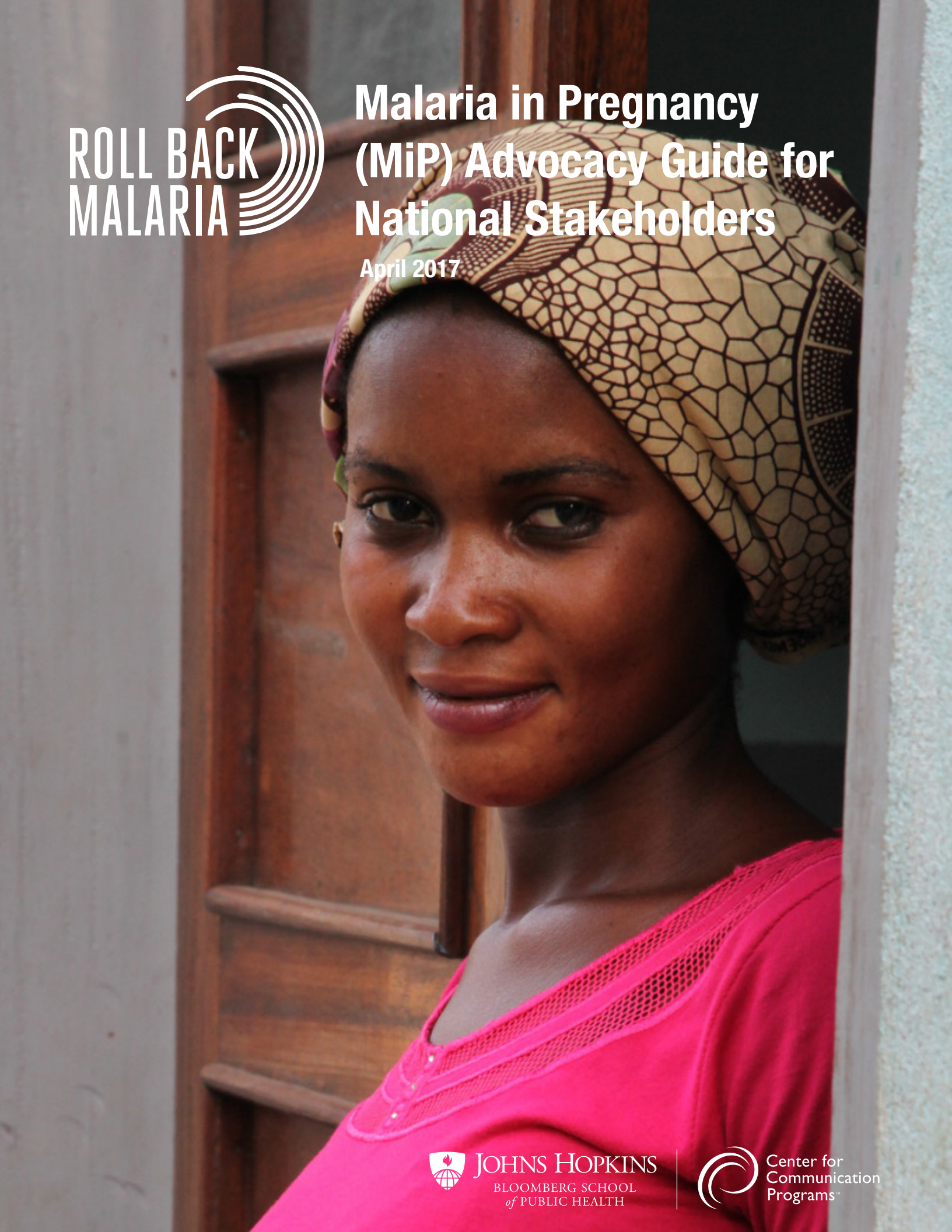

ROLL BACK MALARIA

Malaria in Pregnancy (MiP) Advocacy Guide for National Stakeholders

April 2017

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Center for Communication Programs™

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Acknowledgements

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Abbreviations

ANC	Antenatal care
ACTs	Artemisinin-based combination therapy
ALMA	African Leaders Malaria Alliance
APLMA	Asia Pacific Leaders Malaria Alliance
APMEN	Asia Pacific Malaria Elimination Network
ARMM	Advocacy for Resource Mobilization for Malaria
CCP	Johns Hopkins Center for Communication Programs
CEO	Chief Operating Officer
CHW	Community health worker
CSR	Corporate social responsibility
DHIS	District Health Information System
DHS	Demographic and Health Survey
EmONC	Emergency obstetric and neonatal care
EPI	Expanded Programme on Immunization
FANC	Focused antenatal care
FP	Family planning
GHO	Global Health Observatory
HWG	RBM Partnership's Harmonization Working Group
ICT	Internet communication technology
IRS	Indoor residual spray
ITPp	Intermittent preventive treatment during pregnancy
ITPp-SP	Intermittent preventive treatment of malaria in pregnancy with sulfadoxine-pyrimethamine
ITN	Insecticide-treated mosquito net
LLIN	Long-lasting insecticidal net
MAWG	RBM Partnership's Malaria Advocacy Working Group
MCDMCH	Ministry of Community Development, Mother and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
MICS	Multiple Indicator Cluster Surveys
MiP	Malaria in pregnancy
MiPWG	Malaria in Pregnancy Working Group
MIS	Malaria Indicator Surveys
MNCH	Maternal, newborn, and child health
M&E	Monitoring and evaluation
MP	Member of Parliament
NMCC	National Malaria Control Centre
NMCP	National malaria control program

PMNCH	Partnership for Maternal, Newborn, and Child Health
PR	Public relations
PSA	Public service announcement
RALG	Regional and local government authority
RBM	Roll Back Malaria Partnership
RDT	Rapid diagnostic test
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
RH	Reproductive health
SDG	Sustainable Development Goal
SP	Sulfadoxine-pyrimethamine
TOR	Terms of reference
TWG	Technical working group
UN	United Nations
UNICEF	United Nations Children's Fund
US-PMI	United States President's Malaria Initiative
WHO	World Health Organization

Purpose of This Malaria in Pregnancy Advocacy Guide

Developed by the USAID-funded VectorWorks project of Johns Hopkins Center for Communication Programs in concert with theRoll Back Malaria Partnership (RBM) Malaria in Pregnancy Technical Working Group (MiPWG), the aim of this malaria in pregnancy (MiP) advocacy guide is to provide malaria and reproductive, maternal, child, and adolescent health (RMNCAH) stakeholders in malaria-endemic countries with the tools to advocate for scaling up MiP interventions. To achieve scale up, countries must

- Ensure resources are available to fund the scale up of MiP interventions,
- Ensure compliance with the latest World Health Organization (WHO) guidance on MiP (2015, 2012)[1,2,3] and;
- Improve ANC platforms to include a comprehensive package of MiP prevention and care.

Who Should Use this Guide

Audiences for this guide include stakeholders in endemic countries with both stable endemic and unstable non-endemic areas where immunity to the malaria parasite among adults may be lower. Stakeholders include country- and district-level government officials and implementing partners/advocates focusing on malaria and RMNCAH who can advocate to key decision makers at the country level for the scale-up of lifesaving MiP interventions.

It is highly recommended that national malaria and RMNCAH stakeholders form a national technical working group (TWG) to address the scale up and harmonization of MiP into RMNCAH and antenatal care (ANC) platforms. By following this guide and using the tools within, stakeholders can work strategically to achieve their defined goals through specific advocacy activities.

How to Use This Guide

This guide consists of two parts. *Part I: MiP Advocacy Guidance* provides guidance on achieving each step of the advocacy cycle. *Part II: MiP Advocacy Tools* includes a set of tools and templates stakeholders can use to build an advocacy framework, as described in *Part I*.

Stakeholders can use the *MiP Accountability Tool* to hold national decision makers accountable for achieving progress on reducing MiP in their countries.

Further, this guide should be used in tandem with a variety of other tools the MiPWG has developed, including the MiP infographic, consensus statements and others. These and other MiP-related documents are located in **Table 3** and on the MiPWG web site: http://www.rollbackmalaria.org/architecture/working-groups/mipwg.

This guide can help stakeholders use these tools more strategically.

Why Advocacy for Malaria In Pregnancy?

Malaria in pregnancy (MiP) is major public health concern that significantly impacts maternal and child health in countries with both moderate and high malaria transmission rates. Consider the following:

- MiP is linked to more than 10,000 maternal deaths and more than 100,000 neonatal deaths annually (11% of all neonatal deaths).[4]
- Malaria infection during pregnancy carries serious risks for pregnant women, fetuses, and newborns, including anemia, severe malaria, spontaneous abortion, stillbirth, premature births, and low birth weight.
- As malaria prevalence declines, adverse consequences will likely increase in pregnant women because they will have less immunity to protect themselves and the fetus.
- In areas of unstable malaria transmission, pregnant women are at an increased risk of severe malaria and death; where malaria transmission is stable, maternal anemia and low birth-weight babies occur at higher rates, decreasing the chance of maternal and infant survival respectively.[4]

Effective tools are available to prevent and treat MiP, so advocacy efforts must ensure key decision makers are investing in and being held accountable for scaling up MiP interventions where needed. These interventions include i) intermittent preventive treatment during pregnancy (IPTp), ii) appropriate case management, and iii) distribution and promotion of long-lasting insecticidal nets (LLINs) as part of routine ANC.

A critical step in addressing this health issue is to call on national decision-makers to invest in the scale-up of MiP interventions. Equally critical is for national malaria control programs (NMCPs) and RMNCAH programs to jointly harmonize policies, guidelines, and implementation strategies related to MiP and develop stronger ANC platforms, all of which will reduce mortality of and morbidity in pregnant women and children.

One persistent challenge in malaria advocacy efforts is a lack of national-level advocates consistently working on the ground. This *MiP Advocacy Guide* provides guidance and tools for malaria and RMNCH stakeholders at the country level—particularly technical implementers—to advocate for the scale up of MiP interventions.

Scale Up MiP Prevention Interventions

According to WHO, the three-pronged approach for malaria in pregnancy—promoting LLIN usage for pregnant women, scaling up IPTp, and ensuring effective case management—should be delivered through routine focused ANC as part of a comprehensive package to promote health, detect existing diseases, prevent and detect complications of pregnancy, and encourage birth preparedness for all pregnant women.

At present, WHO recommends that following administration of the first dose of IPTp starting in the 2nd trimester (i.e., 13 weeks), pregnant women should receive an additional dose of IPTp-SP at each contact with a health provider, up until the time of delivery (provided the contacts occur with doses of IPTp-SP administered at least one month apart to ensure maximum protection). WHO does not recommend a maximum number of doses of IPTp-SP. Evidence suggests that among pregnant women in sub-Saharan Africa, IPTp with at least 3+ doses of SP was associated with a higher birth weight and lower reduced risk of low birth weight (2.5 kg) than compared to the standard two-dose regimens.[5]

Several studies have shown how these interventions are cost-effective and work to reduce maternal and newborn mortality and morbidity. One study using the Lives Saved Tool (LiST) modeling tool, found that 300,000 deaths could have been averted across 25 African countries if intermittent preventative treatment of malaria in pregnancy with sulfadoxine-pyrimethamine (IPTp-SP) and insecticide-treated net (ITN) coverage was 80% from 2009–2012.[6] Under trial conditions in Mozambique, a 2010 study demonstrated that the protective role of IPTp-SP reduced neonatal mortality.[7] A year later a study in Mozambique also demonstrated the cost effectiveness of providing IPTp at routine ANC services.[8]

An outline of the WHO three-pronged approach is included in *Appendix C*.

What is Advocacy?

Advocacy is a process operating at political and social levels for a desired change, aiming to create an environment that removes barriers to policy implementation and equitable resource allocation. It also contributes to shifting beliefs and norms related to taking action to improve a health outcome. Advocacy can help set an agenda and catalyze change—for example, to advocate for resources to scale up MiP interventions to improve maternal and child health outcomes and strengthen ANC platforms.

Each step of the advocacy cycle (see **Figure 1** and **Table 1**) is supported by advocacy activities that generate movement from one stage to the next—activating leadership toward commitment, building partnership and collective action, and using data to tell stories. Part I of this document will provide greater detail on each step of the advocacy process.

At the country level, it is important that a cohesive and dedicated partnership is formed among influential stakeholders and civil society that can move an advocacy agenda forward. Refer to *Step 3. IGNITE with MiP Partnerships and Opportunities*, for guidance on developing a national TWG.

