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THE ALL PARTY PARLIAMENTARY GROUP ON MALARIA & NEGLECTED TROPICAL DISEASES (APPG)

LEAVING NO ONE BEHIND: INCLUSION, INTEGRATION, SUSTAINABILITY, HEALTH SYSTEMS, NTDS & MALARIA PROGRAMMES

TUESDAY, 16TH· OCTOBER · 2018

UKaid

COUNTDOWN

Calling time on Neglected Tropical Diseases

From L-R: *Dr Louise Kelly-Hope, Mr Karsor Kollie, Professor Sally Theobald, Jeremy Lefroy MP, Dr Luret Lar, Mr Okefu Oyale Okoko*

ACKNOWLEDGEMENTS

A wonderful appreciation to all our panellists – Karsor Kollie (Liberia Ministry of Health), Luret Lar (Sightsavers Nigeria), Okefu Oyale Okoko (Nigeria Federal Ministry of Health), Dr Louise Kelly-Hope (Centre for Neglected Tropical Diseases, LSTM) and Professor Sally Theobald for steering the engaging informed discussions.

We deeply appreciate Joan Fahy of Liverpool School of Tropical Medicine's Neglected Tropical Diseases (LSTM NTDs) department for putting the COUNTDOWN programme and the Centre for Neglected Tropical Diseases in touch with the APPG on Malaria & NTDs, thereby making this meeting happen.

We also wish to extend tremendous gratitude to the following members of parliament and peers for making time to join the discussions: Jeremy Lefroy MP for chairing the meeting so adeptly, Lord Alexander John 'Sandy' Trees, Louise Ellman MP, Stephen Twigg MP, Catherine West MP, Kate Osamor MP and Paul Williams MP. Grateful to Tamar Ghosh of RSTMH for attending the panel discussions.

Great thanks to Nicole Vecchio for organising this meeting and resolving our technical difficulties with the presentations at Portcullis House.

Many thanks to the team from Liverpool School of Tropical Medicine and Sightsavers who worked to realise this meeting. Many thanks to our partners' partners for coming out to show support – AIM Initiative, SCI Control, Sightsavers among others as this list is not exhaustive.

INTRODUCTION

This meeting took place in the Wilson Room at Portcullis House, House of Commons on Tuesday, 16th October 2018 between 18:00 – 20:00. Jeremy Lefroy, MP (Member of Parliament) who is Chair of the APPG on Malaria & Neglected Tropical Diseases (NTDs) introduced Professor Sally Theobald who led the session. Notable attendees included the APPG Vice Chair – Catherine West, Labour MP for Hornsey & Wood Green; Stephen Twigg, Labour MP for West Derby in Liverpool, Dame Louise Ellman, Labour Cooperative politician and MP for Liverpool's Riverside, Lord Alexander John Trees - former Dean of the Faculty of Veterinary Science at University of Liverpool, Lord Ian McColl of Dulwich and Tamar Ghosh, Chief Executive from the Royal Society of Tropical Medicine and Hygiene.

Other guests included, Anna Wickenden Global Director from the AIM Initiative, Aparna Barua Adams, Project Manager from the International Coalition for Trachoma Control and representatives from the Wellcome Trust (Diogo Martins), GSK and Crown Agents.

First right – Jeremy Lefroy MP **L-R:** Stephen Twigg MP, Aparna Barua - ICTC

In her opening statement, Professor Theobald highlighted the just concluded Health Systems Research Conference that took place in Liverpool and discussions from there around community health systems, multisectoral action and leaving no-one behind. She urged all to link debates from #HSR2018 to NTDs; and the critical importance of NTDs to universal health coverage and the Sustainable Development Goals.

Attendees learned that the Global Symposium on Health Systems Research is a global community of researchers, policymakers, civil society representatives and health practitioners. The conference attracted 2400 delegates from 146 countries with 52% coming from low middle-income countries (LMICs). The conference's hashtag #HSR2018 was used over 6million times throughout the course of the conference, It was timely to hold the conference in 2018, celebrating both the 40th anniversary of the Alma Ata Conference and the 40th anniversary of the UK's National Health Service.

Mr Kollie, Centre

Mr Karsor Kollie, the NTD Country Director & the COUNTDOWN Programme's lead for Liberia kickstarted the presentations with '*Health system Strengthening through integrated case management of Neglected Tropical Diseases in Liberia*'. The audience learnt of the challenges faced in integrating services such as rough terrain, vertical programmes not responding to health needs due to donor restrictions and capacity strengthening. All of this made more challenging with hard to reach communities and poor infrastructure. Though standardising what truly constituted integration was difficult, it was acknowledged that there were cross-cutting areas where interventions could be provided such as integrating treatment and continuously reviewing and expanding interventions to extend access. The key lesson from integration was – health systems cannot be sustained if the government does not take ownership. Mr Kollie emphasised that though many partners support Liberia, sustainability will remain an issue if local/in-country capacity is not improved.

