International Meeting on Integration of Onchocerciasis Control into National Health Systems and Co-implementation of Neglected Tropical Diseases (NTDs) and some components of Malaria Control.

Addis Ababa 25-27 June 2008
Opening Session

1. The first follow-up International Meeting on Integration of Onchocerciasis Control into National Health Systems and Co-implementation of Neglected Tropical Diseases (NTDs), and some components of Malaria Control took place at the Hilton Hotel, Addis Ababa, Ethiopia, from 25-27 June 2008. The meeting, a follow-up to one held in Brazzaville, Congo in February 2007, was held at the kind invitation of the Federal Democratic Republic of Ethiopia, and jointly hosted by the Ministry of Health, WHO Country Office, WHO/AFRO (ATM/OTD) and APOC. The meeting was attended by top-level policy and decision-makers on health from six countries - Ghana, Nigeria, Sierra Leone, Tanzania, Uganda and the host country Ethiopia - WHO Africa Region, as well as representatives of donors, Non-Governmental Development Organizations (NGDOs) and other health system support groups. These included Directors of Disease Control and Public Health, Programme Managers of Onchocerciasis and Malaria control, as well as representatives of the USAID, the Carter Center, Liverpool School of Tropical Medicine, Sight Savers International and Christoff Blinden Mission (CBM).

2. The Ethiopian Minister of State for Health, Dr Shiferaw Teklemariam, officially opened the meeting, with WHO Country Representative Dr Fatoumata Nafo-Traore in attendance. The Minister welcomed the participants and expressed Ethiopia’s pleasure at hosting the meeting, which he described as an opportunity for Ethiopia to share with other countries its experiences on integration of community-directed interventions into the national health system as well as co-implementation of some NTDs with malaria, using the Health Extension Workers programme. Dr Shiferaw said that NTDs, as symptoms of poverty and disadvantage, had acquired a bad reputation as disabling and deforming diseases afflicting about one billion people or one-sixth of the world’s population. The Minister called on stakeholders to move beyond declarations, to the implementation of various decisions to empower communities and strengthen health systems, toward the achievement of the health Millennium Development Goals (MDGs). He described Onchocerciasis control as an “ongoing success story from which we need to draw lessons badly needed to successfully deal with the other neglected tropical diseases and control of malaria”. According to the Minister, APOC’s Community-Directed Treatment with Ivermectin (CDTI), also known as community-directed intervention (CDI) strategy “has to be followed to ensure that the other neglected tropical diseases are no more neglected.”

3. In her address, the WHO Country Representative in Ethiopia, Dr Nafo-Traore, stressed that addressing NTDs appropriately, should be an essential element of poverty reduction programmes. She underscored the need for increased international commitment and initiatives to improve the status and health security of the world’s population, especially in Africa, noting that integration and co-implementation of compatible health interventions would improve coverage, bring equity to health service delivery and ultimately improve the socio-economic situation of nations.
4. Professor Adenike Abiose, Chair of APOC’s Technical Consultative Committee (TCC), recalled the World Health Assembly resolution 47.32 of 1994, which requested WHO member States to take advantage of the community-directed strategy to strengthen primary health care, noting that APOC had continued to encourage countries to co-implement onchocerciasis control with other disease control interventions.

5. Welcoming participants, APOC Director, Dr Uche Amazigo, said that Africa, relative to its size and population, bore the greatest burden (about 90%) of NTDs and malaria. This situation, she said, required the doubling of efforts by stakeholders and the adoption of strategies that would facilitate the delivery of health services through multiple interventions. Dr Amazigo thanked the Government of the Federal Democratic Republic of Ethiopia for accepting to host the meeting and to share with other countries the Ethiopian integration approach commended by APOC partners as one of the best examples of integrated health delivery services.

6. Professor Mamoun Homeida, who chaired the session after the opening ceremony, welcomed participants and set the tone for the deliberations by reminding the attendees that the meeting would be judged not only by the quality of recommendations but especially follow-up actions on implementation.

**Agenda**

The agenda of the meeting was modified to include a field visit to communities implementing integrated approach of health service delivery.

