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Report of the Meeting of Programme Managers for the Elimination of Lymphatic Filariasis

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1. INTRODUCTION

Lymphatic filariasis (LF) is one of the most disfiguring diseases and is the second leading cause of permanent disability. The disease is endemic in 80 countries across the world.

In May 1997, the fiftieth World Health Assembly adopted a resolution (WHA50.29) calling for the global elimination of lymphatic filariasis as a public health problem. A global strategic plan prepared by WHO indicates that to eliminate the disease (<1/1000 population in five consecutive years) by 2020, all endemic areas in Member States should be covered by the elimination programme by 2010. The two main strategies are: (1) reducing the spread of infection by interrupting the transmission through mass drug administration (MDA) with a two-drug combination - diethylcarbamazine and albendazole - to the entire population in the endemic areas, and (2) disability alleviation through morbidity management and relieving and preventing suffering.

Implementation of the Regional Strategy to Eliminate Lymphatic Filariasis

At par with the global strategy, the strategic plan for the South-East Asia Region was formulated with consensus on the strategy and targets at the Programme Managers' Meeting in Orissa, India, in 2000. This plan was further revised at the Bi-regional Programme Managers' meeting held in Bali in July 2002 and the strategic plan for 2003-2007 formulated. Seven of the nine endemic countries are now implementing MDA.

Glaxo-Smith-Kline (GSK) has pledged to donate albendazole for the LF elimination programme until the global target year for elimination-2020. A Global Programme Review Group was created as a requirement of the MoU signed between WHO and the donor to set up guidelines and requirements for the donation. In anticipation of the scaling up of programme activities, six Regional Programme Review Groups (RPRG) were established by 2001. The grouping of countries into the PRGs was based on the geographical and epidemiological distribution of the disease. Thus, the countries of the South-East Asia Region were included in two groups (a) Indian Subcontinent PRG –

Bangladesh, India, Maldives, Nepal and Sri Lanka, and (b) Mekong Plus PRG – Indonesia, Myanmar and Thailand.

In 2002, a bi-regional meeting of SEAR and WPRO countries with participation of both Indian Subcontinent and Mekong Plus countries was held. In 2003, the programme managers meeting was held separately for the Indian Subcontinent and Mekong Plus groups so as to give greater focus to individual countries in each group. Further, holding the 4th RPRG meeting back-to-back with the programme manager's meeting enabled the RPRG members to interact with the country managers, thereby facilitating better review and optimizing of cost-effectiveness.

The programme manager's meeting helped to review progress towards achieving the elimination targets.

2. OPENING SESSION

The first meeting of the Indian subcontinent's Lymphatic Filariasis Programme Managers was opened by Dr B.D. Chataut, Director-General of Health Services, Ministry of Health, Nepal.

Dr Mahendra Bahadur Bista, Director, Epidemiology and Disease Control Division, Department of Health, Ministry of Health, Nepal, welcomed the programme managers and other participants.

Address by the Regional Director, WHO

The address by Dr Uton Muchtar Rafei, Regional Director, WHO South-East Asia Region, was delivered by Dr Klaus Wagner, WHO Representative to Nepal.

Dr Uton, highlighted lymphatic filariasis as a major cause of disability, social stigmatization, economic loss and a major burden on the health and social systems. He pointed out that globally, this disease was the second leading cause of permanent and long term disability and that over 1.1 billion people were at risk of infection, with over 120 million already affected in 80 countries. Lymphatic filariasis occurred in five of the six countries in the Indian subcontinent, with India accounting for the major part of the burden. Approximately 524 million people comprising 47% of the global figure were at risk of infection in these five countries. Fortunately, effective tools were available to eliminate this infection as a public health problem. Therefore, it

was important to continue to support and strengthen the existing programmes in these countries.

The Regional Director said that by the end of 2002, 56 million people had received mass drug administration in 32 countries throughout the world. Of these, three countries from the Indian subcontinent-Bangladesh, India and Sri Lanka had covered 34.8 million people. Nepal had also commenced MDA in June 2003, targeting 500 000 population in one district.

Dr Uton, thanked Glaxo-Smith-Kline for providing albendazole free of charge to all MDA implementing countries and for pledging the supply until 2020.