Dr Louise Kelly-Hope who leads the Monitoring & Evaluation Operational Research at the Centre for Neglected Tropical Diseases (CNTD) at the Liverpool School of Tropical Medicine focused on Lymphatic Filariasis (LF), a leading cause of disabilities around the world. The audience saw the two types of disabilities caused by LF such as lymphoedema and hydrocele. Lymphoedema patients require mostly home care and improvement in hygiene practices such as using soap to wash their affected limbs, and for hydrocele patients, surgery offers relief.

CNTD, the audience learned, uses the Global Programme to Eliminate Lymphatic Filariasis (GPELF) Strategic Framework to guide activities including the use of innovative SMS data collection tool which helps to link health workers to patients. Thanks to this reporting tool, more than 27000 patients of LF have been reported across the 7 countries where CNTD works, with 19,000 health workers trained on lymphoedema

care. CNTD has worked extensively in Tanzania and Malawi from the case studies presented.

Dr Kelly-Hope in conclusion said harnessing existing health worker structures and the use of an innovative tool could help community programmes.

Mr Okoko Centre

Mr Okefu Oyale Okoko, the Assistant Director/Head, Integrated Vector Management Branch, for the National Malaria Elimination Programme (NMEP) at the Nigeria Federal Ministry of Health enlightened the audience on 'Health Systems for all: Cross-learning from the NTD Programme to the Malaria Programme' exploring the Nigeria experience. Nigeria carries around 25% of the world's burden of NTDs and whilst more still needs to be done to achieve the goal of reducing malaria deaths to zero, some gains are becoming evident. Malaria cases in Nigeria have reduced from 42% in 2010 to 27% in 2015 thanks to support from international partners and donors. However, inadequate access to health care persists.

Nigeria has a coordination framework that helps with programme planning and implementation. The Malaria Programme operates based on 6 technical branches which include: Case Management, Integrated Vector Management, Advocacy, Communication & Social Mobilisation, Monitoring & Evaluation, Programme Management, Procurement & Supply Chain Management.

Both the NTDs and Malaria programmes have managed to get partner support including funding contribution from the Federal and state governments. However, a huge funding gap remains, especially for malaria where 13 out of 37 states are still not supported. the

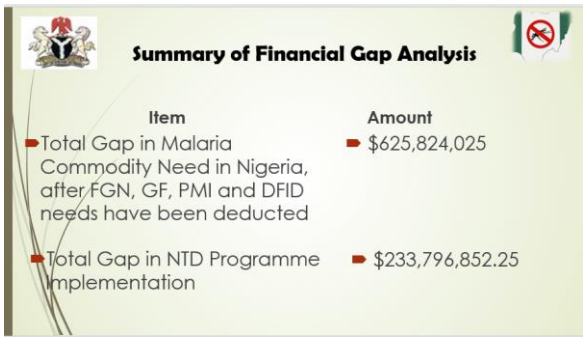

Figure above from Okoko's presentation illustrates the financial gap for both programmes, with malaria needing almost thrice the funding compared to the NTDs programme.

Dr Luret Lar Centre

Dr Luret Lar tackled the issue of 'Maximising community engagement in Nigeria: Participation as a research and implementation strategy'. Dr Lar emphasises community engagement is key, and this was core to the participatory research process undertaken by COUNTDOWN partners - Sightsavers in Kaduna in the North West of Nigeria and Ogun in the South West. A situational analysis explored community ideals of an NTD programme. A 'transect walk' through the community was used to interrogate the different structures available and how they could be used (or better used) to improve programme delivery. Community-based drug distributors and their communities wanted health information translated into their local languages.

To conclude, Dr Lar said participatory research processes can support the 'leaving no-one behind agenda' and better understand the experiences, barriers and challenges faced by migrant communities and peripheral areas. Early involvement and communication with stakeholders is critical to successful community engagement.

Panel Discussions: Reflections on key emerging themes.

Led by Professor Theobald, discussions from the panellists were encouraged to discuss mechanisms from their various countries to support co-implementation, multisectoral action and strategic partnership with the private sector.

Mr Okoko highlighted that in Nigeria., there are plans by the government to subsidize malaria treatment in the private sector. The federal government will use 1% of internally generated funds from the private sector to fund health sector interventions which will boost local mobilization of resources. For this reason, key persons in the private sector need to be encouraged to bring their colleagues on board.

He added that sectors like Environment, Defence and Education among others attended meetings which include all the stakeholders, ensuring a holistic approach is adopted with great results.

In Liberia, Mr Kollie said the private sector is part and parcel of the health care delivery system and should constitute part of the engagement.

The panel discussions segued into Q&A with the audience.

Question 1: The examples given show there is no real collaboration between programmes, as we discuss multisectoral engagement. How do you intend to tackle this?