**Objectives/Expected Outcomes of the meeting**

7. Dr J. Namboze outlined the four objectives and expected outcomes of the meeting as follows:

**Objectives:**

- To update participants on the recommendations of the last international conference on Primary Health Care and health systems in Africa and share experiences on CDI
  - To review the status of implementation of recommendations made during the Brazzaville February 2007 meeting
  - To inform participants about the current strategic direction for co-implementation of NTDs and malaria control towards achieving the health MDGs
  - To disseminate the findings of research on community-directed interventions and promote the use of community-directed approaches for malaria, neglected tropical diseases (NTDs) and other control programmes including co-financing mechanisms
Expected Outcomes:

- Participants to agree on how to implement the Ouagadougou Declaration on PHC; the use of community-directed approaches to set up sustainable mechanisms within the health systems, and increased access to essential medicines, commodities and services
- To document the achievements and challenges of co-implementation and extract lessons learnt for greater involvement of communities in health care delivery
- Countries will be informed about the current global strategic direction on NTDs and malaria control to enable them harmonize activities in the country strategic plans
- Participants to have a better understanding of integrated community-directed interventions for the control of malaria, NTDs and other diseases, and existing financing mechanisms for co-implementation
- Country strategic plans for up-scaling integration and co-implementation of multiple health interventions to incorporate community-directed strategies

Method of Work:

- Update participants on the Ouagadougou Conference on PHC and the Bill & Melinda Gates Foundation meeting in Seattle.
- Country presentations
- Round table discussions
- Group work

Ouagadougou Declaration by the International Conference on PHC

8. The meeting was briefed by Dr G. Fobi on the outcome of the international conference on Public Health Care (PHC) and health systems in Africa, held in Burkina Faso, 28-30 April 2008. She outlined the Ouagadougou Declaration, which stressed the importance of CDI and the implications of the Declaration for integration of disease control programmes into broader health systems in Africa.
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Co-implementation of multiple health interventions – benefits and challenges

9. In her presentation, Dr Ngozi Njepoume gave an overview of Nigeria’s experience on integration and co-implementation. She defined co-implementation as the creation of linkages among existing programmes, for the purpose of improving delivery of interventions within the resources available to the programmes concerned. She noted that, co-implementation can streamline implementation, resulting in improved outcomes of health interventions in a community-based setting using the CDI strategy. To achieve this requires commitment at the highest political level.

Dr Njepoume noted that The Carter Center, in collaboration with the RBM (Roll Back Malaria Project of the Federal Ministry of Health (FMoH), successfully integrated the Lymphatic Filariasis (LF) elimination programme with malaria intervention in 2 States of Nigeria (Plateau and Nasarawa). Also, the APOC supported CDI study in Oyo, Kaduna and Taraba States for co-implementation of five interventions - ivermectin treatment, Vitamin A supplementation, ITN distribution, DOTs and Home-management of malaria - has demonstrated the potential benefits and the challenges in the co-implementation of health interventions.

Benefits of co-implementation include:

- LF elimination, Onchocerciasis control, improved nutrition and immunity to measles attack, treatment of TB, prevention of malaria in the vulnerable, control of soil-transmitted helminths (STH)
- Community empowerment for control and ownership of their health
- Ensures Health Care delivery to the poor, remote and needy communities
- Promotes the highest level of community participation (Citizen control)
- Builds trust and partnership between communities and Health Care system, thus promoting acceptance and sustainability of intervention

In discussions that followed the two presentations, participants raised the question of why the Alma-Ata Declaration failed. It was noted that there was a decline in health financing and that health interventions became vertically managed because they were donor or disease driven instead of being people driven.

Furthermore, while Alma-Ata defined the path for PHC, CDI as a new model underscored by the Ouagadougou Declaration shows how to do what needs to be done. Participants outlined the challenges and opportunities associated with the implementation of the CDI strategy. It was agreed that for CDI to succeed as a powerful tool in the revitalization of PHC and to strengthen health systems, there should be policy change, strong political will and mobilization of resources at national and international levels. Other crucial factors include proper coordination to ensure access to universal health, availability and equitable distribution of commodities and proper logistics. There should also be a strategic plan for sensitization of countries to ensure sustainable implementation of the Ouagadougou Declaration.
Community-Directed Interventions (CDI): Process of implementation

10. The presenter Dr Elizabeth Elhassan defined Community-directed intervention as a health intervention that is undertaken at the community level under the direction of the community itself. It involves empowering communities to build partnerships with health system support groups, with the communities as the most important partners. As an example, community involvement led to the treatment of 54 million poor people with Mectizan® in 16 APOC countries in 2007.