Address by the Director-General of Health Services Ministry of Health, Nepal

In his regional address, Dr B.D. Chataut, Director-General of Health Services, Ministry of Health, Nepal, said that at par with WHO's global target of elimination of lymphatic filariasis by 2020, Nepal had adopted the WHO strategy to eliminate LF as a public health problem. MDA using co-administration of DEC and albendazole and morbidity management of the affected persons to prevent and alleviate LF related disability had been undertaken. Dr Chataut said that Nepal conducted the first-ever MDA in the Parsa District in May 2003 targeting the entire population of about 500 000 people.

Underlining the importance of external support to the resource-limited countries for scaling up ELF activities, he said that LF can be eliminated only by working together in partnership, like Global Alliance for Elimination of LF.

3. TECHNICAL SESSION

Election of the Chairperson, Vice-Chairperson and Rapporteur

Dr Mahendra Bahadur Bista, Director, Epidemiology and Disease Control Division, Ministry of Health, Nepal, was elected chairperson; Dr Jotna Sokhey, LF Programme Manager and Director National Anti-Malaria Campaign, India, was elected vice-chairperson. Dr Moazzem Hossain, LF Programme Manager, Bangladesh was elected Rapporteur.

Adoption of the Agenda

The meeting adopted the agenda as given in Annex 3.

Objectives of the meeting

The objectives of the meeting were:

- To review the status of LF elimination in endemic countries in the Region with a view to identifying and making recommendations on operational and technical issues including research needs.
- To share new knowledge and experience in the area of LF.
- To discuss and refine the Elimination of Lymphatic Filariasis (ELF) programme.

Overview of Global Programme and Global Alliance to eliminate LF

Dr Gautam Biswas in his presentation highlighted the important aspects of the Global Programme and the Global Alliance to eliminate LF. He said that a Technical Advisory Group had been established and the Programme Review Group regionalized; meetings of Regional Programme Review Groups were being held in all endemic regions and meetings of programme managers were held for all regions. The following topics were also covered:

Mapping of distribution of LF

- Progress of mapping had been slower than expected in many countries. While 38 countries had completed mapping, 20 countries were in the process of doing so.
- The present Immuno Chromatogenic Test (ICT) cards have good sensitivity and specificity but need to be read preferably at 10 min. (and definitely within 30 minutes.) They were being used in national programmes for mapping. The manufacturer had sought approval for a new version of ICT cards with revised specifications that can be read between 2 hours and 24 hours but will proceed only on condition that the programme will use the new cards with new specifications. However, the programme managers preferred the existing cards to the suggested ones.

Mass Drug Administration

- The number of countries implementing MDA had increased from 12 in 2000 to 37 in 2003; the number of people covered increased from 15 million in 2000 to 58 million in 2003. Documentation on the safety of co-administered drugs was completed before the start of MDA. Attention was being paid to the disability prevention component as part of MDA.
- Progress on mapping was slower than expected.

The following table summarizes the details of MDA in different regions:

Table: Status of MDA in different regions

	No. of endemic countries	Population at risk in endemic countries (millions)*	Population at risk in endemic countries (%)	No. of countries started MDA	Population at risk covered in 2002 (millions)	% of at risk population covered in 2002
Africa	39	477	37.9	9	9.4	1.97
Americas	7	9	0.7	2	0.6	6.18
Eastern Mediterranean	3	29	2.3	2	2.5	8.69
Mekong Plus	11	214	17.0	5	11.4	5.34
Indian Subcontinent*	5	524	41.6	3	34.5	6.58
PacELF	15	6	0.5	11	1.2	18.20
Total*	80	1259	100	32	59.5	4.73

*Population at risk adjusted according to mapping

Alleviation of disability due to LF

- The basic principles and framework for a national LF-related disability prevention strategy have been formulated. Informal consultations on

increasing access for management of hydroceles and another informal consultation on the application of the ICF classification to LF-related disability had been conducted.

- Attention was focussed on building capacity at the national level and projects were initiated in Burkina Faso, Tanzania, Sri Lanka, Haiti, Brazil, and the Dominican Republic whereas training workshops were held in India.
- A training package for self-care at the community level had been developed.

