

Integration of mass drug administration programmes in Nigeria: the challenge of schistosomiasis

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Problem Annual mass drug administration (MDA) with safe oral anthelmintic drugs (praziquantel, ivermectin and albendazole) is the strategy for control of onchocerciasis, lymphatic filariasis (LF) and schistosomiasis. District health officers seek to integrate treatment activities in areas of overlapping disease endemicity, but they are faced with having to merge different programmatic guidelines.

Approach We proceeded through the three stages of integrated MDA implementation: mapping the distribution of the three diseases at district level; tailoring district training and logistics based on the results of the mapping exercises; and implementing community-based annual health education and mass treatment where appropriate. During the process we identified the “know-do” gaps in the MDA guidelines for each disease that prevented successful integration of these programmes.

Local setting An integrated programme launched in 1999 in Plateau and Nasarawa States in central Nigeria, where all three diseases were known to occur.

Relevant changes Current guidelines allowed onchocerciasis and LF activities to be integrated, resulting in rapid mapping throughout the two states, and states-wide provision of over 9.3 million combined ivermectin–albendazole treatments for the two diseases between 2000 and 2004. In contrast, schistosomiasis activities could not be effectively integrated because of the more restrictive guidelines, resulting in less than half of the two states being mapped, and delivery of only 701 419 praziquantel treatments for schistosomiasis since 1999.

Lessons learned Integration of schistosomiasis into other MDA programmes would be helped by amended guidelines leading to simpler mapping, more liberal use of praziquantel and the ability to administer praziquantel simultaneously with ivermectin and albendazole.

Bulletin of the World Health Organization 2006;84:673-676.

Voir page 675 le résumé en français. En la página 675 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 676.

Background

Pablos-Mendez et al., in their October 2005 editorial in the *Bulletin* entitled: Knowledge translation in global health¹ argued that research must be part of a strategic process that moves evidence-based, cost-effective interventions to true practice. Barriers to the implementation of effective interventions lead to what the authors called the “know-do” gap. Research should help us to understand those barriers that prevent bringing what we know to the logical conclusion of action in the field and resultant better health or better health services.

Community-based annual mass drug administration (MDA) with safe and effective oral drugs is the principal strategy for the control of onchocerciasis.

presenting a barrier to the integration of programmes that should logically work together synergistically.

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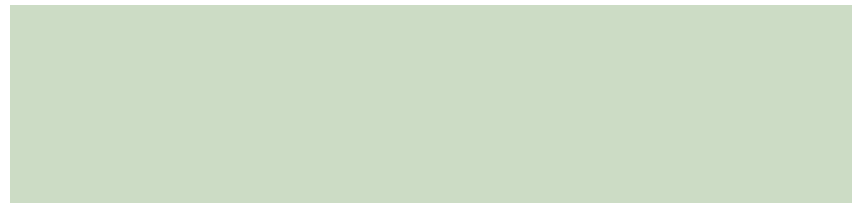
Ref. No. 06-029652

(Submitted: 3 January 2006 – Final revised version received: 9 March 2006 – Accepted: 11 May 2006)

was an excellent opportunity to link the two multicountry WHO programmes in Nigeria. The approach taken was to launch the LF programme from within the mature APOC-supported programme. Albendazole tablets would be given concurrently with the ivermectin tablets already being delivered, together with additional health education.

But we hoped for more than the obvious linkage of onchocerciasis and LF. Efforts to control schistosomiasis were (and are) lagging behind the LF and onchocerciasis initiatives in Nigeria.

The Schistosomiasis Control Initiative,⁴ another large regional initiative similar to APOC and GAELF, had not chosen Nigeria as a one of its programme coun-



cada enfermedad que impedían una integración eficaz de esos programas.

Contexto local Un programa integrado lanzado en 1999 en los Estados de Plateau y Nasarawa en el centro de Nigeria, donde se sabía que se daban las tres enfermedades.

Cambios destacables Las directrices existentes permitieron integrar las actividades contra la oncocercosis y la filariasis linfática, lo que se tradujo en un rápido mapeo en los dos Estados, y en el suministro en el conjunto de esos territorios de más de 9,3 millones de tratamientos combinados de ivermectina-albendazol contra las dos enfermedades entre 2000 y 2004. Sin embargo,

las actividades contra la esquistosomiasis no pudieron integrarse eficazmente debido al carácter más restrictivo de las directrices, lo que se tradujo en un mapeo de menos de la mitad de los dos Estados, y el suministro de sólo 701 419 tratamientos de prazicuantel contra la esquistosomiasis desde 1999.

Enseñanzas resultantes La integración de la esquistosomiasis en otros programas de AMM se vería facilitada si se modificaran las directrices para poder simplificar el mapeo, usar de forma más flexible el prazicuantel, y administrar simultáneamente este producto junto con la ivermectina y el albendazol.

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