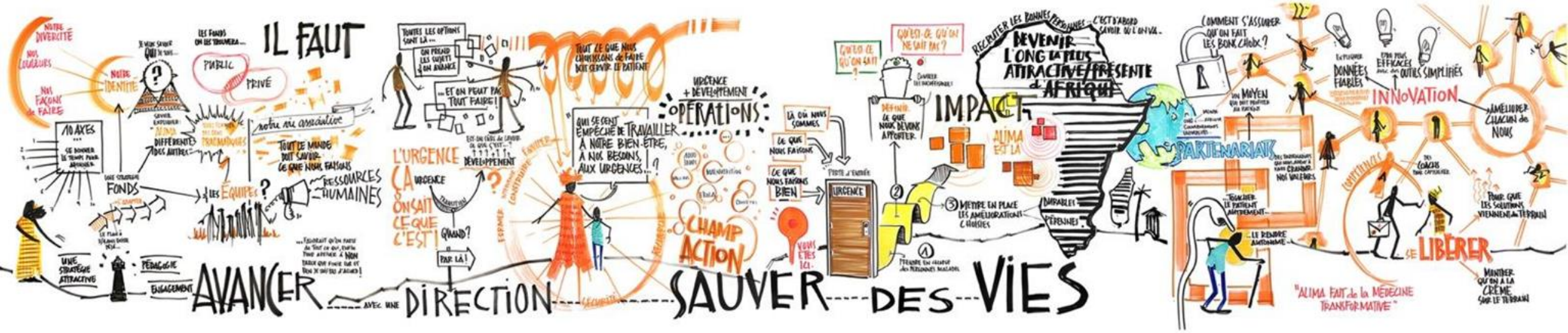


GTFCC

November 2019 – NEW DEHLI

SOIGNER
INNOVER
ENSEMBLE

2019

01

GENERAL PRESENTATION

• ALIMA

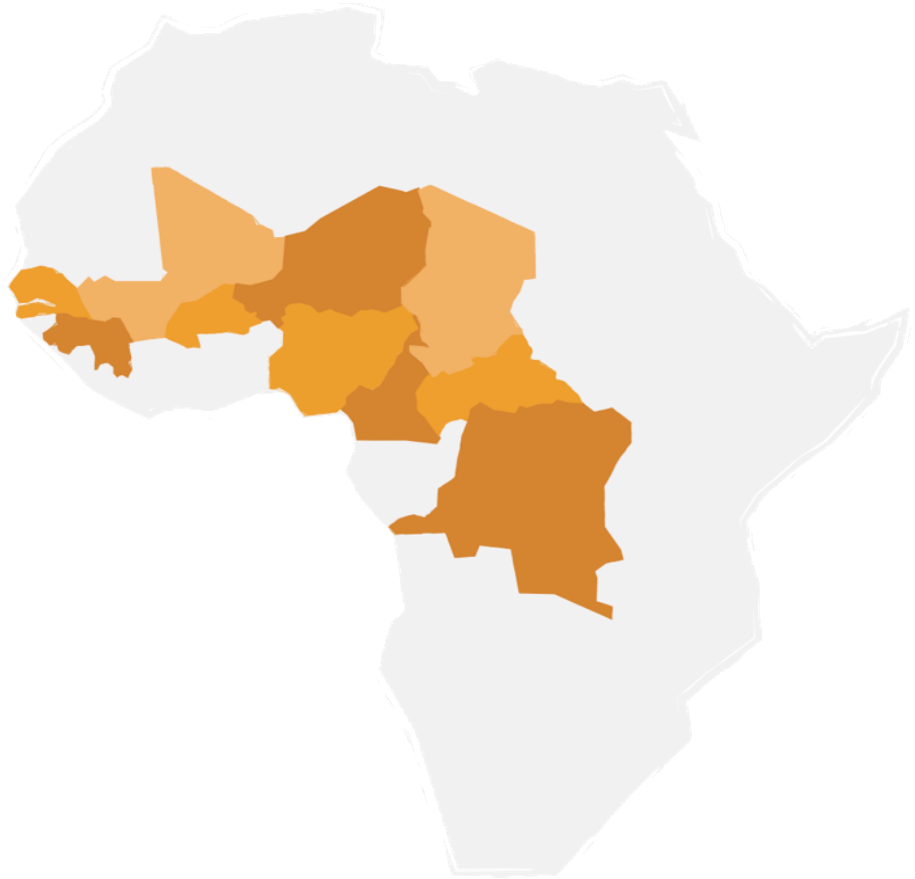
Creation : 2009

CARE - INOVATE - TOGETHER

+ de 2 million patients treated since 2009

41 interventions
10 research projects

1 800 field employees