Capacity building

- Regional training and capacity building programmes were continuing. These included country-specific technical assistance projects.
- Guidelines on monitoring as recommended by TAG and a set of “How to implement” manuals for district-level managers had been developed.
- The highest priority was given to supporting countries which had initiated a mapping exercise to complete it in the shortest time and to conduct Independent assessment and validation of mapping surveys.
- Steps were taken in ensuring adequate supply and use of quality diagnostic tests.
- Efforts were made to ensure continuity and effective coverage of MDA in implementation units where MDA was in progress and in countries where MDA was initiated to expand geographical coverage. Support was offered to countries / provinces to integrate strategies for disability prevention into the existing national programmes.
- Generic training packages for lymphoedema management for self-care and for medical personnel for hydrocele surgery by standard operating procedure were produced. Guidelines for Implementation Units to increase access to hydrocele surgeries and lymphoedema management were also developed .
- Operational links with other home-based care for chronic diseases units were encouraged and new training modules for programme managers produced.
- The annual report on Lymphatic Filariasis 2002, an advocacy report, **“The Story of Egypt”**, and a template for the adaptation of a comic

book on lymphatic filariasis for schoolchildren in sub-Saharan Africa were produced

Global Alliance for ELF (GAELF)

- GAELF aims to scale up MDA to cover 350 million people at risk by 2005, establish prevention of LF-related disability in 50% of the LF-endemic countries and develop technical capacities within each region to support the country initiatives to eliminate lymphatic filariasis.
- A strategic planning workshop was conducted in December 2003 at Liverpool. A five-member collegial secretariat, two task forces, one for fund raising and advocacy and the other for communication and GAELF 3 were formed. It will maintain regular information-sharing and consultation with GAELF partners, review the progress of the GAELF task forces on a quarterly basis, provide policy guidance to the task forces and report progress to the GAELF partners.

Implementation Status of ELF in the Indian Subcontinent

Endemicity and strategy to eliminate LF

- The five endemic countries in the Indian subcontinent, represent 50% of the global burden of LF. About 540 million people in these countries are at risk with about 40 million already affected.
- All countries are committed to achieve the goal of ELF and have formed national task forces to eliminate LF. While Maldives is yet to verify its endemicity level and the strategy, other endemic countries have adopted the strategy of mass drug administration (MDA) to eliminate LF.

Mapping

- WHO, along with other relevant stakeholders has offered technical and financial assistance to the national programmes to conduct mapping. However, a few issues still need attention. They include uncertainties over defining of IU – district vs smaller population units, use of old data vs new data, low priority in some places and accessibility issues such as civil disturbances in some areas and difficult geographic terrain.

MDA

In the Indian subcontinent 540 million people are at risk of infection, constituting 52% of the global population at risk. By the end of 2002, 37

million people compared to 22 million in the rest of the world had been covered under MDA with combination drugs. In addition, India covered 59.08 million affected people under the DEC alone strategy.

Among the issues and constraints that need to be addressed are, inadequate funds, need for strengthening social mobilization and assessment of coverage, and uncertainty in some places in defining the IU and criteria for expansion into next IUs.

WHO and other partners of GAELF had offered assistance to national programmes in various ways. This included technical guidelines, training modules on MDA, arranging visits by experts, support for social mobilization, drugs and support for drug quality assurance, and support for monitoring and evaluation.

Disability Alleviation

National programmes have started to pay increasing attention to this component but there is a need to increase access to the cases in the community, identify and train care givers, identify and list/register lymphoedema and hydrocele cases, establish a referral mechanism and conduct surgery for hydrocoele. Finally, the disability alleviation services should be integrated with the existing PHC systems to ensure long-term sustainability.

WHO and other partners have supported the national programmes by providing technical advice, training modules, arranging intercountry workshops and assisting in project development and obtaining funds from donor agencies. A model community project on disability alleviation was launched in Sri Lanka in 2003.

Country presentations

Bangladesh

Bangladesh has completed mapping in 24 of its 64 districts, of which 23 were found to be endemic. It is planned to complete mapping before the end of 2004.

