

Integrating LF MMDP Activities into National Public Health Systems: Experiences Towards Universal Health Coverage

Session Date: Saturday, October 27

Session Time: 1:00pm – 4:00pm

Session Location: Maurepas, 3rd Floor

Session Description: Globally, significant progress has been made in the interruption of lymphatic filariasis (LF) transmission. Morbidity management and disability preventions (MMDP) activities in LF endemic countries are starting to pick up. As countries broaden their LF elimination efforts, there is an important opportunity to capture experiences from ongoing interventions aimed at integrating LF MMDP activities into public health systems for universal health coverage and sustainability.

The aim of this session is to highlight experiences that national programs and their partners have had in integrating LF MMDP activities into the public health system in endemic countries in Africa and Asia, including challenges, obstacles, and lessons learned from Burkina Faso, India, and Nepal.

Following the presentations, audience members will be invited to share their experiences in LF integration and discuss operational research gaps and priority needs. The panel will compile a list of essential steps to contribute to a successful integration of LF MMDP interventions into national health systems, as well as a list of research priorities

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KEY DISCUSSION POINTS

Jonathan King of the World Health Organization (WHO) set the stage for the session. Morbidity management and disability prevention (MMDP) is critical to improving the lives of people affected by LF. These services are expected to be maintained through the primary health care system, and therefore the issue of MMDP integration into primary care is critical. Further, availability of MMDP will be a critical indicator of equality to track progress towards universal health coverage (UHC). Currently, lack of data availability and reporting is a critical issue for tracking the progress of the Global Programme to Eliminate Lymphatic Filariasis (GPELF).

Suma Krishnasatry of T.D. Medical College in Kerala presented on Kerala's experience integrating services into primary care services. The local government of Kerala has set an objective of

ensuring availability of the recommended minimum package of care in all implementation units (IUs) by 2020. In order to achieve this, Kerala has been holding MMDP workshops attended by clinicians and nurses based on the WHO MMDP workshop. Over 3 to 4 days, the workshop focuses on the clinical and programmatic aspects of MMDP care and involves group work to create a proposal to develop an MMDP clinic in their setting. As a result, 184 participants have been trained across six workshops (June 2017-May 2018). Subsequently, the training participants have had the confidence to initiate MMDP activities, resulting in 82 new clinics being established within existing health system infrastructure across 14 districts. She shared several key lessons learned, including: the existence of gaps in provider knowledge of MMDP prior to workshop; the power of the MMDP workshop to motivate clinicians to the need and utility for MMDP services; and the importance of local governmental funding to support services. She recognized the need for burden assessments to localize patients, improving access to available services, achieving 100% geographic coverage, scaling-up of MMDP services to other endemic states, and the inclusion of LF MMDP into India's UHC package of care.

Pradip Rimal shared his experiences from the Nepal National LF Elimination Programme with integrating MMDP services into the national health system. MMDP activities were initiated in 2016. First, morbidity mapping was undertaken using the existing health infrastructure and an extensive network of female community health workers. Nepal is in the process of conducting a house-to-house survey, supported by mHealth tools, to collect morbidity information from 72 districts; mapping is expected to be completed over the next three years. Hospitals at various levels (central, regional, zonal, and district) are provided annual hydrocele surgery targets and more than 7,337 surgeries have been completed between 2016 and 2018; impact assessments in select hospitals have shown an increase in patient quality of life post-surgery. For lymphedema care, MMDP care centers are being established in all endemic districts to provide lymphedema management care and hydrocele referral services. The integration of LF and leprosy services, including training and protocol development, provides cost-sharing opportunities. Further, patients with lymphedema and leprosy share self-help groups. Several challenges were identified, including: resource and time-intensity for conducting MMDP activities; hospitals failing to reach annual hydrocele surgery targets; and underutilization of MMDP services due to low community awareness. Various solutions were proposed including the use of an NTD morbidity database, hydrocele review meetings to improve hydrocelectomy performance and output, and improved social mobilization and community awareness activities.

