

Group Guidelines

Chair: Dr. Humberto Montiel, PAHO/WHO, Costa Rica

Group 1: Financing the National PELFs: Identifying Alternatives for 2006 & Beyond—The Need for a Regional Plan & the Way Forward

Dr. Eric Ottesen, Emory University

Overview

A multi-center study to identify the cost of lymphatic filariasis (LF) programs was conducted by the Emory University Lymphatic Filariasis Support Center (LFSC), initiated by Ann Haddocks, who investigated the economics of this topic across several countries. Program managers and economists from the selected countries worked together to help shape a protocol to address the question of how one determines actual program cost. Some countries in the study used the albendazole + ivermectin treatment (the African countries), and some used albendazole + diethylcarbamazine citrate (DEC) (the Philippines, Egypt, and two countries from the Americas).

What are the program's costs?

For the Americas, results were obtained from the Dominican Republic (DOR) and Haiti, put together by health economists. The study covered two kinds of costs: “total cost”—the value of all resources used in a program, including donated items, and “program cost”—actual cash disbursements plus resources provided by national government and communities. The study covered costs in the DOR, for 2002 and 2003, and in Haiti over three years (in Leogane) and over one year (in Minot). The program cost (running cost per person treated) in the DOR dropped from US\$1.87 per person for the first year to US\$0.87 per person in the second year. In Haiti, the program cost per person treated dropped from US\$2.23 to US\$1.30 in the same area and to US\$1.10 in Milot. These program costs are high on the world scale; in some parts of Africa, for example, program

cost is just US\$0.10 to US\$0.15, or US\$0.40 at the most. India's program cost is probably the cheapest, because of economies of scale and the relative economies of the countries. In any event, the cost per person treated dropped over time, as the programs matured.

Cost assessment studies (2001–2005)

- Cost analysis (see Table 1)
 - Generic protocol (and “automated spreadsheet”)
 - Workshop with national programs finalized protocol
 - Studies undertaken in
 - Burkina Faso
 - DOR
 - Egypt
 - Ghana
 - Haiti
 - Tanzania
 - Philippines

Where do these funds come from now?

In terms of the total cost of the entire program, the private sector is responsible for a large proportion, with the government sector paying the next highest level. In terms of program costs (actual running costs), however—without the cost of drug distribution, etc.—the government is contributing the majority of funds to these programs. So the country governments are already contributing to running these programs. Figures 1 and 2 show the financing breakdown for the total costs and program costs for Burkina Faso, DOR, Egypt, the Philippines, and Tanzania.

Table 1. Total cost and program cost per person treated (albendazole + DEC)

Country	Year	MDA	Population at risk (current MDA areas)	Population treated	Program cost (\$US)	Program cost (\$US) per person treated	Total cost (\$US) per person treated	MDA coverage rate (%)
DOR	2002	1	142,000	115,411	\$216,000	1.87	3.10	83%
DOR	2003	2	333,000	250,059	\$217,000*	0.87*	1.56*	75%
Egypt	2000	1	2,088,000	1,795,553	\$2,412,000	1.37	1.80	86%
Egypt	2001	2	2,638,000	2,320,602	\$3,109,000	1.00	1.34	87%
Haiti (Leogane)	2000	1	150,000	105,750	\$236,000	2.23	n/a	71%
Haiti (Leogane)	2001	2	150,000	79,713	\$156,000	1.96	n/a	53%
Haiti (Leogane)	2002	3	150,000	121,139	\$158,000	1.30	n/a	81%
Haiti (Milot)	2002	1	126,000	100,376	\$110,000	1.10	n/a	79%
Philippines	2003	3	691,000	556,912	\$105,842	.19	0.41	81%

* Adjusted for DOR peso devaluation

Figure 1. Combined average *total funding* sources (Burkina Faso, Dominican Republic, Egypt, Philippines, and Tanzania)

