Reaching the Unreached
WHERE THERE ARE NO ROADS.....

✓ Post conflict
✓ Weak health systems
✓ Low technical capacity
✓ Low management capacity
Sierra Leone

- Post conflict
- Poor health systems
- Low technical capacity
- *Anopheles* mosquito transmits LF
- LF coendemic with onchocerciasis
- Successful MDA programme that is on track to interrupt LF transmission by 2015

How did Sierra Leone do it?
The strategy

- New political will in post-conflict country keen on moving forward with development
- Building on a well established CDTi programme for Onchocerciasis control
- One Program Manager for all NTD targeted by PC
- Integration of NTD control into Primary Health Care system and working directly with the District Health Management Team.
- Scale to national coverage in 3 years (2007-10)
Training and advocacy

- National Supervisors
- DHMTs
- PHU staff
- Community drug distributors
Challenges

• Competing Health Priorities (Cholera 2012), high infant and maternal mortality, malaria
• Traditional Healers: Witchcraft
• Religious beliefs over medical beliefs
• Impassable roads/bridges to reach hoard to reach community
• Motivation of community volunteers (CDDs)
AFUTURE FREE OF LF
Global Alliance
Liberia

- Post conflict
- Poor health systems
- Low technical capacity (lower than Sierra Leone)
- *Anopheles* mosquito transmits LF
- LF coendemic with onchocerciasis
- Initiated MDA in 2012 and plans to scale up to 100% geographic coverage in two years

Why is Liberia so optimistic?
Strategy

• Government’s commitment to Integrated NTDs implementation
• Integrated NTDs program with one Program Director
• The use of existing CDTI =CDI platform is used for LF and STH
• Size and population of the country
• Better decentralized health system that enable counties to plan and implement their own NTDs interventions
Strategy cont.

• Strong collaboration with National Malaria Control program on IVM
• Increased number of trained health workers and CDDs
• Donor support and commitment
• Increased compliance rate for Ivermectin by communities
Challenges

- Post conflict infrastructural challenges
- Poor motivation of health workers and drugs distributors
- Donor interest in vertical programmes
- Limited financial resources from government
- Poor intersectoral collaboration
- Poor health systems
- Low technical capacity
- Lack of mechanism for morbidity management
Papua New Guinea

- Post conflict
- Stronger health systems
- Technical capacity (lower than Sierra Leone)
- *Anopheles* mosquito transmits LF
- MDA using DEC plus albendazole

- Initiated MDA in 2004 but has struggled to scale up and now a bad spot in the Pacific region.

**Why is PNG struggling?**
PNG endemicity by district

- **Red:**
  - high endemic;
  - >=5% pos

- **Yellow:**
  - low endemic;
  - >=1% and <5% pos

- **Green:**
  - non-endemic;
  - <1% pos

- **White:**
  - unknown

Mf results used if available, otherwise ICT.
How do we reach the population?

• Reaching the populations through the health delivery system has not worked or has produced very limited results
  – Implementation is variable throughout the country
  – The costs of MDA has been very high
  – It had taken a very long time to complete
  – Reporting has been unsatisfactory
Moving forward

- The plan is to group villages into manageable populations
- Appoint and train volunteers
- Ensure the availability of drugs and other tools
- Ensure there is adequate information
- Conduct MDA on an appointed day
- Partners can also be involved so every partner is involved in some way
Challenges

• Recourcing for the volunteers and communities
• Supervising volunteers
• Working with highly decentralized system
• Logistics of the availability of drugs and other tools
THANK YOU
How can we accelerate the process?
HOW INDONESIA ACCELERATE THE PROCESS

RITA KUSRIASTUTI
DIRECTOR OF VB & ZOONOTIC D.C M O H  INDONESIA
1. ACCELERATION OF PROGRAM

1. Maintain the MDA areas to cover the entire endemic population in 1 district (population around 1 mill - 5 mill /districts, 368 districts from 420s, total target pop. 110 million.