The main steps in the CDI Process

- Advocacy/planning meetings with stakeholders
- Training/retraining of health workers - district/fronline health staff, Community Directed Distributors (CDDs) and the community members
- Health staff hold introductory meetings with community leaders
- Planning meetings with the entire community:
  - community decides how to implement
  - community selects implementers
- Community implementation of interventions
- Community reports back to the health system
- Sustained adequate supply of commodities
- Monitoring and supervision by health staff, community self-monitoring
- Reporting at all levels

The presentation also outlined key issues on CDI, which include allowing community members to collectively decide:

- whether they want the commodities/drugs
- how to collect the drugs
- when the drugs will be distributed
- how they will be distributed
- who will be responsible for the distribution and record keeping
- how to monitor the process

Essentials for scaling up implementation using the CDI strategy include development of policies, advocacy sensitization, health education and mobilization, capacity building on CDI, programme management, supply of commodities as well as finance and resource mobilization at all levels for programme activities.
Country Presentations: Follow-up of recommendations of the Brazzaville meeting in February 2007: Achievements and challenges of co-implementation and integration of onchocerciasis activities and other health interventions into the health system

11. There were presentations on Nigeria, Ghana, Sierra Leone, Tanzania, Uganda and the host country Ethiopia, on the implementation of the Brazzaville recommendations and how the governments, control programmes and health partners were integrating management of NTDs into health systems and co-implementing components of malaria control.

Nigeria

This presentation explained that a National Policy is in place in Nigeria and a national working plan is near completion on the integration of NTDs into the national health system. An NTD unit has been established at the Federal Ministry of Health with the Government allocating 50 million naira for NTDs (about 118 naira=1US$). Mapping for some NTDs had been undertaken while Nigeria and Benin are collaborating on onchocerciasis control activities.

Ethiopia

The Ethiopia presentation noted that an integration and co-implementation system was already in place and working effectively with the Health Extension Workers (HEWs) as the fulcrum.

- Malaria has long been recognized as the major public health problem and its control efforts in Ethiopia date back to the 1950s when the Ministry of Health in collaboration with partners such WHO, UNICEF and USAID, launched a control programme.
- Ethiopia has undertaken massive scaling-up of key malaria interventions, including the provision of anti-malaria drugs and rapid diagnostic tests to community health posts and ITNs to households.
  Through enhanced utilization of the interventions (ITN, IRS, case management), the country strives to enter the pre-elimination phase in the coming three to five years.

- The integrated malaria and onchocerciasis control programme (MALONCHO) and the integrated malaria and trachoma control programme (MALTRA) have been launched in affected regions of the country for the integration and co-implementation of interventions.
Uganda

Malaria accounts for 26% of the Burden of Disease in Uganda (BOD Uganda 1995), and is responsible for:

- One in every 3 persons attending Out Patients Departments (33%)
- One in every 4 persons admitted in hospitals (25%)
- One in every 5 child deaths in hospital (20%)
- 70,000 – 120,000 child deaths in a year or 320 deaths every day
- Severe anaemia in children/pregnancy resulting in abortions, low birth weight
- Severe economic losses, lost school days, low economic productivity, long term disability.

To scale-up malaria control through co-implementation with other health interventions, the government launched the Home Based Management of Fever (HBMF) strategy, with the objective of reducing the morbidity and mortality from the disease. The Uganda Health Sector Strategic Plan (HSSP) 2005-2010, seeks to increase to 85% the proportion of the population that receives effective treatment for malaria within 24 hours of the onset of symptoms. Efforts at integration and co-implementation of NTDs and malaria are being pursued under a National Plan for integrated Control of Neglected Tropical Diseases. Common NTDs in Uganda are: lymphatic filariasis (LF), onchocerciasis, dracunculiasis (guinea-worm), schistosomiasis, soil-transmitted helminthiasis (STH), trachoma, human African trypanosomiasis, Buruli ulcer, leishmaniasis and leprosy. Diseases identified as feasible to integrate due to their primary focus of Mass Drug Administration (MDA) campaigns are LF, schistosomiasis and STH, onchocerciasis and trachoma.

