

Intercountry Meeting of Lymphatic Filariasis Programme Managers in the South-East Asia Region

*Report of the Meeting
New Delhi, 5-7 May 2005*

WHO Project: ICP CPC 207



**World Health
Organization**
REGIONAL OFFICE FOR
New Delhi **South-East Asia**

© World Health Organization, September 2005

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

	<i>Page</i>
1. INTRODUCTION	1
1.1 Elimination of LF as a Public Health Problem.....	1
1.2 Regional Strategy	1
1.3 Implementation of the Elimination Strategy.....	2
1.4 Meetings of Programme Managers	2
2. OPENING SESSION	2
3. OBJECTIVES OF THE MEETING.....	3
4. NOMINATION OF CHAIRPERSON	4
5. ADOPTION OF AGENDA	4
6. OVERVIEW OF THE GLOBAL LF PROGRAMME	4
7. REPORT ON THE GLOBAL ALLIANCE TO ELIMINATE LYMPHATIC FILARIASIS.....	5
8. PROGRESS OF ELF IN THE SEA REGION	6
9. FUTURE PLANS IN THE SEA REGION.....	7
10 COUNTRY PRESENTATIONS	7
10.1 Bangladesh.....	7
10.2 India	8
10.3 Indonesia	8
10.4 Maldives	9
10.5 Myanmar	9
10.6 Nepal.....	9
10.7 Sri Lanka.....	10
10.8 Thailand.....	10
10.9 Timor Leste.....	11
11. FOLLOW-UP OF THE RECOMMENDATIONS OF THE 5 TH TECHNICAL ADVISORY GROUP MEETING	11
12. UPDATE ON BRUGIA RAPID ANTIBODY TEST.....	11

13. POINTS FOR CONSIDERATION AT THE 6 TH MEETING OF TAG.....	12
14. MONITORING AND EVALUATION.....	12
15. GROUP WORK	13
16. PRESENTATION OF RECOMMENDATIONS OF SEA RPRG MEETING HELD ON 3-4 MAY 2005.....	13
17. MID-TERM REVIEW OF NATIONAL/REGIONAL STRATEGIC PLANS AND FORMULATION OF STRATEGIC PLANS UP TO 2010.....	14
18. CONCLUSIONS AND RECOMMENDATIONS.....	14
19. CLOSING SESSION.....	15

Annexes

1. List of Participants.....	16
2. Agenda.....	19
3. Recommendations of the Meeting of the South-East Asia Regional Programme Review Group 3-4 May 2005, New Delhi, India	20
4. Framework of the Strategic Plan, 2006-2010	22

1. INTRODUCTION

Lymphatic filariasis (LF) is one of the most disfiguring diseases and a major cause of clinical morbidity. It is the world's second leading cause of permanent disability and a major impediment to socioeconomic development. The disease is endemic in 83 countries with more than a billion people at risk of infection and some 120 million people clinically affected worldwide.

1.1 Elimination of LF as a Public Health Problem

The Fiftieth World Health Assembly in 1997 adopted a resolution (WHA50.29) calling on Member States to work towards elimination of LF as a public health problem, by 2020. Elimination was defined as a microfilaraemia rate of <1/1 000 population for five consecutive years. Following this, WHO prepared a global strategic plan with all relevant stakeholders. The strategy specifies that to eliminate the disease as a public health problem (<1/1 000 population in five consecutive years) by 2020, all endemic areas in the countries need to be covered by the elimination programme by 2010, aiming at gradual reduction and ultimate interruption of transmission with two main strategies: (a) interruption of the transmission through mass drug administration (MDA) of once yearly, single-dose, two-drug regimen with DEC and albendazole, to the entire endemic population for at least five years, and (b) alleviation of disability through morbidity management of clinical cases.

1.2 Regional Strategy

In line with the global strategy, the regional strategic plan for South-East Asia was formulated at the Programme Managers Meeting held in Orissa, India, in 2000. This plan was further revised at the Bi-regional Programme Managers Meeting, held in Bali in July 2002, and a strategic plan for 2003-2007 formulated. The present meeting further revised the plan to extend it up to 2010.

1.3 Implementation of the Elimination Strategy

Glaxo-SmithKline (GSK) has pledged to donate albendazole for the LF elimination programme until 2020, the global target year for elimination. Regional Programme Review Groups were formed following the MoU signed between WHO and GSK. The donor would review the implementation status in the recipient countries and make recommendations on the requirement of albendazole for donation. All nine endemic countries in the South-East Asia Region are now included in the South-East Asia Programme Review Group for Elimination of LF since 2004. In the past, five countries of the Region formed the South Asia RPRG and four countries were with the Mekong Plus RPRG.