Figure 1. MiP Advocacy Cycle

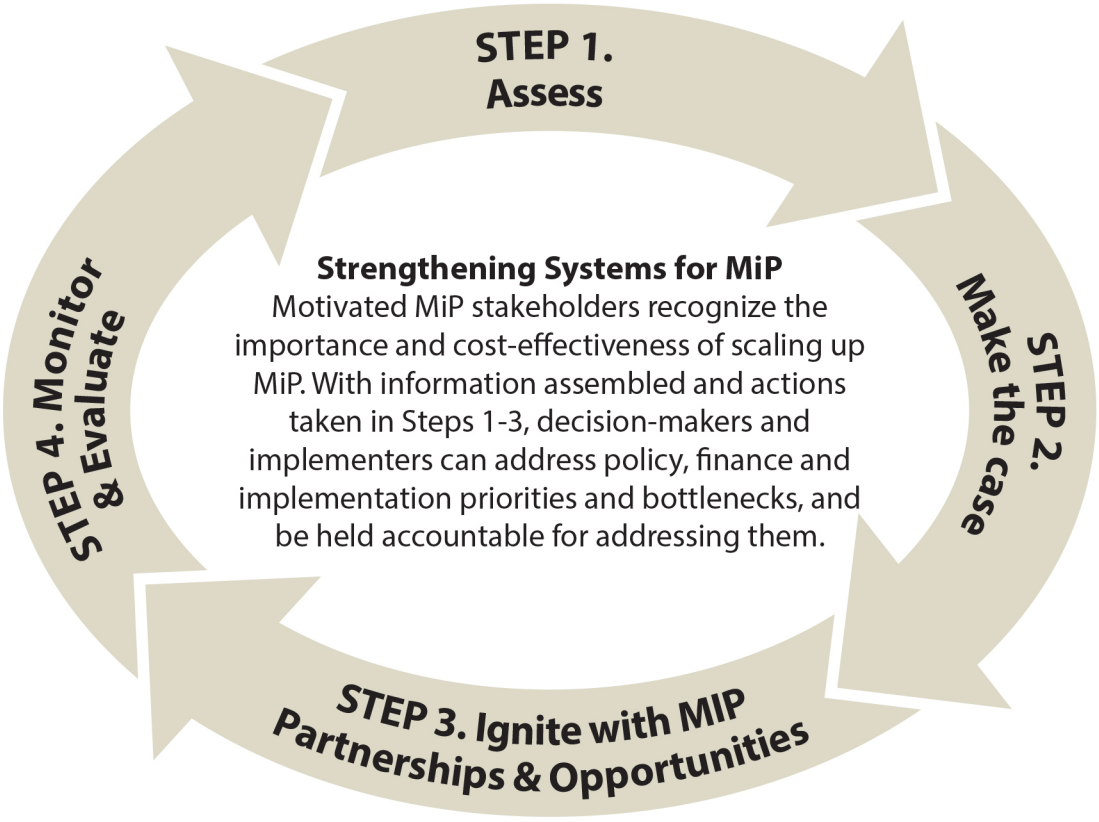


Table 1. MiP Advocacy Steps

Step	Definition
Step 1	**Assess:** It is critical to gain a full understanding the national MiP context in order to define the most pertinent issues and inform the direction of advocacy efforts.
Step 2	**Make the Case:** Once you have identified the issues, you can frame advocacy messages to key audiences—particularly key decision makers and influencers—and set an agenda of issues that are important among targeted groups and the greater public.
Step 3	**Ignite:** By building partnerships and networks of stakeholders and getting the media and public opinion makers to help make your issues salient, you will help catalyze change and move the agenda along.
Step 4	**Monitor and Evaluate:** How will you know your advocacy is successful? Developing advocacy objectives and indicators then monitoring and evaluating your advocacy efforts is essential and increases accountability.

Part I: MiP Advocacy Guidance

Step 1: Assess the MiP Landscape

This section will help you adopt a systematic approach to reviewing secondary data and highlighting important findings that can inform the MiP advocacy response.

Review Existing Data Sources

Advocates use data to understand underlying trends and tell a powerful story to persuade decision makers to act on an issue. Research has shown that decision makers' use of supporting evidence is central to producing change.[8] If many of the studies referenced are unavailable, outdated, or inaccurate, advocates might have difficulty influencing key stakeholders and, importantly, obtaining the additional resources required for scaling up MiP activities.

At the end of this section, after filling out **TOOLs A - C in** *Part II: MiP Advocacy Tools*, advocates will have enough information to identify their MiP advocacy priorities—and to start identifying their target audiences, and crafting their advocacy asks and messages in *Step 2: Make the Case with Messengers and Messages*.

Reliable data sources are readily available on the Internet through credible agencies, institutions, and peer-reviewed professional journals (see **Table 2**). If you are not sure what data exists—or are unsure of the full scope—contact relevant partners among academic and research institutions; global health organizations, such as the World Health Organization (WHO) and United Nations Children's Fund (UNICEF); and malaria control and elimination and reproductive, maternal, newborn, child, and adolescent health (RMNCAH) networks, such as the Roll Back Malaria Partnership (RBM) MiP Technical Working Group (MiPWG), the Partnership for Maternal, Newborn, and Child Health (PMNCH), the African Leaders Malaria Alliance (ALMA), the Asia Pacific Malaria Elimination Network (APMEN), and the Asia Pacific Leaders Malaria Alliance (APLMA). In *Step 2: Make the Case with Messengers and Messages*, we show how to use this data to build targeted messages to decision makers in your country.

While a range of data sources is provided at the end of this guide, **Table 2** highlights some key sources that should be considered for assessing the MiP landscape.

Table 2. Sources of MiP Evidence

Tool	Description
Demographic and Health Surveys (DHS) www.measuredhs.com	Nationally representative population-based household surveys taken every four to five years, designed to produce data that are comparable over time and across countries.
Multiple Indicator Cluster Surveys (MICS) http://www.childinfo.org	Nationally representative population-based household surveys conducted every three years, developed by UNICEF to support countries in filling critical data gaps for monitoring the situation of children and women. MICS surveys are designed to harmonize with data collected through other household survey programs, such as DHS and MIS.
Malaria Indicator Surveys (MIS) www.malariasurveys.org	A standard MIS package assesses key household coverage and morbidity indicators. The MIS surveys also produce a wide range of data for in-depth assessment of the malaria situation within countries, including areas related to MiP. Because the MICS and DHS surveys are only implemented every three to five years, if immediate data collection is required, the MIS survey can be used. This will ensure their comparability with the DHS and MICS surveys over time.
Mid-term National Strategic Plan Reviews	A tool used for reviewing progress and performance of a country's malaria and reproductive health programs linked to strategic and operational plans.
Health Information Management System (HMIS) /DHIS 2	HMIS/DHIS is a data collection system specifically designed to support planning, management and decision-making in health facilities and organizations. It can be used to improve patient satisfaction with facility services.
WHO Global Health Observatory (GHO) Data Repository	The GHO data repository contains an extensive list of indicators, which can be selected by theme or through a multi-dimension query functionality. The GHO is WHO's main health statistics repository.
World Malaria Report	The authoritative WHO global assessment, which includes data on individual country progress and country-based burden estimates.
Peer-reviewed professional journals such as The Lancet	Include research and programmatic studies on a range of health topics.
Local universities, research institutes, and others	Special studies
Government, United Nations (UN) agencies, and implementing partners	Special studies including health facility assessments

Use these and other data sources to complete **TOOL B** in *Part II: MiP Advocacy Tools*. Answers to these questions will inform your MiP landscape. For more MiP-focused resources, refer to the MiPWG website page— http://www.rollbackmalaria.org/architecture/working-groups/mipwg—which includes WHO guidelines, research studies, consensus statements, and other documents. The *RBM Global Call to Action to Increase National Coverage with Intermittent Preventive Treatment of Malaria in Pregnancy* is also available on the RBM website: http://www.rollbackmalaria.org/files/files/resources/call_to_action_report_v5d_EN.pdf

Review Country-level Gap Analysis Data for Malaria

Another source that provides valuable data is a gap analysis tool. Developed by the RBM Country/Regional Support Partner Committee (CRSPC) [formerly the Harmonization Working Group (HWG)], it helps national malaria control program (NMCP) managers to identify programmatic and funding gaps for malaria commodities, including intermittent preventative treatment of malaria in pregnancy with sulphadoxine-pyrimethamine (ITPp-SP) and long-lasting insecticidal nets (LLINs).

The tool contains a series of tabs, including one on LLINs, ANC coverage, indoor residual spray (IRS), artemisinin-based combination therapy (ACT) and rapid diagnostic tests (RDTs), IPTp, and others. To access the gap analysis tool, go to: http://www.rollbackmalaria.org/architecture/working-groups/hwg (under reference documents tab). For more information on completed gap analyses for any given country, contact your NMCP manager or the CRSPC by clicking on the above link (under overview) and reaching out to the contacts.

United States President's Malaria Initiative (PMI) Improving Malaria in Pregnancy from the Ground Up in Guinea

Reprint from the "Stories from the Field" blog

PMI worked with the government of Guinea to revise polices and guidelines with the latest WHO recommendations for MiP. To complement the revised policies and extend access to malaria in pregnancy services, Guinea developed an approach using community health workers (CHWs) to promote ANC attendance. A total of 680 CHWs were trained to deliver targeted messages on ANC (including use of long-lasting insecticide-treated mosquito nets, sanitation, early care-seeking) and IPTp. These messages were integrated into the CHW training manual, and CHWs were encouraged during their home visits to verify whether pregnant women were: 1) keeping their ANC appointment; 2) receiving SP after the 13th week; 3) sleeping under a net; and 4) seeking early care in case of fever. Each CHW received forms to monitor their home visits and notebooks to record his or her daily activities. The CHWs conducted 75,606 home visits and reached 425,748 people (of whom 233,504 were women).

To access visit: https://www.pmi.gov/news/stories-from-the-field/stories-from-the-field---detail/improving-malaria-in-pregnancy-from-the-ground-up-in-guinea

Assess National Malaria and RM-NCAH Policy and Service Delivery Documents

Advocates should look at MiP-related policies and guidelines to gain a better understanding of what areas need to be strengthened, and whether they comply with updated WHO guidance.

Use the table in **TOOL A** in *Part II: MiP Advocacy Tools* to outline the contents in national policy documents and identify gaps. Advocates can use this information to advocate for strengthening policies and guidelines: harmonizing them across national malaria and reproductive health programs and ensuring they are aligned with the latest WHO recommendations.

Identify MiP Advocacy Problems and Solutions

At this stage, we can use problem and solution tables to analyze the MiP situation. The purpose of this section is to delve deeply into the root causes, effects, and solutions for your own country situation. There are six steps to identifying advocacy problems and solutions.[a]

Answer the questions below and include them in **TOOL C** in *Part II: MiP Advocacy Tools* of this guide.

Identify MiP Problem(s)

Start by defining the core problem—for example, ANC services for malaria in pregnancy are inconsistent.
List the effects of the core problem—for example, two effects of inconsistent ANC services for malaria in pregnancy may be 1) high rates of malaria in pregnancy and maternal/child mortality and 2) overburdened and weakened health systems, worker absenteeism, etc.

List the underlying causes of the problem—for example, one cause of inconsistent ANC services for malaria in pregnancy is that malaria and RH policy and guidelines are outdated, unclear and/or not distributed widely. For each underlying cause you list, ask 'why'—for example, "Why are these policies and guidelines not updated and harmonized?" For each answer, ask another 'why' at least four more times. This will help you get to the root cause(s) of the problem.

Identify MiP Solution(s)

Translate the core problem into a solution, and identify solutions by rewriting negative statements into positive ones—for example, "Effective malaria in pregnancy interventions are scaled up through ANC services based on compliance with the latest WHO guidance."
List the effects of the solution—for example, thousands of lives saved, strengthened ANC platforms, strengthened health systems, lower education and employment absenteeism rates, etc.

[a]Adapted from the UNICEF Advocacy toolkit. A guide to influencing decisions that improve children's lives (2010).

List potential advocacy interventions and determine the advocacy actions that need to be taken to solve the problem. For example, 1) advocate to Ministers of Health and NMCP and reproductive health (RH) program officials to treat MiP as a public health and health systems strengthening priority when deciding where to allocation resources; 2) Advocate to private sector to contribute resources—financial or in-kind—to support MiP intervention scale up.

Step 2: Make the Case with Messengers and Messages

This section will help you tailor MiP advocacy messages to the right messengers for the most appropriate key decision makers in your country.

Developing an advocacy platform for MiP requires many people and institutions to get involved to effect and sustain support. It is important to understand who the malaria stakeholders are and how to reach them with advocacy messages.

As such, after filling out **TOOLS D - G** in Part II: MiP Advocacy Tools, advocates will have identified key audiences, and crafted their advocacy asks and messages. They can use this information when strategizing on partnership building and identifying advocacy opportunities in *Step 3: Ignite with MiP Partnership & Opportunities*.

Who Influences MiP Policies and Implementation?

Consider that influencers do not necessarily have the direct power to make the necessary changes, but can influence those who do. Strategic input from influencers can leverage interest and engagement from thought leaders or government officials and contribute to the success of an advocacy effort.

The right government or private sector leaders, traditional and religious leaders, and respected celebrities—such as a First Lady or notable figures from the sports or entertainment industry—can help raise awareness and influence decision makers about MiP. Some can also help facilitate meetings between decision makers so that more in-depth discussions can take place. Consider the following when brainstorming personalities who could become a champion:

- What links are already established with decision makers?
- Who do you know who might know one of your decision makers?
- Is the champion known and respected among them?
- What other potentially useful connections does the champion have?
- What does the champion know about the program and topic?
- How personally invested is the champion in the cause?
- Will the champion require remuneration, or will the time be volunteered?

It is important to note that powerful influencers who have been engaged need to be kept up-to-date on successes and challenges in MiP and should be publicly recognized for their role in achieving MiP goals. Public recognition of decision-makers taking actions toward your advocacy goal—scaling up MiP interventions—have the effect of inspiring peers and other decision-makers to follow. It also will start positioning the investment of MiP scale up as a 'norm.'

TOOLS D – F in *Part II: MiP Advocacy Tools* will help you map the malaria stakeholders in your country and globally so you can think strategically about who needs to be involved in MiP advocacy efforts, how much influence they have on decisions about policies and resources, and how they can be linked together to effect change. All three of the tools include examples for your reference.