Challenges faced by integrated control of NTDs in Uganda include:

- Lack of resources for all programmes as of 2007/8
- Inadequate implementation at all stages – social mobilisation, training, distribution, monitoring and evaluation
- Insecurity: Some districts are permanently insecure e.g. Abim, Kaabong, Kotido, Moroto and Nakapiripirit, and require special arrangements for trainers, supervisors, escorts

Sierra Leone

The presenter explained that Sierra Leone was making some progress on the integration of community-directed interventions into the national health system under a five-year plan of action for integrated control of five NTDs – onchocerciasis, lymphatic filariasis, schistosomiasis, soil transmitted helminthiasis and trachoma. A coalition has been formed with health partners for the integrated management of the five NTDs. The country has established acceptance of CDTI/CDI by district health workers; successful integration of the strategy into PHC system within three years, mapping for LF and a pilot survey for schistosomiasis/STH in one district, as well as the attainment of three years funding for integrated control of five NTDs. Challenges to integration and co-implementation include advocacy for a national policy on NTDs and persuading the Ministry of Health to replace onchocerciasis with NTDs in its budget. There is also a demand by CDDs for incentives in some areas, and this is expected to increase with integrated management of many diseases.
Tanzania
The presentation on Tanzania showed that Onchocerciasis control using the CDTI strategy was being used as an Entry Point for other Health Service Delivery. These include distribution of bed nets for the control of malaria, LF integration into CDTI in 3 Districts, and Eye care activities. The country has developed a draft policy guideline for co-implementation of NTDs and advocacy to programme personnel has been undertaken, while Monitoring and Surveillance of NTDs have been strengthened.

Ghana
The NTD Control programme was initiated in Ghana in 2006 and actual implementation started in 2007. It involves onchocerciasis, LF, STH, and trachoma. The five-year programme of work of the Ghana Health Service demonstrates government’s commitment to the control of NTDs as a major strategy for achieving health for all goal in the country. While integration and co-implementation of onchocerciasis into the health system is on course, co-implementation with malaria control needs more commitment.

12. The discussions that followed the presentations centred on some success stories, lessons learnt, weaknesses and challenges faced by the integration and co-implementation processes in countries and the way forward. The strong mutually beneficial relationship between malaria and NTDs was underscored as being critical to the success of programme integration and co-implementation. To fast-track implementation of the Brazzaville initiative it was agreed that reports of the Addis Ababa meeting and subsequent ones should be shared with other NTD and malaria endemic countries. WHO/APOC should also invite all eligible countries to subsequent meetings and the level of advocacy and partnership should be stepped up. Given their crucial role in the CDI strategy as a means for facilitating integration and co-implementation of multiple health interventions, the meeting agreed that community leaders could be invited to subsequent meetings on these subjects. Participants stressed that the weak linkage between Research Institutions and disease control programmes should be addressed and research findings incorporated in policy and ultimately into practice. NGDOs should be congratulated and recognized for their efforts in promoting co-implementation of NTDs with malaria control.

Summary and recommendations to APOC, WHO, NGDO and other partners

13. In the summary of achievements by countries and challenges, the issue of leadership and harmonization of activities in co-implementation was highlighted. The meeting noted that no country has clearly shown total integration into the PHC system, although some aspects of co-implementation are ongoing. The meeting therefore urged concrete action on the following:

- Policy, strategic Plan of Action on NTDS and malaria control
- Management structure and resource mobilization
- Donors and partners should support co-implementation and show flexibility in the use of funds.
NTD Partnership: breaking down walls to meet the needs of the poorest communities

In his thought provoking presentation on Implementation of NTD control: breaking down walls to meet the needs of the poorest communities, Professor David Molyneux of the Liverpool School of Tropical Medicine, said that following growing global awareness, the issue of NTDs was returning to the international health agenda. Interventions on NTDs, which afflict the poor “bottom billion plus” were now featuring in the agendas of big players such as the Clinton Global Initiative (CGI), the US and UK governments’ announcements pledging support to NTD, the EU/US recent summit, the Carter Center and advocacy at the highest level of WHO with strong commitment of the Director General.