Mass Drug Administration with DEC and Albendazole commenced in 2001 in Panchagar district and was scaled up to cover three more endemic districts in 2002. The reported coverage was 93% of the targeted population

of 5.2 million in these four districts (The programme hopes to cover 25 million people in 2003 if the funds become available.)

The programme has trained 60 doctors in hydrocelectomy and 30 on morbidity management. It plans to commence a community home-based care project on a pilot basis by the end of 2003.

However, the biggest constraint in scaling up MDA in the country has been the lack of funds for the programme.

India

Nine states, namely Andhra Pradesh, Bihar, Kerala, Madhya Pradesh, Tamil Nadu, Uttar Pradesh, West Bengal, Chhatisgarh and Jharkhand contribute 86% of the mf carriers and 97% of the disease cases in the country.

Since the launching of MDA with a single drug of DEC in 1996, India has extended MDA to 31 districts – 11 of them with a two-drug regimen and 20 with DEC alone.

Mapping of LF distribution is in progress. Attention is also focussed on the management of acute and chronic cases through referral services.

During MDA in 2003, 24.1 million people were covered in 11 districts with DEC and albendazole combination and another 50 million people in 20 districts with DEC alone.

In some IUs, several rounds of MDA had been conducted as shown below:

Type of MDA	Number of rounds	Number of IUs (Districts)
DEC alone	7	1
	6	8
	5	1
	4	5
	3	7
	2	3
	1	3
	DEC + Albendazole	3
2		0
1		4

The reported coverage ranged between 23% and 97% in different IUs throughout the country whereas the assessed coverage of consumption during the last two rounds in two states ranged between 24% and 79%.

The existing control measures under the National Filariasis Control Programme are expected to continue with no major changes in the policy.

Maldives

Mapping of LF was completed in 2002 but validation is awaited in some islands with ICT reassessments. Of the 200 inhabited islands only eight are endemic, spread across five of the 19 atolls in the country. Drugs for MDA had been stocked and MDA was planned as these endemic islands showed an endemicity >1% in the past. However, as a pre-MDA assessment with night blood surveys has shown endemicity level <1%, the programme wished to postpone MDA until re-evaluation with ICT is carried out.

Maldives has an IEC programme for LF in place and has also paid attention on surveillance of LF with monthly reporting of cases.

Nepal

The three ecological zones in Nepal are mountains, hills and the terai. Only <8% of its population lives in the mountainous zone not known to be endemic for LF. Of the 75 districts, 38 remain to be mapped but most of these un-mapped districts are in high altitude areas where transmission of LF had not taken place.

Nepal commenced its MDA in 2003 covering 413,000 people out of the targeted 508,000 in Parsa District. It has also used a package of "communication for behavioural change" (COMBI) for social mobilization for MDA. Nepal plans to scale up MDA to three more districts in 2004 targeting over 2 million people in these endemic districts.

Sri Lanka

Sri Lanka has targeted the entire population in all endemic IUs for MDA with DEC and albendazole since 2002. All areas known to have LF transmission have been mapped; eight districts in three provinces were found endemic. Due to civil disturbances it was not possible to complete mapping in the Northern and Eastern provinces. These areas were not known to be having

established transmission. The National Anti Filaria Programme is now in the process of mapping these areas.

Sri Lanka completed its second round of MDA with DEC and albendazole in July 2003. In many IUs, coverage of over 80% was reported but the national programme was still in the process of compiling data. It is planned to conduct an independent evaluation of coverage in all IUs.

The national programme has commenced a community home-based project to alleviate disability due to LF in one IU on a pilot basis. It plans to scale up this intervention to remaining endemic IUs in the near future.

Technical Advisory Group Recommendations

Dr Biswas made a presentation on the issues discussed and the recommendations made at the TAG meeting. The following are the highlights of the presentation:

- The overall progress of GPELF was impressive as demonstrated by the increase in the population covered by MDA and by the development of managerial tools related to training, monitoring and evaluation, and social mobilization
- TAG noted that disability alleviation and prevention and resource mobilization (including operational research and for the development of better diagnostic tools) remain major challenges

TAG welcomed the actions taken by the WHO secretariat in pursuing the recommendations it made at the TAG-3 in 2002. The following were also discussed:

Assessment of drug coverage

Surveyed coverage and geographical coverage.

