World Health Organization Global Programme To Eliminate Lymphatic Filariasis

Lymphatic filariasis - managing morbidity and preventing disability:
An aide-mémoire for national programme managers, Second edition

WEB ANNEX B:
Lymphatic filariasis: Situation analysis tool for morbidity management and disability prevention

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Contents

Introduction

More than a billion people are at risk for a medically diverse group of diseases known as neglected tropical diseases (NTDs). Five NTDs can be addressed through preventive chemotherapy: lymphatic filariasis (LF), onchocerciasis, schistosomiasis, soil-transmitted helminthiases (STH) and trachoma. The goal of integrated preventive chemotherapy is to eliminate LF, onchocerciasis, blinding trachoma and, in some cases, schistosomiasis as public-health problems as well as childhood morbidity from STH. While preventive chemotherapy is a form of primary prevention against these diseases, once an individual is infected, acute and chronic clinical conditions may result that require other management and treatment strategies. For LF these conditions include lymphoedema and hydrocele.

Preventing disability includes the promotion of health, enablement and inclusion of people with chronic manifestations of these diseases. Disability prevention remains an important component of NTD control and elimination efforts. Activities beyond preventive chemotherapy to address these medical and social conditions are known as morbidity management and disability prevention (MMDP), in recognition that their goal is not only to treat clinical symptoms but also to prevent any further medical, psychological and social complications. MMDP is achieved by ensuring that people with disabilities have equitable access to quality-assured health, education, income and community services, including surgery and self-care training.

The Global Programme to Eliminate Lymphatic Filariasis (GPELF) has a goal to provide 100% geographical coverage of essential care for LF-related disease, namely lymphoedema and hydrocele, in endemic areas. By improving the availability of corrective surgery, self-care training and information on morbidity management, programmes not only serve the immediate needs of patients but serve to promote universal health coverage. While preventive chemotherapy activities will end as countries meet their elimination targets in 2020 and beyond, services to manage medical and social conditions must be made available through the health and social systems at national, regional and community levels for many years afterwards.

According to the GPELF standard operating procedures for validation of elimination[1], countries will need to demonstrate three key MMDP elements within their country's LF elimination dossier:

1. Patient estimation: the number of patients with lymphoedema and hydrocele (reported or estimated) by implementation unit;

2. Availability of the recommended minimum package of care: in all IUs with known patients, the availability of at least one facility providing the recommended care; and

3. Readiness and quality of available services: in selected designated facilities, documentation of the readiness and quality of available services (preferred assessment of at least 10% of designated facilities).

[1] https://apps.who.int/iris/bitstream/handle/10665/254377/9789241511957-eng.pdf, accessed November 2019.

Purpose of a situation analysis

The purpose of an MMDP situation analysis is to aid the implementation of national MMDP strategies as part of NTD control and elimination plans by assessing the epidemiologic landscape (including estimated numbers of lymphoedema and hydrocele patients), governance environment, service delivery activities, and opportunities for integration. Ideally, a situation analysis is conducted before initiating MMDP services; however, countries may conduct such analyses at various stages of the programme. This information makes it possible to identify the best platforms and models for improving availability of surgery and self-care training. While NTD programmes are often operated by the public health system, MMDP activities are often under the authority of both the clinical health care system and the social welfare system, and a situation analysis thus serves to bridge these systems and responsibilities.

The 2019 WHO *Aide-memoire for national programme managers on managing morbidity and preventing disability for lymphatic filariasis*[2] defines the major components of the situation analysis (see section 3.1.1) as epidemiology (number of lymphoedema and hydrocele patients), health and social environment, and strategic framework. This situation analysis tool provides a practical methodology for conducting a MMDP situation analysis to support planning and decision-making by national health authorities. For lymphedema management, this tool can be used in combination with the lymphoedema Direct Inspection Protocol (DIP) (Web Annex A), which assesses the readiness and quality of lymphoedema management services provided by health facilities, including knowledge of health staff, availability of required medicines and supplies, and facility infrastructure. For hydrocelectomies, the WHO Tool for Situational Analysis to Assess Emergency and Essential Surgical Care[3] also can be used.

Objectives

Information for the situation analysis should be obtained through semi-structured interviews with key informants among the major stakeholders as well as a review of relevant reports and data (published articles, surveys, sector reports, studies, etc.). No primary data collection (e.g., surveys) is anticipated as part of a situation analysis.