Mr Kollie: Restrictions on how funds could be deployed from funders pose a problem as seen in the case where a patient presenting with Buruli Ulcer and lymphoedema acute attack could not be given treatment for an associated fever because the medical supplies available were slotted ONLY for the malaria programme. At the national level, very little engagement has been undertaken for the private sector to be part of the process, talk less of discussing a standard package of care required from the private sector. Challenges exist at all levels especially at integrating NTDs themselves, multisector and the health system at large.

Question 2: How do you integrate the population involved in the traditional structures within the health systems as in these systems they are still considered important.

Mr Okoko: In Nigeria, there is a lot of awareness creation, partnerships and training with traditional healers. The difficulty is when their practice is shrouded in 'secrecy'. The FMoH recently established the Traditional Medicines Department to better understand their practice and standardise approaches.

Question 3 from Dr Hema Sharma – a Global Health physician at the Royal Free London NHS Foundation Trust and a Consultant on Infectious Disease with GSK directed at Dr Louise Kelly-Hope. How did the community workers implement the care after training?

Dr Kelly-Hope: There is periodical follow-ups with patients mostly home-based care and sometimes surveillance carers have up to 5 patients.

Comment: At this juncture, Aparna Barua, Project Manager from the International Coalition for Trachoma Control announced that an WASH-NTD toolkit which is being developed by WHO and the NNN (NTD NGO Network). The NNN has a series of working groups and it is the NNN WASH Working Group that has been working to develop this new tool. It will be launched by the end of this year and will be publicised by the NNN through social media channels. This NTD & WASH Toolkit will prove handy for the MoHs in mobilising shared resources, human finances among others. So, watch this space.

Comment: A member of the audience, working on malaria highlighted the difficulty in getting data to properly address the needs of programmes especially with respect to engaging the private sector. Mr Okoko remarked that the important thing is to get this

group on board and sensitize them on plans by the programme including where they come in. In Nigeria, he cited that the Medical and Dental Council of Nigeria where most private sector practitioners get their licences could regulate their activities. Data quality assessments (DQAs) are carried out periodically to interrogate data originating from lower levels before they are aggregated at the national level. We are not where we want to be yet but there have been a lot of improvement, Mr Okoko emphasised.

Mr Kollie: There is a need to set a standard of health service delivery package for the private sector and set up a monitoring & evaluation as a check and balance in the Liberian health care delivery system

Dr Lar: In Nigeria, there is data which is of poor quality and often paper-based. But with the world going paperless, e-toolkits are emerging which are gradually responding to this data need.

Dr Louise Kelly-Hope: Reporting systems are needed. Having data reported to the central level gives policymakers a clear picture which incentivises the requested change.

Question 4: Shodigul Alimshoeva from Crown Agents. How has data collection been integrated into the government systems and how do they use it to provide information on disease burden? Is this integrated into the Health Management Information System (HMIS) system?

Mr Kollie: There is a community department in the Ministry of Health (MoH) of Liberia in charge of community health which facilitates integration and provision of services at the community level.

Liberia trains Community Health Assistants (CHA) to be able to identify, provide basic management and report diseases and conditions in the communities beyond five kilometres from the nearest health facility. They collect data and this information then goes to the county level health offices before reaching the HIM system.

Liberia is also developing plans for the community health volunteers to provide community health services within the perimeter of each health facility. The key challenge for all the community health interventions is the risk to sustainability due to partners withdrawal when the funds dry off.

The community health volunteers routinely identify cases based on pictorials and do not diagnose. What this does is, it helps the health practitioners to use their clinical judgement to do clinical confirmation and provide further care and support.

Question 5 & 6: To the FMoH (Mr Okoko) Rurality and poverty is still leading to deaths from malaria in Nigeria how will this be addressed?

(From Diogo Martins, Wellcome Trust Senior Policy Officer) What is the experience on designing programmes for the disadvantaged and how is social justice supported?

Dr Kelly-Hope: We must do it together and find ways to link, find solutions with WASH (Water, Sanitation & Hygiene), find practical solutions on a case by case basis.

Mr Okoko: A lot is happening which is not evident. The FMoH deploys different approaches to different areas. In the North of Nigeria, there is now door-to-door visits to personalise health messaging using Interpersonal Communicators (IPCs) and for the past two months Nigeria has been carrying out a demographic health survey which should provide a better understanding on current situation. One thing to note is that, no one sector has absolute monopoly on health interventions.

Mr Kollie: If you are a decision maker, you might need to prioritise all the people in poor health and include all those that need help. Can we engage with community health as it is the bedrock of access, build capacity of the in-country team to ensure sustainability and can funders and donors be flexible when giving funds to countries so that there is flexibility in moving available resources to areas where they are most needed?

Dr Lar: We must not ignore voices from the communities which are key in achieving the Alma Ata Universal health care declaration. Involve them.

Professor Theobald concluded the discussions and the APPG Chair, Jeremy Lefroy MP gave closing remarks by thanking the panellists for participating in the session and the audience for their engagement.