MINUTES: CCM Taskforce Meeting 12-5-16

Participants: Saul Guerrero (Action Against Hunger-ACF), Leah Ewald (MCSP), Anna Bryant (MCSP), Dyness Kasungami (MCSP), Kerry Ross (USAID), Lindsay Angelo (Canadian Red Cross), Casie Tesfai (IRC), Dolores Rio (UNICEF), Laura McGough (USAID), Saul Morris (CIFF), Prudence Hamade (Malaria Consortium), Helen Counihan (Malaria Consortium), Justine Kalve (MCSP)

ACTION ITEMS:

- **Saul will circulate the data collection form used in Mali and Pakistan.**
- **Saul will circulate Kenya's protocols and journal articles when they are available.**
- **Kerry will share the latest agenda for the community health meeting.**
- **If you have any suggestions for topics for the Commodities Working Group, please send them to Saul.**
- **Justine will circulate a synopsis of the DRC study.**
- **Saul will identify next steps for the task force in 2017**
- **Saul will email idea for face to face meeting.**
- **Dyness will contact WHO for a point person and guidance on the process to include SAM in WHO-approved iCCM materials.**

Minutes:

1. Study: Treating severe acute malnutrition (SAM) using community health workers in Mali, Pakistan and Kenya
    a. Design of the study
        i. Examining, on a small scale, the effectiveness and quality of care of SAM interventions when administered through CHWs, as opposed to facilities.
            1. Kenya: implementation will start in the first quarter of 2017 and will also cover moderate acute malnutrition (MAM) treatment. This study involves Unicef, Save the Children and WFP.
        ii. Setting
            1. Mali: rural areas, scalable compared to other parts of the country. Mostly sedentary agricultural communities.
            2. Pakistan: slightly more urbanized, but primarily rural setting too.

3. Kenya: will cover a larger area in the north of the country

iii. Supportive supervision – there were health staff in the facilities who helped supervise CHWs.

1. Mali: this supervision was limited, so they boosted it a bit (increased number of visits) by piggy backing onto some of the supervision capacity in place for a different Action Against Hunger programs.

2. Pakistan: Action Against Hunger was less involved in supervision due to the structure of the lady health worker system.

iv. CHWs included all community health workers in the 14 target facilities, which were chosen randomly. They were already doing iCCM, and SAM was added on. All had completed secondary education.

v. Survey data was collected using Open Data Kit (ODK).

1. Saul will circulate the form and protocols

b. Data collection is now complete

i. No difference in quality of care compared to facility based treatment in Mali or Pakistan

ii. Mali: coverage was twice as high when delivered by community health workers and outcomes were non-inferior.

iii. In Mali, there was a 50% reduction in cost for care givers when delivered through CHWs, but cost for service provider is higher – supply chain might be part of the reason.

iv. Pakistan: more complicated because ACF is working with Aga Khan University and this has led to delays in the flow of research findings.

1. Clinical outcomes was broadly non-inferior but there were statistically significant difference in the proportion of non-responders (higher for CHWs)

2. No difference in coverage of services (unexpected)

c. Papers

Mali

i. Quality of Care has already been submitted to a journal and received feedback. Second submission expected before the end of the year.

ii. Effectiveness paper will be submitted for the first time before the end of the year

iii. Cost-effectiveness analysis completed. Paper expected to be submitted in Q1 2017.

Pakistan

iv. Cost effectiveness analysis also needs to be finalized

v. Need to explore whether malnutrition impacted the quality of care of other interventions when it was added

2. Saul will share Kenya's protocols and articles, when they are published.

d. Mali: secured additional funding from the same organization that funded the first study and the EU to scale up. Will continue through 2018. Will continue to collect evidence.

i. Will test different types of supervision

2. Symposium 2017: Institutionalizing Community Health Conference (ICHC) early next year – want to have a session looking at nutrition (embedded in broader CCM community) to communicate with people not as involved in nutrition

a. No separate iCCM Symposium planned for 2017 because there is another large community health conference planned in March i.e. the ICHC.

i. The March meeting's agenda is not focused on specific technical areas, but rather on cross-cutting issues.

1. Kerry, who is on the executive committee for the ICHC, confirms this. However, they were concerned about iCCM getting lost if it didn't have its own session, so they flagged sessions that they thought should mention iCCM and informed the presenters. Kerry suggests we do the same thing for nutrition. Kerry says she is happy to help and will share the latest agenda. Then this group can negotiate with the session coordinators.

a. This meeting will include 15 country teams (ministry, civil society, reps from WHO and other missions), several other countries only sending one representative, academia, and other policy makers.

b. Mostly focused on Africa and by invite only

c. Topics include partnerships/financing, research and innovation, and engaging country teams

2. If we can't get nutrition on the agenda, maybe we could have a side meeting since some target people will attend the ICHC.

3. Saul will email ideas/options for a face to face meeting.

b. IRC has been adapting SAM for iCCM by simplifying the existing SAM treatment guidelines. Finalized prototype was used for a study in S Sudan and has already been tested in several countries (Chad, India, Mali, Niger), looking at user-centered design.

c. IRC now feels comfortable enough with the tools to share them, and other agencies have started to request them

i. Want to have an organized group of user organizations to share experience and reach consensus about algorithm

ii. Dyness: are you proposing a different subgroup or a task group for the simplified and adapted treatment guidelines (the latter would only involve specialized technical people)? Need to involve WHO so that ultimately, the material can be added to the existing WHO-approved iCCM algorithm. The group should also learn from the process of adapting and including TB and HIV into iCCM.

1. Want people involved in studies and operational tests to vet the materials

2. Contact WHO for guidance on the process

3. Commodities working group (Supply Chain Management (SCM) Subgroup of the CCM TF)

a. The SCM working group has asked the nutrition subgroup what areas around commodities and supply chain we want them to consider.

b. If you have any suggestions, please send them to Saul.

i. In Myanmar, have a pilot looking at allowing CHWs to prescribe antibiotics

1. Global Fund is pushing for the involvement of other interventions (malaria, HIV) in this pilot. Does that mean they will be providing those commodities in the future?

ii. RUTF – big issue because it's bulky, which raises different issues than other commodities

4. MCSP is participating in a DRC study integrating preventative and curative aspects of nutrition interventions into iCCM. Have JSI IRB approval and are submitting to the Kinshasa school of public health's IRB (implementation to begin Jan/Feb 2017)

    a. Justine will share a synopsis with the group

5. Once we have notes from this call, Saul will identify next steps

    a. Want to go into 2017 with a clearer sense of purpose.