The findings from the situation analysis will enable countries to:

- describe available information and capacity to measure the number and geographic distribution of patients with lymphoedema or hydrocele;
- identify areas needing further patient estimation activities;
- identify the relevant policy frameworks necessary for effective and efficient MMDP services;
- clarify the potential intersectoral coordination mechanisms for MMDP activities;
- determine the place, structure and platforms of current and future MMDP activities; and

[2] http://apps.who.int/iris/bitstream/10665/85347/1/9789241505291_eng.pdf, accessed December 2015.
[3] https://www.who.int/surgery/publications/WHO_EESC_SituationAnalysisTool.pdf, accessed November 2019.

- describe the planning and implementation of MMDP activities – including patient estimation, patient mobilization, training, provision of services (lymphoedema management and hydrocelectomies), monitoring and evaluation (M&E).

Intended users

The MMDP situation analysis is intended for implementation by LF programme managers or technical consultants aiding in LF strategic planning, particularly officials responsible for LF-related clinical conditions of lymphoedema and hydrocele. This analysis should be carried out in close collaboration with relevant programme managers and the various stakeholders. Its output should support planning and decision-making by the national health authorities responsible for MMDP services, particularly how to improve case identification and availability of appropriate care, and health and social services.

Defining stakeholders

A situation analysis is successful only if key stakeholders in LF control or elimination and any ongoing MMDP activities are identified and they are invited to participate in the process. Beyond interviewing people involved in LF activities, other health sector programmes, such as Buruli ulcer, leprosy or diabetes, are potential platforms for integration with LF MMDP activities. Information should therefore be collected from those programmes as well.

In addition to government institutions, interviewing stakeholders from nongovernmental organizations, patient advocacy groups, medical and social associations, research institutions and private sector organizations is crucial, as their activities impact the availability of MMDP services. Consideration should also be given to interviewing community members, and affected people and their families who are (or will be) receiving MMDP services on their perceptions of health-care services and social issues in order to identify opportunities and barriers to strengthening cross-sector collaboration and to engaging communities in MMDP activities.

Annex 1 provides a structured framework to guide countries through the general process of designing and monitoring a LF MMDP programme. This list is not intended to be exhaustive, and countries should adapt the list to their local context. In preparation for a situation analysis activity, countries are encouraged to use these questions to determine appropriate stakeholders to engage during the situation analysis exercise. This framework should be revised throughout the program planning lifecycle and modified based on the results of the situation analysis.

MMDP interview guide

The MMDP interview guide is categorized to facilitate information gathering around four key areas including governance and management, integration and stakeholders, geographic coverage of services, and supporting activities. The MMDP interview guide should be conducted with key stakeholders with the assistance of the following Annex materials.

1. Governance and Management

1.1 Management structure

- Which major unit(s) or department(s) is responsible for LF mass drug administration (MDA) and MMDP activities and in which corresponding ministry or agency? MDA and MMDP for LF may or may not be managed by the same unit or department. Please indicate which diseases or clinical conditions are targeted by the various units or departments.

- Is there a MMDP committee that provides strategic guidance to the programme?

- Is a morbidity focal point assigned either for all NTDs or for LF specifically?

1.2 MMDP strategies

- Does a MMDP strategic plan need to be created or revised?

- What are the country-specific goals of the MMDP activities?

1.3 Health sector policies

- What are the different health sector policies which affect LF MMDP activity service provision?

    - Are any of these policies related to antibiotics, surgery (both clinic-based and field-based campaigns) or integrated management of chronic diseases? If so, attach copies of these policies.

- Is there a national Universal Health Coverage policy? Does it include LF morbidity?

- Is there a national policy for integrating chronic diseases or basic surgical services?

- Are there national policies related to disability? Who has the mandate to implement these policies?

1.4 Health financing

- Are unit cost estimates available for activities related to LF MMDP service provision, e.g. patient mobilization, training, referrals, clinical services?

- Is there identified funding from government or other donors for these activities? What is the gap?

- Is management of lymphoedema/acute attacks and hydrocele surgery included in the Universal Health Coverage package of essential services?

- How is payment of services organized? Are LF surgical and disability services covered by a national insurance scheme?

- Do incentives for health care providers align with the LF MMDP objectives? E.g. do funding reimbursements encourage or discourage a greater volume of hydrocele surgery?