Develop and Tailor MiP Advocacy Messages

Tailoring advocacy messages to each target audience is important because different audiences carry out different actions and have unique personal and professional goals. The RBM MiPWG has developed a list of MiP messages, which are updated regularly: http://www.rollbackmalaria.org/architecture/working-groups/mipwg. For advocacy at the country level, it will be important to adapt, develop, and target messages to the right people.

Tips to create persuasive advocacy messages:[9]

- Convey evidence-based arguments with clear 'asks' and potential outcomes.
- Avoid a rhetorical, opinionated mode of communication; be reasoned in order to open people up to evidence and 'asks.'[b]
- Balance rational and emotional appeals.
- Be concise. The average human mind cannot deal with more than roughly seven points at a time.

[b] An "ask" is a request, such as a request for a donation, or a request to sponsor legislation in parliament.++

TOOL G in *Part II: MiP Advocacy Tools* will guide you through the development of tailored messages based on the context(s) in your country.

Sample global messages and related tools are included in **Table 3** in this section.

Use Your Messages Effectively

Advocates and champions need to speak easily and comfortably about a topic, which means equipping them with talking points and training them to use them. Talking points should express three key messages and clear 'asks,' the combination of which is often called a 'pitch.' The 'ask' is the specific action the decision makers are being asked to do.

The messages convey the importance of the problem, a viable solution, and the benefits of solving the problem. An effective set of messages often combines facts and emotional triggers, and speaks to something important to that particular audience.

Factual Messages

An example of a factual message might be: "Each year, 10,000 pregnant women and 100,000 newborns will die as a result of malaria in pregnancy from *Plasmodium falciparum*. But effective tools exist to prevent and treat malaria in pregnancy." This message would need to tell a story using country-level data on the number of pregnant women and newborns to be more impactful at the country level.

Using data from reliable sources lends credibility to messages and attracts positive attention to the pitch.

Discerning which data to include and organizing the data in graphs, charts, infographics, or other meaningful representations can influence the success of an advocacy initiative. Here are a few tips on using evidence and data in advocacy campaigns:[10]

- Use numbers wisely. Choose credible and current evidence from reputable sources.
- Use numbers strategically—not just to establish the size of the problem, but also the cost of ignoring it.
- Numbers alone often fail to create "pictures in our heads." Provide the narrative first, and then give a few easy-to-remember numbers.
- Most people cannot interpret data; they need narratives and context to link the data to their daily lives and interests.

Emotion-triggering Messages

An emotion-triggering message could convey story of a pregnant mother or child victim of malaria. If the pregnant woman or child died because her antenatal care (ANC) services did not have appropriate drugs, this needs to be stated, and the story must be true and credible. Pictures also can be useful, although it is important to choose pictures that will not offend. Pictures of the good that is possible can be more effective than pictures of distressing situations. A combination of the two may do equally well.

Messages to Reflect Common Concerns

The final key message should present a win-win opportunity for audiences. For example, by scaling up MiP interventions, communities have access to malaria prevention and treatment options, lives will be saved, health systems will be less burdened by malaria, and there will be positive effects on households, national health systems, and the economy. The benefits should be as specific as possible, realistic, and important to the decision makers.

As an example, a national RH director under the Ministry of Health (MOH) will likely be interested in messages that articulate how MiP affects other areas of maternal and newborn health—and that scaling up MiP, as part of regular ANC services, can lead to a reduction in maternal and newborn mortality and morbidity and strengthen ANC platforms. Messages to elected politicians might emphasize the burden of MiP on families, communities, and health systems, and may feature stories from malaria victims in their communities. Since private sector leaders are concerned with how their profits are affected by malaria, messages to them should be tailored to emphasize that scaling up MiP interventions is good for business. (See *Step 3. Ignite Partnerships and Opportunities* for more information on engaging the private sector).

Testing Messages before Using Them

Key messages should be informally tested with colleagues and with friends or partners who work in the same sector as the decision makers. This will give some indication of how well they resonate and what adjustments should be made. It is essential to give audiences a clear idea of what is being asked of them. This 'ask' might change as a relationship develops, but providing a clear 'ask' from the beginning can inspire confidence and make it easier to move forward.

Table 3. Existing MiP Advocacy Tools

MiP Advocacy Tool	Location
Infographic on Investing in Malaria in Pregnancy in Sub-Saharan Africa: Saving Women's and Children's Lives	www.rollbackmalaria.org/files/files/working-groups/MiPWG/RBMMiPWG%20Infographic%2023May2016.pdf
Malaria Resource Package toolkit, including training resources, programming resources and reference materials	http://reprolineplus.org/resources/malaria-resource-package
International Journal of Gynecology & Obstetrics: A systematic review of the impact of malaria prevention in pregnancy on low birth weight and maternal anemia	www.sciencedirect.com/science/article/pii/S0020729213000519
Other: A number of other MiP documents useful for advocacy can be found on the MiPTWG web page, under the "References" tab	www.rollbackmalaria.org/organizational-structure/working-groups/mipwg

Advocates can use these tools for a variety of advocacy opportunities that are explored in *Step 3. Ignite with MiP Partnerships and Opportunities*.

Table 4. Sample Message for MiP by Audience

Audience	Decisions that these audiences make	Priorities and special interests	Ask(s)	Supporting message themes
Minister of Health	Example: Makes strategic decisions that affect policies and guidelines Allocates funding from the health budget to fund operations and health programs Oversees all health directorates within the MOH	Example: Health systems strengthening Maternal and child health	Example: Ensure that national malaria and RH policies and guidelines are aligned with the latest WHO guidance for MiP Ensure that malaria resources are available to scale up MiP interventions in accordance with the latest WHO guidance	Example: MiP has broad health impacts, burdening health systems and creating catastrophic affects on maternal and child health outcomes, including maternal and infant mortality. MiP requires comprehensive ANC services to deliver effective services to combat MiP. If spending increases to cover the scale up of MiP interventions, it could reduce maternal and child deaths and the burden on health facilities overall.
Minister of Finance	Example: Oversees the strategic planning for the Government of Sierra Leone Allocates funding to government programs	Example: Economic development Agricultural development	Example: Increase the health budget in accordance with the Abuja targets, so MiP interventions can be scaled up	Example: MiP is responsible for 10,000 maternal and 100,000 newborn deaths and burdens health systems and economies, including the agricultural sector where women make up the majority of workers. MiP interventions are cost-effective and proven to work and save lives of women and their babies.
Member of Parliament	Example: Allocates funding for the health budget	Example: Getting elected (voters) Serving the population	Example: Approve additional funding request to scale up MiP interventions	Example: MiP is responsible for 10,000 maternal and 100,000 newborn deaths. It burdens health systems, and creates catastrophic affects on overall health of the communities you serve, including the local economy. MiP interventions are cost-effective and proven to work and save lives of women and their babies.
Donors	Example: Funds/finances malaria and RMNCAH programs	Example: Meeting targets, reporting positive returns on investment to respective government policy makers	Example: Support scale up of MiP interventions	Example: As part of overall health systems strengthening, reaching targets for MiP necessitates investment in improving comprehensive antenatal care services. As malaria prevalence declines, the adverse consequences of *P. falciparum* infections have been shown to increase in pregnant women. This is relationship is important to consider as countries move towards malaria elimination, because it will likely result in pregnant women having less immunity to protect themselves and the fetus.

Audience	Decisions that these audiences make	Priorities and special interests	Ask(s)	Supporting message themes
NMCP and RH Directorates	Example: Prepares work plans and budgets Oversees implementation of work plans Develops and updates policies and guidelines	Example: Reducing malaria burden and increasing optional reproductive health behaviors	Example: Jointly strengthen efforts to scale up MiP interventions in accordance with the latest WHO guidance to reduce maternal and child deaths Strengthen and harmonize national malaria and RH policies and guidelines with the latest WHO guidance for MiP	Examples are the same as above, with consideration to the following: Globally, approximately 300,000 neonatal deaths could have been averted if IPTp-SP and insecticide-treated net (ITN) coverage among pregnant women and their newborns had been 80% between 2009–2012. MiP requires comprehensive ANC services to deliver effective services to combat MiP. Working jointly to strengthen ANC services to address MiP will achieve greater impact. As malaria prevalence declines, the adverse consequences of *P. falciparum* infections have been shown to increase in pregnant women. This is relationship is important to consider as countries move towards malaria elimination, because it will likely result in pregnant women having less immunity to protect themselves and the fetus.
Private Sector	Example: Contributes and invests human and financial resources	Example: Profits, growing business, networking with other professionals	Example: Be a champion for women and children and advocate for increased domestic spending to scale up MiP interventions Support MiP intervention scale up (support can be through funding, services or other in-kind contributions)	Example: Companies that invest in the scale up of MiP interventions receive returns on investments in terms of reduced worker absenteeism, increased productivity, and improved company image.
Civil Society Implementing Partners	Example: Advocates for the scale up of MiP interventions	Example: Making a difference in communities Earning respect from community	Example: Call on decision makers to do more to reduce MiP Monitor actions and hold decision makers accountable	Example: Malaria is devastating to families, children and communities, causing deaths especially to pregnant women and children, and affects education. They have a right to live a life free of malaria.

Step 3: Ignite with MiP Partnerships & Opportunities

As stated earlier, advocacy efforts must include a time investment in building relationships, as creating a constituency or coalition is key to achieving your advocacy goals. In short, there is strength in numbers.

Informed by this section, advocates can fill out **TOOLS H—I** in *Part II: MiP Advocacy Tools* to help them identify private sector partners, strategize on partnership building and identify advocacy event and media opportunities.

Form a Technical Working Group

The RBM *Consensus Statement on Optimizing the Delivery of Malaria in Pregnancy Interventions* (October 2013)[11] strongly urges RMNCAH programs and NMCP to work together, with the former managing the implementation of MiP while the latter provides the technical oversight. These partnerships can also bring new perspectives, skills, strengths, and resources to the table. One way to do this effectively is to develop a TWG that covers MiP and optimal ANC delivery.

It is up to each individual country to determine which members need to be on a TWG, this may depend on the issues that need to be resolved. However, it is important that the group consists of government decision makers from both the NMCP and the RMNCAH programs to ensure a more coordinated national approach. Other members might include representatives from UN agencies, bilateral organizations, private sector, NGOs, and research institutions; including representatives from service delivery and other disease areas, such as HIV and TB, would also be beneficial for coordination purposes.

The TWG begins with a common goal focused on specific areas of scaling up MiP interventions—for example, harmonizing policies and guidelines, sharing resources for commodities and training, ensuring the funding is available for scale up, etc. An effective working group meets regularly (e.g., quarterly) and typically reports to a management or executive team. Too cumbersome a structure or too high a time commitment might discourage participation. The important thing is to allow enough time to move forward on the plan of action while ensuring accountability, coordination of efforts, and communication between partners and leadership.

Terms of Reference for the TWG
Developing a terms of reference (TOR) document provides a formal framework for a TWG. A TOR typically includes the vision, goal, and objectives of the TWG; a description of the work to be done conjointly and separately; the roles and responsibilities of each partner, including methods of accountability; legal considerations; and a clear method for resolving disputes. One example of a success partnership between a RH unit and a NMCP occurred in Zambia. The programs harmonized policies, training materials, and coordinated

According to the RBM 2013 consensus statement, a partnership between NMCP and RMNCAH programs can be key to achieving the following:

- Determining gaps in RH and malaria control policy and guidance as well as human, financial, and capacity-building resources
- Harmonizing RMNCAH and NCMP policies and guidelines at the national level and effective integration at the service-delivery level
- Coordinating service delivery training on the latest WHO recommended MiP interventions and procedures and support to ensure comprehensive MiP services and strengthened existing health-care system by addressing weaknesses in policy dissemination, supply chain management. and support
- Coordinating communication campaigns at community and facility level for MiP that include community engagement efforts
- Galvanizing government decision makers, private sector, and civil society to support scale up efforts through data sharing, networking and partnership building, and awareness-raising activities
- Improving data collection and an effective monitoring and evaluation (M&E) framework that incorporates the MiP three-pronged approach and improves the quality of ANC
- Sharing financial and technical resources for scaling up MiP interventions and strengthening ANC platforms, including training programs and investments in commodities
- Exchanging knowledge and expertise around malaria; reproductive, maternal, newborn, and child health; and other programs

program implementation to achieve a high percentage of women (69.4%) receiving at least two doses of IPTp-SP. A **sample TOR from Zambia** for a FANC technical working group where MiP is discussed is included in *Appendix B*.

Engage Implementing Partners and Civil Society Organizations

Engaging implementing partners and civil society organizations can catalyze change from the ground up and put pressure on governments to fill critical gaps.

It is important for communities to be empowered to increase demand for early and comprehensive ANC services, IPTp uptake, ITN use, appropriate dosage of folic acid, and effective case management. They should also have the capacity to hold the government accountable for the delivery of quality ANC services—including IPTp, ITNs, and case management for MiP—and for articulating the needs of vulnerable populations in important decision-making bodies at the national level, particularly Global Fund Country Coordinating Mechanisms (CCMs). For more information on CCMs, see http://www.theglobalfund.org/en/ccm/.

Civil Society and implementing partners can use the *MiP Accountability Tool* in *Appendix A* and existing national level scorecards to help monitor national-level advances, gaps in MiP and ANC coverage, and progress as advocacy unfolds.

Importantly, civil society and implementing partners working on RMNCAH, malaria, and complementary health areas can be engaged to communicate the importance of IPTp, ITN usage, and effective case management to communities at risk of malaria. Communication campaigns at the community and facility levels need to promote early and comprehensive ANC attendance among pregnant women and raise awareness of the benefits of IPTp, ITN usage, and the prompt diagnosis and treatment of malaria.

