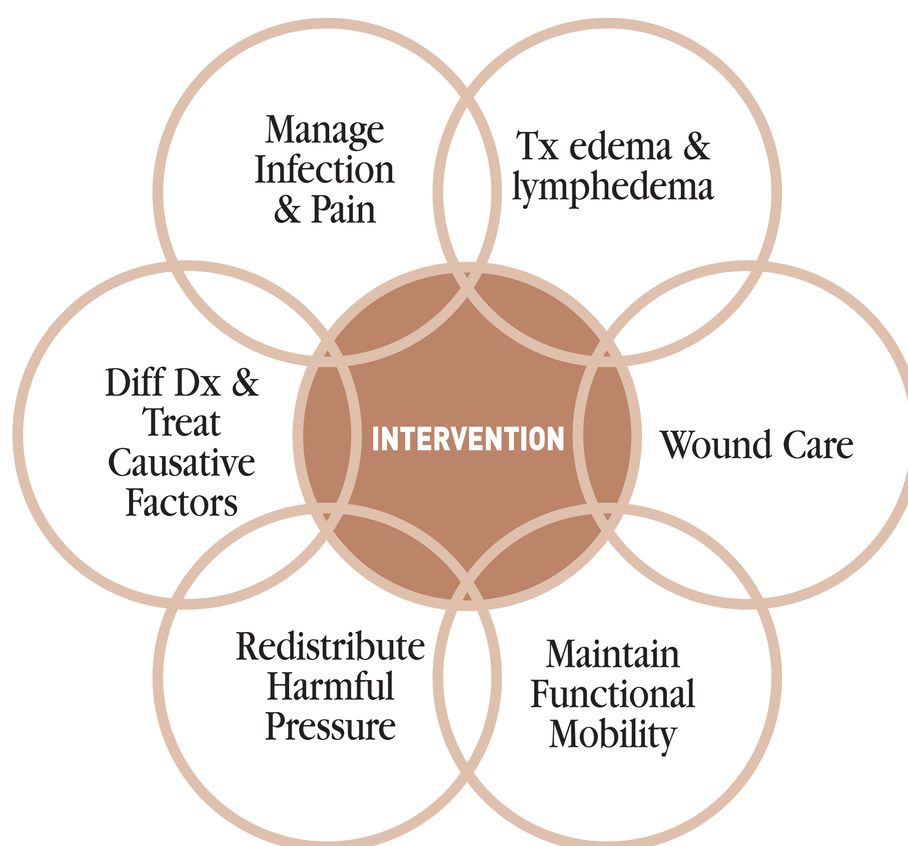
The Working Group on the Integration of Wound-Lymphedema Management Across Diseases in Resource-Poor Settings

Geneva, September 2007

Meeting report



Prevention of disability due to chronic illness in resource limited settings

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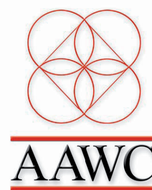
and all Workshop Participants



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Introduction

Background

For close to five years, WHO has been exploring ways and means to promote an integrated approach to the implementation of disease control programs. This drive towards integration by both WHO and countries is viewed as a window of opportunity for effective, sustainable and successful control of a number of diseases. At the Lymphatic Filariasis Workshop on Disability Prevention for Field Managers sponsored by Handicap International in Accra, Ghana, July 10- 12th, 2007, the targeting of neglected tropical diseases for integration by the WHO African Region was emphasized in light of the very limited resources allocated for their control.

Integration in this context is defined to be the creation of linkages among existing programs for the purpose of improving delivery of services and utilizing resources. This strategy is expected to lead to streamlining in the implementation of activities and synergism in the outcomes from activities. The ultimate goal is to improve efficiency of the existing health care delivery system by avoiding creation of parallel and/or alternative structures. In order to achieve integration without compromising the goals and objectives of individual programs/organizations effective planning at various levels is crucial.

A recommendation of the participants in the Ghana workshop was to explore the potential for integration at various levels among the stakeholders present. At the meeting, M. Geyer (Chatham University; Consultant), S. Girois (Handicap InternationaI; Chair, NGDO LF Network) and P. Brantus (Independent Consultant for Handicap International) discussed the potential for integration of wound management services (including control of edema/lymphedema) across diseases. Following the meeting this became a priority as a confluence of problems, possible solutions and political circumstances created a window of opportunity to collaborate with another organization to attain morbidity management goals in resource-poor settings. This organization was the Association for the Advancement of Wound Care (AAWC) through their new program, the World Wound Care Alliance (WWCA).