2. Integration and MMDP stakeholders

2.1 Integration opportunities

- Which other health programmes are possible opportunities for integration of lymphoedema management due to similar activities, platforms or data collection systems, e.g., diabetes, heart failure, leprosy, podoconiosis, Buruli ulcer, mycetoma?
    - How feasible is integration with these programmes, including data sharing?
    - What common activities are available to help care for patients with lymphoedema and those with other chronic diseases?
    - Are there similar indicators among programmes, e.g. geographical coverage, frequency of referrals to a health facility?
    - How feasible is joint training of health staff, informal caregivers and patients in hygiene and skin care, exercises and technical follow-up of patients?
    - Other surveys such as the WHO Model Disability Survey (MDS) or the WHO Service Availability and Readiness Assessment (SARA) might be considered as sources of information or data collection.
    - For each programme, at a minimum, state: (i) the geographical area it covers; (ii) how often activities are implemented; and (iii) the unit or department responsible for implementation of activities (Annex 2).
- Which other health programmes are possible opportunities for integration of hydrocele management due to similar activities, platforms or data collection systems, e.g., hernia repair, urology programme, essential surgical services programme, general surgery programme?
    - How feasible is integration with these programmes, including data sharing?
    - What common activities are available to help care for patients with hydrocele?
    - Are there similar indicators among programmes, e.g. geographical coverage, frequency of referrals to a health facility?
    - How feasible is joint training of health staff in surgery and technical follow-up of patients?
    - Population-based surveys such as the WHO Model Disability Survey (MDS)[4], the WHO Surgical Assessment Tool[5] or the WHO Service Availability and Readiness Assessment (SARA)[6] might be considered as sources of information or data collection.

[4] https://www.who.int/disabilities/data/mds/en/, accessed November 2019.
[5] https://www.who.int/surgery/eesc_database/en/, accessed November 2019.
[6] https://www.who.int/healthinfo/systems/sara_introduction/en/, accessed November 2019.

- For each programme, at a minimum, state: (i) the geographical area it covers; (ii) how often activities are implemented; and (iii) the unit or department responsible for implementation of activities (Annex 2).

2.2 Stakeholders

- Who are the critical stakeholders for:
    - Advocacy and policy development?
    - Patient identification/estimation?
    - Patient mobilization?
    - Health care worker training?
    - Curriculum development?
    - Service delivery for acute attacks and lymphoedema management?
    - Service delivery for hydrocele surgery?
    - Monitoring and evaluation?
- Should community health workers/volunteers be involved in LF MMDP activities? Is there a role for them in patient estimations? Patient mobilization? Training patients? Following up patients?
- What stakeholders, e.g. nongovernmental organizations, were previously or currently involved in activities related to hydrocelectomies or lymphoedema management? (Annex 3)

3. Geographic coverage of services

3.1 LF patient distribution

- Which implementation units (IUs) have the highest prevalence of LF infection (measured by filarial microfilaraemia or antigenaemia)?
- How many people are estimated to require services for lymphoedema? For hydrocele?
- In how many implementation units are services required?
- What are the most recent estimates of patients with lymphoedema or hydrocele by district? Indicate the source and date of estimates in Annex 4.
    - What are the main strategies used to identify and report patients with lymphoedema or hydrocele (e.g. active case-finding, passive surveillance)?

- If estimates of the number of patients are not available, refer to *Methods of estimating number of lymphoedema and hydrocele patients* (Annex 5) for further activities that might be necessary.

3.2 Designated facilities – lymphoedema management

- What lymphoedema management activities, for LF or other etiologies, have taken place in the previous 5 years? Summarize previous activity results in Annex 6.

- What is the most appropriate platform(s) for MMDP services moving forward, e.g., facility-based, facility-based with community health workers, community-based?

- What type(s) of health facilities (e.g. district hospitals, health centres, health posts) are designated to provide lymphoedema management services?

- How many IUs have public or private facilities which provide lymphoedema management services? Use a master health facility line-listing if available. Indicate for each IU the total number of facilities providing services in Annex 4.

- Are appropriate physical, social and vocational rehabilitation services available? At which administrative levels (region, district, community) are these services available? Where are they based, e.g. at district hospitals? Through home-based care?

- How ready are health facilities to provide lymphoedema management? Indicate the current status of facilities in Annex 7. Refer to Direct Inspection Protocol for guidance on assessing health facility readiness (Web Annex A).

- What are the funding sources for self-care training materials or any supplemental materials for acute attack/lymphoedema management? E.g. antiseptics, antifungals, analgesics/anti-inflammatory, oral/injectable antibiotics (See lymphoedema procurement calculator for example materials.) Funding could come from national LF MMDP programme, NGOs or other partners, national insurance scheme, private payments, etc.

- Does the MMDP programme provide enrolled lymphoedema patients with a hygiene kit? If so, what materials does it contain, e.g. soap, gauze, antifungal cream, antibacterial cream, bucket, towels, basin, cup, IEC materials, shoes? If so, will the kit be replenished after initial distribution and how often?

