RBM MIP Working Group meeting, November 15th, 2016
ASTMH, Atlanta, USA
Meeting Minutes

Agenda Items:

1. Welcome & Introductions

2. Overview of Work Plan & Accomplishments:
   - Accomplishments:
     - Global events to help increase prioritization of MiP, such as partner meetings
     - Advocacy:
       - Development of MiP infographic launched through World Malaria day and through multiple partner websites. Reinforces addressing MiP, the burden of MiP and the key interventions to use for MiP.
       - MiP Advocacy Guide being developed by JHUCCP with inputs from the WG
     - Coordination activities with the Global Fund
     - New Products and Tools:
       - Early IPTp Uptake Toolkit
       - Case Management Job Aid
     - Policy Development and Promotion:
       - Participation in WHO ANC guidelines development
   - Work plan priorities:
     - Policy
       - Support WHO in dissemination of new ANC guidelines
       - Promote new evidence and new WHO guidance to countries to help expand MiP programming.
     - Advocacy
       - Dissemination of MiP Advocacy tool
       - Strengthen platform of ANC for integrated service delivery, including MiP interventions.
       - Advocate for increased supply for quality assured SP for IPTp
     - Programmatic Initiatives, Products and Tools
       - Rollout of toolkit to assess early 2nd trimester pregnancy
       - Rollout case management job aid for women of reproductive age
     - Research
       - Safety and efficacy of antimalarial drugs in women on CTX
       - Assessment of adherence to CTX among HIV-infected pregnant women
       - Updated maps of IPTp-SP effectiveness by different strata in SSA
       - Clinical trial on safety and efficacy of IPTp with DHA-PPQ in areas of high SP resistance.
     - Coordination
       - Continued collaboration with RBM WGs as well as new structures (e.g. partner committees)
       - RMNCHA integration

3. MiP Highlights, Challenges and Opportunities

Discussion:

- Lots of SP stock outs at national and local levels due to issues with manufacturing. There is only one SP manufacturer, Guillin. What can this WG do to ensure that there are fewer stock outs of SP?
    - There are efforts in place to bring on new manufacturers, but it will take some time.
    - In some countries there is a perception of SP as a failed drug and not prioritized. By bringing on a new manufacturer there is a great opportunity to address those perceptions as SP specifically for IPTp with new packaging to encourage countries to procure SP.
        - Malawi is in the process of doing a clinical trial on safety and efficacy research of SP in one district.
    - SP has been specially kept for pregnant women. ALu is used for treatment of other women and often the SP stock outs occur when there is not enough ALu.
- Abt Associates would like to offer their services in increasing participation from the private sector provider side. The role of the private provider role has expanded in diagnostics and referrals and training pharmacists to do diagnostics is important.
    - SHOPS Plus program is continuing to work on aspects of quality with the private providers and it's important to not forget the private sector in work plan activities.

ACTION ITEM: *The work plan is a living document so if anyone has any suggestions, inputs or would like to take the lead on any activities, please let either Elaine or Viviana know.*

4. Update on WHO ANC Guidelines: Clara Menendez

   These are brand new as they were released just last week.

    - New recommendations:
    - Nutrition interventions:
        - A.2.2: intermittent oral iron and folic acid supplementation
    - Maternal and fetal assessment:
        - B.1.3: intimate partner violence
        - B.1.8: TB: systematic screening for active TB in pregnant women as part of ANC
    - HIV: there is now a distinction between high and low prevalence settings. In low prevalence settings it is not necessary to test for HIV.
    - Preventive measures:
        - IPTp-SP is recommended for all pregnant women. Dosing should start in the second trimester and be given at least one month apart with the objective of ensuring that at least three doses are received.
        - Oral pre-exposure (PrEP) should be offered as an additional prevention choice for pregnant women at substantial risk of HIV infection as part of combination prevention approaches.
        - Group ANC provided by qualified health care professionals may be offered as an alternative to individual ANC for pregnant women.
        - ANC Contact Schedules: ANC care models with a minimum of 8 contacts are recommended to reduce perinatal mortality. (See chart below)

WHO FANC model	2016 WHO ANC model
First trimester	
Visit 1: 8-12 weeks	Contact 1: up to 12 weeks
Second trimester	
Visit 2: 24-26 weeks	Contact 2: 20 weeks Contact 3: 26 weeks
Third trimester	
Visit 3: 32 weeks Visit 4: 36-38 weeks	Contact 4: 30 weeks Contact 5: 34 weeks Contact 6: 36 weeks Contact 7: 38 weeks Contact 8: 40 weeks
Return for delivery at 41 weeks if not given birth.	