With 1,800 members, the AAWC is the largest multidisciplinary wound care association in the US and one of the largest in the world. The WWCA project was launched in the spring of 2007 with logistic support and coordination provided by Health Volunteers Overseas (HVO). This project was initiated and largely implemented by J. Macdonald, MD, current president of AAWC. Using a train-the-trainer model, the goal of WWCA/HVO's international service program is to provide education at the primary care level to improve the long-term prevention and management of disability related to wounds and edema/lymphedema from a variety of diseases and conditions. At the time of the Ghana meeting, WWCA was in the process of preparing wound and lymphedema management training guidelines and materials for volunteer use in sites in Cambodia, Peru and India projected to begin in the fall of 2007.

Through their mutual work in wound and lymphedema management, M. Geyer and J. Macdonald had developed a relationship over the past ten years. In fact, M. Geyer's Benter Lymphedema Project in India had been linked to the WWCA program by providing both primary and community-based training in lymphedema management through a WWCA site at the Christian Medical College and Hospital, Vellore, India. Knowledge that the volunteers for WWCA/HVO would have all of the requisite skills to provide training across neglected tropical diseases and many other chronic illnesses led M. Geyer to push for a meeting between key actors from WHO, the NGDO LF Network (Handicap International, LEPRA), AAWC/WWCA, and HVO. S. Girois generously offered to have Handicap International-France and Handicap International-Switzerland organize and host a meeting that was held in Geneva, CH on September 13-

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Proceedings

The proceedings are described in chronological order. The group reached conclusions and recommendations at the end of the first day. The next day, only four participants met to condense the record for the report. No changes were made by the smaller group on the second day, just clarification of content.

A. During the morning, common themes and elements were explored at the system & services levels. The

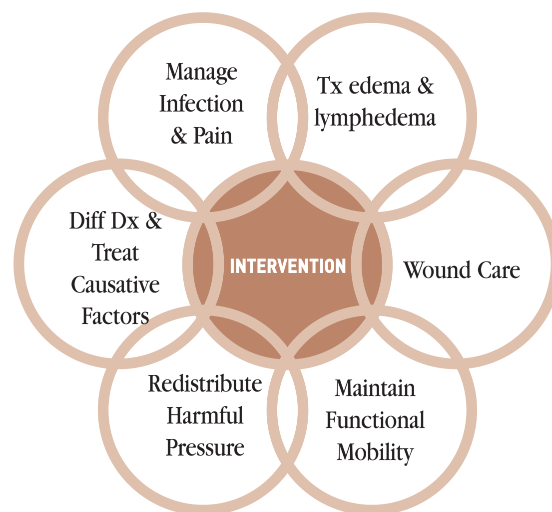

Figure 1.0 Common elements of wound-lymphedema management clinical interventions

The figure above includes all of the major clinical interventions discussed by the group that are common to the vast majority of targeted diseases and conditions and; therefore, would be the most appropriate for integration.

Differential diagnosis and treatment of specific causative factors

- Diagnostic tests & evaluative procedures
- Medication
- Nutrition
- Hygiene
- Lifestyle behaviors (smoking, drinking, lack of exercise, foot care, etc.)

Redistribute harmful pressure, prevent shear & traumatic injuries

- Appropriate footwear, standard
- Appropriate footwear, accommodative
- Appropriate footwear, pressure redistribution
- Support surfaces for other body parts (seat cushions, & full-body support, etc)
- Pressure redistribution to reduce impact on healing wounds

Maintain functional mobility

- Assistive technology / mobility devices
- Gait, transfer & functional training
- Exercise for ROM, strength, cardiovascular & respiratory endurance

Wound care- basic principles

- Assessment
- Wound bed preparation
- Cleanse, irrigate, debride
- Dressing selection & application

The link between edema/lymphedema management and wound healing was emphasized. Because they are interrelated, it is important to recognize that any wound management program would include edema/lymphedema management as well.

B. The majority of interventions at the clinical level would apply to all diseases, but additional disease-specific interventions would also be included (see Figure 2.0 below) in the management strategy. The level of service delivery for specific interventions has yet to be operationally defined.

