Preventing malaria during pregnancy for women across Uganda

THE BIG PICTURE

In Uganda, many women live in malaria-endemic areas, putting them at high risk for contracting the illness while they are pregnant. Malaria in pregnancy (MiP) significantly increases the risk of maternal anemia, miscarriage, stillbirth, prematurity, and low birth-weight babies. In 2011, nearly 250,000 pregnant women in Uganda contracted malaria.

Despite new global standards for MiP prevention, Ugandan health advocates knew that outdated government policies were contributing to higher rates of MiP due to confusion and lack of coordination among health workers and women. A group of committed organizations, led by PATH, worked closely with the Ministry of Health (MOH) to improve efficiency and standards of care by forming a group to increase coordination across government programs and departments. As a result, the government recently launched an addendum to the country's national policy on malaria. This addendum serves to bring Uganda's policies into alignment with global recommendations and harmonize the government's MiP guidelines internally.

PATH/Evelyn Hockstein

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IDENTIFYING THE POLICY CHALLENGE AND OPPORTUNITY

The global health community has made significant progress in the fight against malaria over the last decade, but more than 30 million pregnant women continue to live in malaria-endemic areas of sub-Saharan Africa, 1.6 million of them in Uganda. MiP significantly increases the risk of maternal anemia, miscarriage, stillbirth, prematurity, and low birth-weight babies.[1]

In 2014, the World Health Organization (WHO) issued revised recommendations for preventing MiP with a package of interventions: intermittent preventive treatment with sulfadoxine-pyrimethamine (IPTp-SP); use of insecticide-treated nets; and prompt and appropriate case management.[2] While research has proven the simplicity and cost effectiveness of widespread use of IPTp-SP, scale-up has been slow in most of sub-Saharan Africa. In Uganda, antenatal care (ANC) attendance is high, but IPTp-SP uptake remains low.[3] Ninety percent of pregnant women attend ANC, but 40 percent of those women don't receive the antimalarial at the currently recommended level. Health experts in the

country attribute this gap in part to a lack of coordination and communication between national decision-makers and local facilities on malaria prevention responsibilities and protocols.

In attempts to improve women's and children's health, the government of Uganda has included malaria prevention during pregnancy in its policies since 2001. In 2011, the MiP policy was integrated into the national malaria guidelines, with a number of agencies and programs—including the National Malaria Control Programme (NMCP), the Reproductive Health Division (RHD), and the AIDS Control Programme—sharing responsibility for implementation.

Advocates, led by PATH and including WHO, JHPIEGO, and the President's Malaria Initiative, knew that better coordination of policies and implementation could lead to reduction in malaria rates and improve uptake of IPT-SP. With the release of new global guidelines, they saw an opportunity to work with the government to amend and better align policies.

The advocates focused on multiple objectives. First, they prioritized creation of a cross-departmental MiP Action Group that could create a shared vision for the MOH's work on MiP. Formation of this group was critical because it would include leadership that could affect change within the MOH. Once operational, the goal of this group would be to align and update the NMCP and RHD guidelines through a policy addendum, which would provide the basis for increased budgets and improved services for women within communities. In addition, advocates hoped to modify the government's policy on IPTp-SP by increasing the dosage for pregnant women from three to seven, in line with WHO recommendations.

IMPLEMENTING THE STRATEGY

PATH and its partners first completed a policy analysis, mapping MiP policies and responsibilities across programs and departments. The timing was right, in their view, because recent high-level meetings had highlighted the need for greater coordination across departments. Advocates, however, were careful to respect the MOH's need to lead the process, so they worked carefully and patiently to gain buy-in from managers and other decision-makers in the NMCP and RHD.

Once formed, the MiP Action Group took ownership of developing a shared vision between the NMCP and RHD. The group's key achievement was defining the roles of MiP work within the MOH. This process was executed through a series of meetings, supported and coordinated by advocates, where it was determined that the NMCP would be in charge of policy, while responsibility for implementation would lie within the RHD.

Then, the MiP Action Group convened the current Maternal and Child Cluster working group, which includes high-level health decision-makers and oversees a range of health issues, to review global recommendations and the group's work to date. They held two meetings—one to share the new WHO guidelines, present evidence, and build support. At the second meeting, participants reviewed and drafted an addendum to current Uganda guidelines.

Through this process, advocates played a critical role behind the scenes. As the MiP Action Group developed, challenges arose; some decision-makers opposed to the group's objectives, including increasing recommended dosage for IPTp-SP. Others were concerned about potential budget implications of policy changes. Advocates met these challenges by methodically compiling and presenting

PATH's 10-Part Approach to Advocacy Impact

Successful policy advocacy is guided by systematic analysis and pragmatic processes. PATH's ten-part framework, outlined below, is a methodical approach to policy change that has helped over 600 individuals in more than 100 organizations in countries around the world achieve health policy change.

- Identify the advocacy issue.
- State the policy goal.
- Identify decision makers and influencers.
- Identify the interests of the decision makers and influencers.
- Clarify opposition and potential obstacles facing your issue.
- Define your advocacy assets and gaps.
- Identify key partners.
- State the tactics you need to reach your goal.
- Define your most powerful messages.
- Determine how you'll measure success.

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evidence on MiP in both Uganda and the region, drawing on the expertise of researchers and implementing partners. They also worked to speed up what could have been an even lengthier process by proactively arranging in-person meetings with the MOH, preparing for meetings, and drafting letters.

ACHIEVING THE POLICY GOAL

In 2013, advocates met their first critical objective of establishing a cross-program MiP Action Group, which signaled a major step toward improved coordination and communication about MiP policies and practices. Recently, another milestone was achieved when the policy addendum drafted by the group was adopted as national policy. This important addendum aligns policies within the government and increases the recommended IPTp-SP dosage in order to improve women's health and reduce malaria among pregnant women in the country.

FACTORS FOR SUCCESS

- **Improved coordination within the government can be just as critical as policy change.** While Uganda already had an existing MiP policy, advocates knew that health care for pregnant women would not improve without better coordination within the government. They prioritized better cooperation and dialogue as a critical first step through the formation of a MiP Action Group.
- **Strong evidence and relationships with decision-makers are important for building trust and moving the process forward.** The expertise and reputation of the advocates played a strong role in maintaining momentum and overcoming initial opposition.
- **Ownership by the MOH was key.** Advocates worked largely behind the scenes to provide decision-makers with the evidence they needed to draft the policy addendum and carry it forward.

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Advocates met challenges by methodically compiling and presenting evidence on MiP in both Uganda and the region, drawing on the expertise of researchers and implementing partners.

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