Five countries have already completed mapping of the distribution of LF while mapping in the remaining four countries was progressing with the aim of completing the exercise by 2006. By 2005, all nine endemic countries were implementing mass drug administration (MDA) and were in different stages of scaling up. Increasing attention has been focused by all the countries on alleviation and prevention of disability of affected patients.

1.4 Meetings of Programme Managers

The first meeting of programme managers, held in Orissa, India, in February 2000, deliberated on finalizing the Regional Strategic Plan for 2000-2004 for elimination of LF in the SEA Region. In 2002, a bi-regional meeting of SEAR and WPRO countries was held. In 2003, a meeting of programme managers of the Indian Subcontinent was held and Mekong Plus countries was held. The fourth meeting of programme managers, held on 5-7 May 2005, included all endemic countries in the Region and was held back-to-back with the meeting of the SEA Regional Programme Review Group (RPRG) for elimination of LF. Like on the previous two occasions, holding the programme managers' meeting back-to-back with the RPRG meeting facilitated better review and interactions optimizing cost-effectiveness.

2. OPENING SESSION

Dr Than Sein, Director, Noncommunicable Diseases and Mental Health, WHO/SEARO, welcomed the participants and read out the inaugural address on behalf of the Regional Director, Dr Samlee Plianbangchang.

In his address, Dr Samlee said that the intercountry meeting would provide a useful forum for national and state programme managers, Regional

Programme Review Group (RPRG) members, WHO and other key partners to review the progress of LF elimination in the Region, identify constraints and challenges, and plan for scaling up activities for elimination of lymphatic filariasis.

He highlighted that lymphatic filariasis is a leading cause of permanent disability, social stigma and economic loss with a heavy burden on health systems. Globally, over one billion people are at risk of morbidity due this infection with 120 million already having the disease. Recognizing this, the Fiftieth World Health Assembly adopted a resolution calling on Member States to work towards elimination of LF as a public health problem by 2020. Following this a Global Alliance for Elimination of LF (GAELF) was formed in 1999 to assist Member States while resources and critical activities needed to achieve the goal.

All countries are now implementing mass drug administration and are in different stages of scaling up. He highlighted the resource constraints that affected the smooth scaling-up of elimination activities but commended the endemic countries of the Region on the progress made towards elimination. He thanked all the partners for their contributions towards implementing the elimination strategy.

He emphasized the need to prevent and alleviate suffering of those who are already affected by scaling up the recommended community home-based disability alleviation activities. He also stressed that investment in LF elimination has an impact on reducing poverty and on achieving the Millennium Development Goals.

3. OBJECTIVES OF THE MEETING

The objectives of the meeting were:

- (1) To share experiences and exchange information on the progress of lymphatic filariasis elimination in nine endemic countries of the Region, identify operational and technical constraints, including research needs, and decide on appropriate solutions and actions, and
- (2) To review and follow-up on the recommendations of the Regional Programme Review Group for Lymphatic Filariasis Elimination relating to implementation and scaling-up of mapping, mass drug administration and community home-based disability alleviation activities in the countries.

4. NOMINATION OF CHAIRPERSON

The list of participants is at Annex1.

Dr P.L. Joshi (India) was nominated as Chairman and Dr Saw Lwin (Myanmar) as Co-Chairperson. Dr Tilaka Liyanage (Sri Lanka) and Dr Moazzem Hossein (Bangladesh) were nominated as Rapporteurs.

5. ADOPTION OF AGENDA

The agenda as contained in Annex 2 was adopted unanimously.

6. OVERVIEW OF THE GLOBAL LF PROGRAMME

Dr Gautam Biswas (WHO/HQ) presented an overview of the global programme. The following points emerged:

- Forty-one of the 83 LF endemic countries in the world are implementing LF elimination. About 1.2 billion people are exposed to the risk of LF and about 10% of these (120 million) are affected with either microfilaraemia or disease manifestations, 50% of them in the SEA Region. About 60 million people are estimated to be having symptomatic disease manifestation, 14 million of whom have chronic lymphoedema and 2.5 million are affected with hydrocele.
- The economic loss due to LF is estimated to be very huge. India alone loses US \$ 1.5 billion every year due to LF. The return on investment on LF elimination has been found to be as high as 6:1 in China; the ratio could be higher in the SEA Region.
- Nearly 60% of the LF problem is in the SEA Region; 30% in the African Region; 5% in the Eastern Mediterranean Region; 4% in the Western Pacific Region and 1% in the American Region.
- Since the launching of the programme in 2000, mapping of the distribution of LF had been completed in 45 countries till 2003; eight more countries completed the exercise in 2004. MDA has been scaled up in all the regions. The following table shows the status of implementation of MDA in each region:

Table. Status of implementation of MDA, by region

Region	Countries implementing MDA		Proportion of endemic population covered with MDA (Percentage)
	Number	Percentage	
Africa	9/39	23	6
America	4/7	57	28
Eastern Mediterranean	2/3	67	20
South-East Asia	9/9	100	52
Mekong Plus	4/8	50	65
PacELF	13/17	76	38

- In 2004, about 108 million people were targeted for MDA with two-drug strategy and 82 million of them were reported to have ingested the drugs. The majority was in the SEA Region which targeted 64 million population of which 51.7 million people were reported to have ingested the drugs. In addition, India had targeted 326 million for MDA with DEC alone strategy.
- The impact of MDA on mf clearance as assessed through sentinel sites has been found to be very encouraging. Of all sentinel sites in different regions, 13–62% sites had achieved complete clearance of microfilaraemia while 25–75% of the sites had achieved 25–75% clearance after 2-3 rounds. Only 13 out of 100 sentinel sites had observed clearance rates of less than 50%.
- Major aspects supported by WHO included technical assistance for monitoring, stopping MDA; capacity building, supply of quality drugs and diagnostics, operational research and funding.
- Future strategy and the population to be covered up to 2008 have been identified. Dr Biswas stressed the need to scale up MDA and match the demand with resources.

7. REPORT ON THE GLOBAL ALLIANCE TO ELIMINATE LYMPHATIC FILARIASIS

A report on the Global Alliance to Eliminate LF (GAELF) was presented by Ms John Fahy and Mr Andy Wright. The Executive Group (EG) of GAELF

guides the development and implementation of (a) communication strategies, (b) partnership development and (c) involvement of major donors and partners. The Representative Contact Group (RCG) comprises 30 members selected from different partner groups. RCG acts as a link between EG and Alliance partners for various activities pertaining to effective implementation of ELF. Two programme managers from the SEA Region and the Chairperson of SEA RPRG are also members. The EG activities involve arranging regular teleconferences, action plans, RCG update, advocacy and fund-raising at national and international levels.

GlaxoSmithKline has shipped 307 million tablets of albendazole to 38 endemic countries till December 2004. The SEA Region had received 64% of the shipment drug. Based on present estimates, requirement of albendazole tablets would be about 280 million during 2007.

8. PROGRESS OF ELF IN THE SEA REGION

Dr Derek Lobo presenting the progress of ELF in the SEA Region made the following points:

- The progress of implementation of ELF activities has been very satisfactory as South-East Asia became the first region to have all LF endemic countries implement MDA by 2005. MDA with DEC+albendazole has covered 51.2 million population in the Region during 2004. India had covered 360 million population under DEC alone in 190 districts in 2004 while seven districts had been covered under DEC+albendazole. All the other eight endemic countries in the Region had implemented co-administration with DEC+albendazole in all the implementation units (IUs) covered to date.
- The numbers of districts covered under MDA during 2004 were 32 in Bangladesh, 202 in India, 170 (sub districts) in Indonesia, 33 in Nepal, 1 (island) in Maldives, 39 in Myanmar, 8 in Sri Lanka, 336 (sub districts) in Thailand and 13 districts in Timor-Leste. More than 80% coverage has been reported in eight endemic countries excluding Timor-Leste where MDA commenced in 2005.
- Adequate baseline data have not been collected in some areas prior to implementation of MDA. The required number of sentinel and spot-check sites have not been selected in some places. There is a need for clear planning and selection of standardized indicators for stopping MDA.

- Disability alleviation is being augmented with model projects in Sri Lanka and Indonesia as well as future planned projects (2005-06) in Timor-Leste and Myanmar. Hydrocelectomy as a routine surgery is being implemented in India, Myanmar and Sri Lanka, while the other endemic countries are planning to increase access to hydrocelectomy surgery. A camp approach is also being followed in Bangladesh and some areas in India.

9. FUTURE PLANS IN THE SEA REGION

Dr E.A. Padmasiri in his presentation made the following points:

- In line with the global target of achieving elimination by 2020 the SEA Region too formulated its strategic plans. However, it seems feasible that the Region could aim to achieve elimination status by 2015 and maintain the elimination status thereafter.
- Mapping had been completed in four countries by the end of 2004 and four more countries would complete it by 2005. Indonesia will accelerate and complete mapping exercises by 2006.
- By 2005, five of the nine endemic countries, namely India, Maldives, Sri Lanka, Thailand and Timor-Leste will target entire endemic populations for MDA. These countries would achieve LF elimination within the next five years. Sri Lanka and Thailand will move on to verification for absence of transmission for stopping MDA by 2007. The other four countries will scale up MDA at a pace depending on the availability of financial sources. It is aimed that by 2010, all the remaining IUs in the endemic countries would have started MDA.
- Attention will be focused on surveillance and research specially addressing issues on maintenance of elimination status.
- Meeting the demand of the required resources will be the biggest challenge. WHO plans to increase its efforts at advocating development and maintaining partnerships at global, regional, country and state levels. National governments too will increase their efforts in this regard.