The presentation noted that, based on available evidence, reduction of the NTD burden was feasible and cost-effective, using currently available tools and affordable/donated drugs. It was noted that implementation of NTD control programmes, which deliver between 15 and 30 percent economic return, will also contribute to the attainment of some MDGs. The high cost of implementation of programmes for control of the “big three” diseases – HIV/AIDS, Malaria and TB – does not match the achievement of the set goals/target, compared to the relatively cheap cost of less than 0.50 US cents spent on treatment per person per year recorded by the NTD programme delivery.

USAID Financing NTDs

Dr Angela Weaver’s presentation outlined the US government’s Presidential Initiative for NTD control, involving the US $350 million announced in February 2008 for the control of NTDs in an integrated manner. She said the Presidential Initiative would build on the USAID existing integrated NTD programme, with the target of delivering treatment to 300 million people in high disease burden countries in Africa, Asia and Latin America in five years. The next step, Dr Weaver said, was the engagement of partners such as APOC for the implementation of the NTD support programmes to scale up service delivery.

Integrated Community-Directed Interventions (CDI) Research: multi-country study: results and future plans

Dr Elhassan made a presentation on the mechanism, process and outcome of the CDI multi-country multi-site study requested by APOC and supervised by the WHO-based Special Programme for Research and Training (TDR) Geneva. The study, carried out in Cameroon, Nigeria, Uganda and Tanzania, showed that when communities are empowered to take charge of health interventions, drug distribution and treatment doubled in most cases. The interventions involved in the study were ivermectin distribution for onchocerciasis treatment, Vitamin A supplementation; distribution of
insecticide-treated bed nets, home-based treatment of fevers in under-fives and the Directly Observed Treatment Short-course (DOTs) strategy for Tuberculosis.

The study demonstrated that cost-effective and impressive delivery of multiple health interventions can be achieved through the empowerment of communities using the community-directed approach. Of the five health interventions of the research only DOTs did not show marked improvement. A follow-up presentation by Dr Byamungu elaborated on the results and lessons learnt from the study using the Uganda experience. Both presentations provoked an animated discussion by participants, who noted that while the research was still at the experimental stage, follow-up actions were required. The participants also called for caution in deciding which interventions should be co-implemented. There was a consensus that, despite the poor performance of DOTs in the four-country research, this should be incorporated into subsequent studies, with efforts made to determine why it did not succeed like the other interventions in the four-country research study. The implications of the study for non-oncho endemic communities where CDI is not implemented should also be explored.

Community-Based Malaria Control: Challenges and strategic direction

17. Professor Georges Ki-Zerbo outlined the WHO/AFRO Framework for accelerated Malaria Control developed within the context of high global commitments such as the Abuja 2006 Summit, the 2007 WHO Assembly resolution on World Malaria Day, the October 2007 B&MG Forum, the UNSG call for universal coverage of malaria interventions and the Ouagadougou Declaration of the PHC conference. He noted that these commitments had implications in terms of partnerships, resource mobilization and strengthening national programmes, particularly in their capacity to integrate and decentralize service delivery at community levels.

The presentation proposed the decentralization of malaria service delivery at peripheral health facility and community levels, based on integrated district operation plans; user friendly guidelines, and regular supply of diagnostics, medicines and commodities. It also pointed out that reaching the vulnerable, rural poor would require national authorities coordinating their efforts with NGOs and civil society that have existing channels to these hard-to-reach groups. All these interventions will require logistics, planning, district management and supervision to be strengthened said Dr Ki-Zerbo, who explained that the WHO/AFRO’s strong commitment to the control of NTDs and malaria involved the establishment of administrative clusters.

