**RBM MiP Working Group meeting, June 27, 2023**

**Meeting Minutes**

1. Kristen Vibbert, Jhpiego
2. Abena Poku-Awuku, MMV
3. Julie Gutman, CDC/PMI
4. Maud Majeres Lugand, MMV
5. Kassoum Kayentao, MUSO
6. Stephanie Rapp, MUSO
7. Seynabou, RTI
8. Hellen Barsosio, KEMRI
9. Matt Chico, LSHTM
10. Frédéric Guigma, Jhpiego Burkina Faso
11. Maurice Bucagu, WHO
12. Goodluck Tesha, Jhpiego Tanzania
13. James Andati, JHU
14. Ashley Garley, USAID
15. Abdallah Lusasi, NMCP Tanzania
16. Ashley Malpass, USAID
17. Camille Bignon Houetohossou, NMCP Benin
18. Patrick Walker, Imperial College, London
19. Odete Cossa, Jhpiego Mozambique
20. Dale Halliday, Unitaid
21. Caroline Osoro, KEMRI
22. Lazare Loua, NMCP Guinea
23. Jackson Sillah, WHO AFRO
24. Chonge Kitojo, USAID Tanzania
25. Silvia Schwarte, WHO
26. Radhika Khanna Hexter, Malaria Consortium
27. Prudence Hamade, Malaria Consortium
28. Nnenna Ogbulafor, NMCP Nigeria
29. IniAbasi Nglass, MSH
30. Clara Menendez, ISGlobal
31. Silvia Schwarte, WHO
32. Bonny Onyango, Fonjo Foundation
33. Estrella Lasry, The Global Fund
34. **MiP WG co-Chair transition:**
    1. Maurice is retiring from WHO at the end of June.
       1. We want to thank Maurice for his tireless efforts on behalf of pregnant women.
    2. Dr. Chonge Kitojo has been elected to fill the vacant co-Chair position. Welcome Chonge!
35. **Presentation:** ***Accelerating Access: A preview of findings from the ProCCM Trial***, Kassoum Kayentao & Stephanie Rapp, Muso

Presentation Discussion:

* 1. Can you share the slides?
     1. Unfortunately, the slides cannot be shared at this time since the research is still being peer reviewed.
  2. Nigeria experience on iCCM: we’ve noticed a significant increase in service provision and a decline in health indeces. For malaria, test positivity rates in areas where iCCM is deployed have actually dropped compared to non iCCM areas. iCCM goes a long way to take services to reach people.
  3. What are your considerations/thoughts for governments/partners who would want to think about in adopting this model? What are the most important things to consider up front?
     1. There are some initial recommendations, but always growing this and hearing feedback from partners.
        1. For MOHs, we see proactive case detection on the part of CHWs. It didn’t make a different on child mortality, but did make a difference on prenatal care access.
        2. For countries including RH services in their package of community health care, we recommend they work on this proactive case detection. It is minimal cost if you are already paying CHWs so it is really about their workflow so this is one of our strong recommendations.
           1. What drove that drop in child mortality and these overall improvements when you look at the pre/post results really has to do with the model as a whole – the integrated package – the primary care facility and the user fee removal. So our big push is for institutions, governments and partners to keep investing in all these three: professional community health care, improved primary health care facilities and the removal of point of care fees.
           2. Different countries are on different journeys – some countries across SSA have been able to remove user fees, especially for target populations.
     2. Overall message is that this model is possible and can have a significant impact even in the face of conflict. These results show what is possible so that if we continue investing and make the adjustments required, we can still provide valuable health care and can see improvements in outcomes.
  4. Payment of CHWs is important, but challenge to realize in a sustainable way. What was the payment to CHWs and how you see this being sustained long-term?
     1. In Mali there is an agreement across all of the states/partners that CHWs be paid in line with minimum wage (approximately $75 per month). CHWs across Mali are paid through partners (GF, GAVI, etc.). It wasn’t controversial or unique that the CHWs involved were paid. There is policy in Mali to set up legal parameters for the payment to pass through the domestic budget.
     2. Sustainability: This is a tough question. These plans need to be costed out so countries/partners are looking at appropriate ratios of CHW:people – recognizing what ratios are possible when you have a full-time CHW, the amount of site visits they can accomplish can help people to understand that good coverage might not cost quite as much as people think.
  5. Conflict setting: Mobility of a population is challenging – out-migration – was it an issue?
     1. There was some in and out migration during the time. To face this type of migration we developed a strategy of using mobile clinics to reach people affected.
     2. One of the studies to be published is a process evaluation that was embedded. We did a lot of quantitative interviews that will capture some of this. We identified each patient with a unique identifier so we could track individuals. Mobile clinics were used to ensure care wasn’t interrupted for communities that were cut off by violence. There was both in-migration and out-migration so the amount of people in the study each year stayed the same.
  6. Cost-effectiveness of proactive case detection?
     1. The $11.41 comes from a cost analysis of the whole intervention. They will also be doing a cost-effective analysis of the proactive piece. This is ongoing and will be available in a few months.
     2. There may be different elements – the initial investment in both arms is pretty similar. We’re investing in these improved primary care facilities, the fee removal, and the paid professional CHWs who are working full time with supervision. So those input costs are similar across both arms so it is really about whether the CHW is using more meds if they are doing PACD and about whether the time split looks different. That evidence is coming and we want to use it to inform conversations with governments and partners
  7. How are CHWs selected and trained?
     1. They are recruited from communities in partnership with community health associations/leaders. Looked for CHWs who could work in French.
     2. Their training is 36 days and there are annual refresher trainings + monthly place of work supervision visits with 1:1 feedback.

1. **C-IPTp Consensus Statement:** 
   1. ACTION ITEM: Please let us know if you are interested in contributing to the development of this.
      1. We will collect all of the names and set up a meeting.
      2. Maud, Elaine, IniAbasi, Caroline have volunteered this far.
2. **Annual Meeting:**
   1. The meeting will be held in Geneva September 12 & 13 – venue TBD
      1. This will be a meeting to discuss high-level global topics and support of country efforts within the broader ANC platform
      2. The meeting planning committee is working on developing the agenda which will be shared as soon as it is finalized
         1. We had sent out two surveys seeking inputs to the agenda so thank you to all who responded to those questions.
      3. This year we will be asking those who need participation support to submit a sponsorship request form. This will be shared shortly.
      4. Reminder: Research abstract submissions are due July 17th.