10 COUNTRY PRESENTATIONS

10.1 Bangladesh

Thirty-two out of a total 64 districts in Bangladesh with about 70 million population are identified as endemic to filariasis. MDA of the 2004 round was carried out in 10 IUs with a total population of 11.75 million. Coverage rates

of over 80% have been achieved in all the IUs. Increased attention has been focused on disability management. It also provides such services in a filaria hospital run by an NGO and in several health centres. By 2004, 1673 patients with filariasis including 288 hydrocoelelectomies, have been managed through these centres. However, community home-based disability alleviation projects have not yet started.

The programme has received support for ELF from LEPRU UK/Bangladesh, Liverpool LF Centre, AusAid, JICA and WHO in addition to internal sources including funds from HNPSP/World Bank. Thus, programme areas are going to be extended to 15 IUs in 2005 covering a total population of 20.40 million.

10.2 India

Co-administration with DEC+albendazole was done in seven districts; six in Tamil Nadu and one in Kerala. Most of the regions had achieved good coverage.

Although it was not a WHO recommended strategy, India had also targeted 202 endemic districts in 20 states/union territories for MDA in 2004. MDA with DEC alone had been undertaken in 195 districts except in three states (Assam, West Bengal, and Jharkhand) due to logistical problems. In addition, the coverage was less than 10% in some IUs in Gujarat, which was on account of taking up MDA in selected pockets of the districts. A stronger social mobilization campaign for MDA has been planned for 2005 with special attention to low coverage districts.

Thirteen new IUs with more than 43 million population have been proposed for inclusion in MDA during 2005 in addition to 202 districts already covered. Mopping up operations to improve drug coverage have also been planned to be conducted two weeks after MDA.

The national government almost completely funds the ELF programme including countrywide MDA. However, some financial and technical support has also been provided by Gates Foundation, DFID and WHO.

10.3 Indonesia

Mapping has been carried out in 170 out of 2860 IUs. MDA has been conducted in 55 IUs in 2004. The reported coverage has been more than 80% in most places. MDA has been discontinued in one IU due to non-

availability of funds but it is hoped to restart the activities early. The programme is also paying attention to disability management. A total 377 health personnel have been trained through 13 training courses.

The ELF programme in Indonesia has received support from AusAid, GTZ, and ADB and significant budgetary support from the national government and decentralized government institutions.

10.4 Maldives

Maldives has carried out MDA in 2004 in its only singular endemic island known as L. Fanadhoo. This island had a population of 1826. Ninety-eight percent of the eligible population or 86% of the total population ingested the drug. Maldives will continue with five rounds of MDA to eliminate LF. The country has also focused attention on increasing vector control activities following the tsunami in December 2004 which affected a number of previously-endemic islands.

10.5 Myanmar

Mapping of LF endemicity is expected to be completed by 2006. LF has been found to be endemic in 39 out of 63 districts in the country. The reported coverage was 94.2% of eligible population and 82.6% of the total population of IUs. About 40% of the population at risk has now been protected under the programme. Three deaths have been recorded during MDA. Investigations revealed that they were not related to MDA drugs.

Myanmar has also paid attention to alleviation of disability due to LF. During 2004, 102 surgical operations for hydrocoelectomy were performed. Significant support has been provided by Gates Foundation, WHO, Liverpool LF Support Centre and Sasakawa Memorial Health Fund. In 2005, the national programme will target 22.7 million people for MDA.

10.6 Nepal

Mapping has progressed in Nepal which showed that 33 of the 75 districts are endemic and 10 non-endemic while 32 still remained to be mapped. Nepal had commenced MDA in 2003 in one district with two more being added in 2004. In all, 1.5 million people have been covered under the ELF programme in 2004. However, there is a need to improve sentinel surveillance. Attention has been focused on alleviation of disability of LF. About 7200 health

personnel had been trained in ELF through 190 courses. Nepal expects to further scale up MDA to cover five districts in 2005.

The programme has received technical and financial support from Gates Foundation, WHO EHP/USAID, WHO and World Bank in addition to receiving significant contributions from the national governments.

10.7 Sri Lanka

Sri Lanka has mapped the known endemic areas and has now covered the entire endemic population, which is nearly 10 million in eight districts, with MDA over the last four years. Reported coverage has been over 85%. The programme had also made appreciable attempts to independently evaluate MDA coverage. One such survey had shown that the actual coverage has been slightly lower, being 80.8%. Another coverage survey, carried out in 30 schools, had shown a coverage of 87.1%. The programme had been routinely and extensively carrying out sentinel surveys which had shown a steady decline of MF rates to a level below 1%. In addition, special surveys had been carried out for high-risk groups (inmates of prisons), demonstrating mf positive rates of 1.22 to 1.29%.