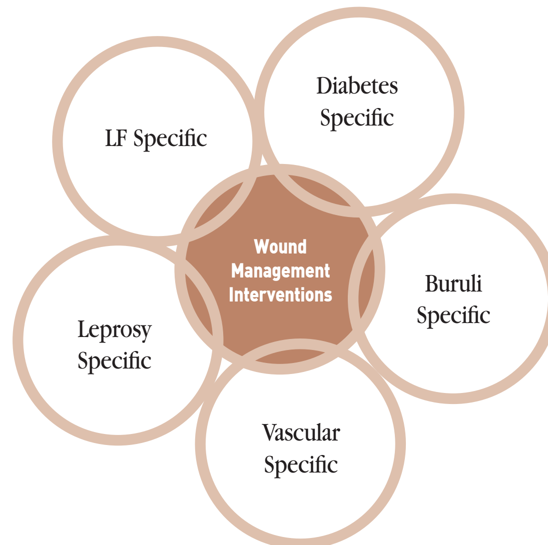

Figure 2.0 Diagram emphasizing the need for disease specific guidelines in addition to the common wound-lymphedema interventions

C. Group Structure In order to maintain the greatest flexibility, the group decided against formalizing the structure into a coalition. The consensus was to remain a working group with guidance from WHO regarding process and policy decisions. The name of the group was established as the Working Group on Integration of Wound-Lymphedema Management across Diseases in Resource-Poor Settings.

D. Presentations by WHO Staff In the afternoon, G. Biswas, MD first presented an overview of the Lymphatic Filariasis program which described the basic community home-based care intervention protocol. Outcomes of the mass drug administration in combination with the basic intervention strategy were also presented. Historical perspective on the selection of a single, basic clinical indicator to monitor the effects of the intervention was presented by P. Brantus, MD. It was noted that the selection of the frequency of acute filarial attacks as an indicator for LF interventions took a period of 3 years. Additional indicators being considered proved either too complex or redundant. The need to identify such an indicator for wound management interventions was emphasized.

Later in the afternoon, K. Asiedu, MD presented an overview of the Buruli Ulcer program. The pathophysiology, epidemiology, and common methods of treatment of the disease were described. The benefit of an integrated wound and lymphedema management approach to neglected tropical diseases as well as other chronic illnesses was apparent to all. It was reported that no WHO guidelines currently exist for wound management.

Conclusions and Recommendations

With the support of the WHO representatives present, the group consensus regarding action plans was to:

- Identify collaborators to assist with defining the epidemiology as well as the economic burden of chronic wounds and lymphedema; e.g. the LF Support Center, Rollins School of Public Health, Emory University, USA; the LF Support Centre, Liverpool School of Tropical Medicine, UK and many others

- Prioritize work on wound and lymphedema guidelines and a corresponding training curriculum as follows:
  - **Complete a Best-Practices in Wound Management white paper manuscript following the WHO guidelines process**
    - Include general principles for all chronic wounds (basic)
    - Consider a basic clinical indicator for monitoring and evaluation of wound management interventions in resource-poor settings
    - Include clinical treatment for specific diseases/conditions
    - Utilize the public health approach for resource-poor populations; i.e., wound and lymphedema management must be integrated into existing health care systems and should begin with management strategies at the community home-based care level
    - Describe the potential impact of wound management integration across diseases that have been targeted by WHO
    - The white paper will be the primary responsibility of J. Macdonald with assistance from an international panel of experts; an example is the recently published "Best Practices in Lymphedema Management", September 2006
  - **Set a target date for 2008 to schedule a follow-up informal consultation under WHO coordination and guidance in Geneva**

- Under WHO coordination and guidance, implement multi-center pilot projects for woundlymphedema management interventions. Projects would use protocols similar to the operational research designed to test and validate the public health approach in lymphatic filariasis.

- Monitoring and Evaluation
  - **It was suggested that selecting appropriate clinical and process indicators for field testing could be an activity of the group**
  - **The value of the WHO-DAS was discussed as a tool for both clinical and program evaluation**

- Problems with patient follow-up were discussed at both the health system and the community level. In order to determine solutions for improving communications between the patient and the health system or the NGO, additional data is needed.
  - **It was suggested that with input from WHO and the WG-IW-LM, a systematic and organized data collection process could be implemented in the near future using WWCA volunteers**

- Coordination of Work Group Activities
  - **WG-IW_LM WHO Coordinator: Kingsley Asiedu will coordinate for the WHO related activities**
  - **WG-IW-LM External Coordinator: Mary Jo Geyer will serve as the group coordinator for those activities external to WHO Follow-Up**
    - Pierre will send the WHO guidelines for implementation of disability prevention at the district level to other members of the group
    - The WHO guidelines for preparing guidelines will also be distributed to the group

- Handicap International will seek funding to organize a second Lymphatic Filariasis Workshop on Disability Prevention for Field Managers with a focus on Footwear in 2008
  - **Pierre Brantus will send a presentation on footwear from the Leprosy NGDO group to aid in a project to design footwear for use in LF and diabetic foot patients initiated by Mary Jo Geyer and pedorthic /orthotic colleagues from the US**

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