Stopping MDA

Additional steps are needed to confirm the <1% mf prevalence cut-off point. It was recommended that additional steps be taken to confirm that transmission is not resumed. The detailed steps are given in Annex 4.

Verification of absence of transmission ; Indicators for disability prevention; Modelling for decision making & ICT cards

TAG recommends the use of the existing ICT cards following the multi-centric studies validating the specificity and sensitivity of ICT, educating programme managers to follow manufacturer's guidelines.

Antibody detection tests for Brugia

TAG found the results very encouraging. ***Introduction of DEC fortified salt***

Introduction of DEC fortified salt in Guyana was discussed and TAG recommended close follow up and sharing of experience.

Impact of MDA on reducing microfilaraemia

TAG observed encouraging results from Egypt and Haiti. It recommended standardized reports.

Quality standards for DEC

TAG recommended that all procurements of DEC by the national programmes should meet the current USP standards and pass the test for piperazines in the Indian Pharmacopoeias (IP) 1996. Preferably, the requirements of DEC should be procured centrally by the national programmes from WHO pre-qualified manufacturers.

Pharmacovigilance

TAG welcomed the framework developed by the secretariat. It noted that active surveillance for Adverse Drug Reactions (ADR) had been terminated, but recommended that passive surveillance should remain a high priority and national programmes should continue to reinforce their efforts to identify, respond to and report Serious Adverse Events (SAEs) promptly.

Disability Prevention

TAG welcomed the framework developed by the secretariat and hoped that disability prevention will be given priority by the national programmes.

Synergies with soil transmitted helminths

TAG supported the initiatives described by the secretariat to capitalize on these opportunities. Synergies with other disease control programmes will need to be looked at holistically.

Social mobilization

TAG acknowledged the progress made in incorporating social mobilization strategies and noted that more support was needed at the district level for the development of social mobilization and communication activities. It also highlighted that capacity building for programme managers and other staff in the areas of social mobilization and communication should be given priority.

TAG encouraged the programmes to explore private sector partnerships in advertising and marketing in key areas of the filarial elimination programme.

Strategic Plan for scaling up activities in 2003-2005

TAG supported the strategic direction for scaling up activities in 2003-2005. It also noted with concern the resource constraints which were affecting plans for the rapid expansion of activities.

Revised Monitoring and Evaluation Guidelines

Dr Robin Houston presented the revised monitoring and evaluation guidelines. Following the presentation, detailed discussions were held and related issues clarified.

TAG had appointed a Monitoring and Evaluation Working Group to address unresolved issues related to determining 'coverage' of populations undertaking MDAs, criteria for stopping MDA, verifying absence of transmission and the research needs of monitoring and evaluation. This group had highlighted many issues and made important recommendations. Existing guidelines on monitoring and evaluation would be slightly modified with some additions. TAG had accepted these modifications but recognized the need for field testing new applications and alternatives in different settings. The revised guidelines will be circulated to the programme managers early. As highlighted below, the programme managers were briefed on monitoring and evaluation modifications. Attention was needed to improve the assessment of reported coverage to verify if all distribution centres report and if census data were the latest and accurate.

It is also important to keep in mind the possible bias when interpreting sentinel coverage as more attention may have been paid in these areas which may also not be representative of all endemic areas. It will be important to add survey coverage for interpretation. A cluster survey protocol on similar lines with the EPI 30 cluster survey design had been developed.

Under earlier recommendations, sentinel sites would need to have assessed mf rates as follows: (a). baseline before 1st round of MDA, (b). after 3rd round of MDA (mid term) (c). after 5th round (final) (d). 3 years after stopping MDA (end). The purpose of the changes in the recommendations is to provide quicker, cheaper and an alternative strategy to identify any transmission and to prevent premature stopping of MDA. The suggested changes are shown in Annex 4.

Operational Research

Prof. Ramachandran led a discussion on the identification of local-level research issues with a presentation related to LF. The house noted the importance of operational research and that the relevant research questions, including needs of the programme, must be identified and addressed.