Round Table session

18. The round table session on Scaling up Malaria Community-based programmes through co-implementation with other health interventions, featured presentations on the experiences of countries. This was followed by a discussion, with participants underscoring the ‘win-win’ benefits that would result from co-implementation partnerships for malaria and other health interventions, especially to communities.
Malaria should be used a rallying disease in the advocacy for integration of NTDs and co-implementations of multiple health interventions. The participants agreed that countries incorporate NTDs in their next applications to the Global Fund for integrated funding support. That way, the NTDs including oncho as well as the three major diseases - HIV/AIDS, Malaria and Tuberculosis - will leverage on the potential improvement in integrated funding to achieve deliverable outcomes that will benefit poor rural communities. The main conclusions of this session were mainly the following:

1. The issue of leadership and coordination must be clearly articulated before activities of co-implementation are embarked on. This should lead to the development of a policy and plan. Among the issues to be agreed on is the package that will need to be delivered.
2. Specific for malaria, it is important to design the integrated programmes focusing around the NTD target groups;
3. Results from the different studies should be ploughed into implementation;
4. It will be important to design a good M&E system to inform programme implementation. This should also include a good supervisory mechanism.
5. Initial mapping of the diseases is also very important so as to give the right package to the targeted populations.

Financing Co-implementation

19. APOC Director, Dr Amazigo, briefed participants on the outcome of the recent Bill & Melinda Gates Foundation meeting held in Seattle, US. A presentation from Ghana was used to illustrate the challenges facing programme managers in reporting to various donors and programmes. The meeting emphasized the need for a harmonized system of interventions to make funding easier and harmonized reporting. It was stressed that unambiguous engagement of countries, control programme managers, donors and communities would help clear the grey areas, especially for the benefit of poor, needy, hard-to-reach and disadvantaged populations.

Dr Joseph Koroma made a presentation on Sierra Leone’s Experience and Planning for Co-implementation of multiple health interventions in a post-conflict country. He explained that Sierra Leone’s 1991-2001 civil conflict adversely affected health intervention programmes in the country. Despite this, by 2005, all National Onchocerciasis Control Programme (NOCP) activities had been integrated into the National health system with the PHC system in use at all levels. With the support of partners, Sierra Leone is also co-implementing five NTD interventions including Guinea worm and LF.

The Uganda Experience presented by Dr D. Lwamafa, (Commissioner NDC, Uganda Ministry of Health) indicated that a national Plan on integration and co-implementation was in place but there were challenges, including:

- Lack of resources
- Demand for incentives by CDDs

The NTD secretariat is leading the operation and the envisaged benefits include: improved compliance by communities, partnership, improved in-country communication,
strengthening of the health system, Child Health Day plus, taking CDI to target communities, capacity building and resource mobilization.

In the discussion that followed, participants stressed the need to make malaria the rallying disease for successful integration and co-implementation of NTDs. Advocacy to strengthen partnerships between NTDs and Malaria control programmes should also be intensified. Policy change is needed at the WHO level to guide countries on the path of effective integration and co-implementation.

**Group Work**

20. The meeting split in two for group work. Group A discussed research findings on the community-directed strategy and how to promote the use of community-directed approaches for the control of malaria, NTDs and other control programmes. Group B reviewed the country strategic plans for integration and co-implementation 2008-2010: Best practices, targets, CDI expansion beyond onchocerciasis endemic areas. Specific issues addressed by the Group sessions on integration and co-implementation processes included:

- Benefits
- Challenges
- Country ownership and control
- Human resources
- Partnership
- Planning
- Mapping
- Commodities procurement and availability
- Programme Financing and resource mobilization
- Monitoring

21. In the subsequent plenary session, the meeting reviewed deliberations of the two groups. This was followed by country presentation of national strategies/plans to scale up integration of CDTI activities into health systems and co-implementation of NTDs with components of Malaria control. Subsequently, the meeting urged the countries to fine tune these national strategies/plans countries under the title of Joint plans for the integration and co-implementation of NTDs with malaria control, with emphasis on the empowerment of communities for accelerated service delivery. Capacity building should also be prioritized to strengthen national health systems toward the attainment of the health Millennium Development Goals.
Field Trip to an Ethiopia CDI Community

