr. Orji concluded that community-based programs are an important approach to consider in protecting women from MiP because they promote community ownership and empower communities to find solutions that best fit their unique needs. These programs also strengthen ties and coordination between the formal health sector and communities, increasing uptake of IPTp-SP and bolstering ANC attendance.²⁴

Research to inform community-based health care in Tanzania

Dr. Sigsbert Mkude of Tanzania's National Malaria Control Program presented on the status of community-based service delivery in his country, as well as MiP interventions. Though nongovernmental organizations and development partners are working in different geographic areas to complement health facility-based services with community approaches, currently, Tanzania does not have a national program for community-based health care (CBHC). A national task force, which includes many government officials, is currently drafting CBHC guidelines, but engagement of the community in MiP interventions has not been explored as part of this process.

There is great need for innovative approaches to increase the uptake of IPTp-SP in Tanzania, where coverage hovers around 32 percent. Dr. Mkude emphasized the importance of dialogue and evidence exchange between countries, stating that these recent findings will be critical to present to the MiP Task Force in Tanzania.²⁵

Community Directed Interventions

Community Directed Interventions (CDI) is an approach in which communities direct the planning, implementation, and delivery of a health service. First, health providers and partners introduce a range of interventions and explain the CDI approach. Then through a series of community meetings that cover all aspects of service delivery, from setting responsibilities to monitoring and financing, the community ultimately selects the implementers, who are trained by health workers.

“We’ve been lukewarm on the issues of community delivery, but we need to advocate.” -Prof. Anthony Mbonye, Uganda Ministry of Health



The health care system can work with community structures to protect as many women as possible from malaria in pregnancy.

Addressing gaps in IPTp-SP coverage through community channels in Uganda

The final presenter, Professor Anthony Mbonye, commissioner for health services at Uganda’s MOH and member of the MiP Technical Working Group, spoke about working toward scaling up community-based IPTp-SP services in Uganda. He emphasized the importance of reaching women in the community and addressing missed opportunities at the facility level; though 90 percent of Ugandan women attend ANC more than once, just 40 percent receive a second dose of IPTp-SP during these visits.

Prof. Mbonye highlighted that between 2007 and 2010, studies in Burkina Faso, Malawi, and Uganda demonstrated that IPTp-SP could be safely administered at the community level. Uganda, for example, saw an increase in coverage to 68 percent following health education messaging and IPTp-SP delivery by community drug distributors. Dr. Mbonye stressed that there is very strong evidence that access to IPTp-SP increases when offered at the community level. However, due to inadequate resources, conflicting policies, and poor coordination between ministerial units, many women are still not being reached.

Prof. Mbonye outlined solutions to address these issues within the Uganda context. Based on the results of successful pilot initiatives, health policies and guidelines should be revised to recommend delivery of IPTp-SP through community channels, and the curriculum for integrated case management should be updated to include IPTp-SP content. Prof. Mbonye called on individuals to advocate for policy change and to help in linking the malaria and reproductive and maternal health communities.

Prof. Mbonye also highlighted the critical need for governments to motivate and retain CHWs, ensuring that the resources spent to train this cadre are viewed as an investment in improving community health. Remuneration through a monthly stipend, he suggested, could help bolster community health programs, many of which are currently voluntary.²⁶



An expectant mother hopes that malaria interventions during pregnancy can be made more accessible to women like her who have difficulty accessing a health facility.

IDENTIFYING CHALLENGES AND SOLUTIONS

After technical experts presented their new evidence on community-based solutions for MiP treatment and prevention, participants spent the afternoon summarizing main take-aways and identifying gaps in malaria care for pregnant women.

Data clearly show that Kenya and other countries in the region have not reached targets for IPTp-SP coverage; while providing IPTp-SP during ANC visits is the ideal platform for MiP prevention, new and innovative approaches are needed to complement distribution at ANC. Participants agreed that community-based distribution provides an additional way to reach pregnant women with IPTp-SP, improving uptake and bolstering ANC by encouraging women to seek care.

Having reached consensus on the need for enhanced IPTp-SP provision through both ANC visits and community distribution channels in Kenya, participants examined barriers to introducing and scaling up community-based interventions, as well as potential policy and programming solutions. Break-out groups were facilitated by Pauline Irungu and Wanjiku

Manguyu, policy and advocacy officers in PATH's Kenya office, and each group captured the highlights of their conversation for a report back to the full forum. Dr. Nancy Kidula, reproductive health consultant, led a closing session to summarize the findings of the day and build consensus for a recommended program of action.

The following are initial action steps recommended by participants, to be jointly pursued by relevant stakeholders in alignment with the upcoming review and evaluation of the Kenya NMS in 2017.

COMPILING GLOBAL RECOMMENDATIONS AND EMERGING EVIDENCE FOR POLICYMAKERS.