3.3 Designated facilities – hydrocele management

- What activities, including hydrocelectomy camps, have taken place in the previous 5 years? Summarize previous activity results in Annex 6.

- What type(s) of health facilities (e.g. regional and district hospitals, surgical centres) are designated to perform hydrocelectomies? If no facilities are designated to perform hydrocelectomies, what type(s) of health facilities provide other surgical services (e.g. urology or general surgical services)?

- How many IUs have public or private surgical facilities which provide hydrocelectomies? Use a master health facility line-listing if available. Indicate for each IU the total number of facilities providing services in Annex 4.

- How ready are health facilities to perform hydrocelectomies? Indicate the current status of surgical facilities in Annex 7.

- What are the funding sources for hydrocelectomy supplies? (See hydrocele surgery procurement calculator for example materials.) Funding could come from national LF MMDP programme, NGOs or other partners, national insurance scheme, private payments, etc.

4. Supporting activities

4.1 Patient mobilization

- What factors might influence service delivery and/or patient access to MMDP services? These could include:
  - religious and cultural influences
  - stigma
  - special groups or indigenous populations
  - languages spoken and read
  - literacy
  - economic status
  - decision-making structures in households
  - access to safe water sources
  - access to transportation and distance to health facilities
  - access to footwear for lymphoedema patients
  - access to assistive technology and devices
  - rainy season period
  - agricultural cycles (planting, harvesting).

- Which active community networks and structures (health workers, religious leaders, traditional healers, community volunteers, women's group, youth groups, teachers or schools, etc.) could help in understanding local perceptions and in planning strategies to strengthen community involvement in mobilizing patients for MMDP interventions?

- What sources of information are available to disseminate health messages; these could include local leaders, religious leaders, health-care staff, influential individuals (formal and informal), as well as media (radio, print, TV)?

- Are there existing information, education and communication (IEC) materials pertaining to MMDP or related health programs? What are the key messages? Who are the targets? Has the IEC material been adapted to the local context and languages? (Annex 8)

4.2 Training

- What are the current skills and training needs of frontline health-care staff related to lymphoedema and acute attack management? Provide the number of people who would need to be trained to deliver the basic recommended package of care.

- What strategies are used to train (or retrain) health workers on lymphoedema management? E.g. cascade training, in-service training, medical curriculum

- Where are lymphoedema patients trained – at district hospitals or health centers or home?

- Who trains lymphoedema patients – clinicians or community health volunteers or model patients?

- What are the current skills and training needs of health-care staff related to hydrocelectomy? Provide the number of people who would need to be trained to implement hydrocelectomy.

- What are the existing policies and mechanisms for medical or clinical education and practice? Briefly indicate whether techniques for hydrocelectomy and lymphoedema management (as applicable) are included.

4.3 Referrals

- Where are patients with acute attacks referred? What are the criteria for referral?

- What commonly used referral systems exist for referring patients with complicated lymphoedema or hydrocele, if any?

- Do any community-based rehabilitation and/or self-help groups exist at the community level?

4.4 Follow up

- What follow up schedule exists for lymphoedema patients? E.g. weekly for the first month, biweekly for 6 months, monthly for a year, then as needed

- Who is responsible for follow up of lymphoedema patients – clinicians at health facilities or clinicians at home or community health workers/volunteers?

- What follow up schedule exists for hydrocele patients?

- Who is responsible for follow up of hydrocele patients?

4.5 Monitoring and evaluation

- Is LF (infection, hydrocele and lymphoedema) included in the health management information system (HMIS)?

- What indicators are used to monitor MMDP activities for all areas and patients? (Annex 9) How are these linked to HMIS or other national health system reporting?

- Who collects monitoring information on lymphoedema and hydrocele activities? How is it aggregated and transmitted? How is this linked to national health system reporting?

- Has an evaluation of lymphoedema or hydrocele patients taken place? If so, what indicators were used? (Annex 9)

Synthesis of findings

The person leading the situation analysis should compile and summarize the results of the information collected and the stakeholder interviews into a written report. The report should include a listing of those involved in the situation analysis, a summary of answers and tables (such as the templates contained in annexes 1–7) as needed. The summary table in Annex 1 can also be used to synthesize findings from the stakeholder interviews.

Furthermore, the tables presented in Annex 4 follow the same structure as WHO's PC Epidemiological Data Reporting Form concerning information for lymphoedema and hydrocele cases. Therefore, programmes can use the situation analysis process to generate and prepare information for this form.