Resource Mobilization with the Private Sector

Countries that have been relying mostly on donor funding for health programs are increasingly being held accountable for strengthening domestic financing for health. Forming partnerships with the private sector is one approach for governments to mobilize additional domestic financing for malaria generally and MiP in particular.

When engaging companies for MiP, consider not only financial resources they bring to the table but also the expertise or services they can share, such as distribution, marketing, and other areas of management. MiP stakeholders should take stock of the major companies in their country and consider reaching out to them and private-sector membership organizations (e.g., Rotary Clubs) to engage them in MiP campaigns.

Table 5 includes a list of options for involving the private sector in MiP.

Table 5. Private Sector Involvement in MiP

Private sector involvement	Public sector key benefits	Private sector key benefits
Sponsorship	Funding or in-kind support (e.g., free media) for MiP campaigns	Company name associated with a public benefit
Workplace malaria protection and treatment provision	Improved health outcomes and decreased burden on public health system	Decreased absenteeism, meeting corporate social responsibility (CSR) objectives, better relationship with community
Private sector health care delivery (service promotion) for MiP	Improved coverage for ANC health services, decreased burden on public health system	Access to MiP policy support, commodities, training, staffing Additional clients
Media Collaboration	Increase audience exposure to MiP messages, improved outcomes	Reaches audience with positive messages, enhanced reputation, income (for media company)

When trying to engage the private sector to invest in scaling up MiP interventions, the challenge is to counter the argument that MiP is a problem for the government, not corporations, to solve. Consider using messages to the private sector that focus on returns on investment to them specifically, as businesses in a malaria-endemic country. More and more, companies are viewing their development efforts in terms of "enlightened self-interest," as opposed to or in addition to corporate social responsibility (CSR).

For example, small and large businesses have proven to be powerful contributors in the fight against malaria, with malaria cases and absenteeism decreasing by more than 90% as a result of workplace malaria campaigns.[12] In Zambia, for example, malaria-related spending at three company clinics decreased by more than 75%. A conservative estimate showed that those companies gained an annualized rate of return of 28%.[12]

Advocates must learn to use the language of business in their advocacy with companies—return on investment, increased productivity, reduced absenteeism, good public relations (PR), and access to a community of like-minded decision makers (e.g., other business and government leaders)—as these are areas of general interest. Companies may more readily take action once they understand the impact of MiP on their staff and business.

Begin by brainstorming potential partners based on what is already known, hoped for, or believed about them. Gathering as much

information as you can about each of the potential partners from reports, articles, the Internet, and professional and personal contacts, using the following criteria to shortlist 5-10 organizations that might be a good fit for a proposed partnership.

- Core business: Does the organization have expertise or resources (e.g., infrastructure, systems, technology) to help meet the MiP scale up needs?
- Geography: Does the organization operate in the areas where MiP scale up expects to focus?
- CSR, corporate affairs, or company foundation: Has the organization already invested in health? Does the organization own or sponsor a youth club, sports team, or other venture that would be a good platform for demand generation?
- Leadership: Has the Chief Executive Officer (CEO) or senior management staff invested time in a health or social issue?
- Relationships: Has the organization or its leadership worked with other potential partners or the government in the past? Do leaders participate on boards of directors of other relevant organizations?

Use Interpersonal Strategies to Build Relationships with the Private Sector

Once you have a short list of companies to approach, consider interpersonal strategies to approach partners and build relationships behind the scenes. In large part, advocacy outcomes depend on the relationships advocates develop with decision makers. Advocacy experts suggest three ways of approaching decision makers:[13]

- Establish points of entry—Think of what you have in common with decision makers you want to approach. If you share the same values and goals, it will be easier to build trust.
- Schedule a meeting—A meeting with a decision maker is an opportunity to convey your message while you have their focused attention.
- Invite them to visit—Even if the decision maker does not attend your meetings or events, a staff member may come. Treat the staff member in the same manner you would treat the decision maker.

TOOL H in *Part II: MiP Advocacy Tools* can help you analyze your own country's private sector opportunities.

Identify MiP Advocacy Opportunities

Whether you are mobilizing resources or raising awareness for policy or social change, it is important to find the right opportunities to convey your advocacy messages and publicly take decision makers to task. You can achieve this objective using influential speakers, compelling data and passionate appeals, and creating the right moments. It is also important to provide a space for networking among stakeholders who might not meet regularly under normal circumstances (e.g., private sector and ministers of health). Advocacy events usually include high-level decision makers such as ministry officials, donors, business executives, senior technical staff at global health organizations, and

other credible and notable figures such as ambassadors. Sometimes they include celebrities in sports or entertainment. This section provides some suggestions on leveraging key opportunities for malaria advocacy.

Develop MiP Advocacy Opportunities

Use **TOOL I** in *Part II: MiP Advocacy Tools* as a starting point to build your own calendar of events. Consider events that might not be malaria-focused but can be framed in a MiP context, such as a nutrition or agricultural fair and national and international issue awareness days, such as Women's Day. Advocates can hold malaria-themed side events with influential speakers and promote and distribute advocacy materials, signage, and other tools, while generating media. The most important aspect of the calendar is to create opportunities for partners and leaders to network.

Examples of advocacy opportunities to engage leaders include the following:

- Site visits to communities and community health centers providing ANC services—this may be especially effective for elected officials who can see first-hand how malaria and MiP affects their communities
- Awards ceremonies that recognize leaders in their efforts to prevent MiP and strengthen ANC platforms with comprehensive services
- A malaria-themed business symposium that recognize active leaders in malaria and MiP can highlight the economics of malaria and MiP, and provide an opportunity for private and public leaders to network and form partnerships
- A photo exhibit during a public event can encourage discussions about the toll of malaria and MiP on communities, while champions give public remarks about what needs to be done to reduce the MiP and MNCH burdens
- A letter campaign from national government leaders (e.g., head of state) to district or private-sector leaders imploring them to support the scale up of MiP interventions

Remember that advocacy is not a series of 'one-off' events but a cycle that builds partnerships, sets an agenda about MiP, and motivates policy action, all of which requires ongoing monitoring and follow up to move forward and succeed.

Table 6. Sample Calendar of MiP Advocacy Events

Date	Advocacy Goal	Advocacy Event	Location	Target Audience	Champions	Key Messages
3/8/17	Raise awareness about importance of MiP	International Women's Day National Forum with First Lady	National	Government officials including key decision makers, private sector	First Lady	Each year, MiP is responsible for 10,000 maternal and 100,000 newborn deaths. MiP interventions are proven to work and save lives of women and their babies.
4/10/17	Agree on the Importance of harmonizing of malaria and RH policies and guidelines	MiPTWG meeting	Capital City	Government officials including MOH, NMCP, and RH programs	Minister of Health	MiP requires comprehensive ANC services to deliver effective services to combat MiP. Working jointly to strengthen ANC services to address MiP will achieve greater impact.
5/25/17	Increase private sector contributions to MiP	Malaria Business Leaders Forum	Capital City	Celebrities, private sector, high-level government officials	Celebrities, Business Leaders	Companies that invest in malaria and the scale up of MiP interventions receive returns on investments in terms of improved company image, reduced worker absenteeism and increased productivity.
7/25/17	Media coverage to put pressure on decision makers to invest in MiP Raise awareness of the need for comprehensive ANC services	Media field visit to health post	Western Region	Government officials, including key decision makers, and the private sector	MP in the Western Region Woman celebrity (singer)	Each year, MiP is responsible for 10,000 maternal and 100,000 newborn deaths. MiP interventions are proven to work and save lives of women and their babies. MiP requires comprehensive ANC services to deliver effective services to combat MiP.

Generate Media

Media can set the public agenda, which in turn can set the policymaker agenda. MiP advocates must think creatively about how to convince journalists to report on MiP, and partnering and maintaining relationships with them is key.

Develop Op-Ed Pieces and Human Interest Stories

Getting an opinion-editorial (op-ed) piece published can grab the attention of various groups, including elected officials, business and community leaders, and the general public. When evaluating op-ed submissions,

Table 7. Tips for Building and Leveraging Media Relationships

Action	Description
Develop a media list	Offer yourself as a contact on health and MiP articles to journalists who write about health issues, and ask if you can send them information
Conduct press briefings	Hold a press briefing with RMNCAH and malaria experts during special malaria and maternal and child health-related events
Develop a press kit	Include basic information about MiP as well as a list of resources, key messages, identified gaps, etc.
Conduct site visits	Take decision makers and the media to program or event sites (e.g., ANC services) and introduce them to experts and beneficiaries.
Look for photo opportunities	If you have field trips, send photographs to the media immediately after the trip, including captions describing each photo
Identify human interest stories	Think of how your initiative impacted ordinary people and tell it from their perspective
Be selective and creative	Think about unusual ways to tell a story about malaria
Train journalists	Organize workshops or informal meetings with journalists to explain the issues, and hold story contests awarding the best stories about MiP
Build media coalitions	Include journalists as part of a network and make sure to support and recognize them

A sample press release is in *Appendix D*.

newspaper editors look for pieces that are of interest to the public and exhibit originality of thought and freshness of viewpoint, timeliness, strength of the argument, and expertise on the issue.

Tips for writing a strong op-ed piece:

- The topic should be timely and newsworthy.
- The author should have expertise on an issue that should be of interest to the public.
- Pieces should express a single, clear point of view and be supported by data.
- Writing should be powerful and appeal to a general audience.
- Pieces should leave a lasting impression and end with a clear call to action.
- Pieces should be concise—700 to 1,000 words maximum.

Try to share real-life stories—for example, ordinary people or celebrities who suffered or knows someone who suffered from MiP. The story of one person with MiP can create a more lasting impact than simply reciting dry statistics. While telling the story, weave in facts and figures about MiP. Bridge the story with an appeal for the need to scale up MiP interventions and strengthen the ANC platform with comprehensive services. Take it further and include development issues. Emphasize the duty of the governments to be held accountable for these efforts.
A tragic story alone will not always lead people to conclude that a change in the system is required or that the government should do something about it. Without addressing accountability, the burden of MiP might be interpreted as a need for charity, or may lead to the victims being blamed (e.g., more pregnant women could protect themselves if they tried harder). An effective story should connect an isolated case to evidence and trends, as well as to policy interventions and resource mobilization. This can help non-expert audiences relate to complex public policy, finance, and public health issues.[10]

A sample opinion piece is in *Appendix E*.

Step 4: Monitor And Evaluate MiP Advocacy

This section provides guidance for advocacy program monitoring and evaluation (M&E). M&E is essential for accountability and for ensuring that lessons are learned so that future advocacy initiatives can be made better. Constant impact monitoring enables you to look for evidence of change as you go, so that you can make changes if your assumptions were wrong and progress is slow.

By the end in this section, and after filling out **TOOLS J—K** in *Part II: MiP Advocacy Tools,* advocates will have identified objectives and indicators for their MiP advocacy.

Develop MiP Advocacy Objectives

An easy way of developing measurable advocacy objectives is to ask the following three questions:

- What do you want your advocacy to do?
- When do you want key decision makers to do it?
- What is the benefit if the key decision makers do what you want them to do?

Examples of SMART—specific, measurable, attainable, relevant, and time-bound—objectives are listed in the table below,

Table 8. Sample Advocacy Objectives and Indicators

Advocacy Objective	Advocacy factors being addressed	Example indicators
Within the next three months, national malaria and RH decision makers and malaria and RMNCAH program implementers will know the importance of scaling up MiP interventions—based on the latest WHO guidance—to improve MNCH outcomes and strengthen ANC services	Awareness	Number of RH and NMCP decision makers who know about MiP issues and actions to address them
Within the next six months, key MiP stakeholders from malaria and RH pro-grams will develop a technical working group to harmonize policies and guide-lines with the latest WHO guidance, scaling up MiP interventions	Policy Change	Formation of a MiP technical working group
Within the next year, five new private sector partners will invest in scaling up MiP	Resource Mobilization	Number of new private sec-tor partners investing in MiP

together with the behavioral factor each aims to influence. The third column of the table provides sample indicators to measure progress towards achieving the objective.

To help you establish SMART objectives, keep the following tips in mind:

- Identify and focus on advocacy asks that will have the greatest impact in MiP and MNCH
- Use only one action verb in each objective since using several verbs implies that several activities and/or behaviors are being measured
- Be specific about the target population and the issue being addressed by the objective

A template to develop SMART advocacy objectives for MiP can be found in **TOOL J** in *Part II: MiP Advocacy Tools* of this guide.

Establish Appropriate MiP SMART indicators

Once SMART advocacy objectives have been established, it is important to track their progress by identifying related indicators. Specifically, indicators contain succinct measures with numerical value so trends can be identified and comparisons can be made. Commonly, indicators are expressed in percentages, rates, or ratios.

Generally speaking, indicators come in three types:

- Input indicators—related to resources, contributions, and investments that go into an advocacy process
- Output indicators—refer to activities, services, events, and product that reach the key and influencing audiences
- Outcomes—refer to changes achieved, particularly in the social, financial, or policy areas

The table below summarizes the different types and category of indicators.

A template to develop SMART advocacy objectives for MiP can be found in **TOOL K** in *Part II: MiP Advocacy Tools* of this guide.