- Improve the MDA areas which only partial
- ISSUES: implementing unit: district vs subdistrict / epidemiological endemic areas
DISTRICTS CONDUCTED MDA IN 2011

Legend:
LF Endemic District: 368
Non Endemic District: 129
2. Improve the program management by:

- improving case finding, reporting and recording
- involve community in census of the people (door to door)
- ensure drug availability, distribution and monitoring of the drug taken by the community
- improve the referral system and SAE cases
3. Improve human resources capabilities by
   - training (surveillance, RR, planning)
   - strengthening managerial skill
   - Communication skill
   - improve of monitoring and evaluation skill

4. DEVELOP NATIONAL GUIDELINE, NATIONAL PLAN TOWARDS LF ELIMINATION 2020, ROAD MAP
DISTRIBUTION OF STRAINS OF FILARIAL IN INDONESIA

Legend:
- **Blue**: *Brugia malayi*
- **Yellow**: *Wuchereria bancrofti*
- **Red**: *Brugia timori & Wuchereria bancrofti*
2. **ADVOCACY & INTEGRATION**

1. Enhance National Committee /Task force
2. Advocacy to the high level leaders as well as local government leaders --→ enhance political commitment, financial support for operational cost at district level.
3. Strengthen the LF program in line with HSS and other “strong program funding” (Malaria, leprosy) as well as with STH → school health program
3. PARTNERSHIP

- INVOLVE OTHER SECTORS (EDUCATION, ENVIRONMENT, PUBLIC WORK, FINANCE, PARLIAMENT MEMBER)
- PRIVATE SECTOR (C.S.R)
- NGOs, FBOs, Women Health Workers
4. Improve research agenda

- base line survey
- mid term evaluation after 2 round, 4 round, 5 round
- T.A.S → good KIT (for Brugia)
5. SUPPORT FROM INTERNATIONAL

- WHO
- DONOR (USAID, AusAID, etc)
- INT’L NGOs: RTI, Rotary, World Vision, Sabin etc) for technical assistance as well as funding support
ELF Operational Cost 2010–2014

- Operational cost
- Drugs Procurement
- Other Operational Cost
- Other Capital Cost
- Survey
- Program Management
- Social Mobilization, Advocacy
- Training
THANK YOU
MDA in Nigeria – How can we accelerate progress?

Chukwu Okoronkwo
NTDs, Federal Ministry of Health,
Abuja, Nigeria
Introduction – Nigeria

- 36 States and FCT with over 160 million pop
- 541 LGAs LF endemic of 705 LGAs mapped
- Over 106m persons at risk
- Only 175 LGAs (32%) covering at-risk population of about 33m (31%) reported MDA in 2011
- Less than half of LGAs covered reported treatment coverage >80%

Legend:
- Endemic LGAs (541)
- Non-Endemic LGAs (164)
- Unmapped LGAs (69)

Source: NOCD/NLEF, NTDs Branch, Dept of Public Health, FMoH, Nigeria
Technical Issues

Barriers

- Non-conduct of baseline survey
- Inadequate planning & poor coordination skills of State Coordinators (expansion plans, census updates, inventory mgt)
- Poor supervision
- Some LGAs are yet to be mapped

Solutions

- Conduct baseline in sentinel sites
- Adequate management & technical training for State team members
- Conduct comprehensive census updates
- Complete mapping
Financial/administrative Issues

Barriers

- Inadequate counterpart funding
- Late release of approved funds by partners
- Dependency on assisting NGDO

Solutions

- Advocacy and sensitization at highest levels
- Improve integrated/coordinated implementation of NTD programmes
- Mobilize additional partners
Political Issues

- **Barrier**
  - Policy makers’ desire to extend MDA to constituents even when LF is non-endemic or has not been mapped

- **Solution**
  - Sensitization and advocacy targeted at policy makers at all levels
Thank you for your attention
How can we accelerate the process?

Upendo John Mwingira- MD,MtropMed
NTD Programme Manager-Ministry Of Health Tanzania(Mainland)
Introduction

- 44 million People
- 947,300 sq km
- 5 PCT NTDs
- >10 Case Management NTDs
- LF endemic in all except 2 (mapping 2004)
- NTD programme started in 2009
- Mapping for LGF completed
Tanzania: NTD Control Program
Achievements

- Functioning NTD coordination units at National, Regional and districts levels
- Finalization of the NTD master plan
- Treatment of 11.3 million People, 25 million treatments in 76 implementation units (2011)
- Trained 6,800 Health Workers, 15,000 primary school teachers and 68,000 community drug distributors (CDDs)
- Interruption of LF transmission in Tandahimba
- Interruption of Onchocerciasis in Muheza, Korogwe, Rungwe districts
- Interruption of Trachoma in Lushoto and Iramba
Technical challenges(1)