The programme managers were requested to identify operational research topics that need urgent attention and submit draft proposals to SEARO for review by RPRG. Small grant funds could be made available through RPRG for the research proposals.

Alleviation Disability due to LF

Prof. Shenoy made a presentation on the pathogenesis of elephantiasis, the principles of management of patients with disability due to LF and his experience in managing such patients.

He explained that the factors leading to disability due to LF are primarily the parasitic infection and the secondary bacterial infection. He said that parasite-induced pathology was seen among those with early infection with no other physical manifestation.

He elaborated that the predisposing factors for acute adeno-lymphangitis are underlying lymphatic damage and the entry lesions in the skin that favour bacterial invasion. In his clinical studies, ADL attacks were found to be more common during the rainy season rather than the dry season in the southern

parts of India. Local skin hygiene with regular washing with soap and water, simple exercises, elevation of foot and appropriate use of antiseptic creams had dramatically reduced the incidence of ADL attacks. In one of his studies using these preventive efforts where 127 patients were followed up for 2 years, 47 did not get any ADL attack during the study period. Of those who had such attacks, the frequency had been reduced in 72% while severity was reduced in 95%. It had also been possible to sustain the intervention at low cost and with less resources.

Prof. Shenoy also led the discussion on how to improve implementation of community-based alleviation of disability due to LF in endemic areas. It was revealed that Sri Lanka had commenced a model community home-based programme in one IU which would be extended to the other endemic areas. Funding support had been obtained from donors facilitated by WHO.

India had conducted training programmes for State-level trainers on LF morbidity management. It had adapted the WHO modules for the training. The training programme would be extended to the district level where 36 districts had already been selected. It would then be taken to the Primary Health Unit level.

Productive discussions on the subject ensued with all participants agreeing on the need to expand the services to the affected patients. Bangladesh, Maldives and Nepal also showed a keen interest to commence pilot projects on disability alleviation in a selected endemic area.

Mobilizing the Community to Ensure High Coverage of MDA

Both Nepal and Sri Lanka where COMBI (Communication for Behavioral Impact), had been implemented shared their experiences. Various innovative methods including media advertisements, poster campaigns, appropriate use of audio-visuals, employment of filarial field assistants with attractive advertising uniforms had been used. According to the field level feedback, these methods either singly or in combination had helped to achieve a high coverage.

It was highlighted that effective social mobilization was the cornerstone for achieving a high compliance rate. While appreciating the technical assistance offered by WHO and other stakeholders, programme managers identified non-availability of funds as major obstacles in the implementation of effective social mobilization.

Supply of Albendazole

Mr. Andy Wright of Glaxo SmithKline briefed the house on the albendazole donation programme and the supply mechanism. He reaffirmed that the company will provide albendazole free of charge to WHO for every country that needs it until LF is eliminated as a public health problem. In effect, the company will provide five billion tablets over 20 years. In addition, Glaxo SmithKline as a proactive partner with the Global Alliance partners, had provided start-up funds for Alliance building, and for some workshops, meetings and communication materials. It had also provided some funds for LF academic centres. He also clarified that the albendazole supply chain took an overall 7.5 months. From its primary plant in Mexico it took three months to reach the plant in France and another three months for the tablets to reach the GSK warehouse in France from where it took another 4-6 weeks to reach the recipient country.

Group discussion on Fund Raising (Agenda item XII)

Group work was conducted to discuss and identify national-level alliance for ELF, the constraints and suggested solutions to overcome them. It was noted that a committee for fund raising had been formed at the ad-hoc Global Alliance meeting in Liverpool in Dec 2002 which is currently active. A fund raising consultant was advising this committee. Advocacy materials and tools for fund raising were being developed. Donors were being approached WHO would continue to approach bi-lateral and multilateral donors, Emory University would approach the US donors and the Liverpool School of Tropical Medicine would approach European donors.

Six Regions and the endemic countries were also expected to raise funds at the regional and national levels. However, it was apparent that it would not be possible to have adequate funds raised through international donors for the country level implementation of ELF activities. Hence, the importance of local-level fund raising was stressed.