Table 9. Sample Indicators and Categories

Indicator Category	Indicator Type	Examples
Process Indicators (monitoring indicators)	Input indicators	• MiP Champions • Funding for MiP advocacy activities • Equipment
	Output Indicators	• Number of media outputs about MiP (e.g., newspaper articles, radio coverage) • Number of MiP champions coached with MiP messages • Number of meetings held with RH and NMCP officials to form a TWG • Number of private sector stakeholders reached to invest in MiP
Outcome Indicators (evaluation indicators)	Outcome indicators	• Number of MiP TWG meetings held • Number of malaria and RH policies and guidelines updated with latest WHO guidance on MiP • % of ANC service providers promoting and administering IPTp and LLIN usage based on updated national guidelines • Number of private sector companies funding MiP scale up

Establish a Reference Point

For indicators to show any change or progress towards the advocacy objectives, a reference point needs to be established. Reference points act as a measure of comparison, a starting point, which helps to determine the amount of progress that is being made. The reference point is usually defined before or at the very beginning of an intervention. The table below describes the different stages at which reference points can be determined and highlights specific considerations in emergency settings.

Set Targets

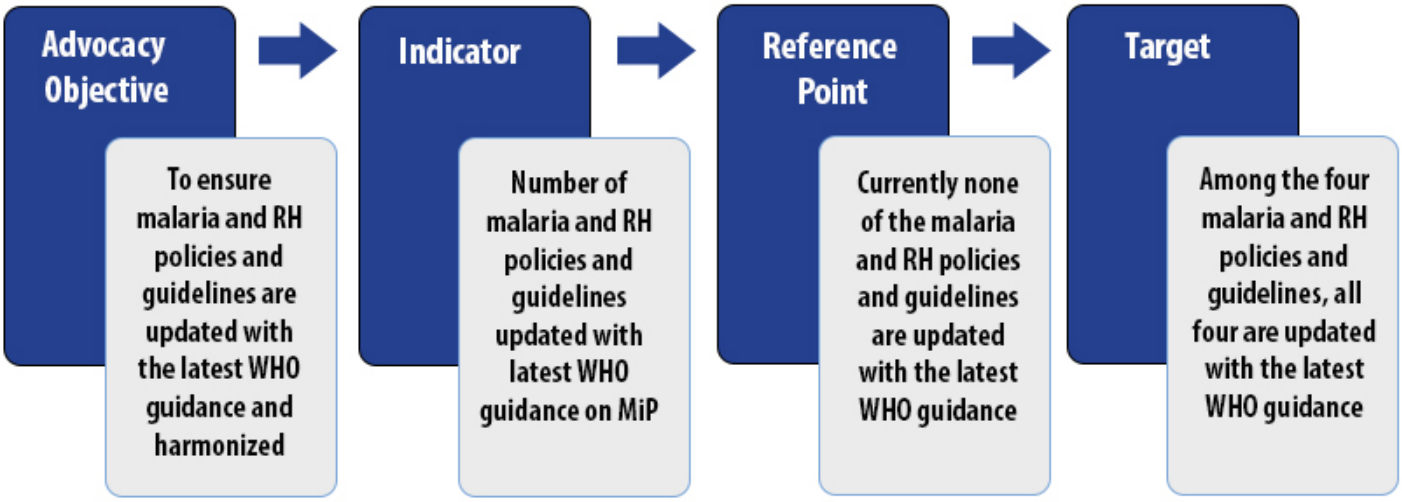
Based on the reference point and the advocacy objectives, targets can be established to determine whether the advocacy response is progressing as planned. Targets define the amount of change that should be seen in the program indicators to reflect progress towards the advocacy objective and the overall advocacy goal.

Figure 1 on the next page represents visually the link between advocacy objectives, indicators, reference point and target.

Table 9. Reference Points

Stage at which point of reference is being established	Description
Before the Advocacy Interventions	This is generally referred to as a baseline. In advocacy, baseline data might not already exist, such as the percentage of ANC service providers trained on delivery of MiP interventions based on updated national guidelines. Instead, implementers would need to collect baseline data using surveys or other tools.
During Advocacy Interventions	At this stage, periodic monitoring reports provide a reference point.
After Advocacy Interventions	A reference point can be established by collecting program indicator data through surveys. Depending on the advocacy outcome indicators, it may also include data collection from a sample group that was not exposed to the intervention and with similar characteristics to those targeted by the advocacy response.

Figure 2. Linking objectives, indicators, Reference Point, and Target



MiP Accountability Tool

A MiP accountability tool is included in *Appendix A*. Country-level advocates can use this tool to monitor the country's progress in MiP, specifically in terms of policy development, commodity financing, and programmatic outcomes. This information will help countries assess and monitor shifts in the MiP landscape, help identify priorities, and hold government officials accountable for addressing MiP. Specifically, this tool aims to monitor the following:

- MiP policies—summary information on the MiP policy environment, including adherence to updated WHO guidelines for MiP and the activation and commitment of MiP TWGs
- MiP financing—summary of the financing landscape for MiP commodities, including prevention, treatment, and case management
- MiP outcomes—summary information on MiP outcomes in the time period preceding data collection

The MiP accountability tool can be adapted to different contexts, can be adapted to collect data on a range of issues, and implemented using existing data sources from international-, national-, and district-level data as feasible.

Part II: MiP Advocacy Tools

TOOL A: Policy, Guidance and Pre-Service Training Assessment

Purpose: This tool has three parts that are designed to help identify the status of national policies and guidelines in terms of updates and harmonization, and whether those policies and guidelines are clearly and effectively being communicated and implemented at the service and community level.

Directions:

- Refer to the guidance in *Step 1: Assess the MiP Landscape*, particularly related to policy documents on pages 16-17.
- Gather national reproductive health (RH) and national malaria control program (NMCP) guidelines and policies, as well as the updated WHO recommendations for malaria in pregnancy (MiP)
- Review national guidelines and policies and answer the questions in the table
- Use the findings to answer the questions in the following two checklists. You may also need to interview reproductive, maternal, newborn, child, and adolescent health (RMNCAH) or national malaria stakeholders to answer some of the questions in checklists 2 and 3.

Note: In 2013, USAID and the United States President's Malaria Initiative (US-PMI) supported a 19-country review of policies and guidelines. Those results are located here: http://www.mchip.net/node/1813.

1. Policy/Guidance Checklist

Policy/ Guidance Document	Institution accountable (e.g., NMCP, RH Directorate)	Was it up-dated with latest WHO treatment guidance?	Was it up-dated with latest WHO IPTp* guidance?	What, if anything, was unclear?	Notes
National malaria policy					
National malaria guidelines					
National RH policy					
National RH guidelines					
Training materials					
Supervision materials					
Pre-service					

* intermittent preventative treatment during pregnancy (IPTp)

2. Malaria and RMNCAH Policies, Training, and Pre-Service Documents Checklist

Related to the exercise above, please answer the following questions.

1. Have MiP standards, based on national guidelines, been adopted and used by both managers and providers to improve the quality of MiP services? ___Yes ____ No

2. Are tutors and preceptors at pre-service education institutes transferring the most up-to-date evidence to their students about MiP, including the latest WHO guidelines? ___Yes ____ No

3. Are pre-service education efforts updated and strengthened with the latest WHO guidelines to ensure graduates have the knowledge and skills to enter the work force? ___Yes ____ No

4. Have trainers been trained in MiP content and training skills to transfer knowledge and skills to providers? ___Yes ____ No

5. Have guidelines that include recommendations from the latest WHO guidelines and have been disseminated to health providers in public and private sectors? ___Yes ____ No

6. Is civil society communicating the importance of IPTp and insecticide-treated nets (ITN) usage as well as effective case management to communities at risk of malaria? ___Yes ____ No

7. Specifically, do the national malaria policy and guidelines provide clear guidance on:
   - IPTp timing and dosage? ___Yes ____ No
   - Directly observed treatment (DOT)? ___Yes ____ No
   - Promotion and distribution of ITNs? ___Yes ____ No
   - Promotion of distribution of ITNs during ANC? ___Yes ____ No
   - Diagnosis of malaria using rapid diagnostic tests (RDTs) and/or microscopy? ___Yes ____ No
   - Treatment for MiP, including clear information on timing and dosage? ___Yes ____ No

8. Do the national RH policy and guidelines provide clear guidance on:
   - IPTp timing and dosage? ___Yes ____ No
   - DOT? ___Yes ____ No
   - Promotion and distribution of ITNs? ___Yes ____ No
   - Promotion of distribution of ITNs during ANC? ___Yes ____ No
   - Diagnosis of malaria using RDTs and/or microscopy? ___Yes ____ No
   - Treatment for MiP, including clear information on timing and dosage? ___Yes ____ No

9. Do the national training and pre-service documents include the following:
   - IPTp timing and dosage? ___Yes ____ No
   - DOT? ___Yes ____ No
   - Promotion and distribution of ITNs? ___Yes ____ No
   - Promotion of distribution of ITNs during ANC? ___Yes ____ No
   - Diagnosis of malaria using RDTs and/or microscopy? ___Yes ____ No
   - Treatment for MiP, including clear information on timing and dosage? ___Yes ____ No

3. ANC Services Related to MiP Checklist

Answer the questions below, and in cases where the answer is 'no,' describe why not.

1. Are ANC user fees reduced or eliminated as barriers to ANC services and the uptake of IPTp?

   __Yes __No _____

2. Are communication campaigns at community and facility levels promoting early and comprehensive ANC attendance among pregnant women and raise awareness of the benefits of IPTp, ITN usage, and the prompt diagnosis and treatment of malaria? ___Yes ____ No

   _____

3. 3. Are health providers promoting early and comprehensive ANC attendance? ___Yes ____ No

   _____

4. Are community engagement activities empowering communities to increase demand for early and comprehensive ANC services, including IPTp uptake, ITN use, routine folic acid and effective case management?

   ___Yes ____ No _____

5. Is civil society holding government accountable for the delivery of quality ANC services, including IPTp, ITNs, and case management for MiP? ___Yes ____ No

   _____

6. Are health providers receiving routine updates in MiP programming as a comprehensive component of focused ANC services either through in-service training, supportive supervision, mentoring and/or other professional development? ___Yes ____ No

   _____

7. Are MiP supplies and medicines including ITNs, sulfadoxine-pyrimethamine (SP), iron-folic acid and clean drinking water with cups available in health facilities for clients during ANC visits? ___Yes___ No

   _____

8. Are providers and health managers trained to collect data in health registers, report data in Health Management Information System (HMIS) and use data for decision making to improve the quality of ANC, including MiP interventions? ___Yes ____ No

   _____

9. Are supplies of RDTs and artemisinin-based combination therapy (ACTs) available at ANC to diagnose pregnant women showing signs and symptoms of malaria? ___Yes ____ No

   _____

TOOL B: Assessing the Malaria in Pregnancy Landscape Worksheet

Purpose: This worksheet will help highlight the important findings that can inform the malaria in pregnancy (MiP) advocacy response by providing a template for you to summarize data obtained and reviewed. Many of the questions can be answered through the data sources mentioned in the guide; however, some questions may need to be answered through interviews conducted with national malaria control programs (NMCP) and reproductive health (RH) program managers and/or staff.

Directions:

- See *Step 1: Assess the MiP Landscape* for information on data sources for this exercise pgs. 13-16.
- Review available data that you have obtained.
- Where necessary, interview program managers in national malaria control or reproductive health programs.
- Insert the key information from each reviewed document in the template.
- Use the information summarized in the table to answer the questions at the end of this worksheet.

MiP Burden

1. How many national malaria cases per year?

   _____

2. How many cases of MiP per year?

   _____

3. How many cases of malaria-related maternal anemia per year?

   _____

4. What is the malaria mortality rate in the country per year?

   _____

   a. What is the all-cause maternal mortality rate?

      _____

   b. What is the maternal mortality rate due to malaria-related causes? What is the maternal mortality rate due to anemia-related issues?

      _____

   c. By how much has malaria decreased (or increased) in the country in the past five years?

      _____

5. What is the burden of MiP on national health systems?

   _____

6. How does MiP affect other sectors (e.g., agriculture, education) in your country?

   _____

   a. Do any studies on malaria's impact on these areas exist in your country (e.g., sources could include Ministry of Health, Ministry of Agriculture, World Bank, local universities, implementing partners or global health organizations)?

      _____

MiP Data Gaps

1. Is your MiP epidemiology data up-to-date and accurate?

   _____

   a. If not, what challenges exist in ensuring data is up-to-date and accurate?

      _____

   b. What needs to change to ensure data is up-to-date and accurate?

      _____

2. If your country's data on the impact of MiP in the country is non-existent or outdated, what are the steps needed to get this information? How can international organizations, research institutions, and universities support this effort?

   _____

3. Are health registers are up to date with latest WHO-promoted MiP indicators?

   _____

4. Do the district health information systems (DHIS) measure the coverage of IPTp and LLINs report changes in coverage over time?

   _____

MiP Commodities and Financing Gaps

1. What are your current and projected gaps for malaria in the next three years?

   _____

   What is it per MiP commodity:
   a. Long-lasting insecticidal nets (LLINs): _____
   b. LLINs required for antenatal care (ANC): _____
   c. Artemisinin-based combination therapy (ACTs): _____
   d. Rapid diagnostic tests (RDTs): _____
   e. Intermittent preventative treatment during pregnancy (IPTp): _____
   f. Iron/folic acid: _____

2. What is the current coverage of ANC services (where less than universal, include current ANC coverage and percent scale up over time)?

   _____

3. How much funding does the government contribute to MiP commodities as part of ANC services (e.g., LLINs, IPTp-SP, ACTs)?

   _____

4. How much funding does the government contribute to behavior change communication for MiP?

   _____

5. How much funding does the government contribute to service provider training for MiP?

   _____

6. Who are the main donors and how do they fund MiP components? Has funding increased/decreased in the past five years? Why?