Challenge
• Delays in data collection, compilation and reporting
• Limited Programme Monitoring
• Lack of Rapid and affordable Diagnostic tools
• Limited Funds to deal with Morbidity issues:
  - Lymphoedema
  - Hydrocele Surgeries

Possible Solutions
• Development of NTD database to feed in MIS
• MIS to be integrated into the HMIS
• Encourage and support programme Monitoring
• Increased advocacy and support for Morbidity management
Technical challenges (2)

Challenge

• Dealing with LF in Integration world
e.g. LF have most of guiding tools

• Low capacity with accelerated efforts

• Dealing with Drug logistics

Possible Solutions

• Development of clear Guiding tools on all NTDs

• Increase capacity at all levels through Training

• Drug logistician to support the programme
Administrative challenges

Challenge
- Dealing with Multiple partners/Donors in the ‘integration context’
- Limited government /local contribution
- Poor infrastructure to reach out the needy ones

Possible Solution
- Joint planning
- Increase capacity on programme management
- Having a country strategic plan and policy guidelines
- Encourage and support an effective government ownership
- Increase local advocacy at a levels
- Engage more partners from different sectors
- Use of existing supply chain
Opportunities

• Existing Health system
• Existing interventions e.g the IRS for Malaria
• Existing partnerships and collaboration
• The London Declaration and global momentum
• NTD integration
• The Post MDG agenda
• Asanteni sana,
• Thanks so much all of you for supporting us
• Thank YOU ALL for Listening!
Strategies for Achieving Disability Prevention and Morbidity Management
TOGO
National Lymphedema Program

Dr Améyo Monique DORKENOO
NPEFL
Components of lymphedema program

**Case detection and Referral**
- “Anyone with a “big leg” should come to dispensary”
- Using TV, Radio, Public criers, Posters, CHWs

**Case management**
- **Training in self-management in the health centers**
  - Training by trainers model using a training manual (1 nurse/health center in the whole country and 1 CHW/village in endemic districts)
  - IEC (flip charts, posters)
  - Step by step demonstration of washing to the patient
- **Home based self management**
  - Startup kit for washing (soap and towels)
  - With the support from a family member

**M&E**
- Follow up of the patient by a CHW (patient booklets ....endemic district only)
- Patient follow up in health centers (patient booklets)
- Periodic supervision at all levels

**Sustainability**
- Inclusion of lymphedema management in the training curricula (Nurses, MDs)
Scaling-up

Launch
Population
June 07 1.1 million
May 08 2.1 million
June 08 4 million
Mars 09 6.1 million
Patients Enrolled in the Program

Stop MDA

- endemic
- non endemic
- Lome
- Total
Opportunities and challenges

Opportunities

• Operational research (USAID/IMA/CDC)
  – Feasibility of a countrywide morbidity control program +++

• Start-up funding for
  – Training
  – IEC material
  – Washing kits
  – Supervision

• Small country with a well functioning and decentralized health system

Challenges

• High turnover of the trained staff

• Long term compliance of the patients (need for continuing BCC activities)
Current status

• **Funding**
  – Securing of funding not affected by stopping MDA but based on existence well functioning program

• **MOH is still very engaged in the program**
  – Financial support for supervision activities
  – Staff of the national program coordination maintained after MDA stopped

• **Redeployment of the trained medical staff**
  – Refreshers training and supervision are needed

• **Continuing sensibilisation of the community**

• **Health services will continue to provide care to patients beyond 2015, target of the elimination of LF in Togo**
Community Based Support for Lymphedema Patients
India

Mr. Jonathan Rout
Project Officer
Churches Auxiliary for Social Action
Lymphatic Filariasis in India

- India constitutes over 40% of the global LF burden
- Population: ~ 37 million
- Literacy Rate: 64%
- Poorest state in India
- Highly LF endemic (3.5-6.3 million infected)
Components of the Program

- Community-based lymphedema management
- Provide care and treatment for lymphedema patients
- Multifaceted approach
  - Health education to entire communities
    - Education to provide support to government led MDA
  - Registry of lymphedema patients in the district
  - Extensive lymphedema management training
    - Training –of-trainers model
  - Follow-up of patients, impact assessment
Sequence of Activities