An alliance

Budget 2018 : 41 M€

SOIGNER
INNOVER
ENSEMBLE

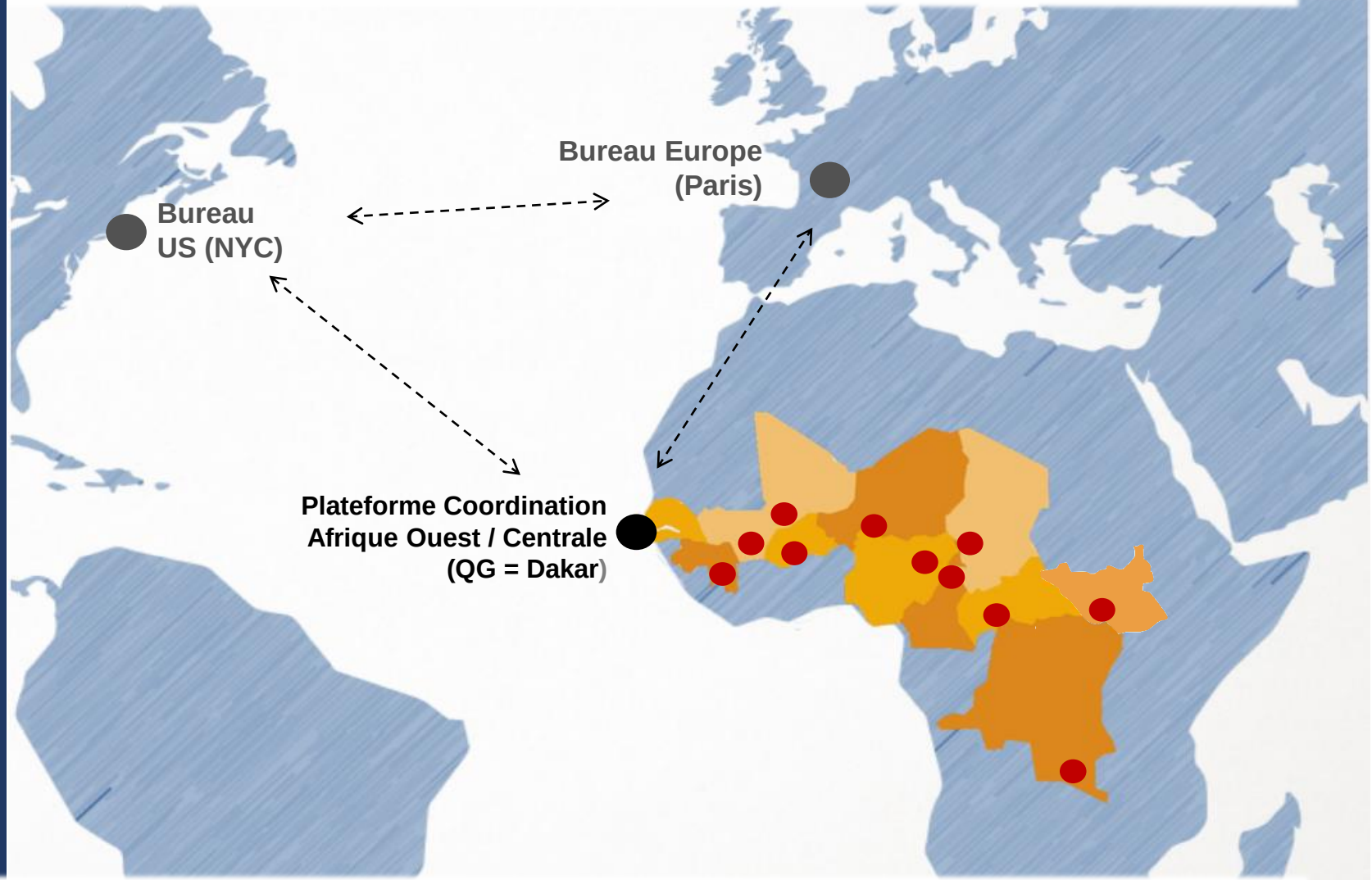
1

THE NGA AS SOLUTION TO COMBINE LOCAL AND INTERNATIONAL EXPERTISE.

The solution can only come from the combination of effective international assistance WITH one of the actors on the ground, concerned, stronger to act from the first moment.