The pilot project on community home-based disability alleviation that commenced in 2003 has progressed well. In the district it was implemented, 217 hydrocelectomies were carried out in 2004.

MDA will continue in 2005 too targeting about 10 million people for the fourth consecutive time. The programme has received external financial and technical support from Gates Foundation, DFID, WHO, LF Support Centre-Liverpool, Nestle Lanka, and LF Support Centre – Emory University.

10.8 Thailand

Thailand has completed three rounds of MDA. The overall coverage of MDA has been 85% of the eligible population and about 80% of the total population. Mf rate has been brought down to zero in most IUs following MDA.

In 2005 too, the programme will target the entire endemic population of 175 000 for MDA for the fourth consecutive annual round. The programme is entirely funded by the Government of Thailand while it also received some technical assistance from WHO.

10.9 Timor Leste

Timor-Leste has adopted an integrated approach for elimination of LF along with control of STH and eradication of yaws. A National Task Force has been established. Mapping has been completed all 13 districts have been identified as endemic.

The country has planned to cover all the implementation units in a phased manner with the first round MDA in 2005 targeting nearly one million population. It has also planned to synchronize deworming round with MDA with a gap of about six months between the two interventions.

The programme has received tremendous financial and technical support from Sasakawa Memorial Health Fund, AusAid and WHO.

11. FOLLOW-UP OF THE RECOMMENDATIONS OF THE 5TH TECHNICAL ADVISORY GROUP MEETING

The role of TAG is essentially to provide technical guidance to the global programme at all levels of implementation. Being a science-based programme, TAG has a responsibility to make sure the decisions and recommended actions are evidence-based on current knowledge and understanding of the epidemiology of the disease. The last meeting of TAG was held in February 2004 and the next meeting is scheduled to be held in September 2005. Many technical issues in relation to programme implementation were also discussed at TAG-5, details of which are given in TAG-5 report. As a follow up of the recommendations, scientific meetings on operational research were held in Philadelphia, USA, in November 2004 and in Miami, USA, in January 2005 further addressing some of these issues.

12. UPDATE ON BRUGIA RAPID ANTIBODY TEST

An update on Brugia rapid antibody test was provided by Dr C.P. Ramachandran. This has been evaluated in an international multi-centric study carried out by nine institutions. In total, 1288 persons in Brugia-endemic areas were subjected to Brugia rapid test. The study had revealed 95% sensitivity and 99% specificity. The field trials in Sarawak involving 1 095 persons showed 87% sensitivity and 75-92% specificity. The sensitivity achieved was found to be good. Brugia rapid test detected ten times more cases than thick blood smear.

In another study involving 512 persons including many children in non-endemic areas of Malaysia, tests showed 100% negative results. Field trial in *B. timori* in East Timor showed 100% sensitivity and 100% specificity. Follow-up of treated microfilaria carriers showed decline in IgG4 antibody level. Cross-reaction with *W. bancrofti* in different endemic areas had shown variation in results, warranting further elucidation.

Brugia rapid test had demonstrated high sensitivity in the detection of *B. timori* infection. Brugia rapid dip sticks were used to map Brugia-endemic areas in Timor-Leste.

The use of Brugia rapid antibody test, together with ICT, has the potential to replace night blood filming in areas where both brugian and bancroftian filariasis exist. The forthcoming TAG meeting in August 2005 will further discuss this issue and make a recommendation on its use for mapping and monitoring of LF endemicity as well as its place in studies on verification of elimination.

13. POINTS FOR CONSIDERATION AT THE 6TH MEETING OF TAG

The present meeting of Programme Managers discussed important points for consideration at the next TAG meeting. Among the points discussed were the importance of sustaining and improving coverage and compliance with MDA, social mobilization, challenges in achieving adequate coverage with disability prevention programmes, need for operational research on LF elimination goals at global, regional and national levels.

14. MONITORING AND EVALUATION

Dr Gautam Biswas led the discussion and functioned as the main facilitator at the session on new monitoring and evaluation guidelines.

The revised guidelines would facilitate evaluation of the impact of intervention measures and provide information on when to terminate MDA. If there is deviation in the expected results, programme managers could make necessary changes in the strategy. The most important components in the monitoring of ELF encompass assessment of the proportion of people actually ingesting the drugs and the impact of MDA on the prevalence of microfilaraemia. Specific indicators for monitoring have been identified for comparison in space and time.

The personnel involved in monitoring should be familiar with the indicators and correct methods for collecting data. The health personnel will need to be trained on the significant aspects of different components of monitoring for successful implementation of the programme. Baseline data in every implementation unit should be collected as per guidelines. The number of eligible population for MDA will have to be arrived at through door-to-door enumeration and updating of information before every round of MDA.