- Register all lymphedema patients via house-to-house survey
- Perform health education = ‘mass awareness’
- Recruit task force volunteers (≥ 1/village)
  - Lymphedema management training
  - Basic first aid
  - Each task force volunteer follows ~ 20 patients
- Perform village demonstrations and door-to-door teaching of lymphedema management techniques
- Provide each patient with booklet, soap, antifungal cream, towel, and shoes for some patients
- Refer to PHC system for ADLA episodes, complicated lymphedema
Health Education on Lymphatic Filariasis

Wall paintings

Posters

Leaflets

Street plays
Lymphedema Management Training

In the classroom

In the field
Impact of Community-Based Lymphedema Management on Quality of Life and Perceived Disability in Lymphedema Patients — Orissa State, India, 2010 (*submitted*)

Summary Findings:
- Quality of life improved significantly among patients in the program.
- Frequency of ADL episodes = the strongest predictor of disability.
- Daily washing was associated with lower disability scores.
- One year of community-based LM resulted in thousands of person-years of productivity saved if extrapolated over the entire district.
Increasing compliance with mass drug administration programs for lymphatic filariasis in India through education and lymphedema management programs*

Com-MDA: Community-based pre-MDA education program
Com-MDA+LM: Community-based pre-MDA & lymphedema management
Acknowledgements

- Government of India, State of Orissa
- CDC
- IMA World Health
- Global Network for NTDs
- All community participants
A FUTURE FREE OF LF
Global Alliance
Panel Session: Strategies for Achieving Disability Prevention and Morbidity Management
November 19th, 2012

New therapeutic options for lymphedema

Achim Hoerauf
Institute for Med. Microbiology, Immunology and Parasitology (IMMIP)
Bonn, Germany
Aim of this study:

1. to determine whether improvement of filarial lymphedema (LE) by doxycycline is restricted to patients with ongoing infection (CFA-positive), or whether the majority of CFA-negative patients with LE would also show a reduction in LE severity.

2. to analyse to what extent LE is caused by *Wolbachia*. To this, the *Wolbachia*-depleting antibiotic doxycycline will be compared with amoxicillin, which does not target *Wolbachia* but only opportunistic exogenous bacteria that may worsen LE.

Participants:
Men and women with LE stage 1-5 (according to G. Dreyer et al., Basic Lymphoedema Management, 2002)

3 Treatment arms:

**Doxycycline** 200mg/d for 6 weeks, N = 41 (24 months follow-up)

**Amoxicillin** 1000mg/d for 6 weeks, N = 31 (24 months follow-up)

**Placebo** matching doxycycline for 6 weeks, N = 36 (24 months follow-up)
**Doxycycline improves or halts progression of lymphedema**

24 months after treatment start

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Improvement</th>
<th>No change of pathology</th>
<th>Progression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lack of progression</td>
<td></td>
</tr>
<tr>
<td>Doxycyclin</td>
<td>36.6%</td>
<td>95.1%</td>
<td>58.5%</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>3.2%</td>
<td>71.0%</td>
<td>67.7%</td>
</tr>
<tr>
<td>Placebo</td>
<td>5.6%</td>
<td>44.4%</td>
<td>38.9%</td>
</tr>
</tbody>
</table>

*Fisher's exact test

Doxycycline vs. Amoxicillin: $P < 0.001^*$
Doxycycline vs. Placebo: $P < 0.001^*$
Amoxicillin vs. Placebo: $P = 0.042^*$

“Doxycycline improves filarial lymphedema independent of active filarial infection: a randomized controlled trial”
Doxycycline improves or halts progression of lymphedema independent of active filarial infection
24 months after treatment start

“Doxycycline improves filarial lymphedema independent of active filarial infection: a randomized controlled trial”
Before treatment with Doxycycline for 6 weeks:
Stage 3 right leg

24 months after treatment start:
Stage 1 right leg
**Conclusion**

Doxycycline is beneficial in reverting or halting the progression of early stages of filarial LE (stage 1-3), regardless of whether there is still active infection or not. This finding thus expands the benefits of doxycycline to the entire population of patients suffering from LE.