EXPERTISES

- Ambassadeurs
- Expertise technique / recherche
- Fundraising / Communication



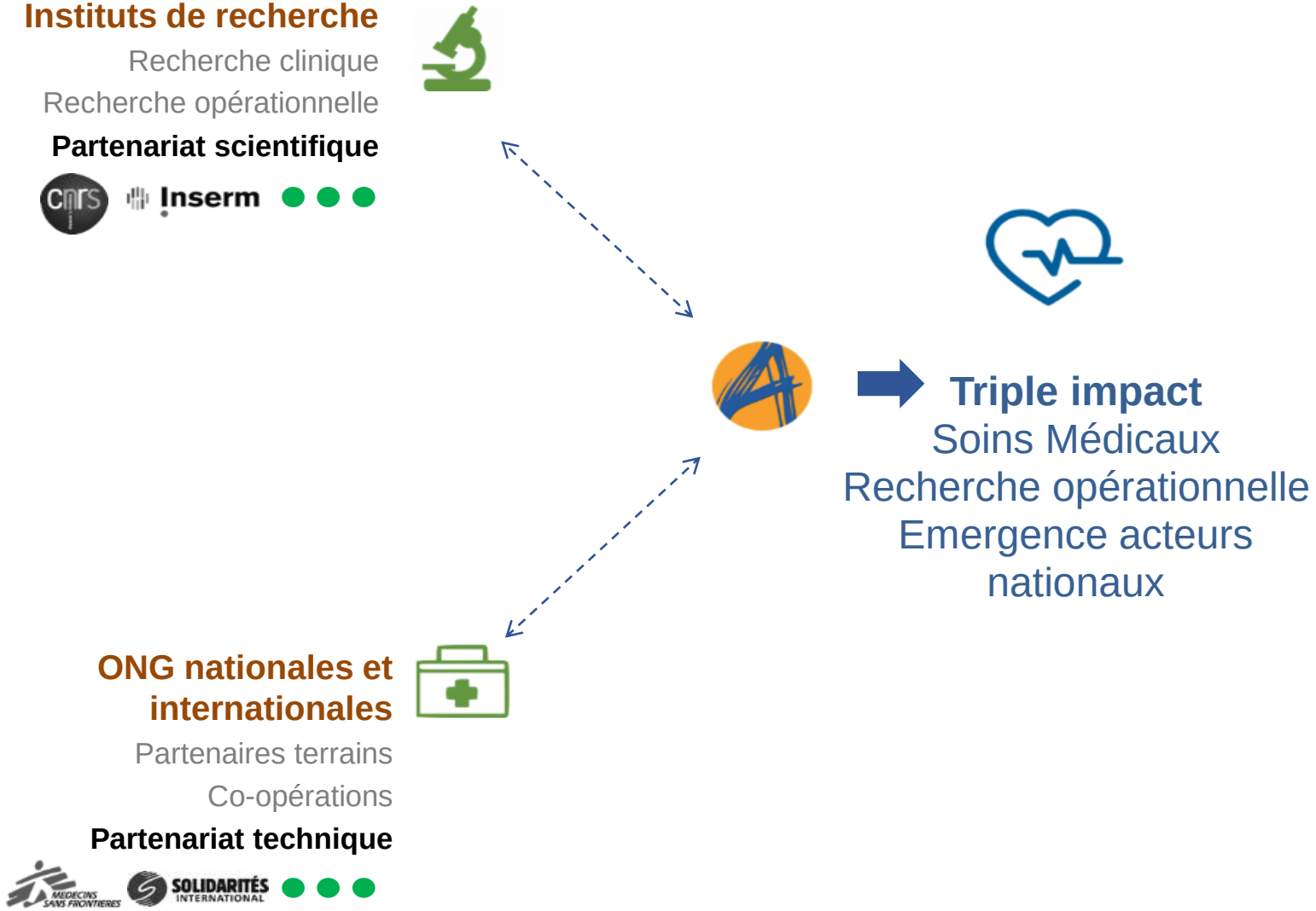
EXPERTISES SUR LE TERRAIN

- Médecins
- Infirmiers
- Experts humanitaires
- ONG & projets locaux
- Logisticiens
- Gestionnaires

2

THE NGA AS TOOL FOR ASSOCIATE RESEARCH AND CARE IN EMERGENCY.

Our trademark:
Aggregate the progress of key players in Research and Care
Continuously combine the latest scientific advances and best practices