   _____

7. What opportunities exist to increase funding from current donors or to add new donors (e.g., strengthened malaria advocacy in Global Fund CCMs for MiP, multi-sectoral approaches to reach donors or government ministries that do not normally fund MiP?)

   _____

   _____

8. How many Global Fund Country Coordinating Mechanisms (CCM) members can advocate for pregnant women who are vulnerable to malaria?

_____

_____

9. What opportunities exist to mobilize additional resources from the private sector? How feasible is it to engage the private sector in national malaria and reproductive health strategic plans?

_____

10. What have been your primary funding challenges for MiP commodities and services over the past five years?

_____

11. What are the other primary challenges you face related to stock outs of MiP commodities?

_____

12. What are the other primary challenges you face related to funding service-provider training related to MiP?

_____

_____

What are the other primary challenges you face related to funding behavior change communication related to MiP?

_____

_____

13. What assets does your country have to strengthen advocacy for MiP (e.g., active civil society, champions)?

_____

_____

TOOL C: Problem and Solution Tables

Purpose: Filling out this worksheet will provide a clearer picture of the effects of the core problem that needs to be solved, the root causes of the problem and the potential solutions and benefits of solving the problem.

Directions:

- Follow the guidance outlined in *Step 1: Assess the MiP Landscape, Identify MiP Advocacy Problems and Solutions*, pg. 16.
- Consider the information summarized in the table when completing the next steps
- If more MiP information is needed to guide this process, refer to additional malaria in pregnancy (MiP) resources: http://www.rollbackmalaria.org/architecture/working-groups/mipwg

Core Problem	
Effects	**Underlying Causes (For each cause identified, ask "why" at least five times)**

Solutions	
Effects	**Advocacy Actions**

TOOL D: Malaria in Pregnancy Stakeholders

Purpose: Filling out this worksheet will help you identify which key decision makers are the most appropriate for your advocacy messages.

Directions:

- Refer to the guidance in *Step 2: Make the Case with Messengers and Messages*, *Who Influences MiP Policies and Implementation?*, pg.18.
- Fill out the table below. This exercise is best completed with a group in brainstorming sessions.
- Consider the information summarized in the table when completing the next steps.

	Description	Examples	Who plays or will play the key role in your country? (by name)
Key country-level decision makers	Decides on policy changes and financial allocations for MiP interventions specifically	Ministers of Health, and national malaria control program (NMCP) and reproductive health (RH) program managers	
Private sector	Decides on how much to invest in MiP interventions, contributing either financially or in-kind (e.g., services)	Private health industry, agricultural industry, ex-traction industry, finance/ banking, media, telecom, food/beverage industry, tourism (e.g., airlines, hotels), and parastatals (e.g., membership associations)	
Donor agencies / organizations	Decides how much donor funding a country receives for MiP interventions	Global Fund Country Coordinating Mechanisms (CCMs), US Agency for International Development (USAID)/ President's Malaria Initiative (PMI), UK Department for International Development (DFID), World Bank, World Health Organization (WHO), International Federation of the Red Cross and Red Crescent (IFRC), UNITAID, regional development banks, and other donors	
Implementers/ civil society/ service providers	Takes concrete steps in implementing, adopting and promoting the change and making it effective	NMCPs; RH programs, district health management teams; malaria and reproductive, maternal, newborn, child, and adolescent health (RMNCAH) implementing partners; civil society	
Champions	Have access to and/or influence of key decision makers, are well known and respected	First Ladies, traditional leaders, religious leaders, chiefs, ambassadors, politicians, celebrities, etc.	
Experts	Can produce evidence that the issue is relevant for the decision makers	Research institutions, universities, etc.	
Key affected populations	Have the right to live a life free of malaria	Pregnant women and families	

TOOL E: Stakeholder Influence

Purpose: Filling out this worksheet help you prioritize your advocacy efforts based on the level of influence of your stakeholders.

Directions:
Similar to the previous exercise, refer to *Step 2: Make the Case with Messengers and Messages* section for guidance. Once you have an understanding of who needs to be involved in malaria in pregnancy (MiP) advocacy, complete this table by answering the following questions:

- How influential are they in scaling up malaria in pregnancy prevention interventions? For mobilizing resources? Affecting policy? Rate stakeholders on a scale of 1 to 5, with 5 being the most influential in mobilizing resources for malaria). For instance, the Minister of Health, national malaria control program (NMCP) manager, and reproductive health (RH) directorate might be rated higher than the other stakeholders (depending on the country context).
- What are their goals? What are their primary goals? It is important to understand their goals and how closely or remotely they relate to the MiP advocacy goals. This helps to understand how to frame your messages and asks in terms of common concerns and building "win-win" scenarios.

Individual Stakeholder (name and/or title)	Level of Influence in MiP Policy	Professional / Personal Goals/Interests
Example: Minister of Health	5	Maternal, newborn, and child health (MNCH), private sector partnerships
Example: First Lady	5	Maternal mortality, agriculture
Example: RH Director	5	Teenage pregnancy, maternal mortality
Example: UNICEF Country Representative	3	MNCH, education, health systems strengthening
Example: XYZ Bank Executive	2	Corporate social responsibility: Water, sanitation, and hygiene (WASH), MNCH; Business: public image, opening new markets in rural areas

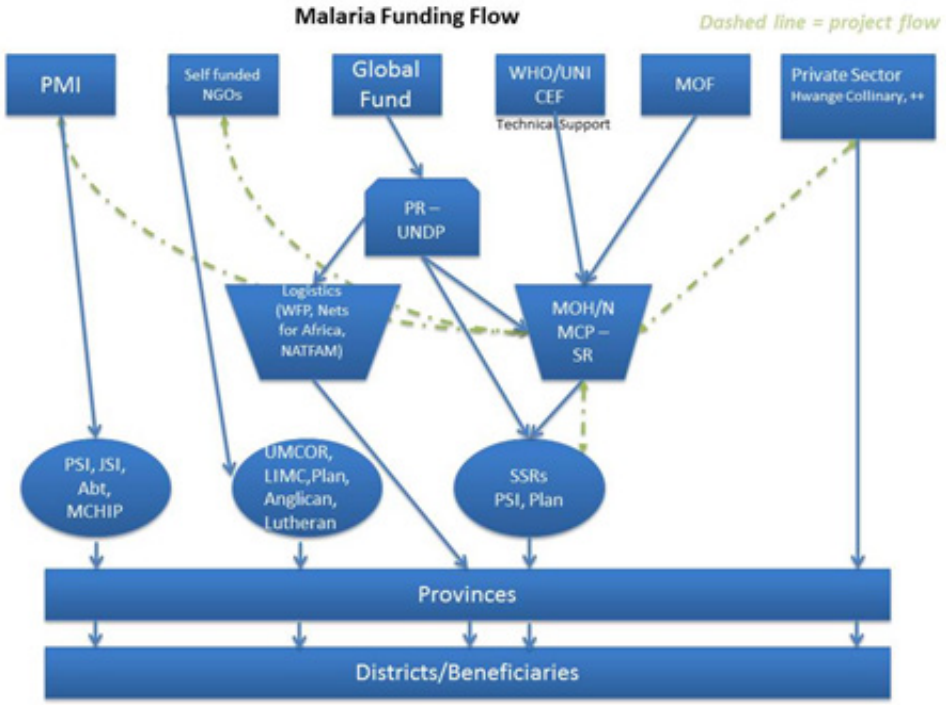
TOOL F: Stakeholder Linkages Maps

Purpose: Mapping exercises help you gain a better understanding of the nuances within the structures and systems in your country that need to be considered when planning your malaria in pregnancy (MiP) advocacy. This information will help guide decision making about primary and secondary audiences and influencers as well as other aspects of the advocacy strategy.

Directions:

- This exercise should be completed with stakeholders who know the national systems and structures. In addition, you may need to conduct interviews with stakeholders who have this knowledge.
- Refer to completed **TOOLS D** and **E** to help you complete these maps.
- It is best to draw the stakeholder mapping to get a better visual representation. You may use the NetMapping[c] approach[14], which you can find out more about here: http://netmap.wordpress.com.
- Once you have created these maps, discuss the implications for your advocacy approach. Make sure that someone is taking notes, and documenting discussions and outcomes.

A sample funding flow is included below.



[c]Adapted from the *Net-Map Toolbox: Influence Mapping of Social Networks.*

1. **Draw a MiP funding flow map.** Draw a map of the funding flows from the national to the local and service level. For example, you can draw a map or several maps that show:

    a. How does the funding flow from one entity (such as a donor) to another, such as the Ministry of Health (MOH) down to the local clinics for ANC services?

    b. Who else is involved in this flow (e.g., parliamentarians, reproductive health (RH) directorate, etc.)?

2. **Draw a chain of command map of MiP.** Draw a map of the chain of command among stakeholders.
    a. For example, what is the reporting structure linking the national malaria and RH offices with local-level ANC services (especially where policy decisions are concerned)?

3. **Indicate the level of influence**. For each map, indicate which stakeholders have the largest influence on your advocacy goals by drawing circles around those decision-makers. For example, those with the largest influence would have the largest circles drawn around them.

4. **Discuss your findings.** Once you have completed your maps, discuss the outcomes and key findings with other stakeholders.

5. **Validate the results.** Validation could be done in one-on-one meetings with officials who know the system you have defined, or through a second stakeholder meeting. It will be important to validate your results to make sure they are as accurate as possible.

TOOL G: Malaria in Pregnancy Advocacy Messages for Key Audiences

Purpose: To ensure that your malaria in pregnancy (MiP) advocacy messages are appropriately tailored to your audience, it is important your 'asks' are clear and that your messages support your 'asks'. This tool has two parts: 1) a sample messaging table that you can adapt for your country context and 2) a message checklist to help ensure that your messages will have impact.

Directions:

- Refer to the messaging sections in *Step 2: Make the Case with Messengers and Messages* for guidance, see pgs. 18-20.
- Fill out the table below to your country context. Identify target audiences, the decisions they make or affect, and the messages that need to be targeted to them.
- Use the completed **TOOLS E** and **F** to help you fill out the table. Refer to **Table 3** in *Step 2: Make the Case with Messengers and Messages*, if needed.
- Once you build targeted messages and asks in worksheet 1, use the checklist on the next page to ensure your messages are strong.
- It will help to become familiar with MiP content by visiting the Roll Back Malaria Partnership's (RBM) website at www.rollbackmalaria.org; reading RBM publications on MiP, MiP key messages and information sheets.
- If need be, refer to additional MiP resources: http://www.rollbackmalaria.org/architecture/working-groups/mipwg

1. Sample Messaging Table

Audience	Decisions that these audiences affect/ make	Priorities and special interests	Ask(s)	Supporting message themes
Minister of Health				
Minister of Finance				
MPs				
NMCP and RH directorates				
Private sector				
Donors				
Civil society implementing partners				

2. Message Checklist

Question	Response
Have three clear messages been developed?	
Is there a clear 'ask'?	
Do the messages provide a clear rationale for why the decision maker should take action?	
Do the messages include facts, emotional triggers and potential benefits to the partner?	
Have the messages and 'asks' been tested?	
Do the messages resonate with people who are similar to the decision maker(s)?	
Have the champions and other intermediaries been adequately briefed on the key messages and 'ask'?	

TOOL H: Private Sector Partnerships Assessment Worksheet

Purpose: This worksheet will help highlight opportunities for mobilizing resources from the private sector for scaling up malaria in pregnancy (MiP) and strengthening antenatal care (ANC) platforms. Some questions will need to be answered through interviews with national malaria control program (NMCP) and reproductive health (RH) program managers and/or staff and other key stakeholders in the country.

Directions:

- Refer to the guidance in the private section sections in *Step 3: Ignite with MiP Partnership and Opportunities*, on pgs. 26-28.
- Where necessary, interview program managers in NMCP or RH programs as well as other key stakeholders knowledgeable about public-private networks
- Use the information to inform a private sector engagement strategy

1. Which companies contribute to malaria prevention and control in your country?

_____

_____

   a. What do they contribute?

   _____

   b. How much do they contribute?

   _____

   c. When and how often do they contribute (e.g., World Malaria Day, throughout the year)?

   _____

   d. In which areas of the country?

   _____

2. Which are the most powerful/wealthiest companies in your country and what social or public health causes interest them?

_____

_____

   a. Which are interested in malaria and/or women and children's issues and maternal mortality specifically?

   _____

3. What types of expertise or in-kind support would you like to leverage from companies in your country to scale up MiP interventions?

_____

_____

4. How feasible is it to engage the private sector in the national malaria and/or RH strategic plans related to MiP?

_____

_____

   a. Which stakeholders would need to be involved?

   _____

5. Do any private sector coalitions exist in your country?

_____

_____

   a. How do they contribute to malaria control, RH, or MiP issues specifically?

   _____

6. What are the challenges you have faced in trying to engage the private sector to contribute to MiP interventions? What did you ask them to do?

_____

_____

7. What data exists on how malaria MiP affects worker productivity in your country (e.g., returns on investment)?

_____

_____

   a. How can companies, universities, civil society, research organizations, and others, support the program to collect data?

   _____

TOOL I: Advocacy and Media Opportunities Worksheet

Purpose: These workshops will help highlight opportunities for raising awareness of malaria in pregnancy (MiP) issues in the public sphere through events, activities, and media.

Directions:

- Refer to the guidance in the advocacy opportunities and media sections of *Step 3: Ignite with MiP Partnership and Opportunities*, pgs. 28-32.