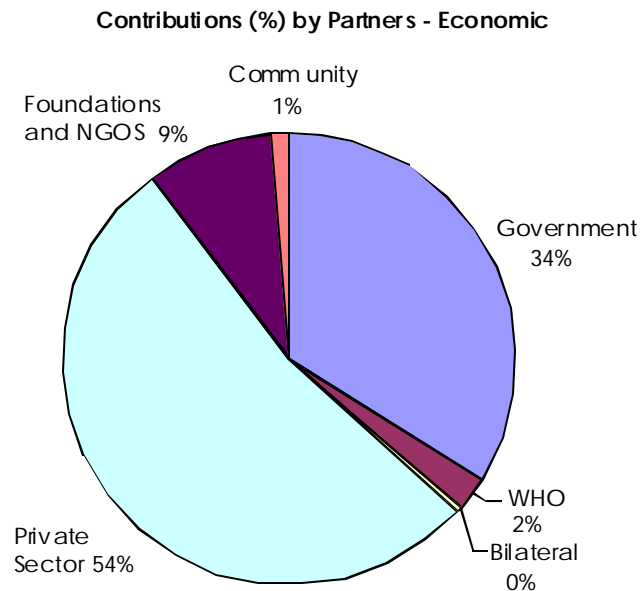
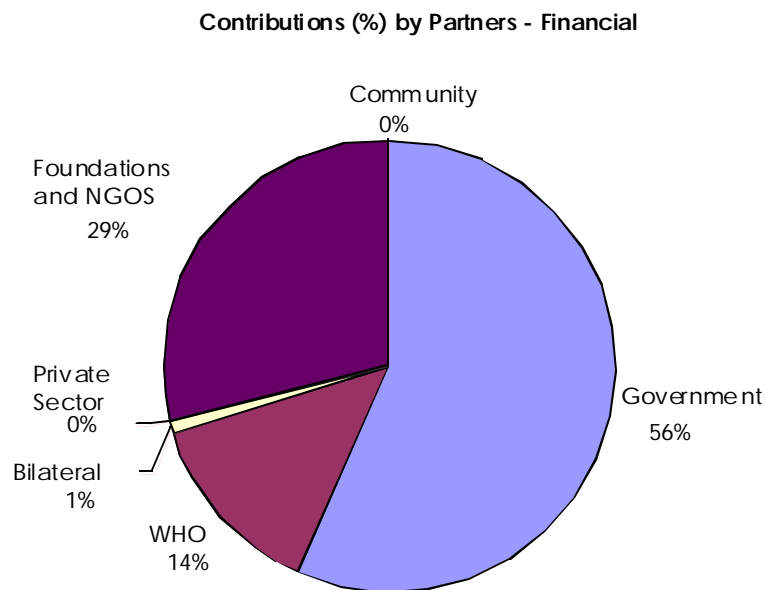


Figure 2. Combined average *program* funding sources (Burkina Faso, Dominican Republic, Egypt, Philippines, and Tanzania)



What have other countries done to find additional funds?

Using HIPC (Highly Indebted Poor Countries Initiative) [debt relief] funding, Burkina Faso, for example, has come up with US\$400,000 (see Table 2). Ghana is also using debt relief funds, as well as funds from the Catholic Medical Mission Board (for morbidity work). In Togo, program funding was linked through projects supported by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). Another option that has been used to increase funding is integration with other programs—probably the best way for the LF program to succeed in attracting the financing it needs.

What are the funding needs for each country, where can it be found (other than general development funds), and what can the Regional Program to Eliminate Lymphatic Filariasis (RPELF) do collectively—via PAHO, the RPRG, and other groups involved in fighting LF— to help obtain those funds?

Funding from the Bill & Melinda Gates Foundation (which has shifted its focus to support of basic research as opposed to implementation) may help the Americas region preferentially, because so much operational research is done here.

Table 2. Resource mobilization sources

Country	Source	Amount
Burkina Faso	HIPC Handicap International	\$400,000 ??
Ghana	HIPC / Ghana Sector-Wide Approach (SWAp) for Health Development / Catholic Medical Mission Board (CMMB)	\$200,000 \$1 million over 5 years
Tanzania	HIPC	??
United Republic of Tanzania (Zanzibar)	Izumi Foundation	\$50,000 for 1 year
Togo	GFATM	\$70,000 per year for 5 years
West African Morbidity Project	Johnson & Johnson NORAD (Norwegian Agency for Development Cooperation)	\$30,000 worth of surgical supplies/equipment \$80,000
Mekong Plus countries	Asian Development Bank (ADB)	??
PacELF (Pacific Programme to Eliminate LF)	Japan Overseas Cooperation Volunteers (JOCV); Voluntary Service Overseas (VSO)	Program staff “volunteers”

Group 2: Developing a Workplan for 2006–2007 to Advance Morbidity Control in the Americas

Facilitator: Dr. Ana Maria Aguiar, Aggeu Magalhães Research Center (Centro de Pesquisas Aggeu Magalhães; CPqAM), Fiocruz/Recife

Introduction

There is an imbalance of power between the two pillars of the program: mass drug administration (MDA) and morbidity. While the stronger part of the program, the part with financing, tries full-force to gain its objective, the other part of the program tries to survive. In theory, the morbidity program should include prevention, treatment, and relief for those already suffering or incapacitated. But the most that can be obtained, in reality, is to try to identify (map) the disabled. As identified in last year's meeting, critical problems in implementing the morbidity program include insufficient data on the number of identified cases, whether or not they are being followed up, and if so, where.

One contributing factor to the weakness of the program is the inadequate or complete absence of mandatory notification. Other factors include the lack of centralized data collection at the country, state, or city level; and difficulty in determining actual prevalence or incidence of morbidity and/or defining with any certainty the filarial etiology of identified cases, due to the lack of standard case definitions and/or appropriate mechanisms to capture them. The issue of financial resources is also an impediment to developing the regional morbidity program. At present, fewer resources are invested in the two facets of the morbidity program than in the MDA.