In addition, the synthesis of the situation analysis should discuss the following points:

- Is there a reasonable estimate of the number of patients with lymphoedema or hydrocele to initiate MMDP activities?

- What opportunities do current national policies provide for MMDP activities?

- What are the major barriers that need to be addressed to deliver the basic recommended package of care?

- Are existing national, regional and district platforms for addressing MMDP issues functional and sufficient? If not, what needs to be done to create functional platforms?

- Do other platforms exist that could be used for integration with MMDP activities?

- Are there potential models to use to provide access to self-care or surgical services for lymphoedema or hydrocele patients?

- What are the resource gaps in implementing MMDP activities?

- Recommend the critical next steps necessary to design and implement a MMDP strategy that is incorporated into the health system.

Annex 1. Key questions for designing a MMDP programme

These questions are intended to guide countries through the general process of designing a LF MMDP programme. This list is not intended to be exhaustive, and countries should adapt the list to their local context. The ultimate, long-term objective of an MMDP programme is to ensure the essential package of care is available, being accessed and is sustainable through the health system. Answers to these questions may be used to provide the policy or SOP for MMDP if needed.

Please fill in the answers in the right-hand column. Additional exploration might be required to answer some questions and responses may need to be revised throughout the programme planning lifecycle.

Question	Answer
GOVERNANCE AND MANAGEMENT	
Management Structure	
Which department(s) is responsible for implementing MMDP services?	
Does a national MMDP committee already exist or should one be created? If yes, who should participate on such a committee?	□ Yes, already exists □ Yes, should be created _____ □ No, not necessary
Should the national LF programme have an MMDP-specific focal point? If so, which position?	□ Yes, _____ □ No
MMDP strategy	
Does a morbidity management and disability prevention plan need to be created or revised?	
What are the country-specific goals of the MMDP activities?	

Health sector policies	
What are the different health sector policies which affect LF MMDP activity service provision?	□ Antibiotic usage and delivery □ Delivery of basic surgical services □ Integrated management of chronic disease □ Disability □ Medical/clinical education □ Universal health coverage □ Other (specify) _____
Health financing	
Are unit cost estimates available for activities related to LF MMDP service provision, e.g. patient mobilization, training, referrals, clinical services?	
Is there identified funding from government or other donors for these activities? What is the gap?	
Is management of lymphoedema/acute attacks and hydrocele surgery included in the Universal Health Coverage package of essential services?	
How is payment of services organized? Are LF surgical and disability services covered by a national insurance scheme?	
INTEGRATION AND STAKEHOLDERS	

Integration opportunities	
Which inter- or intra-sectoral programmes are possible opportunities for integration of acute attack/lymphoedema services? *(check all that apply)*	□ NCDs (i.e. diabetes, heart failure) □ Leprosy □ Podoconiosis □ Buruli ulcer □ Madura foot □ Other (specify) _____
Which inter- or intra-sectoral programmes are possible opportunities for integration of hydrocele services? *(check all that apply)*	□ Hernia repair □ Urology programme □ Essential surgical services programme □ General surgery programme □ Other (specify) _____
Stakeholders	
At which level should stakeholders be engaged in developing and implementing MMDP? *(check all that apply)*	□ National-level □ Regional-level □ District-level □ Health facility-level □ Community-level □ Other (e.g. NGOs) _____ _____
Who are the critical stakeholders in advocacy and policy development?	

Who are the critical stakeholders in patient identification/estimation?	
Who are the critical stakeholders in patient mobilization?	
Who are the critical stakeholders in health care worker training?	
Who are the critical stakeholders in curriculum development?	
Who are the critical stakeholders in service delivery for acute attacks/lymphoedema?	
Who are the critical stakeholders in service delivery for hydrocele surgery?	
Who are the critical stakeholders in monitoring and evaluation?	

<table>
<tr><td>With which activities can community health worker/volunteer networks be used for LF MMDP activities?

(check all that apply)</td><td>□ Patient estimations

□ Patient mobilization

□ Training patients

□ Following up patients

□ Other (specify) _____

□ Not at all

□ Not applicable</td></tr>
<tr><td colspan="2">GEOGRAPHIC COVERAGE OF SERVICES</td></tr>
<tr><td>In how many implementation units are services required?

(attach available data by implementation unit, if available)</td><td>
<table>
<tr><td>Total number of IUs</td><td></td><td></td></tr>
<tr><td></td><td>Lymphoedema /ADL</td><td>Hydrocele</td></tr>
<tr><td>Number of IUs with known patients</td><td></td><td></td></tr>
<tr><td>Number of IUs with <u>no</u> known patients</td><td></td><td></td></tr>
<tr><td>Number of IUs with patient estimations pending</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>How many people are expected to require services?