22. Participants undertook a field trip to the Debre Zeit community in Ethiopia’s Oromia Region, 45-kilometres east of Addis Ababa, and saw first-hand how the Health Extension Workers programme is driving the integration and co-implementation of health interventions in Ethiopia’s health system. As mentioned by the Minister of State for Health Dr Shiferaw Teklemariam in his opening address to the meeting, the field trip was an opportunity for the participants to learn from Ethiopia’s experiences on integration of community-directed interventions into the national health system and co-implementation of some NTDs with Malaria using the HEWs programme. The participants were impressed to see health centres manned by female health workers. It was also fascinating to note that the health centres used simple health tools. The health workers were very knowledgeable about the communities they served and there were up-to-date records on disease management, including charts on households visited or treated. There was also evidence of effective monitoring. The participants interviewed and interacted with community leaders, household members and health extension workers. They recommended the highly successful health care delivery system to other countries.

Closing Statements

23. In his closing remarks Dr Zerihun Tadesse, DDC Ethiopia, thanked participants for their rich deliberations. He said their quality participation had added much value to demonstrate that it was not ‘just another meeting’. He urged countries to implement the recommendations of the meeting to ensure that integration and co-implementation of NTDs with malaria control took pride of place in the national health systems. Dr Amazigo, on behalf of the APOC management and staff, expressed gratitude to the Government of Ethiopia and the Ministry of Health for hosting the meeting. She also thanked WHO/AFRO for co-financing the meeting, and donors, partners, NGDOs and other stakeholders for their sustained support. Dr Amazigo equally commended the participants for the quality of their contributions and far-reaching recommendations, noting that the meeting was part of efforts of APOC and partners to ensure that NTDs and Malaria ceased to be public health problems in Africa.

Speaking on behalf of the participants, Dr D. Lwamafa, Commissioner for Health Services, Department of National Disease Control, Ministry of Health Uganda, called for joint meetings of English and French speaking nations of Africa on the prevention and control of NTDs given that disease transmission does not respect national borders. He urged Africa to present a united front to collectively address health threats and also achieve the goal of fostering inter-country collaboration on the continent. Dr Lwamafa also thanked the Government of Ethiopia for hosting the meeting, and partners, who financed the meeting. He commended APOC management and staff for leading sustained disease control and pro-poor initiatives.
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**Date and Venue of next meeting**

24. The representative of Ghana expressed his country’s offer to host the next follow-up meeting in 2010. Details, including the actual dates will be worked out by the secretariat and communicated to participants.
Communiqué

Thirty years after the Alma-Ata Declaration there is renewed interest in the Primary Health Care (PHC) concept as the approach to strengthen the health systems and achieve the Millennium Development Goals. The opportunities offered by this renewed interest and commitment of the international community provide an opening for additional funding for integration and co-implementation of NTDs and malaria interventions to meet the needs of especially the poorest and hard-to-reach communities.

An International Meeting on Integration of Onchocerciasis Control into National Health Systems and Co-implementation of Neglected Tropical Diseases (NTDs) and some components of Malaria Control took place in Brazzaville, Congo in 2007. The first follow-up meeting was held at the Hilton Hotel, Addis Ababa, Ethiopia from 25-27 June 2008 on the kind invitation of the government of the Federal Republic of Ethiopia. The meeting was jointly hosted by the Ministry of Health, WHO Country Office, WHO AFRO (ATM) and APOC.

The meeting was attended by top-level policy and decision makers on health from six countries - Ghana, Nigeria, Sierra Leone, Tanzania, Uganda and host country Ethiopia – WHO Africa Region, as well as representatives of donors, Non-Governmental Development Organizations and other health system support groups. Participants included Directors of Disease Control and Public Health, Programme Managers of Onchocerciasis and Malaria Control as well as representatives of the USAID, the Carter Center, Liverpool School of Tropical Medicine, Sight savers International and cbm (formerly Christian Blind Mission).

The Ethiopian Minister of State for Health, Dr Shiferaw Teklemariam, officially opened the meeting with the WHO Country Representative Dr Fatoumata Nafo-Traore in attendance. The Minister welcomed participants to the meeting. He expressed his country’s pleasure at hosting the meeting, which he described as an opportunity for them to share with other countries Ethiopia’s experiences on integration of community-directed interventions into the national health system as well as co-implementation of some NTDs with malaria, using the Health Extension Programme.