All country managers showed interest and recognized the importance and need for local fund raising but some were not sure on how to proceed. They requested that a "toolkit and manual" for fundraising be made available in due course. The group agreed that early demonstration and documentation of success stories on elimination would be critical to attract donors. The need for the Region to have a fund-raising plan and to identify current and potential donors was also highlighted.

4. SYNCHRONIZING MDA WITH STH DE-WORMING ROUNDS (Agenda Item XIII)

Dr Padmasiri made a presentation on synchronizing MDA with the de-worming rounds conducted to control soil-transmitted helminth (STH) infections. All participants showed interest on ways to improve synchronization of the two interventions. The commonality between the two interventions with albendazole being central for benefits in both filarial and STH control was highlighted.

It was pointed out that an MDA round with DEC + albendazole combination in co-endemic areas can serve as :

- (a) one of the two rounds of de-worming required in high endemic areas with STH prevalence >70%
- (b) the single round of de-worming required in moderately endemic areas with STH prevalence between 50% & 70%
- (c) providing general de-worming benefits to the community especially the underserved
- (d) an opportunity to increase the awareness in the community on STH

Synergistically, de-worming has its effects on filarial reduction through anti-filarial effects of the de-worming drugs, in addition it provides opportunities for combined health education against multiple parasites and possibilities for use of trained personnel in de-worming for MDA .

Both national and district level coordination of activities related to the two interventions would be critical. Some countries have already completed STH ecological mapping according to the prevalence of STH. They are being matched with the LF endemicity maps.

Synchronizing de-worming rounds with MDA will provide greater benefits to the community. Bangladesh would include de-worming in their Vit A distribution campaign which would cover children below the age of five. This campaign would cover several endemic districts that are also scheduled for MDA. The Ministry of Health, Bangladesh, would consider the timing of these two campaigns so as to have a gap of six months in order to maximize de-worming benefits.

Some programme managers indicated that some of these activities were already being coordinated at the national and regional levels.

5. RECOMMENDATIONS

The group made the following recommendations:

Initial Assessment and mapping

- (1) Mapping should be completed by 2005.
- (2) In the absence of the more operationally feasible ICT card tests, programme managers preferred the use of the existing ICT cards (read at 10 minutes) to the alternative one that has to be read between 2 and 24 hours.

Interruption of transmission through MDA

- (3) There was general consensus among participants that the combination of DEC and albendazole had a greater filaricidal effect than DEC alone. The group felt that the use of DEC alone is likely to prolong the achievement and sustenance of interruption of transmission which will have resource implications for the country.
- (4) MDA with DEC and albendazole co administration should be scaled up.
- (5) To have the best epidemiological impact and efficient use of resources, extension of MDA in new areas should, as far as possible, be done in contiguous endemic IUs.
- (6) In IUs, where both de-worming programmes for soil-transmitted helminths and MDA for ELF are planned, synchronized use of albendazole and DEC co-administration, is recommended.
- (7) National programmes should continue and reinforce their efforts to identify, respond to and report severe adverse experiences (SAE) promptly to WHO and other agencies specified in their national guidelines.

Monitoring and Evaluation

- (8) WHO should provide the revised guidelines on monitoring and evaluation to national programmes at the earliest. National programmes should have easy access to the tools recommended in the guidelines.

Disability Prevention

- (9) More emphasis should be placed on prevention and alleviation of disability due to LF. Every programme should implement disability alleviation activities in at least one IU by 2004.

Operational Research

- (10) Operational research issues at the country level should be identified and national programmes encouraged to prepare and forward a list of ongoing and proposed research activities to WHO/SEARO.

Social Mobilization and IEC

- (11) National programmes are encouraged to pay increased attention to achieve high drug coverage through effective social mobilization and IEC campaigns. Supervised administration of drugs and monitoring should be emphasized.

Resource Constraints

- (12) Most National Programmes, while committed to upscale MDA, do not have access to sufficient funds and require supplemental funding over and above the national governmental resources. The Global Alliance for ELF is working to raise external funds, however, countries are also encouraged to raise funds from local donors.