(attach available data by implementation unit, if available)</td><td>_____ lymphoedema

_____ hydrocele</td></tr>
<tr><td>What is the most appropriate platform(s) for MMDP? (consider if platforms might</td><td>□ Facility-based</td></tr>
</table>

vary by IU based on local factors)	□ Facility-based with community health workers/volunteers □ Community-based
In how many implementation units are services already being provided? *(attach available data by implementation unit, if available)*	_____ lymphoedema management _____ hydrocelectomies
At which administrative levels are rehabilitation services being provided?	□ Regional □ District □ Community-based
Does the MMDP programme need to provide to health facilities any supplemental materials for acute attack/lymphoedema management? *(check all that apply)* *(see lymphoedema management procurement calculator)*	□ Antiseptics □ Antifungals □ Analgesics/anti-inflammatory □ Oral/injectable antibiotics □ Lymphoedema/acute attack supplies □ Other (specify) _____
Will the programme provide enrolled lymphoedema patients with a hygiene kit?	□ Yes □ No
If a hygiene kit will be provided, what materials will the kit contain? *(check all that apply)*	□ Soap □ Towels □ Gauze □ Antibacterial cream □ Antifungal cream □ Basin

	□ Bucket □ Cup □ Shoes □ IEC materials □ Other (specify) _____
Will the kit be replenished after the initial distribution? If yes, how often? Which items will be replenished?	□ Yes, _____ □ No
Will the MMDP programme provide any materials necessary for hydrocele surgery? If so, which ones? *(see hydrocele surgery procurement calculator)*	□ Yes, _____ □ No
Who is responsible for supply and inventory management for any provided supplies?	
SUPPORTING ACTIVITIES	
Patient Mobilization	
What are the most appropriate strategy(ies) to mobilize patients to seek care (e.g. radio, flyers, and health extension workers)?	
What information, education, and communication materials are most appropriate for patients? *(check all that apply)*	□ Public awareness poster □ Morbidity manual □ Flip-chart □ Patient pamphlets □ Patient booklets □ Instruction card □ Instructional video □ SMS messages □ Other (specify) _____

Training	
What strategy will be used to train (or retrain) health workers on lymphoedema management?	□ Cascade training □ In-service training □ Medical curriculum □ Other (specify) _____
Where will lymphoedema patients be trained?	□ District hospital □ Health centre □ Home □ Other (specify) _____
By whom should lymphoedema patients be trained?	□ Clinician □ Community health workers/volunteers □ Model patients □ Other (specify) _____
What training needs exist for training surgeons on hydrocelectomy? What methods will be used for surgeon training?	
Referrals	
Where will acute attacks be referred? What are the criteria for referral?	
Where will lymphoedema be referred? What are the criteria for referral?	

What is the referral system for complicated cases of hydrocele? What are the criteria for referral?	
Follow Up	
What follow-up schedule should be established for lymphoedema patients (e.g. weekly for the first month, bi-weekly for 6 months, monthly for a year, then as needed)	
Who will be responsible for follow-up of lymphoedema patients?	□ Clinician at health facility □ Clinician at patient's home □ Community health workers/volunteers □ Other (specify) _____
What hydrocele patient follow-up schedule should be established?	
Who will be responsible for following hydrocele patients up?	□ Surgeon □ Clinician □ Nurse □ Other (specify) _____
Monitoring and Evaluation	
Is lymphoedema a nationally reportable disease in the health management information system (HMIS)?	□ Yes □ No
What indicators will be used to monitor lymphoedema activities for all	√ Total number of lymphoedema patients by IU √ Number of health facilities providing

areas/patients? (√ = WHO indicators)	lymphoedema management by IU √ Quality assessment in 10% of designated health facilities □ Total number of lymphoedema patients visiting health facilities for treatment and follow up for lymphoedema/acute attack care □ Total number of health workers trained in lymphoedema management □ Change in frequency and duration of acute attacks □ Change in size (i.e. circumference, volume, stage) of affected limb □ Quality of life measures □ Functional measures □ Economic measures □ Other (specify) _____
Who will collect monitoring information on lymphoedema activities? How will they be aggregated and transmitted?	
Is hydrocele a nationally reportable disease in the HMIS?	□ Yes □ No
What indicators will be used to monitor hydrocele activities for all areas/patients? (√ = WHO indicators)	√ Total number of hydrocele patients by IU √ Number of health facilities providing hydrocelectomies by IU √ Quality assessment in 10% of designated health facilities □ Total number of surgeons trained in hydrocelectomy □ Total number of patients undergone hydrocelectomy