**Recommendations**

Patients with LE stage 1-3 should benefit from a 6-week course of doxycycline every other year or even yearly.

→ Integration of a 6-weeks doxycycline therapy into morbidity management
THE AFRICAN FILARIASIS MORBIDITY PROJECT

THE PAST

THE PRESENT

AND THE FUTURE
OBJECTIVE

BUILD CAPACITY for

– Filarial Hydrocele Surgery
– Reconstructive Plastic Surgery for Genital Lymphoedema
– Hygiene Therapy for Lymphoedema
PILOT PHASE 2004 - 2005

• PROJECT FORMED 2004, GATES FOUNDATION FUNDING

• INITIALLY WEST AFRICA

• MAINLY TRAINING IN FILARICELE SURGERY, ALSO HYGIENE THERAPY LYMPHOEDEMA

• ALWAYS IN COLLABORATION WITH COUNTRY PROGRAMMES
POST – PILOT PHASE
2005 - 2010

• FUNDED MAINLY FROM HDI (NORAD)

• TRAINED 443 PEOPLE IN 10 W. AFR. COUNTRIES + TANZANIA AND MALAWI

• SOME CAPACITY BUILDING IN HYGIENE THERAPY FOR LYMPHOEDEMA

• INDEPENDENT EVALUATION 2006
  – Many lost to follow-up; gone back to work, away for seasonal agriculture
  - 92.4% very satisfied with the results of their surgery (399 reached of 1,771 patients operated on up to that time in 3 evaluated countries)
LF-HYDROCELE SURGERY TECHNIQUE

PRINCIPAL ASPECTS

• LOCAL ANESTHESIA (or spinal)

• ANTIBIOTIC COVER!!!!

• MIDLINE, LONGITUDINAL INCISION

• DELIVER HYDROCELE SAC AND EMPTY THE FLUID

• REMOVE THE SAC AND CAREFUL SUTURING OF THE RESULTING EDGE

• VERY CAREFUL HEMOSTASIS TO STOP ALL BLEEDING POINTS, BEFORE SKIN CLOSURE

• SPECIAL ELASTIC COMPRESSION BANDAGING TECHNIQUE TO PREVENT SWELLING AND BLEEDING. NO DRAIN!!
HERNIA SURGERY TRAINING

DONE AT THE SAME TIME, WITHOUT BEING PART OF THE FORMAL PROGRAMME UNTIL NEW FUNDER FROM 2011, JOHNSON & JOHNSON SUGGESTED THIS BE MADE EXPLICIT
FILARICELE SURGERY
FILARICELE SURGERY CONTD

RESECTION OF TUNICA
RESULT

Bandaging Step 5: Having taped the end of the crepe suspend the bandaged scrotum with a tape that goes from one side via the apex to the other side.
ACHIEVEMENTS through Aug. 2012

29 workshops in 12 African Countries: Burkina Faso, Gambia, Ghana, Liberia, Mali, Malawi, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Togo

469 people trained

3975 patients operated by trainers and trainees together
Resources

1. LF Hydrocele MANUAL, Revised 2007. English and French at www.hdi.no


3. Report on 1,128 hydrocelectomies, average follow-up 8.6 years:

NEEDS FOR THE FUTURE

• EXTEND TO EAST AFRICA AND ASIA

• GET LF SURGERY INCLUDED IN ROUTINE MEDICAL TRAINING IN ENDEMIC COUNTRIES

• CAPACITY BUILDING ON RECONSTRUCTIVE SURGERY FOR GENITAL LYMPHOEDEMA

• FUNDING MAINLY BY JOHNSON & JOHNSON THROUGH INT’L VOLUNTEERS IN UROLOGY (ivumed.org)
Needs for the FUTURE cont’d

1. MORE FILARICELE SURGERIES NEEDED
   25% - 40% (- 70%) of adult males have filaricele in highly endemic areas

2. RECONSTRUCTIVE SURGERIES
   Requires highly expert tertiary care, skin grafting

3. HERNIA PATIENTS NEED SURGERY TOO

4. ONGOING REPORTING AND EVALUATION OF LF SURGERIES IN ALL COUNTRIES

5. TRAINING OF MORE DOCTORS

6. MORE PUBLICATIONS ON FILARICELE SURGERY AND GENITAL RECONSTRUCTION
THANK YOU.