**RBM MiP Working Group meeting, February 22, 2023**

**Meeting Minutes**

1. Kristen Vibbert, Jhpiego
2. Abena Poku-Awuku, MMV
3. Bright Orji, Jhpiego Nigeria
4. Julie Gutman, CDC/PMI
5. Maud Majeres Lugand, MMV
6. Matt Chico, LSHTM
7. Maurice Bucagu, WHO
8. Lolade Oseni, Jhpiego
9. Nnenna Ogbulafor, NMCP Nigeria
10. Patrick Condo, CDC
11. Felicia Amoo-Sakyi, Jhpiego Ghana
12. Patrick Walker, Imperial College, London
13. Kate Wolf, Jhpiego
14. Iniabasi Nglass, MSH
15. Hellen Barsosio, KEMRI
16. Jenny Hill, LSTM
17. Joseph Hicks, Imperial College, London
18. Landrine Mugisha, NMCP Burundi
19. Odete Cossa, Jhpiego Mozambique
20. Lazare Loua, NMCP Guinea
21. Caroline Osoro, KEMRI
22. Jackson Sillah, WHO AFRO
23. Ashley Garley, PMI/USAID
24. Abdalah Lusasi, NMCP Tanzania
25. Mildred Komey, NMCP Ghana
26. Felicia Babanawo, Jhpiego Ghana
27. Ahmed Saadani Hassani
28. Stephanie Dellacour, LSTM
29. Seynabou Gaye, RTI
30. Silvia Schwarte, WHO
31. Anna Munsey, CDC
32. Ashley Malpass, PMI/USAID
33. Prudence Hamade, Malaria Consortium
34. Radhika Khanna Hexter, Malaria Consortium
35. Susan Youll, PMI/USAID
36. Agnes Janafo, NMCP Liberia
37. Wajilovia Chilambo, NMCP Zambia
38. Raoul Olakoi
39. Aboubacar Sadou, PMI/USAID
40. Radina Soebiyanto, USAID
41. Fady Toure, NMCP, Mali
42. Akuzike Banda, NMCP Malawi
43. Innocent Hezron Peter, Mbeya Zonal Referral Hospital, Tanzania
44. Bonny Onyango, Fonjo Foundation
45. Brenda Okech, UVRI - IAVI
46. Dorothy Achu, NMCP Cameroon
47. Denka Camara, NMCP Guinea
48. Camille Bignon, NMCP Benin
49. Julie Buekens, MCDI
50. **1st trimester ACT use:**
	1. Links to technical briefs were sent out last week and will be posted to the MiP WG site in the near future.
		1. The guidance will allow countries to have an easier time moving forward with policy change.
		2. Briefs contain a lot of information and links to WHO resources
	2. Webinar was held last week with Andrea Bosman presenting on the new WHO guidance, Stephanie Dellacour on the evidence, Hellen Barsosio on monitoring and Dr. Abdalah Lusasi on the Tanzania experience.
		1. Other countries have also already made this policy change and have experiences to share.
			1. ACTION: Please let us know if country to country sharing is needed, we can host an internal webinar
			2. ACTION: Please let us know if the WG can provide additional assistance around policy change
		2. We will be sending out a recording of the webinar
51. Presentation: ***The utility of pregnant women as a sentinel surveillance population for malaria in Geita, Tanzania*** – Anna Munsey, CDC

Please see the PDF slides attached with this email.

1. Presentation: ***Using antenatal clinic surveillance data to estimate malaria transmission trends in Burkina Faso, Mozambique and Nigeria*** – Joseph T. Hicks, Imperial College, London

Please note that these slides are not available to the public at this time.

Presentation Discussion:

* 1. Interesting to see that primigravida used nets less than multigravida ANC attenders and higher prevalence in younger patients which relate more closely to under five prevalence Does the stage of pregnancy coming to ANC one effect the prevalence of malaria infection This should have implications for policy and making sure young non pregnant women have access to nets before pregnancy perhaps giving a net at weddings?
		1. We have data on positivity by # weeks in pregnancy but we haven't looked into that data from this area yet. Would be interesting to look into. And yes, great points about women in first pregnancy, there seems to be a missed opportunity there for ITN coverage. We've discussed potential channels for earlier ITN distribution - for example when registering for marriage certificate etc.
		2. Yes, prevalence is typically a lot higher in younger pregnant women in all the data we've seen. This is likely partly to do with differences in exposure - in particular in surveys LLIN usage in women is typically lower immediately prior to first child. It's also a large part due to the density of infection whereby placental infections are higher density during the first pregnancies women experience infection - in subsequent pregnancies women then mount an immune response they acquire to their first pregnancies. Great idea of giving bednets to newlyweds.
	2. Can you please explain how if you have two different measurements from two different data sources, how would you assess which of the two is correct? What is it about the ANC data that makes us more confident that it is less prone to variability?
		1. ANC is a specific population that is well geographically distributed and has less care seeking bias since women are more likely to go into an ANC clinic than maybe would care seek for example, for a fever. It is an easy to capture population that might provide a bit less variability than some other data sets used.
		2. You can see the telltale signs of it as a routine data source and it is subject to biases, but the biases are easy to spot because you see a big change in the number of pregnant women (you know with a reasonable expectation of what the number of pregnant women should be month to month) whereas with malaria you are left asking questions if there is something going wrong with the data or because you have less people. If you have a very high number of women testing positive you can trade 1 data set off each other. You can do quality control checks more easily, but it is never going to be perfect.
	3. Does ANC surveillance account for different use of microscopy and RDT at ANC screening for malaria?
		1. Interesting question about microscopy vs RDT, I haven't encountered use of microscopy for testing at ANC, perhaps others can comment on that.
		2. Malaria model does incorporate differences between microscopy and RDT that are pregnancy specific. We are hoping to add some mechanisms into our model about the differences in prevalence between children and ANC. One of those mechanisms is an immunological mechanism for why detection changes depending on a woman’s providity which would then affect which test you will be positive on. This requires a specific kind of data set we are hoping to work with in the future.
	4. Since the time period of the study was during COVID, do you have any insights on how COVID impacted your results?
		1. COVID: There are numbers on the number of ANC attendees and the number of tests being performed in routinely protected data set to get a sense of whether attendance changed due to the pandemic which would affect th results. Also have some longer data sets in Western Kenya where we do see an interruption in data collection due to COVID, but women still went to ANC because they wanted to check on the pregnancy. ANC might be able to be a way to fill in gaps when there are major interruptions in other major data sets.
		2. What we've seen is that COVID disrupted all other types of surveillance a lot more both in terms of availability of care and we're starting to see data where lot of older people coming with fever and testing positive for malaria coinciding with known covid waves. Also given the pause in population-based survey I think COVID gives a real example of resilience.
		3. I believe ANC attendance during the height of the pandemic was very country-specific. Some places saw notable drops while others didn't.
			1. In Tanzania data they didn’t see a decrease in ANC because of COVID. ANC attendance tended to be pretty high during the pandemic. Adds to the idea that ANC tends to be pretty resilient during a major pandemic which is a good sign for it’s utility for data.
	5. Will testing pregnant women be able to also be used in surveillance and mapping of where malaria cases are coming from and help with stratification of response and the drive towards elimination?
		1. In fact, testing all pregnant women at first ANC might have benefits outside a way of looking at prevalence but also to give an ACT if positive to clear the parasites before commencing IPTP
	6. Comment/suggestion: Ecological study – looking specifically at malaria/MiP, but malaria more broadly: the use of chloroquine. Anecdotally there were several instances where chloroquine was used for a COVID treatment. We know better than that, but there would be some sort of individual level of protection and it might be something we want to look at more – did central medical stores have a larger demand for chloroquine during the pandemic?

1. Updates on MiP WG Annual Meeting, 2023
	1. Proposed dates: July 20, 21, & 22 in Kigali, Rwanda
		1. This is immediately following the Women Deliver conference so anyone attending that will be well positioned to join the WG meeting as well.
		2. Stay tuned for additional information
		3. ACTION: Please let us know if you are aware of a conflict with any major malaria or MH conference/meeting/deadline
2. Partner Updates:
	1. Global Fund:
		1. Calendar for submission of funding requests:



* + 1. 2 funding requests received so far
		2. Interest in implementing C-IPTp in countries with low IPTp3 coverage.
		3. No talk in the FR about ACTs in the first trimester, but will expect a decrease in the Oral Quinine orders (for countries including Quinine in their requests) as national guidelines are adapted based on the new recommendation.
		4. Several countries are doing combined requests HIV, TB and malaria, and it is an opportunity to push for more integration of services/funding at ANC.
		5. Several countries planning to implement PMC, so another place for integration with other activities.
1. **Call to Action**
* ***Thank you to all who signed our Call to Action!*** [https://endmalaria.org/speed-up-scale-up-of-iptp](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fendmalaria.org%2Fspeed-up-scale-up-of-iptp&data=04%7C01%7CKristen.Vibbert%40jhpiego.org%7C96e4d3c0c9704a3b3ae208d9bbb5b332%7C26ef7fd22a7f4135a2e4de9acf168b2a%7C0%7C0%7C637747211353061630%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=uvvPiqizvbif9F0bZg9t6HcLXTx30lIpvIN%2BUGksPZk%3D&reserved=0)
	+ - We met our goal of receiving over 1,000 signatures!