**RBM MIP Working Group meeting, March 14, 2017**

**Meeting Minutes**

Participants:

1. Maud Majeres Lugand, MMV
2. Julie Gutman, CDC
3. Jenny Hill, LSTM
4. Lee Pyne-Mercier, The Bill & Melinda Gates Foundation
5. Kristen Vibbert, MCSP/Jhpiego
6. Elaine Roman, MCSP/Jhpiego
7. Matt Chico, LSTMH
8. Kate Wolf, MCSP/Jhpiego
9. Ebenezer Sheshi Baba, Malaria Consortium
10. Azucena Bardaji, ISGlobal
11. Silvia Schwarte, WHO
12. Valentina Buj, UNICEF
13. Andrea Bosman, WHO
14. Barbara Rawlins, MCSP/Jhpiego
15. Lisa Noguchi, MCSP/Jhpiego
16. Lisa Nichols, Abt Associates
17. Mike Toso, HC3
18. Jackson Sillah, WHO AFRO
19. Kathryn Bertram, HC3
20. Patricia Gomez, MCSP/Jhpiego
21. Kate Wright, MSH

***Apologies to everyone for the technical difficulties! Thank you very much for regrouping so quickly.***

**Agenda Items:**

1. **MERG Update**, Barbara Rawlins—Postponed until the next RBMMiPWG teleconference
2. **WHO ANC MiP Briefer**

MiP Brief in the context of the updated WHO ANC guidelines:

* WHO recommended drafting a brief with further guidance to countries to continue to roll out and accelerate MiP programming in the context of the updated recommendations.
	+ The latest version of the brief was shared with WHO which provided feedback this week.
	+ Elaine and Viviana are incorporating their feedback and will then share the updated version with the sub task group of WG partners.
	+ We hope the brief will be ready by World Malaria Day for dissemination and we also plan to share it with participants at the WHO Kigali meeting.
1. **Update on WHO Kigali ANC dissemination brief**
* We recognize this meeting is an opportunity to disseminate the ANC Brief and help the forward progress of the integration of MiP into comprehensive ANC.
* The original meeting dates have been postponed and the tentative new dates are June 27-30, but still need to be confirmed.
	+ We will send out the dates, as well as the agenda, once everything is confirmed.
	+ UNICEF will be involved through the MH team and will help to disseminate the information internally.
1. **Spotlight Presentations on MiP:**
2. ***The protective effect of IPTp-SP against the dual burden of malaria and STIs/RTIs in pregnancy, Matt Chico, LSTHM***
* Adverse birth outcomes associated with curable STIs/RTIs: stillbirth, IUGR, preterm birth, low birthweight
* Prevalence of malaria and curable STIs/RTI in pregnancy in sub-Saharan Africa: Malarial estimates are a bit higher in West and Central Africa than in East and Southern Africa.
* Prevalence of malaria and curable STI/RTI co-infection in pregnancy in Zambia: Out of 171 studies, only 1 mentioned co-infection of malaria and STIs so this new study provides a unique data set of new evidence of co-infection.
* Protective effect of IPTp-SP against malaria and curable STIs/RTIs in pregnancy in Zambia
	+ Women given > 2 IPTp-SP doses compared to 0-1 had their odds of experiencing any adverse birth outcome (stillbirth, low birthweight, preterm delivery or intrauterine growth retardation) reduced by 45%, and 13% further with > 3 doses when compared to 2 doses.
	+ Women who received > 2 IPTp-SP doses compared to 0-1 dose had their odds of delivering preterm reduced by 58%, and 21% further with > 3 doses.
	+ Women who delivered preterm and received > 2 doses of IPTp-SP versus 0-1 were:
		- 76% less likely to have had a malaria infection (OR = 0.24; 95% CI 0.09, 0.66)
		- 94% less likely to have Neisseria gonorrhoeae or Chlamydia trachomatis (OR = 0.06; 95% CI 0.01, 0.64) at delivery.

**Key Take-aways:**

* Malaria, gonorrhoea and chlamydia did not contribute to preterm delivery with more IPTp-SP use
* TB and BV infections did not contribute to preterm delivery with more IPTp-SP use
* Sulfadoxine exerts effect against non-malaria and non-STI/RTI causes of adverse birth outcomes
* IPTp-SP protections against curable STIs/RTIs in pregnancy and fills treatment gap in syndromic management of curable STIs/RTIs

**Discussion:**

* It’s fine to share the presentation with colleagues. Note that in the actual papers there is a balanced discussion of the study limitations.
* The reaction from MH colleagues thus far has been positive. As long as we’re not talking about elbowing out the indication and the treatment that would typically be provided, then it is seen as clearly beneficial and value added coming from the malaria world for improving birth outcomes. There’s a lot of burden related to reproductive health and this can help to improve the general reproductive health status of women who may not engage with the health system very often.
1. ***WWARN SP Resistance Data Access Group, Jenny Hill, LSTMED***

<http://www.wwarn.org/working-together/study-groups/sp-resistance-data-access-group> (explanation + call for data)

<http://www.wwarn.org/molecularsurveyor/> (map of resistance markers)

* LSTMED has been working with WWARN to track developments in SP resistance.
* This project is currently in the conceptualization stage and the questions are concerning where this would be housed, and how it could be used.
	+ If you have any feedback on utility and use, and any potential data sources, please contact Jenny Hill: jenny.hill@lstmed.ac.uk

**Discussion:**

* Challenge is for implementers on the ground to understand the threshold and the guidance concerning the resistance markers. Perhaps along with the maps some bullet points could be included about what it means and what it doesn’t mean, in order to inform the interpretation process at the country level.
* There are piecemeal efforts at the country level to collect information on resistance, but the collection process is not standardized so it is challenging to put together what the data actually says. Malaria Consortium is working with LSTHM in 6 countries to collect this data and will present on this during the WARN meeting.