The Minister called on stakeholders to move beyond declarations to the implementation of various decisions so as to empower communities and strengthen health systems towards the achievement of the Millennium Development Goals (MDGs). He described Onchocerciasis control as an “ongoing success story from which we need to draw lessons badly needed to successfully deal with the other neglected tropical diseases.”

The objective of this meeting was to follow up on the implementation of the recommendations of the Brazzaville meeting in February 2007 by countries, foster inter-country collaboration, promote exchange of experiences and lessons learnt on integration and co-implementation of malaria and NTDs interventions and make recommendations.
The meeting noted that progress had been made by some countries in the implementation of the 2007 recommendations. The majority of the countries had put in place management structures for co-implementation, developed strategic plans of action and some are co-implementing with some flexibility in the use of donor funds. However, there are still challenges with regards to country leadership, development of policy, mapping of diseases, resource allocation, community empowerment, inter-country collaboration and political commitment.

Countries were informed of the current global strategic direction on NTD and malaria control to enable them to harmonize activities in the country strategic plans.

The meeting recognized that the multi-country study on Community-directed interventions (CDI) undertaken in Uganda, Cameroon and Nigeria has provided strong evidence for integrated delivery of ivermectin, vitamin A supplementation, home-based management of malaria and long lasting insecticide treated bed nets.

In order to ensure the integration\(^1\) and co-implementation\(^2\) of malaria and NTDs the meeting made the following recommendations:

**Governments:**

1. Countries should lead the co-implementation process in policy, strategic planning, implementation, monitoring and reporting, and adopt the CDI strategy in line with Ouagadougou Declaration on PHC and Health Systems, for up scaling integration and co-implementation of NTDs and malaria control interventions.

2. Further operational research on integration of DOTS involving national researchers and/or research institutes should be undertaken.

3. Countries should allocate financial and other resources from national budgets to address their resource and capacity needs on co-implementation and provide progress report before the next meeting.

4. The meeting strongly urges countries to consider co-implementation of malaria and NTDs as a component of proposals to the Global Fund.

5. Countries should develop/finalise national policy on NTDs before the next meeting and advocate for its inclusion in the national health policy.

6. Ministries of health should avoid fragmentation by bringing the co-ordination of NTD programmes under one unit, to reduce the work load of Programme managers and improve co-implementation and cost efficiency.

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1. Integration is the inclusion of programme activities in the broader health system with strong community involvement.

2. Co-implementation is the strategy of bringing two or more programme initiatives together to increase efficiency and avoid fragmentation.
7. Programme Managers use innovative ways to engage Ministers of Health to prioritize NTD control, for example, presentations at national assemblies and use of the media to increase political will and support for the NTD programmes in countries.

8. Countries should accelerate and complete the mapping of NTDs before the next meeting in 2010. Where available, data from literature should be used to identify known endemic areas and exclude them from mapping.

9. Programmes should give pharmaco-vigilance the needed attention, manage drug reactions, document and report all cases and undertake studies in multiple drug administration.

10. Countries should report on the status of implementation of the above recommendations at the next meeting in 2010.

**WHO AFRO/APOC**

11. APOC should share the results of the Addis Ababa meeting with the four Anglophone countries that did not attend and undertake advocacy visits to bring them on board.

12. WHO should provide technical support to countries to develop/finalise national strategic plans on NTDs before the next meeting in 2010.

13. WHO AFRO and Country Offices should advocate that UNDAF\(^3\) put co-implementation of NTDs and malaria control on their agenda.

14. The meeting urges AFRO to allow the participation of DPC Advisers in WHO Country Offices in future follow-up meetings in view of their important role in the promotion of co-implementation of NTDs and malaria control.

**Partners/Donors**

15. Global Fund and other donors should be urged to support countries to strengthen health systems through integration and co-implementation of malaria and NTDs control programmes.

16. Donors should provide additional resources to address operational research needs for integration and co-implementation of NTDs and malaria based on country priorities.

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\(^3\) UNDAF: United Nations Development Assistance Framework
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