Challenges

Current challenges in the regional morbidity program include

- creating or identifying monitoring systems to evaluate the program of morbidity (in regard to lymphedema, e.g., a monitoring system is needed to evaluate the quality of

life of patients pre- and post-cure; access to surgery; and post-surgical follow-up)

- ensuring patient access to basic prerequisites for treatment (e.g., in the case of lymphedema, a sufficient supply of potable water and soap, for self-care, and community services to guide the family in providing home care)
- promoting the exchange of information and experiences between the professionals that deal with clinical cases
- integrating reference services to create a streamlined flow of information within the systems of higher-level care, working with community agents, and identifying the existing health system as well as clinical and specialized services in the community, for special cases (this can be difficult, particularly for cases of lymphedema, due to the lack of established protocols in regard to patient identification, follow-up, and monitoring).

Hydrocele

Because of the importance of hydrocele as a disease indicator in a particular region, training in medical and nursing schools on its proper diagnosis is crucial. More professional training in the health system was also identified as a regional need due to an insufficient number of surgeons with expertise in hydrocele surgery. There is some debate regarding proper surgical intervention, indications for surgery (regarding the size of the hydrocele, associated symptoms, etc.), and the most appropriate technique (e.g., whether or not to use the Norões technique¹). This would depend on whether there has been any standardization regarding hydrocele treatment in the country; if there have been any scientific studies on how much to follow up

¹ Technique used by Dr. Joaquin Norões of Brazil

morbidity sequels; and if there has been a good response regarding any particular technique. It must also be determined if there is sufficient identification in public hospitals regarding the conditions under which these surgeries should be performed, and if they would require special payment.

Critical program components²

Crucial components for an effective morbidity program include

- sufficient data on
 - number of identified cases (follow-up)
 - difficult because of lack of notification
 - need to centralize data (country, state, municipality)
 - knowledge of true prevalence & incidence
 - define filarial etiology
 - define mechanisms of identifying cases
 - monitoring & evaluation (use of indicators)
 - quality of life (lymphedema)
 - surgery and follow-up (hydrocele)
- improved access to treatment
 - lymphedema
 - ensure patient has clean water and soap
 - provide encouragement (family; support groups)
 - promote more sharing of information / experiences among professionals
 - build referral networks (flow chart)
 - self-care
 - Community Agents
 - existing health care services
 - specialized clinics (special cases)

- hydrocele
 - enable proper diagnosis in medical schools / nursing schools
 - conduct professional training
 - insufficient amount of trained surgeons
 - surgical intervention
 - indications for (e.g., size, symptoms, etc.)
 - standardization of surgery techniques?
 - ✓ the Norões technique (universal use? follow-up?)
 - inadequate public hospital (requires payment)
- increased integration with other programs
- improved inter-country communication
 - establishment of protocols
 - case identification
 - follow-up
 - monitoring
- stronger financial resources.

Future directions

Future actions to advance morbidity management in the Americas should

- expand case detection (surveys, use of key informants)
- stimulate case notification
- expand self-care
- expand hydrocele surgery
- stimulate integration with other local programs
- increase inter-country communication
 - exchange information on experiences
 - create regional protocol for treating patients
 - establish morbidity program indicators
 - update information regarding program development in each country.

² 5th Regional Program Managers Meeting (RPMM), Paramibo, Suriname, 2004

Group 3: Verification of Elimination of LF in Individual Foci: Task for the RPRG, or Whom?"

Facilitator: Dr. Patrick Lammie, Centers for Disease Control and Prevention (CDC)/Atlanta

Overview

Dr. Lammie noted that because of the enormous amount of experience in the area of verification of elimination on the part of the delegation from Brazil, he would serve only as a facilitator to help guide the discussion around three specific issues:

1. *Use of resources.* A large amount of resources are invested to verify that a focal point has eliminated lymphatic filariasis (LF) and that transmission has been interrupted. Those resources are being taken away from other programs. Therefore, a consistent strategy should be applied in determining verification. The determination of the required level of time and effort devoted to this will be guided by the experiences of the Brazilian Program to Eliminate Lymphatic Filariasis (PELFI). The question is "Is this [amount of effort] enough? Or is it too much?" Can these discussions be used to guide verification procedures for the next focal point? And can these same strategies be used to evaluate other initial sites in the Americas?
2. *The Americas Regional Program to Eliminate Lymphatic Filariasis (RPELFI) contribution to the Global Program to Eliminate Lymphatic Filariasis (GPELFI).* Much of the

research expertise for the Global Program resides in the Americas region, which has strong human resources with tremendous expertise and the use of new laboratory tools and epidemiological approaches, including mapping and surveillance techniques. A research plan that mirrors the action plan described by Group 2 is needed. Based on the work done in Salvador, or Maceió, or La Tortue, or some of these other settings, what kind of surveillance is appropriate after mass drug administration (MDA) has stopped? What type of surveillance is necessary in a situation where a focus is extinct? Can recommendations be developed from this region to guide the Global Program?

3. *Regional Program Review Group (RPRG) jurisdiction.* The third issue is almost a procedural question: Should verification be a topic in the domain of the RPRG? The answer is "Yes." But it must be defined. How will this process take place? How should a set of guidelines that can be administered uniformly be devised? How can a process be devised that will be acceptable to LF colleagues in other regions of the world? This is another opportunity to help define some of these issues for the Global Program.