	□ Percentage of patients who received a hydrocelectomy with infection within 5 days of surgery □ Percentage of patients who received a hydrocelectomy with hematoma within 5 days of surgery □ Percentage of patients who received a hydrocelectomy with failure of surgical incision to close □ Hydrocele recurrence rate □ Other (specify) _____
Who will collect monitoring information on hydrocele activities? How will they be aggregated and transmitted?	
Will an evaluation of lymphoedema patients take place?	
What indicators will be used (if any) to evaluate a sample of lymphoedema patients?	□ Number of lymphoedema patients visiting health facilities for treatment and follow up for lymphoedema/acute attack care □ Number of health workers trained in lymphoedema management □ Change in frequency and duration of acute attacks □ Change in size (i.e. circumference, volume, stage) of affected limb □ Quality of life measures □ Functional measures □ Economic measures □ Other (specify) _____

Will an evaluation of hydrocele patients take place?	
What indicators will be used (if any) to evaluate a sample of hydrocele patients?	□ Total number of surgeons trained in hydrocelectomy □ Total number of patients undergone hydrocelectomy □ Percentage of patients who received a hydrocelectomy with infection within 5 days of surgery □ Percentage of patients who received a hydrocelectomy with hematoma within 5 days of surgery □ Percentage of patients who received a hydrocelectomy with failure of surgical incision to close □ Hydrocele recurrence rate □ Other (specify): _____

Annex 2. Intradepartmental collaboration on MMDP

Other disease or condition	Activities supported	Geographical scope	How often activities are implemented?	Unit or department responsible

Annex 3. Stakeholders providing MMDP support

Name of stakeholder	Activities supported	Geographical scope	Engaged with MOH (Y/N)	Funding sources	Year(s) of support

Annex 4. Estimates of the number of lymphoedema and hydrocele patients at implementation unit (IU) level

National summary of number of lymphoedema and hydrocele patients	Lymphoedema	Hydrocele
Total number of IUs (national)		
Number of IUs with known patients		
Number of IUs with **NO** known patients		
Number of IUs with patient estimation pending		
Number of IUs with at least one facility designated to provide recommended basic package of care		
Total number of designated health facilities providing care		
Cumulative number of patients		
Number of patients who received care in the reporting year		

Region/ Province	Name of implementation unit	Total Population*	Lymphoedema				Hydrocele				Comments
			Total number of patients	Method of patient estimation	Date of patient estimation	Number of health facilities providing service	Total number of patients	Method of patient estimation	Date of patient estimation	Number of health facilities providing service	

* Where possible, use a source of population data standardized across the country.

Annex 5. Methods for estimating the number of lymphoedema and hydrocele patients

Methodology	Instrument	Outcome	Advantages	Disadvantages
Population-based cross-sectional surveys				
MDA coverage surveys	Physical examination or survey questions	Prevalence estimate for the IU	• Low cost due to integration	• Not powered to detect clinical cases • Poor geographical coverage as not all IUs have coverage surveys • Occurs only in areas with PC MDA • People may not self-identify to surveyor • Self-reported patients may need to be confirmed by health staff
TAS (community-based)	Physical examination or survey questions	Prevalence estimate for the IU	• Low cost due to integration • Survey teams are already visiting households • Conducted after several rounds of MDA, and twice after MDA stops	• Most TAS are not community based • Occurs only in areas with LF MDA • People might not self-identify to surveyor • Self-reported patients may need to be confirmed by health staff
Other surveys	Adding questions onto other surveys (e.g. WHO disability model survey, DHS, MIS)	Prevalence estimate for the survey area	• Low cost due to integration	• Has to be coordinated at national level • Data estimates may be disaggregated at levels other than IUs • Timing depends on health programme implementing the survey
• Key informant interviews				

TAS (school-based)	Survey questions added to TAS module	Estimated count of patients within the evaluation unit	• Low cost due to integration • Conducted after several rounds of MDA, and twice after MDA stops - One study showed teachers are the most accurate community key informants	• Not standardized • Large variations in accuracy • Possible underreporting of cases (particularly for hydrocele) • If only asking teachers, would need to be supplemented by other key informants
Community key informants	Survey of defined number of community key informants (village chief or representative) on morbidity burden in the village *Or* Town crier asking people with swollen legs to gather in a central location in the village	Estimated count of patients within the survey area	• Ease • Flexibility • Low cost	• Not standardized • Large variations in accuracy • Possible underreporting of cases (particularly for hydrocele)
Health personnel key informants	Survey of defined number of health personnel on morbidity burden in their catchment area (similar to health clinic survey)	Estimated count of patients within the survey area	• Ease • Flexibility • Low cost	• Accuracy depends on cultural aspects, health-care use and trust in health personnel • Not standardized • Possible underreporting of cases
• Health facility surveys				
Health facility surveys	Sample of health clinics with defined number of providers sampled	Prevalence estimate for the survey area	• Easier than household surveys • Possible in areas with and without MDA	• Patients may not present to health facilities • Possible underreporting of cases