Malaria Prevention (IPTp-SP)

- Policy makers could also consider supplying women with their first SP dose at the first ANC visit with instructions about the date (corresponding to 13 weeks of gestation) on which the medicine should be taken.
- WHO recommends a package of interventions for preventing and controlling malaria during pregnancy which includes promotion and use of ITNs, appropriate case management with prompt, effective treatment and in areas with moderate to the high transmission of Plasmodium falciparum, administration of IPTp-SP
- There is some evidence that high doses of supplemented folic acid (i.e. 5 mg daily or more) may interfere with efficacy of SP in pregnancy. Countries should ensure that they procure and distribute folic acid supplements for antenatal use at the recommended antenatal dosage (i.e. 0.4 mg daily).
- The malaria GDG noted that there is insufficient evidence on the safety, efficacy and pharmacokinetics of most antimalarial agents in pregnancy, particularly during the first trimester.

Implications for MiP control:

- IPTp: for all women
- ITNs: not clear who provides them
- Antimalarials in 1st trimester
    - GMP guidelines: quinine is recommended for 1st trimester, but ACTs in first trimester has not yet been officially changed. Currently ACTs only recommended in absence of quinine
        - ERG has made a recommendation in favor of ACTs in 1st trimester, but it has not yet been officially changed.
- HIV co-infection:
    - Contrimoxazole prophylaxis is unclear
    - PrEP implications

Discussion:

- What are the plans for dissemination?
    - Not sure.
- Contact 1 at 12 weeks is too early for 1st dose of IPTp. This is a huge concern because the next contact isn't until 20 weeks. This a setback for IPTp and what should we do as a WG about this?
    - This requires more discussion with the group that developed the guidelines before they are sent to countries and they create confusion. We need to advocate and start a discussion with the RHR team who created these guidelines so they are harmonized with MiP and HIV.

    - This is the recommended schedule, but there is flexibility to adapt this to a local context so this is where the WG can really make a difference to disseminate guidelines with the right advocacy to use these guidelines to meet the needs of pregnant women.
  - The lack of clarity around Cotrimoxazole is going to be problematic in Mozambique where there is a high HIV prevalence.
    - More harmonization is needed!
  - There is concern that by listing specific weeks, some women may not receive the IPTp-SP because they are not coming during that specific week.
    - Experience indicates that having more general guidance works better, such as "every 4-6 weeks".
  - A critical point will be the process of contextualizing to country contexts.
    - We need to understand the timelines for dissemination and the plans so that we can support this process and advocate for adaptation to country contexts.
    - There is an opportunity within this WG. We can pull together an advocacy brief or companion brief that can accompany and support the dissemination.
  - Group ANC and task shifting
    - MCSP will develop a strategy for this so we can try to include these concerns.

5. Highlights of working group products:
   - MiP SBCC Guidance Tool, Mike Toso, HC3
     - http://sbccimplementationkits.org/malaria-in-pregnancy/drafting-a-malaria-in-pregnancy-strategy/
       - This is an easy to use tool that helps with situational analysis. The site includes:
         - A template to use when developing a strategy
         - A map of different strategies from around the world
       - You can get feedback on your strategy through the RBMSBCC WG

   - Advocacy Strategy Guide, Kathryn Bertram, Vector Works, JHUCCP
     - The website for the guide is: http://www.vector-works.org/resources/malaria-in-pregnancy-mip-advocacy-guide-for-national-stakeholders/
       - It's a how-to guide providing guidance on strategic advocacy planning while using existing MiP advocacy products such as the RBMMiPWG Infographic
       - Guidance and tools are available to promote and track scale up of MiP in countries
       - JHUCCP will work through the RBMMiPWG and MiPTWGs in countries to collect feedback from countries on its use and then make modifications within 6 months
     - A request for the WG partners is for more data on effective use of MiP interventions for advocacy
   - MiP Country Profiles, Kate Wolf, MCSP/Jhpiego
     - Under the MIP working group, MCSP and PMI are developing a series of MIP country profiles to explore post -2012 progress on IPT programming.
       - The profiles will help to identify which countries have best practices to share and where there are still bottlenecks to be addressed.

6. Meeting close