1. Advocacy Opportunities

Date	Advocacy Goal	Advocacy Event	Location	Target Audience	Champsion	Key Messages

2. Media Opportunities

Timeframe	Activity	Story Idea	Contact Information for People to Interview

TOOL J: Defining SMART Malaria in Pregnancy Advocacy Objectives

Purpose: This worksheet will help you identify appropriate objectives for your malaria in pregnancy (MiP) advocacy.

Directions:

- Refer to the guidance on developing objectives in *Step 4: Monitor and Evaluation MiP Advocacy,* pgs. 33-34.
- This worksheet has two parts. Please complete part one (identifying MiP advocacy objectives) before moving onto part two (checklist for assessing whether your objectives are SMART—Specific, Measurable, Attainable, Relevant, and Time-bound).
- While completing the worksheet, ensure you keep the advocacy goal in mind
- Use the data from the MiP landscape to help you complete this worksheet
- Consider the information summarized in the table when completing the next steps

MiP Advocacy Goal: _____

1. Identifying MiP Objectives

Question	Answer	
Who is the intended audience of the advocacy?		
What is the action to be taken by the intended audience?		
How will this action contribute to the advocacy goal?		
In what timeframe will the audience need to take the action?		
What is the expected level of change within the given timeframe (percentage, rate, etc.)?	Current Level	Expected Level
Based on the information highlighted by this table, formulate the advocacy objective or objectives here:		

Once you have developed objectives, you can use the checklist below to assess whether they are SMART and to identify how to improve them.

2. SMART Objectives Checklist

Look at the communication objectives defined above and answer the question on the checklist below.

Criteria for assessing the objective	Yes	No
1. Is the advocacy objective SMART		
• Is the objective Specific? (Is the target population, geographic location and the activity required of them clear?)		
• Is the objective Measurable? (Is the amount of expected change defined?)		
• Is the objective Attainable? (Can it be achieved within the timeframe stated and with the resources available?)		
• Is the objective Relevant? (Does it contribute to the overall program goal?)		
• Is the objective Time-bound? (Is the timeframe for achieving the objective stated?)		
2. Does the objective relate to a single results?		
3. Is the objective clearly written? (Are the desired action and outcome clear?)		

If you have answered 'no' to any of the above question on the checklist, you should redefine the objective to ensure if fits all the above criteria.

Improved advocacy objective:_____

_____

TOOL K: Advocacy Output Indicators

Purpose: This worksheet will help you link the communication objectives, reference points, and targets for your advocacy goal.

Directions:

- Refer to the indicators, reference points and targets sections in *Step 4: Monitor and Evaluation MiP Advocacy*, pgs. 35-37.
- Refer to the objectives developed in the previous tool in this section and using the information and sample above, develop reference points and targets for each objective.

Advocacy Goal:		
Objective 1:		
Indicators	Reference Points	Targets
Objective 2:		
Indicators	Reference Points	Targets
Objective 3:		
Indicators	Reference Points	Targets

Appendices

Appendix A. Malaria in Pregnancy Accountability Tool

Data for the indicators below are typically collected through population-based household surveys. Ideally, these surveys will be nationally representative surveys such as the Demographic and Health Survey (DHS), the Malaria Indicator Survey (MIS), or the Multiple Indicator Cluster Survey (MISC). Information on funding and gaps can be found through the gap analyses that are conducted with national malaria control programs with the support of the RBM Partnership (see *Step 1. Assess the MiP Landscape* for more information). Governments and implementers can easily adapt this accountability tool to their own national landscape and MiP priorities. For more information on MiP indicators that can be used for this accountability tool, see the resources below.

- The WHO's Malaria in Pregnancy: Guidelines for measuring key monitoring and evaluation indicators can be found here: http://apps.who.int/iris/bitstream/10665/43700/1/9789241595636_eng.pdf
- The SBCC Implementation Kit for Malaria in Pregnancy, which includes information on communication objectives and measuring and evaluation, can be found here: https://sbccimplementationkits.org/malaria-in-pregnancy/

MiP Policy						
Indicator	**Source**	**Status**				
Latest WHO guidance for malaria in pregnancy (MiP) is incorporated into National Malaria Control Program (NMCP) guidelines and practices. Specifically, guidelines for these areas: • Timing and dosing for intermittent preventive treatment of MiP with sulfadoxine-pyrimethamine (IPTp-SP) (2012, 2014) • Long-lasting insecticidal net (LLIN) use for pregnant women (2008) • Folic acid intake recommendations with SP (2012) • Use of microscopy or rapid diagnostic tests (RDTs) for diagnosis (2015) • Treatment of MiP by trimester (2015)	National malaria policy and guidelines	2017	2018	2019	2020	2021
Latest WHO guidance for malaria in pregnancy (MiP) is incorporated into Reproductive Health (RH) national guidelines. Specifically, guidelines for these areas: • Timing and dosing for intermittent preventive treatment of MiP with sulfadoxine-pyrimethamine (IPTp-SP) (2012, 2014) • Long-lasting insecticidal net (LLIN) use for pregnant women (2008) • Folic acid intake recommendations with SP (2012) • Use of microscopy or rapid diagnostic tests (RDTs) for diagnosis (2015) • Treatment of MiP by trimester (2015)	National RH policy and guidelines	2017	2018	2019	2020	2021
Management of MiP Programming						
Indicator	**Source**	**Status**				
National technical working groups (TWGs) are formed with representation from NMCP and RH programs to support MiP programming	NMCP/RH	2017	2018	2019	2020	2021
MiP TWGs meet on a regular basis, at least three times a year	NMCP/RH	2017	2018	2019	2020	2021
NMCP- and RH program-designated staff to lead MiP programming efforts	NMCP/RH	2017	2018	2019	2020	2021
IPTp national action plans are in place	NMCP/RH	2017	2018	2019	2020	2021

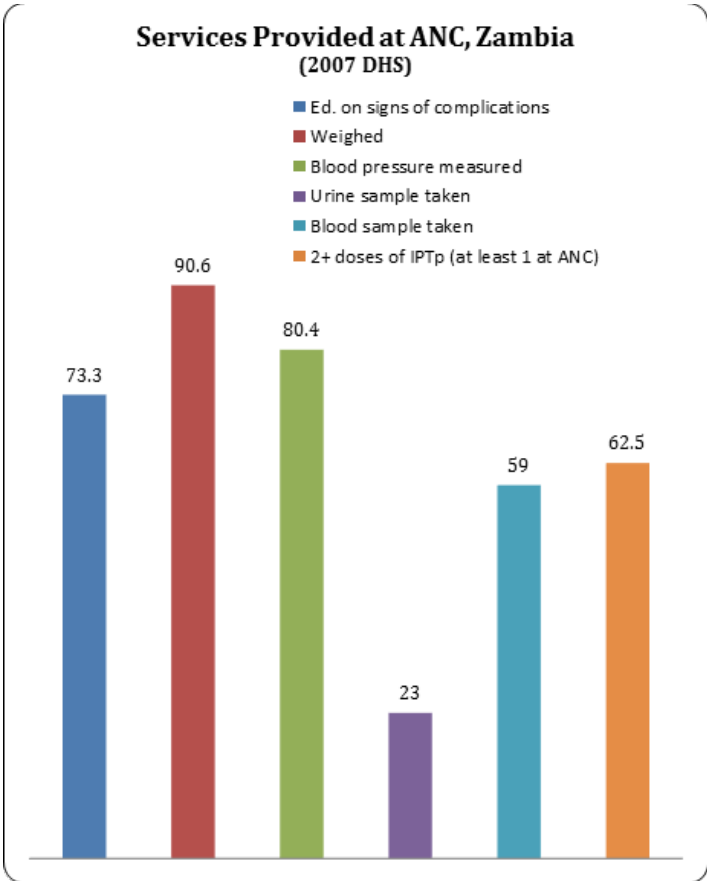
Epidemiology and Behavior						
Indicator	**Source**	**Status**				
Proportion of pregnant women who slept under a net the previous night	Demographic Health Information System (DHS), Malaria Indicator Survey (MIS), or Multiple Cluster Indicator Survey (MICS)	2017	2018	2019	2020	2021
Proportion of women that attended at least one, two and three ANC visits during the last pregnancy	DHS, HMIS/ DHIS 2	2017	2018	2019	2020	2021
LLIN coverage (% of at risk populations)	MIS or DHS	2017	2018	2019	2020	2021
Indoor residual spraying (IRS) coverage (% of at risk populations)	MIS or DHS	2017	2018	2019	2020	2021
Proportion of pregnant women receiving at 3 or more doses of IPTp-SP during ANC	MIS, DHS, or MICS; HMIS/ DHIS 2	2017	2018	2019	2020	2021
Funding						
Indicator	**Source**	**Status**				
LLIN/IRS financing 2015 projection (% of need)	NMCP/RH/ ALMA scorecard	2017	2018	2019	2020	2021
Public sector RDT financing 2015 projection (% of need)	NMCP/RH/ ALMA scorecard	2017	2018	2019	2020	2021
Public sector artemisinin-based combination therapy (ACT) financing 2015 projection (% of need)	NMCP/RH/ ALMA scorecard	2017	2018	2019	2020	2021
Public sector IPTp-SP financing <year> projection (% of need)	NMCP/RH	2017	2018	2019	2020	2021

Public sector social and behavior change communication financing <year> projection (% of need)	NMCP/RH	2017	2018	2019	2020	2021
Health Provider						
Indicator	**Source**	**Status**				
Proportion of pregnant women in ANC who received IPTp according to national guidelines	Program surveys	2017	2018	2019	2020	2021
Communication						
Indicator	**Source**	**Status**				
Proportion of pregnant women who recall hearing or seeing any malaria message within the last six months	MIS, DHS, Program surveys					
Proportion of pregnant women who perceive they are at risk from malaria	Program surveys					
Proportion of pregnant women who feel that the consequences of malaria are serious	Program surveys					
Proportion of pregnant women who believe the majority of their friends and family currently sleep under LLINs, take IPTp (if they are pregnant), and seek care for fever promptly	Program surveys					
Proportion of pregnant women who are confident in their ability to perform actions to prevent and control malaria in pregnancy	Program surveys					
Proportion of pregnant women with a favorable opinion toward LLINs, IPTp, and ANC personnel (service providers)	Patient exit interviews					
Proportion of pregnant women who believe that sleeping under LLINs, taking IPTp, and seeking prompt care for fever will reduce their risk	Program surveys					
Impact						
Indicator	**Source**	**Status**				
At least 85% of pregnant women attended at least three ANC visits during last pregnancy	DHS	2017	2018	2019	2020	2021
At least 85% of pregnant women at ANC who received IPTp according to national guidelines	DHS, MIS or MCIS	2017	2018	2019	2020	2021
At least 85% of pregnant women at ANC who received an ITN	MIS	2017	2018	2019	2020	2021
At least 85% of pregnant women sleep under an ITN the previous night	DHS, MIS or MCIS	2017	2018	2019	2020	2021
100% increase in coverage of IPTp2 from baseline	DHS, MIS or MCIS	2017	2018	2019	2020	2021
At least 85% coverage with 3 or more doses of IPTp in areas of stable malaria transmission	DHS, MIS or MCIS	2017	2018	2019	2020	2021

Appendix B. Sample Technical Working Group Terms of Reference from Zambia

Background

From 2001/2002 to 2007, Zambia made significant strides in the effort to improve maternal health, reducing the country's maternal mortality ratio from 729 to 591 per 100,000 live births.15 This success has been largely attributed to the variety of maternal and neonatal health interventions implemented by Ministry of Health (MOH), supporting donors and implementing partners through national programs in family planning (FP), emergency obstetric and neonatal care (EmONC), and focused antenatal care (FANC), including malaria in pregnancy (MiP).



The World Health Organization (WHO) and Zambia's own national guidelines, recommend that a pregnant woman attend at least four FANC visits, beginning as soon as the woman suspects she is pregnant. While 93.7% of pregnant women in Zambia attend at least one FANC visit, of those only 60.3% attend the recommended four or more visits and only 19.2% attend their first visit in the first trimester, with the majority (78.3%), attending at four months or later.[1,2,3]

FANC includes a variety of key health services intended to ensure the health of mother and baby through early detection and management of complications, including anaemia, pre-eclampsia, malaria, and sexually transmitted infections. Due to service challenges, such as human resource constraints and commodity stock outs, many women who attend antenatal care (ANC) do not receive all of the recommended tests and services. According to the 2007 Demographic and Health Survey (DHS), when surveyed about their antenatal care during their previous pregnancy, the majority of women reported being weighed and having their blood pressure measured, but significantly fewer women had blood and urine samples taken or received two or more doses of intermittent preventive treatment (IPTp) for malaria while they were pregnant.

It is in light of these challenges that the Ministry of Community Development, Mother and Child Health (MCDMCH), National Malaria Control Centre (NMCC) and cooperating partners have undertaken to establish a FANC Technical Working Group (TWG) to advocate for and coordinate programming to improve the delivery, uptake, and monitoring of FANC services. In doing so, the FANC TWG endeavors to bring Zambia closer to achieving Millenium Development Goal 5 of improving maternal health.