It was highlighted that drug coverage in respect of total population and eligible population should be reflected separately. It was re-emphasized that the choice of sentinel and spot-check sites will need to be made as per guidelines in all the IUs. The mf rate, mf density and disease rate need to be measured in all the selected sites. Verification of interruption of transmission before stoppage of MDA in each IU will be critical to the programme. The guidelines on these aspects were also discussed in detail.

15 GROUP WORK

Group discussions were conducted country-wise with the RPRG members functioning as resource persons. They deliberated on the technical and operational issues; various aspects pertaining to supply of ICT cards; requirement of drugs especially DEC for the next round of MDA; fund-raising issues; capacity building; completion of mapping in identified areas; extension of the ELF programme to new districts and stopping of MDA. The group later made recommendations on the critical issues.

16. PRESENTATION OF RECOMMENDATIONS OF SEA RPRG MEETING HELD ON 3-4 MAY 2005

This was the first time that all nine endemic countries in the Region met under one RPRG and the first time that the RPRG meeting preceded the programme managers' meeting. It helped RPRG to clarify some issues that came up during their meeting and also to discuss their recommendations with the national managers. The recommendations of the RPRG meeting are given in Annex 3. Country-specific recommendations made by RPRG were communicated separately to individual countries.

17. MID-TERM REVIEW OF NATIONAL/REGIONAL STRATEGIC PLANS AND FORMULATION OF STRATEGIC PLANS UP TO 2010

The programme managers have reviewed the respective national strategic plan and formulated a strategic plan up to 2010. A regional plan was accordingly consolidated with inputs from the national programmes. A framework of the strategic plan up to 2010 is at Annex 4.

18. CONCLUSIONS AND RECOMMENDATIONS

The following are the recommendations of the LF Programme Managers Meeting:

- (1) Member States should include additional members from universities, non-governmental and private sectors to strengthen their national task forces.
- (2) ELF programme activities should be integrated where relevant with other tropical diseases like malaria, STH, kala-azar, yaws, and leprosy, wherever feasible, so as to implement these public health interventions cost-effectively.
- (3) Countries which have not yet completed mapping should make all efforts to complete mapping by the end of 2006.
- (4) Countries should make efforts to mobilize national and multilateral/bilateral partners to support LF elimination and also explore the possibility of reducing the cost of implementation of MDA and related activities.
- (5) National programmes should ensure quality assurance of DEC and procure DEC only from WHO pre-qualified manufacturers. In case other manufacturers are chosen, technical assistance of WHO may be sought to audit their GMP (Good Manufacturing Practices) and GLP (Good Laboratory Practices) standards.
- (6) Countries should give high priority to social mobilization and other preparatory activities in order to ensure that the drug coverage (compliance) is increased. Reported coverage should be cross-checked by the recommended surveyed coverage.*

* Reference: WHO CDS CPE CEE 2005 50 - Monitoring and Epidemiological Assessment of the Programme to Eliminate Lymphatic Filariasis (LF)

- (7) National programmes should ensure collection of baseline parasitological data before further scaling up MDA.
- (8) It is observed that progress on the scaling up of disability prevention has been very slow. Countries should expand their disability prevention activities to cover all MDA-implemented IUs without any delay.
- (9) Countries should pay greater attention to other preventive measures at individual and community levels such as use of insecticide-treated bednets and integrated vector control.
- (10) Emphasis should be placed on monitoring the impact of MDA on microfilaraemia as recommended in the WHO guidelines.*
- (11) National programmes should ensure that MDA is not stopped in any IU until the interruption of transmission is assessed, as suggested in the WHO guidelines* and achieved the defined criteria: (a) at least 5 rounds of effective MDA, and (b) microfilaraemia prevalence rate of less than 1% in the population and less than 0.1% in children below 5 years.
- (12) Existing partnerships for ELF at national and state levels should be further strengthened and new partnerships sought.
- (13) WHO should facilitate synchronization of mass drug administration in contiguous intercountry border areas.

19. CLOSING SESSION

Dr Mahroof Ismail, Chairman, expressed great appreciation for inclusion of a large number of implementation units for MDA during 2004. On behalf of WHO, Dr Derek Lobo thanked all the participants for their active participation and all others who contributed to the success of the meeting.