• Other methodologies				
Door-to-door morbidity census	Physical examination or survey questions by health staff	Patient registrar of all patients and location	• Closest to gold standard • One of the most accurate ways to assess burden • Possible in areas with and without LF MDA	• Expensive, especially if using healthcare staff • Time consuming, especially if burden is low
Pre-MDA population registration or MDA implementation	Survey questions by community health workers	Patient registrar of all suspected patients and location	• Comprehensive method with line-listing of cases in areas with MDA	• Suspected cases may need to be confirmed by trained health staff • Occurs only in areas with MDA population registration • Data are often not transmitted from the healthcare centre level to higher levels

DHS, demographic and health surveys; IU, implementation unit; MDA, mass drug administration; MIS, malaria indicator survey; PC, preventive chemotherapy; TAS, transmission assessment survey

Annex 6. Summary of previous LF MMDP activities, by year

Activity	Year 1	Year 2	Year 3	Year 4	Year 5
Number of LF programme staff trained in MMDP					
Lymphoedema					
Number of health staff trained in lymphoedema and acute attack management					
Number of informal caregivers and patients trained in lymphoedema management					
Number of lymphoedema patients monitored					
Number of communities with self-help groups					
Hydrocele					
Number of surgeons and nurses trained in hydrocelectomy					
Number of hydrocele patients managed					

IU, implementation unit; LF, lymphatic filariasis

Annex 7. Information on facilities providing hydrocelectomies and lymphoedema management services, by implementation unit (IU)

	IU A	IU B	IU C	IU D
Hydrocelectomies				
How many facilities are designated to provide hydrocelectomies?				
How many designated facilities have trained health-care staff in hydrocelectomies in the previous 2 years?				
How many facilities actually provide hydrocelectomies?				
How many facilities are not providing hydrocelectomies due to *lack of patients*?				
How many facilities are not providing hydrocelectomies due to *lack of skills*?				
How many facilities are not providing hydrocelectomies due to *lack of functioning equipment and supplies*?				
How many facilities are not providing hydrocelectomies due to *lack of policy approval to perform the procedure*?				
How many patients had hydrocelectomies in the previous year?				
Lymphoedema management				
How many facilities are designated to provide lymphoedema management services?				
How many designated facilities have trained staff in lymphoedema management in the previous 2 years?				
How many facilities actually provide lymphoedema management services?				
How many facilities are not providing lymphoedema management services due to *lack of patients*?				
How many facilities are not providing lymphoedema management services due to *lack of skills*?				
How many facilities are not providing lymphoedema management services due to *lack of functioning equipment and supplies*?				
How many facilities are not providing lymphoedema management services due to *lack of policy approval to perform services*?				
How many lymphoedema patients have been trained and/or monitored for self-care compliance in the previous year?				

Annex 8. MMDP or related condition IEC materials

IEC materials	Organization producing material	Target audience	Key messages	Available languages	Comments

Annex 9. Potential indicators to monitor and evaluate MMDP activities

LF Validation Indicators:

- Total number of lymphoedema patients by IU
- Number of health facilities providing lymphoedema management by IU
- Quality assessment in 10% of designated lymphoedema management health facilities

Other Indicators:

- Total number of lymphoedema patients visiting health centres for treatment and follow up for lymphoedema/acute attack care
- Change in frequency and duration of acute attacks
- Change in size (i.e. circumference, volume, stage of affected limb)
- Quality of life measures
- Functional measures
- Economic measures
- Total number of hydrocele patients by IU
- Number of health facilities providing hydrocelectomies by IU

- Quality assessment in 10% of designated hydrocelectomy health facilities
- Total number of surgeons trained in hydrocelectomy
- Total number of patients undergone hydrocelectomy
- Percentage of patients who received a hydrocelectomy with infection within 5 days of surgery
- Percentage of patients who received a hydrocelectomy with hematoma within 5 days of surgery
- Percentage of patients who received a hydrocelectomy with failure of surgical incision to close
- Hydrocele recurrence rate

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