02

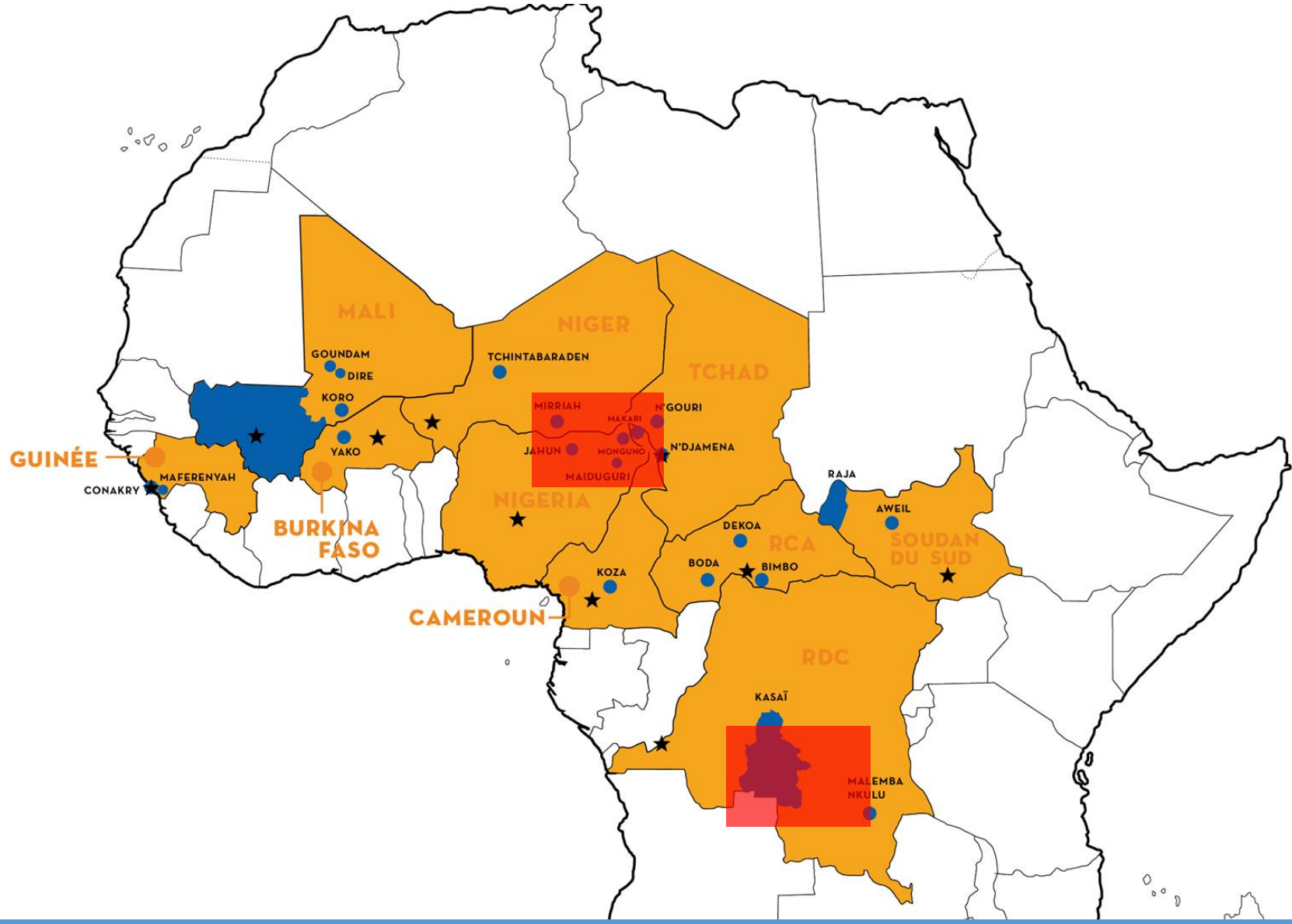
CHOLERA OPERATIONS – CASE MANAGEMENT

ALIMA

DRC 2016, 2017 and 2018
(Kikondja – Kalémie – Haut Lomami – Kasaï)
- 2491 cases
- Mortality CTC from 0 to 1,9%
- Global mortality from 0,45 to 3,6%

Niger 2018
- 433
- Mortality CTC 1,4%
- Global mortality 2,3%

Nigeria 2018
- 2121 cases on 4 spots
- Mortality CTC from 0 to 0,9%
- Global mortality from 0 to 1,4%



PRECONDITION FOR CARE

- **CONFIRMATION/END**

- Epidemic threshold and positive culture of sample OR 1 case confirmed by positive culture of a sample
- From 5 days to 1 month (It will depend on the available sampling kit, the conditions at the sampling site, the distance from the reference laboratory, the time frame for an analysis and the political will)
- End of intervention : 3 weeks under threshold OR with less than 3 active areas OR no cases reported

- **DONORS**

- Proposition depends of country:

Emergency Response focused on cholera case management : short intervention, difficult to address other morbidity, negotiation takes 1 month

Cholera management includes in the global health response : 1 year, better reactivity with low mortality, envelop predefined

- Main result based on mortality in CTC
- Cost per patient : from 343 to 866 €

RESULTS

The precondition leads to a delay of care and generates an increase in cases and mortality (Maradi 109 cases, 5,5% ; Kikondja 547 cases, 2,6% - Kasaï, 14% and 8%)

Despite a low standard of care, cost / patient higher than IPD Paediatric program (+/- 250 €)

CASE MANAGEMENT 1

- **COMMON SET UP** :

- On average, 3 months of intervention
- New or reactivated Cholera Treatment Center and Unit Treatment Center
- New ORS point
- Needs of drugs
- Isolation structure is disconnected from IPD
- Specific support to reference and communication
- For 80%, HR hired especially
- No vaccination

RESULTS

As average, It takes at least 2 weeks to launch a new CTC and to trained the staff

Impact on reference quality and tactical use of ORS point : lot of plan A et B at the beginning or late Plan C - all cases took in charge in CTC (Baga) or high level of CTC admission (> 80% when Plan C are < 30%)

Mortality rate intra-hospit reflects that : < 1% after two/three weeks for non complicated, longer for good management of complicated case

Same for general mortality with death in the community but usually stays > 2%

Pb of perception

At the end of the intervention, HR employed and trained are not usually a benefit to MoH