Tasks of the FANC TWG

Advocacy:

1. Advocate with the Government of the Republic of Zambia and donor partners for funding for FANC interventions
2. Provide guidance to MCDMCH and donors on the allocation of funding for FANC interventions
3. Identify important emerging issues that require attention, such as operational research, capacity development initiatives and new technology in FANC interventions

Coordination:

1. Develop annual action plans for FANC and MiP
2. Harmonize and coordinate FANC activities implemented by MCDMCH and partner organizations, including capacity building of healthcare providers to ensure provision of quality FANC
3. Contribute to the development and update of national policies and guidelines pertaining to FANC and ensure timely dissemination
4. Ensure standardization of FANC information in training materials produced by all MOH and MCDMCH health units, including those materials with information relevant to MiP
5. Liaise with Medical Stores Limited to participate in quantification and monitoring of FANC commodities and to address commodity stock outs
6. Provide a forum for information sharing on FANC. Collect and disseminate information on FANC-related interventions, events, proposals, and research studies

Monitoring:

1. Monitor the implementation of the national FANC and MIP action plans
2. Review reports from the provinces/districts and implementing partners on FANC activities
3. Integrate FANC into national frameworks (e.g., joint annual reviews, SAG, Performance Assessment Tool)
4. Report progress towards achieving FANC milestones and addressing priorities to the Interagency Coordinating Committee for Maternal and Child Health and Nutrition and the Annual Joint Health Sector Reviews

Membership, Chair, and Secretariat

The membership will comprise representatives from the various existing development partners, academic institutions, professional bodies, faith-based organizations, and other private and non-governmental organizations implementing programs or activities related to FANC.

Members are expected to:

1. Participate in quarterly TWG meetings
2. Assume annual responsibility in a rotating secretariat
3. Provide support to the TWG in the form of technical expertise, sponsorship of FANC activities and hosting of TWG meetings, where possible
4. The chair of the TWG is the MCDMCH.

Meeting Schedule

The FANC TWG will meet on a quarterly basis with meetings called by MCDMCH.

Relationship to Other TWGs

The FANC TWG will fall under the umbrella of the Safe Motherhood Working Group and will provide reports to this body at their working group meetings.

The Chair will provide meeting minutes and any other relevant reports and action items to the Malaria Case Management TWG Chair in order to facilitate information sharing on MiP.

Appendix C. WHO Approach to Malaria in Pregnancy

Promoting ITN Use for Pregnant Women

Insecticide-treated nets (ITNs) should be used before, during, and after pregnancy. It is recommended that national malaria control programs (NMCPs) and reproductive, maternal, newborn, child, and adolescent health (RMNCAH) programs jointly advocate for all ITNs to be replaced in a timely manner, to work together toward universal coverage of vector control, and to ensure that advances in integrating ITN delivery into antenatal care (ANC) services are implemented and sustained. It is critical for all pregnant women unaffected areas to sleep under an ITN throughout pregnancy, particularly early in the pregnancy—before the first dose of intermittent preventative treatment of malaria in pregnancy with sulfadoxine-pyrimethamine (IPTp-SP)—and during the postpartum period. Since many women will not know their pregnancy status immediately, malaria-endemic countries should also consider targeting women of reproductive age, to maximize preventive efforts. Delivery of ITNs though antenatal clinics should continue to be promoted but other strategies should also be used to ensure that all pregnant women sleep under an ITN from the beginning of their pregnancy, such as delivery of ITNs by community health workers.

According to a joint statement of global malaria experts,[16] other LLIN distribution channels may also offer opportunities for achieving and maintaining universal coverage in addition to mass campaigns. The recommendation is for NMCP to develop its own LLIN distribution strategy that includes both mass distribution and continuous distribution channels, based on an analysis of local opportunities and constraints, and then document this in the national strategic plan. Program planning and implementation of continuous LLIN distribution should be conducted under the leadership of the NMCP, with maternal health and Expanded Programme on Immunization (EPI) programs, as appropriate. Program implementers have an opportunity to reinforce counseling on the use of LLINs at ANC and immunization services.

Scaling up IPTp in pregnancy

As referenced earlier, the WHO updated the policy recommendation on intermittent preventative treatment of malaria for pregnant women (IPTp) in 2012, promoting the increased uptake of IPTp-SP in all areas of Africa with moderate to high transmission of *Plasmodium falciparum* malaria.[d] Below is a summary of the recommendations for IPTp:

- SP should be given at each scheduled ANC visit, with the first dose being administered as early as possible in the second trimester
- Each dose of SP should be given at least one month apart
- The last dose can be safely administered up to the time of delivery

[d]The Malaria Policy Advisory Committee (MPAC), which made these recommendations, noted that there was insufficient evidence to recomend IPTp-SP outside of Africa.

- IPTp-SP should ideally be administered as directly observed therapy (DOT)
- SP can be given either on an empty stomach or with food
- Folic acid at daily doses of 5 mg or more should not be given together with SP
- SP should not be administered to women receiving co-trimoxazole prophylaxis

Ensuring Prompt and Effective Case Management

Pregnant women with symptomatic acute malaria are a high-risk group, and they must promptly receive proper diagnosis and effective antimalarial treatment, according to national policies updated with the latest (2015) WHO guidelines. These guidelines state the following:

- Pregnant women in the first trimester with uncomplicated *P. falciparum* malaria should be treated with quinine plus clindamycin for seven days (or quinine monotherapy, if clindamycin is unavailable). If treatment with quinine plus clindamycin fails, treat with a combination of artesunate plus clindamycin for seven days.
- Artemisinin-based combination therapies (ACTs) are recommended to treat uncomplicated *P. falciparum* malaria in the second and third trimesters of pregnancy. Alternatively, artesunate plus clindamycin (or quinine plus clindamycin) can be given for seven days during this period.
- For pregnant women with severe malaria, parenteral antimalarials should be administered in full doses without delay. Parenteral artesunate is preferred over quinine in the second and third trimesters.

Prompt and effective case management reduces adverse maternal and newborn outcomes; this must be clearly articulated in all national policies and guidelines. Recent studies show that case management of malaria in pregnancy (MiP) is currently lacking in some countries. For example, in a 2014 study, researchers found that adherence to national policies and guidelines for treating MiP was low and poorest in the first trimester.[5] Further, another study demonstrated reported poor adherence to national policies and guidelines on treatment of MiP, more so in private health facilities.[5] It was found that a major challenge with adherence to guidelines, as in the case of IPTp, is the "existence of conflicting health care worker guidelines for IPTp," as well as a lack of clarity around those guidelines (2013).[17]

Appendix D. Sample Press Release

12TH SEPTEMBER 2013
PRESS STATEMENT

MINISTER OF FINANCE ANNOUNCES
NEW MULTI-SECTORAL MALARIA TASKFORCE:

Kampala. Speaking today at a United Against Malaria Business Symposium in the Sheraton Kampala, Minister of Finance, Planning and Economic Development, Hon. Maria Kiwanuka, announced the call for a multisectoral malaria taskforce, saying that the burden of malaria needs to be dealt with as a coordinated public-private sector partnership in order for Uganda's socio-economic transformation to be fully realized.

According to Kiwanuka, Uganda is expected to spend approximately $23.4 million on the 13 million malaria cases seen in public health facilities annually, which is a strain on the national economy. Overall, households in Africa currently lose up to 25% of income to the disease—spending approximately $104 million on value of lost time and premature deaths. She explained how malaria control is increasingly recognized as an important element of economic development for malaria-endemic countries such as Uganda due to its social and economic impacts. Malaria not only decreases worker productivity, learning and household income and savings, but also leads to a loss of investment opportunities.

Hon. Maria Kiwanuka was speaking at a Business Symposium held by United Against Malaria (UAM)—an alliance of African football, health and advocacy organizations, governments and private sector partners. Since 2009, UAM has been involved in a campaign towards eradicating malaria from Uganda—since 2010, UAM recruited 30 companies in Uganda to begin working on becoming Malaria Safe companies, taking steps to invest in malaria control.

The purpose of the symposium was to encourage greater public-private sector partnerships to ensure investments in malaria for competitive gains to be realized.

For more information, please contact [name] on [number].

Appendix E. Sample Op-Ed

THE WALL STREET JOURNAL – OPINION PIECE
Free Trade and the Fight Against Malaria
Tariffs block medicines and bed nets at African ports. That's crazy.

By YOWERI MUSEVENI AND JAKAYA MRISHO KIKWETE
Updated July 26, 2010 12:01 a.m. ET

This month Uganda has the honor of hosting the annual meeting of the African Union, which brings together more than 40 heads of state to discuss issues of critical importance to our continent. One of them is malaria.

Malaria causes illness and productivity loss for close to 200 million people in Africa annually. It claims the lives of more than 800,000 Africans each year, most of whom are babies and mothers. Over the past decade, an unprecedented effort has been launched to defeat malaria, supported by funding from the Global Fund to Fight AIDS, Tuberculosis, and Malaria. The World Bank and others have contributed too. Thanks to this funding, a huge volume of rapid diagnostic tests, life-saving medicines, and nearly 350 million mosquito nets will be delivered to Africa by the end of 2010. Other efforts, such as spraying households with insecticides, are being scaled up as part of a comprehensive attack on the disease.

African governments are also stepping up the fight. The African Leaders Malaria Alliance (ALMA), representing 28 heads of state, recently established a regional effort to facilitate cost-effective bulk procurement of mosquito nets, working together and with UNICEF.

We must now commit to overcoming barriers to malaria control and treatment, and a key area here is tax and tariff removal. Most antimalaria commodities are currently produced outside of Africa, and when the ships that transport nets, medicines and other essential health products arrive in African ports, their cargoes are often subjected to taxes and tariffs that absorb precious funds, reducing the volume of health goods that can be purchased and creating delays in distribution. Imposing taxes and tariffs on malaria drugs and commodities burdens Africa's already fragile health system and makes malaria prevention and treatment less available to the poor.

Evidence from our countries—Uganda and Tanzania—strongly suggests that removing taxes and tariffs strengthens the fight against malaria and benefits the poor the most. Several years ago, when we removed taxes and tariffs on all antimalaria commodities, the cost of mosquito nets sold in local markets declined, local demand for nets increased, and more small businesses

entered the market to produce and supply these essential commodities. Since then, our countries have become significant manufacturers of insecticide-treated nets that are exported to other African countries. Tax and tariff removal can be good for Africa's people and good for African entrepreneurs.

Careful attention must be paid, however, to the way in which taxes and tariffs are removed. Some countries have opted to grant waivers or exemptions for donated goods, but the reality is that obtaining these waivers can be time-consuming and expensive. And in some countries, legislation requires that exemptions be renewed every year. This process can cause months of delay. Removing taxes and tariffs altogether is by far the most equitable and effective solution. Along with tax and tariff removal, malaria-endemic countries must pay attention to improving customs procedures so that public-health commodities are correctly identified when they arrive at ports. This is important not only to ease the flow of goods into countries, but also to maintain important quality standards as we battle the global problem of counterfeiting and substandard products that can lead to drug resistance.

If African countries are to achieve universal access to critical health-care commodities and meet the goal of reducing malaria-related deaths to near zero by 2015, we need to take definitive steps now. Tax and tariff removal is one of those steps.

The global fight against malaria over the past few years has redefined the standards and expectations that we apply to development assistance. We have set measurable targets that we are working hard to achieve, and we are seeing great reductions in malaria thanks to strategic applications of funding and greater accountability for donor spending. Just as international donors have increased their commitments, it is time for African leaders to intensify theirs by removing costly and counterproductive obstacles to effective malaria control.

Mr. Kikwete is the former president of the United Republic of Tanzania and past convener of ALMA. Mr. Museveni is the president of the Republic of Uganda and a member of ALMA.

Appendix F. Sample National MiP Plan of Action

Goal	To achieve 80% use of IPT by pregnant women by 2018
Objectives:	• To reduce the episode of malaria in pregnant women • To reduce the incidence of maternal anaemia amongst pregnant women • To reduce incidence of low birth weight • To reduce incidence of other malaria-related complications (abortions, stillbirths etc) in pregnancy
Strategies:	• Development of National Malaria in Pregnancy Policy/Guidelines • Integration of IPT and ITN into RH services • Strong advocacy and awareness creation • Creation of enabling environment for the implementation of new guidelines • Community mobilization and BCC • Capacity development and strengthening • Monitoring/Pharmacovigilance • Periodic evaluation
Accomplishments to Date:	**Training** • Trained 30 core trainers on MiP and FANC drawn from each district • Trained RMNCAH and Malaria Program Managers from all districts. • Conducted a Round Table Conference with members of the Society of Obstetrics and Gynaecologists. Over 400 members sensitized. • Trained health workers on MiP, with at least 10 health workers drawn from each district. **National Guidelines** • Printed 10,000 copies of MiP National Policy/Guidelines. **Case Management** • The MOH produced 30,000 algorithm for distribution to all health facilities, especially the PHCs and ANCs in the country. • MOH distributed doses of SP to the districts as part of the GF support

Implementation Plan:	• BCC meetings and workshops • Development and production of IEC/BCC materials • Conduct advocacy workshop to advocate to policy makers in all districts in the country • Distribution of MiP National Policy/Guidelines and algorithms to all districts • Distribution of the already procured SP to the districts, and purchase of additional SP for distribution. Emphasis will be on areas not supported by GF • Supply of haematocrit measurement and birth weight scores • Joint implementation of activities by malaria/RMNCAH implementing partners at all levels. • Training of trainers workshop on MiP in all tertiary health institutions • Training on MiP in non-Global Fund supported areas. • Include IPTp in curriculum of schools of nursing, midwifery, health technology and colleges of medicine. • Supervisory visits • Tracking of activities, and training of M&E officers. MiP monitoring indicators have been incorporated into the M&E form. • Conduct periodic evaluations • Identify research priorities through consensus building meetings • Provision of grants for researchers
Sources of Funding	• Government • Global Fund • DFID • World Bank • WHO • Private Sector • Other development partners

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