Progress made and Challenges ahead in Clinical Research and Development of New Treatments for Human African Trypanosomiasis

WHO and DNDi Symposium
ISCTRC Meeting, Kampala, Uganda
Tuesday, September 22, 2009
6 pm - 7:20 pm, in Victori Ballroom

World Health Organization | DNDi Drugs for Neglected Diseases *initiative*

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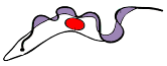
Sleeping sickness: we must remain alert
Recent field experiences of MSF in Africa

30th conference ISCTRC– Kampala



22nd September 2009

Laurence Flévaud- MSF *on behalf of MSF- Neglected disease working group*

Introduction (1)

- Increased H.A.T control activities
  - National HAT control programs, WHO, NGOs
- WHO-(Sanofi)-Aventis agreements (2001-2011):
  - Free anti-trypanosomial drugs
  - Financial support to programs

➔ **Significative impact on reduction of the burden of HAT in the past 10 years**

  - 1997: 36'585 reported cases
  - 2006: 11'382 reported cases

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Introduction (2)

- Lack of practical diagnostic & treatment tools
  - Obstacle to integration of HAT activities within primary health care
  - Do not allowed to cover 100% of HAT infected areas

➔ **Number of reported cases ≠ True number of cases**

- Weekly Epidemiological Report, February 2006:
  - 17'000 reported new cases
  - 50'000 – 70'000 estimated new cases

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MSF Programs 2007-2009

- Recent MSF HAT projects shed some light on some of these « hot spots » in CAR and DRC

- Areas characterized by
  - Remoteness, neglected areas
  - Insecurity (rebel groups, bandits)
    - DRC program close since april 2009

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Summary of MSF activities
jan.2007 – aug.2009

Total # Person screened = 106.098

- Passive screening = 23.328 (22%)
- Active screening = 82.770 (78%)

Total New HAT cases = 3700

- 1st Stage = 2409 (65.1%)
- 2nd Stage = 1291 (34.9%)

Global Prevalence

- Batangafo – C.A.R ➔ 2.7%
- Markounda – C.A.R ➔ 14.3%
- Ango – Bili – DRC ➔ 3.4%

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Main constraints

- **Access to the new HAT patients due to security context**
  - Reduce effectiveness of the program
  - Delay the reduction of prevalence
  - When access is totally denied (DRC)
    - Increase risk of deterioration of the situation
    - HAT patients left without access to diagnostic and treatment
- **Weakness in follow-up of patients post-treatment link to access**
  - Relapses not all identified

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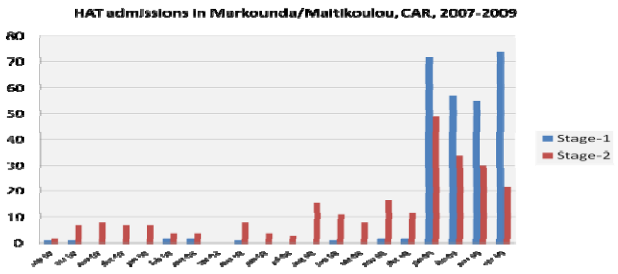
Conclusions from MSF activities

- Active screening is the only strategy which allowed accurate prevalence figures and maximum coverage



- Limited sustainability of current surveillance system strategy to allowed to keep the disease under control

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Discussion & Conclusion

- Control activities cover only a fraction of all endemic areas
- The current epidemiology of HAT is heterogenous between and within countries
- Current priorities should focus on
  - Sustaining and extending surveillance & control efforts in known areas and areas at risk

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Discussion for the future

- Globally HAT is under control but we have to stay vigilant in the at risk areas and ensure support by:
  - Donors for R&D and control programmes
  - NGO operation departments
- The time for global HAT elimination will come; in the meantime, the primary target of activities and communication should be:
  - Disease «control» and/or «containment»
  - R&D for more practical diagnostic and treatment tools
  - NECT – a major step forward but we need the ´magic bullet

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Thank you for your attention!