Many participants agreed that there is a lack of clarity among health workers regarding the revised WHO recommendations. Participants also noted that emerging local, regional, and global evidence needs to be distilled, compiled, and widely circulated to policymakers so that new research can inform national policy. For example, 2012 WHO task-shifting guidance recommends the use of lay health workers to deliver IPTp-SP to pregnant women living in malaria-endemic areas.²⁷ This task-shifting recommendation, however, has not been widely shared with key decision-makers.

In order to bring to relevant stakeholders the data related to community-based approaches for MiP interventions and scaling-up CHW distribution of IPTp-SP, participants called for the collection and synthesis of research and data, along with concise policy recommendations.

RECOMMENDATION

- PATH, in consultation with the MiP Technical Working Group, compiles an evidence dossier on community-based MiP interventions and WHO task-shifting guidance recommending IPTp-SP distribution by CHWs in malaria-endemic areas; the dossier will be presented to the MCU and RMHSU.

UPDATING CURRENT POLICIES TO REFLECT GLOBAL RECOMMENDATIONS.

In January 2013, WHO released a policy brief on the implementation of IPTp-SP, which provides important updates to WHO's 2004 *A Strategic Framework for Malaria Prevention and Control During Pregnancy in the African Region*. WHO now recommends that pregnant women receive IPTp-SP as early as possible in the second trimester and up until delivery, provided that doses are one month apart. The policy brief also states that the second trimester begins at 13 weeks and not at quickening, which typically occurs around 16 weeks.²⁸ Additionally, the previously mentioned WHO task-shifting recommendations support the delivery of IPTp-SP by lay health workers in malaria-endemic areas.

Currently, policy in Kenya does not reflect these updated global recommendations—the Standard Treatment Guidelines (STGs) and NMS jointly recommend a minimum of two doses administered by a health care provider at 16 weeks of gestation, and neither policy allows for the distribution of IPTp-SP by CHWs.^{29,30} The research compiled in the evidence dossier will be critical in advocating to policymakers to update these policies to reflect the correct dosage, spacing, and level at which the medicine can be administered.

Ultimately, the NMS—which extends through 2017—should be updated to reflect WHO task-shifting recommendations supporting CHW distribution of IPTp-SP. In the interim, however, the director of medical services should consider a policy circular, guideline update, or addendum to allow for CHW distribution of IPTp-SP at the community level in order to accelerate accessibility.



PATH/Evelyn Hockstein

Enabling women in Kenya to deliver healthy newborns through preventing malaria in pregnancy needs decisive policy action.

RECOMMENDATIONS

- Following review of the evidence dossier, the director of medical services issues a policy circular or addendum to the current NMS to allow CHWs to provide IPTp-SP at the community level.
- The MCU updates STGs to reflect the WHO recommendation for IPTp-SP distribution beginning as soon as possible in the second trimester (13 weeks) and every month thereafter.
- The MCU revises the 2017 iteration of the NMS to align with the most recent WHO task-shifting guidance, supporting distribution of IPTp-SP by CHWs.

DISSEMINATING REVISED NATIONAL GUIDELINES.

It is critical that all service providers have correct and consistent information regarding IPTp-SP dosage, spacing, and administration during ANC. Recent research in Kenya shows that disseminating guidelines and providing relevant training to service providers can have a positive impact on the uptake of IPTp-SP.

RECOMMENDATION

- The MOH and County Health Management Teams jointly disseminate updated national guidelines and policies to health facilities and train health care workers on MiP prevention through IPTp-SP administration every four weeks starting in the second trimester.

CONCLUSION

Throughout the day, discussion among key stakeholders helped draw a clear picture of Kenya's need for new and innovative approaches to reach women with preventive malaria care. Emerging evidence clearly demonstrates a way forward; when policy allows for community distribution of IPTp-SP, CHWs can effectively administer preventive interventions and also encourage women to visit a health clinic for full ANC. Given the abundance of supportive evidence, it is critical that Kenya creates an enabling environment for community-based approaches through changes in programming and policy.

In alignment with the next steps and recommendations set forth in this consultative process, PATH has committed to supporting evidence review and the development of a dossier and to engaging with decision-making bodies who determine policy change. With input from key MCU and RMHSU staff, as well as members of the MiP Technical Working Group, PATH is dedicated to carrying this agenda forward with our partners to increase coverage of preventive malaria care through community-based approaches, ultimately leading to improved health outcomes for mothers and their babies.

FOR FURTHER INFORMATION

Policies and actions for more effective malaria in pregnancy efforts: http://www.path.org/publications/files/APP_mip_policy_br.pdf

Community-based approaches to intermittent preventive treatment of malaria in pregnancy: A review of recent studies: http://www.path.org/publications/files/MCHN_cba_mip_lit_review.pdf

Community-based approach to intermittent preventive treatment for malaria in pregnancy in Kisumu, Kenya: Exploring the value of utilizing community health workers in malaria in pregnancy prevention: http://www.path.org/publications/files/MCHN_cba_mip_kenya_chw.pdf

Documentary: Malaria in Pregnancy, Kenya: https://www.youtube.com/watch?feature=player_detailpage&v=tYBnF72LmKQ

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APPENDIX A

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