CASE MANAGEMENT 2

- ADMISSION/EXIT CTC

- Clinical diagnostic at 100%
- Use of RRT on 1 project (average / cases : 20% of 2121 cases - 86%+ - no culture comparison)
- Average length oh stay : 3 days

MEDICAL TREATMENT AND MONITORING

- Classical rehydration (SRO / IV / Antibio)
- Monitoring of fluid administration : clinical
- Hypoglycaemia : glucometer (12% - 3,5%)
- Hypokalaemia : clinical diagnostic (5% - 1,5%)
- Co-morbidity : poorly managed (lack of drugs and diagnostic available at MoH level) or documented

(Paludism 9,7% - 1,5% ; MAG 1,3% - 1%)

- Management of vulnerability : few
- Lab exams at CTC : no, only RRT on 1 project
- Mortality review : not performed
- Chemoprophylaxis (Niger MoH – 4474 p - Prison)

RESULTS

Basic standard of care, few medical knowledge and technics for complicated cases

Vulnerability not addressed

Mortality intra-hospit reaches 1%; the large number of admissions positively affects the indicator. When it exceeds during a week, explanation is the gravity.

CASE MANAGEMENT 3

- **CONTEXT**

- Security high
- Endemic hotspot in poor country
- Chronic emergency situation

- **MORBIDITY, PATHOGEN ENVIRONMENT AND AGE**

- Many intervention with +/- 30% diarrhoea morbidity (under 5) or high level of paludism
- Main morbidity covers an other one
- Few documented pathogens but with potential impact (shigella, rotavirus, crypto…)
- Diarrhoea management in all settings and context but not connected with cholera management
- Sometimes % of < 5 years cholerae cases admitted in CTC is > the % of the age group (48%, 34%, 30% or less 10%, 3%, 0%)

RESULTS

Population affected by cholera at risk by other disease (Kikondja - Palu 16000 cases/610 severe – 249 cholera cases)

Case definition and lack of lab test could not guarantee to be all cholera

The dynamic and impact of other hydric pathogens is not known

Does the vertical approach to cholera case management, as a superior emergency to other causes of severe diarrhoea, promote the quality of its expected care?

INTERNAL IMPROVEMENT AND QUESTION

- **IMPROVEMENT**

- Standard protocol for investigation/ripost based on ORS/Wash intervention, focusing targeting proximity areas of index cases and vulnerability within the area
- Systematic mortality review
- Active monitoring of pregnant women during cholerae epidemic
- Creation of knowledge reference teams per country at risk

- **QUESTION**

- Does use of RRT with alkaline peptone water in the surveillance and case management could reduce the need of confirmation by culture, the start of intervention and address the appropriate case management ?
- Can rapid intervention targeted by chemoprophylaxis on index case contacts reduce the spread and risk of mortality?
- In endemic context, wouldn't be better to recommend that all diarrhoea cases, including cholerae, should be taken in dedicated OPD/IPD in order to improve responsiveness and medical quality?
- Could the measurement of waterborne pathogens in the environment by multiplex PCR (Biofire or other) with gastrointestinal panel allow a better knowledge of the areas of vulnerability for a more specific treatment of cases of abundant diarrhoea and a Wash intervention?

RESEARCH ONGOING

- **Ebolus - Patient management with remotely assisted POC-Ultrasound –** Denis Malvy et Richard Kojan, Corral - Armand Mekontso Dessap, CHU Henri Mondor

Improve care for MVE patients with hemodynamic and/or respiratory disorders with a possibility to be apply in all IPD/CTC

Cardiopulmonary ultrasound is performed once or twice a day in patients with circulatory and/or respiratory insufficiency.

Four items are explored (left ventricle, inferior vena cava, anterior and posterior lungs).

An elementary score is applied to each item to assess the benefit-risk of vascular filling (see table)

The total score allows to recommend either the continuation of the filling (if the total score is positive), or the stopping of the filling (if the total score is negative), or to use other decision criteria (if the total score is zero).

Echographe LUMIFY

LUMIFY Ultrasound System

MERCI
DE VOTRE ATTENTION

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