* Reference: WHO CDS CPE CEE 2005 50 - Monitoring and Epidemiological Assessment of the Programme to Eliminate Lymphatic Filariasis (LF)

Annex 1

LIST OF PARTICIPANTS

Bangladesh

Dr Moazzem Hossain
Programme Manager (Filariasis)
Directorate-General of Health Services
Mohakhali
Dhaka

India

Dr P.L. Joshi
Director
National Vector Borne Disease
Control Programme
22 Sham Nath Marg
Delhi-110 054

Dr P.K. Srivastava
Joint Director
National Vector Borne Disease
Control Programme
22 Sham Nath Marg
Delhi-110 054

Dr Jagdeesh Ramasamy
Additional Director (Malaria and Filaria)
DMS Complex
359- Anna Salai
Chennai 600006
Tamil Nadu

Dr M.K. Jeevan
Additional Director of Health Services
Thiruvananthapuram
Kerala

Dr Ramesh Chandra
State Entomologist
Office of Additional Director (Malaria and
Filaria)
Jawahar Bhavan, 4th Floor
Lucknow
Uttar Pradesh

Dr D.S. Dakure
Joint Director (Malaria and Filaria)
Opp. Vishrantwadi Police Station
Yerwada, Alandi Road
Pune
Maharashtra

Indonesia

Dr Hariadi Wibisono
Director of Vector Borne Disease Control
Directorate General of CDC & EH
Ministry of Health, RI
Jakarta

Dr Sitti Ganefa
Chief of Monitoring Section
Sub Directorate of Filariasis
Directorate of Vector Borne Disease Control
Directorate of Health, RI
Jakarta

Maldives

Mr Hasan Samir
Deputy Director
Vector Borne Disease Control Unit
Ministry of Health
Male

Myanmar

Dr Saw Lwin
Deputy Director (Malaria)
Vector Borne Disease Control
Department of Health
Yangon

Dr Khin Mon Mon
National Programme Manager
(Lymphatic Filariasis)
Department of Health
Yangon

Dr Ni Ni Aye
Malariologist
VBDCP Unit
Tanintharyi Division
Yangon

Nepal

Dr Shankar Bahadur Shrestha
Senior Medical Officer
Epidemiology and Disease Control Division
Department of Health Services
Ministry of Health
Kathmandu

Sri Lanka

Dr (Mrs) T.S. Liyanage
Director, Anti-Filariasis Campaign
Ministry of Healthcare, Nutrition and Uva
Wellness Development
Colombo

Thailand

Miss Sunsanee Rojanapanus
Public Health Technical Officer
Bureau of Vector Borne Diseases
Department of Disease Control
Ministry of Public Health
Nonthaburi 11000

Regional Programme Review Group (Members)

Prof Mahroof M Ismail
Professor Emeritus
Faculty of Medicine
University of Colombo
159 Kynsey Road
Colombo
Sri Lanka

Dr P.K. Das
Director
Vector Control Research Centre
Indira Nagar
Pondicherry 605006
India

Dr S.R. Salunke
Director General of Health Services
Directorate of Health Services
Government Dental College Bldg.
4 Floor, PD Mello Road
Mumbai 40001
India

Prof Dato C.P. Ramachandran
8A-4-4, Belvedere
1/63, Off Jalan Tunku
50480 Kuala Lumpur
Malaysia

Prof R. Krishna Shenoy
Former Professor and HOD of Medicine
Chief of Filariasis Chemotherapy Unit
TD Medical College Hospital
Alleppey 688011
Kerala
India

Dr Somei Kojima
Deputy Director
Center of Medical Science
International University of Health and Welfare
Otagawa City
Tochigi Prefecture 324-8501
Japan

Special Invitees

Dr Sombat Chayabejara
107 Soi Pattanakarn 53
Suanluang
Bangkok 10250
Thailand

Liverpool School of Tropical Medicine

Mrs Jaon Fahy
Programme Coordinator
Lymphatic Filariasis Support Centre
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool L3 5QA
UK

LEPRA

Mr Rene Vargas
Development Officer
British Leprosy Relief Association (LEPRA)
Fairfax House
Causton Road
Colchester CO1 1PU
UK

Observers

Dr Chaiporn Rojanawatsirivet
Director of Vector Borne Disease
Ministry of Public Health
Thailand
Mrs. Weena Santabutr
Senior Public Health Technical Officer
Ministry of Public Health
Nonthaburi
Thailand

Glaxo SmithKline

Mr Andy Wright
Director
Lymphatic Filariasis Elimination Programme
Global Community Partnerships
Glaxo SmithKline
WL G 39 GW House West
Berkeley Avenue, Greenford
UK
Mr S.P. Kapoor
GlaxoSmithKline Pharmaceuticals Ltd
Bharat Yuvak Bhawan Building
1 Jaisingh Road
New Delhi
Mr Sameer Deb
GlaxoSmithKline Pharmaceuticals Ltd
Dr Annie Besant Road
Worli
Mumbai 400030
India

JICA

Mr Masao Koda
Senior Programme Officer
Filariasis Elimination Programme

Japan International Cooperation Agency, Japan
Overseas Cooperation Volunteers
Dhaka
Bangladesh