Roland Bougma presented the integration of MMDP services into the national health system in Burkina Faso. He presented two main aspects of integration: the integration of MMDP clinical activities and the integration of MMDP data management into the national health management information system (HMIS). Burkina Faso integrated LF burden assessments into MDA activities and identified approximately 14,000 lymphedema and 20,000 hydrocele cases. Initially, they demonstrated the feasibility of using the health system to implement sustainable LF case management at the community level. Activities included training of health workers, community health workers, and patients; empowerment of model patients as peer educators; the provision of hygiene kits; social mobilization through collaboration with local radio stations; and the use of the FASTT package for hydrocele surgery. The reports of MMDP services are transmitted through monthly reporting forms at the health center and district level, and then through DHIS2 from the regional through national level. Several challenges were presented including the lack of a patient line listing, the need to strengthen the quality of MMDP services and health work capacity, and the mobilization of funds to support MMDP activities.

Ercilio Jive presented the experiences from Mozambique's National LF Elimination Programme with integration of MMDP services into the National Health System. Mozambique

conducted detailed morbidity mapping in nine endemic provinces using community networks, community radio stations, and health care centers. Annual hydrocele surgery targets are provided to surgical facilities based on their capacity; further, the Ministry of Health covers most salaries and consumables for surgeries. Approximately 16,433 hydrocele surgeries were performed between 2016 and 2018. Integrated morbidity supervision has demonstrated an improvement in patient quality of life following hydrocele surgery. Lymphedema management services have been provided in health care centres since 2006. Support and maintenance of lymphedema management care is managed in the community frequently by self-care groups, which were started by NGO support but have subsequently become autonomous. Data reporting for LF MMDP services have been integrated into DHIS2 reporting. After registration into the system, hydrocele cases are referred to a health center for surgical care, while lymphedema patients are referred to a self-care group. Several key challenges were identified, mainly: health center mapping to identify costs and wait times, limited care seeking of lymphedema patients, needed support for surgical wards to continue providing hydrocele care, and the need for targets that are adapted based upon province capacities.

KNOWLEDGE GAPS IDENTIFIED

- Detailed community-level and sex-disaggregated data should be collected to understand the disease burden and direct sufficient resources and services to provide MMDP care.
- Reporting systems and tools to facilitate data reporting from local level to central level
- How to sustain long-term care into health systems in the absence of ongoing LF program or external funding sources?
- How can the inclusion of MMDP data collection in country-level health management information systems, such as DHIS2, play into the broader integration of MMDP into health systems? What are the challenges with integration or examples of success?
- How can people affected by chronic lymphedema develop essential community-based support networks around them?
- How can complex case management (e.g., advanced stage/grade lymphedema or hydrocele or patients with comorbidities) be integrated into the health services?

RECOMMENDED NEXT STEPS

- There is an urgent need to improve the collection and reporting of MMDP data, including sex-disaggregated and district-level data. Data should also include psychosocial risk factors and aspects of care.
- Case studies with examples and lessons learned from successful integration of MMDP into health care services from various countries/regions should be created and disseminated.
- Determine the barriers to patients' access to MMDP services when services are available in the implementation unit.
- Examine in which countries and through which means countries are financing LF MMDP.
- Explore how LF MMDP training is incorporated into pre-service curriculum and if that knowledge is translated into quality patient care.
- Compare different service-delivery methods to determine sustainable pathways to UHC.
- Determine which service delivery strategies (e.g., patient-centered, community-centered, and mental-health focused) lead to the best long-term patient adherence.
- Explore the role of self-care groups in the long-term care of lymphedema patients, experiences, and lessons learned.
- Document which aspects of the LF MMDP minimum package of care have been included in country UHC essential care packages.
- Determine how to link community-based data collection (e.g., SMS burden estimate) and health facility MMDP data with routine reporting through HMIS systems, such as DHIS2.