**RBM MiP Working Group meeting, November 17, 2023**

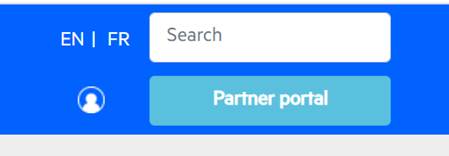
**Meeting Minutes**

1. Kristen Vibbert, Jhpiego
2. Abena Poku-Awuku, MMV
3. Julie Gutman, CDC/PMI
4. Anna Munsey, CDC/PMI
5. Jacques Kouakou, PSI
6. Anne Claire Marrast, MMV
7. Gabrielle Hunter, JHU CCP/SBC WG
8. Halimatou Diawara, University of Bamako
9. Kunda Kialanda, NMCP Angola
10. Maud Majeres Lugand, MMV
11. Hellen Barsosio, KEMRI
12. Matt Chico, LSHTM
13. Sequoia Leuba, Imperial College of London
14. Agnes Banda, MOH Malawi
15. Ashley Garley, USAID
16. Dominique BOMBA, NMCP Cameroon
17. Raquel Gonzalez, ISGlobal
18. Abdallah Lusasi, NMCP Tanzania
19. Elaine Roman, Jhpiego
20. Joe Mugasa, PSI
21. Kayode Afolabi, NMCP Nigeria
22. Kwame Ankobea, USAID
23. Thomas Ritchie, Sanaria
24. Dale Halliday, Unitaid
25. Jackson Sillah, WHO AFRO
26. Chonge Kitojo, USAID Tanzania
27. Charlotte Eddis, PSI
28. Radhika Khanna Hexter, Malaria Consortium
29. Prudence Hamade, Malaria Consortium
30. Nnenna Ogbulafor, NMCP Nigeria
31. Kate Wolf, Jhpiego
32. Bonny Onyango, Fonjo Foundation
33. Azucena Bardaji, ISGlobal
34. Viviana Mangiaterra, SDA Bocconi School of Management
35. **RBM Updates:**
    1. Two days of meetings in Geneva first week of November with the RBM Partnership.
       1. CEO Michael Charles is interested in ensuring better coordination across Working Groups and integrating working groups into full umbrella of RBM.
          1. Feedback was shared with RBM Secretariat and Board and this was taken to heart by the RBM leadership.
          2. Used this opportunity to collectively review RBM strategy and define and determine how technical working groups fall under the RBM envelope.
             1. Standardizing RBM objectives and how Working Groups contribute to these.
             2. Some funding will be available from RBM in 2024 for Working Groups.
       2. Trying to deliberately have more engagement across working groups and work collaboratively on objectives that overlap.
          1. We’ve had some discussions with SBC WG and plan to have a smaller subgroup of members across the two WGs to start thinking about communications to help with C-IPTp at the community level, early ANC attendance, etc.
             1. **ACTION: If you are interested in joining this subgroup, please let Julie, Chonge or Kristen know. Plan is to have first meeting in Q1 of 2024.**
       3. RBM Board meeting is taking place in December with WGs presenting to the Board.
       4. All WGs will be updating TORs in the first quarter of next year.
36. **Presentation:** ***Plus Project: Update to the RBM MIP WG***, Jacques Kouakou, PSI

Presentation Discussion:

* 1. While visiting PMC in Benin, saw problems with paper-based data collection and trying to find children that had received PMC the month before. Has there been any digitization of data or improved tracking tools to make it easier on the provider?
     1. In Benin there are so many data collection tools already – vaccination booklets, tally sheets, etc. We tried to do things for PMC using the existing systems. At country level there are discussions about digitization of data tools. We discussed this with the MOH in Benin during the program design and they are looking into using a digital tool starting with the CHWs because they have a new CHW policy and the tool they will use will be digital. We are very optimistic and hope the tools being used on a regular basis can also be digitalized at the health facility level.
  2. Alignment of PMC and the malaria vaccine in the future – do you have thoughts on how this could work since they are the same age groups?
     1. There is the same target population: children under 2. Both are preventive measures for malaria. Right now there is a study going on in Ghana that has preliminary results that the combination of PMC and the RTS,S vaccine brings an additional value in preventing malaria. At the country level, each country has a subnational monitoring plan to identify which intervention goes where. In CdI for example, there is also SMC and all three interventions target the same population. They have a plan to allow all children to benefit from at least one intervention so they will try to avoid having two interventions in the same district. But with the study in Ghana, these results will help encourage countries to combine the interventions.
  3. When assessing the impact of PMC what are the indicators you are using around efficacy and safety as opposed to coverage? Do you have a control group so that efficacy can be actually demonstrated or have modelling studies been done? We only have evidence of IPTi efficacy which was given three times so it will be really important when using a drug in a way it has not been used before the efficacy and safety data will be very important
     1. The study being done is quasi-experimental. In each country we are doing an impact evaluation. In CdI, for example, we have one implementation district and one control district where the children are not benefitting from PMC. We are comparing outcomes across factors such as malaria cases averted, anemia, etc. At the end of the process we hope to have the efficacy results.
  4. Is there SP resistance in countries where you are doing PMC? How do you monitor this profile along with PMC implementation? In TZ they used DPQ and worried about using SP because of the resistance that exists in parts of the country.
     1. As part of evaluation that goes along with implementation we look at SP suitability that looks at SP resistance. We are very concerned about resistance related to SP since it is the drug we are using. In West African countries -Benin, CdI, Cameroon- we got data on the SP resistance levels. We ensure that the resistance in those parts was not high enough to impact the efficacy of the intervention. In Mozambique they work with CISM which has provided a nice map showing where SP resistance is higher. This guided us in choosing the provinces with lower levels of resistance for the PMC intervention.
     2. We are also doing mapping of SP to see if previous data on SP resistance changes with the intervention. This is one of the purposes of doing the genotype mapping in the implementation countries.
     3. We are very concerned with the resistance. DPQ is an alternative drug, but during a recent discussion with WHO they made a clear statement that if in a particular country they are using DPQ for first line treatment then it should not be used for PMC, even if we are not using it in the same district.
     4. Malaria Consortium has looked at SP-AQ for PMC in areas like Uganda which has high SP resistance and they have seen that SP-AQ maintains high efficacy despite the SP resistance. Countries with very high SP resistance have used SP-AQ successfully which may be a more cost- effective option than going to DPQ.
     5. LSHTM is also collecting information to evaluate the association between IPTp doses administered during pregnancy and PMC doses administered to children of the same mothers.

1. **Follow-up from Annual Meeting:**
   1. The presentations, meeting report and other meeting documents can all be found at the following link: [https://endmalaria.org/events/twenty-third-mipwg-annual-meeting](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fendmalaria.org%2Fevents%2Ftwenty-third-mipwg-annual-meeting&data=05%7C01%7CKristen.Vibbert%40jhpiego.org%7Cd0533dd3d2474269826f08dbe6b48c29%7C26ef7fd22a7f4135a2e4de9acf168b2a%7C0%7C0%7C638357435391199629%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=bljFeXKg9OvAmOvhiaS5jijDzAJGxCRaLihS6KsJqFI%3D&reserved=0)
   2. The documents are available in English and French and you can choose the language in the top right corner of the screen.



* 1. For next steps, we will be sharing a draft of the 2024 workplan based on the commitments made during the action planning session.
  2. **ACTION: Please review the workplan and add any partner activities that you are aware of that should be listed. Please also help to update the status of activities so that it is clear which activities are completed and which are already in process as this will help us to prioritize moving forward.**

1. Partner Updates:
   1. Global Fund: Multiple grants are including versions of C-IPTp. We’re now in the middle of the frenzy of Grant Approvals Committees and will have the final decisions of most grants by the end of the year.
   2. MMV: Want to recognize Abena and her work to set up a panel at the UN General Assembly in New York in September. Abena organized an event which included endorsement speeches made by African First Ladies and a panel discussion focused on experiences in scaling up IPTp.
      1. Following signature campaign, wanted to have a pilot because most First Ladies wanted some action.
      2. Organizing an advocacy pilot and decide as a group which country to do the pilot in and how the advocacy can help increase uptake of IPTp.
      3. The exact plan for the pilot will largely be decided by the national malaria control program as part of their strategic plan and we would then support the pilot.
         1. The pilot would be run not by the NMCP, but potentially by a civil society organization or an academic partner as the NMCP sees fit.
      4. Will make this decision before end of the year and then let everyone know.