Unable to attend

Dr Rama Baru
Global TAG-LF Member
Jawaharlal Nehru University
New Delhi, India

WHO Secretariat

Dr G. Biswas
Medical Officer
Lymphatic Filariasis
WHO/HQ
Dr Derek Lobo
Regional Adviser
Leprosy and other Priority Diseases
WHO/SEARO
Dr E.A. Padmasiri
Short-Term Professional
Elimination of Lymphatic Filariasis and Control
of Soil Transmitted Helminthiasis
WHO/SEARO
Dr Mannan Bangali
National Professional Officer
Vector Borne Disease Control
WHO Representative's Office
Bangladesh
Dr C.K Rao
National Professional Officer
Lymphatic Filariasis
WHO Representative's Office, India
Dr Muhammad Asri Amin
National Professional Officer
Malaria
WHO Representative's Office
Indonesia
Dr Megan Counahan
Short-Term Professional
Lymphatic Filariasis
WHO Representative's Office
Timor-Leste

Annex 2

AGENDA

- (1) Opening session
- (2) Introductions and objectives of the meeting
- (3) Nomination of Chairperson and Rapporteur
- (4) Adoption of Agenda
- (5) Overview of Global LF Programme
- (6) Report on the Global Alliance to Eliminate Lymphatic Filariasis
- (7) Progress of LF elimination in the SEA Region
- (8) Future plans
- (9) Country presentations
- (10) Follow-up of the Recommendations of the 5th meeting of Technical Advisory Group
- (11) Update on Brugia Rapid Test
- (12) Important points for consideration at the 6th meeting of TAG
- (13) Monitoring and evaluation
 - New guidelines/Country experience on monitoring and evaluation
- (14) Group work
- (15) Group Presentations
- (16) Presentation of Recommendations of the First SEAR RPRG Meeting
- (17) Mid-term Review of National/ Regional Strategic Plans and formulation of strategic plans up to 2010
- (18) Conclusions and recommendations
- (19) Closing session

Annex 3

RECOMMENDATIONS OF THE MEETING OF THE SOUTH-EAST ASIA REGIONAL PROGRAMME REVIEW GROUP 3-4 MAY 2005, NEW DELHI, INDIA

- (1) All member countries should include additional members from non-governmental and private sectors to strengthen their national task forces. (It appreciates the formation of state task forces and technical advisory committees in some states/UTs in India and recommends that state task forces be formed in all LF endemic states).
- (2) ELF programme should be integrated with other "neglected" diseases like STH, kala-azar, yaws, leprosy, etc wherever feasible so as to implement these public health interventions cost-effectively.
- (3) Member states which have not yet completed mapping, should make all efforts to do so by the end of 2006.
- (4) Member States should mobilize national and multilateral/bilateral donors to support LF elimination. They should explore the possibility of cost-saving in the implementation of MDA and related activities.
- (5) It was observed that some countries reported mild adverse reactions as serious adverse experiences (SAEs) in their annual reports. Countries should only report events which fall into the definition of WHO guidelines and complete the standard SAE investigation form.
- (6) MDA programmes should ensure quality assurance of DEC and procure DEC only from WHO pre-qualified manufacturers. In case other manufacturers are chosen, assistance of WHO may be sought to audit their GMP and GLP standards.
- (7) It was observed that the information provided in some annual reports and re-applications is incomplete. Countries should provide complete information in the annual reports and re-applications in order to facilitate in-depth assessment of the programme and render technical advice.
- (8) It was noted with concern that the actual drug coverage in some countries/areas was substantially low. Countries should give high priority to social mobilization and other preparatory activities in order to ensure

that the drug coverage (compliance) is increased. Reported coverage should be cross-checked by the recommended surveyed coverage.

- (9) It was noted that MDA was undertaken in some IUs without collection of baseline data. Countries should ensure collection of baseline information before further MDA scale-up.
- (10) It was observed that all endemic countries had addressed the question of disability alleviation; however, progress has been very slow and countries are urged to expand their disability alleviation programmes to cover all MDA implemented IUs without a delay.
- (11) Since South-East Asia is the Region with the highest burden of filariasis, a full-time staff member be assigned to assist the Regional Adviser to provide technical assistance to Member States.

Annex 4

FRAMEWORK OF THE STRATEGIC PLAN, 2006-2010

	SEARO	2006	2007	2008	2009	2010
1	<u>Mapping:</u> Completion of mapping					
2	<u>Mass drug administration:</u> Number of people to be covered (DEC + albendazole)					
3	<u>Mass drug administration:</u> No. of IUs on MDA					
4	<u>Mass drug administration:</u> No. of IUs completing 5 rounds					
5	<u>Disability alleviation:</u> No. of IUs to be covered with community home-based care					
6	<u>Diability alleviation:</u> No. of IUs to have increased access to hydrocelectomy					
7	Estimated approximate budget for the above activities					
8	Expected govt. contribution of the above budget					