Annex 1

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Malaysia

Dr P K Das
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Prof. R K Shenoy
Alleppey, Kerala
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Dr S. R. Salunke
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Partner Agencies

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Emory University, Atlanta, Georgia
USA

WHO Secretariat

Dr Klaus Wagner
WHO Representative to Nepal

Dr Vladimir Janout
MO,WHO-Nepal

Dr Gautam Biswas
FIL/CPE/CDS/HQ

Dr E A Padmasiri
STP – CDS/SEARO

Mr Kiran Bahadur Shrestha
WHO-Nepal

Annex 2

LIST OF WORKING DOCUMENTS

1. Annual Reports of the National ELF Programmes of endemic countries (Maldives and Nepal)
2. Re-applications for supply of albendazole submitted by the endemic countries (Nepal and India)
3. Report of the 3rd RPRG Meeting
4. Report of the 2nd Global Alliance Meeting, New Delhi 2-3 May 2002
5. Report of the Ad-hoc meeting of the Global Alliance held in Liverpool in December 2002
6. Report of the 3rd TAG meeting

Annex 3

AGENDA OF THE MEETING

Tuesday 14 October 2003

0800 hrs Registration

Agenda I: Opening session

08.30 hrs Inaugural address -Dr B.D. Chataut, Director General of Health Services, MoH, Nepal

 Welcome message - Dr Mahendra Bahadur Bista, Director, Epidemiology and disease control division, DHS, MoH, Nepal

 Message from WHO/SEARO - Dr Klaus Wagner – WHO Representative, Nepal

Agenda II: Introductions and Objectives of the Meeting

09.30 hrs Objectives of the meeting – Dr EA Padmasiri

09.40 hrs Introduction of Members of PRG, Participants and WHO Secretariat - Dr EA Padmasiri

09.50 hrs Nomination of the chairperson and rapporteur – Dr EA Padmasiri

09.55 hrs Administrative announcements – Dr Janout Vladimir/ Dr EA Padmasiri

Agenda III: Adoption of Agenda

10.15 hrs Adoption of agenda

Agenda IV: Overview of Global Programme

10.20 hrs Overview of Global Programme and Global Alliance to eliminate LF - Dr Gautam Biswas

Agenda V: Country presentations and overview of implementation of ELF in the Indian Subcontinent

- 10.50 hrs Overview of implementation status of ELF in the Indian subcontinent – *Dr EA Padmasiri*
- 11.05 hrs Country presentations: Country presentations will be made for 15 minutes followed by 10 minutes for discussion for each country to cover issues on mapping, scale up of MDA, other strategies, national strategic plans, lessons learned & constraints.
- a. Bangladesh
 - b. India
 - c. Maldives
 - d. Nepal
 - e. Sri Lanka

Agenda VI: Current TAG Recommendations

- 14.00 hrs Current Technical Advisory Group Recommendations –
Dr Gautam Biswas

Agenda VII: Revised Monitoring and Evaluation Guidelines

- 14.30 hrs Revised monitoring and evaluation guidelines – Dr Robin Houston, Emory University and Dr Gautam Biswas
- 15.30 hrs Discussion on Revised monitoring and evaluation guidelines

Wednesday, 15 October 2003

Agenda VIII: Group Work I

- 08.30 hrs Discussion and identification of local level research issues
- Dr Prof CP Ramachandran & Prof M. Ismail

Agenda IX: Reaching the Affected Patients at Community Level

- 9.30 hrs Alleviation of disability due to LF – Prof RK Shenoy
- 9.50 hrs Discussion on how to reach the affected patients at community level by each country – Discussion to be led by Prof RK Shenoy, Prof M. Ismail & Dr EA Padmasiri

Agenda X: Mobilizing the Community to Ensure High Coverage of MDA

- 10.45 hrs Mobilizing the community for MDA – Experience in Parsa District
- Dr Shanker Bahadur Shrestha
- 11.00 hrs Mobilizing the community to ensure higher coverage of MDA –
Experience in Sri Lanka – Dr Luxman Edirisinghe
- 11.15 hrs Discussion on how to improve the coverage – Discussion to be led
by Prof S. Kojima & Dr EA Padmasiri

Agenda XI: Procurement of Quality Drugs

- 11.50 hrs Supply of Albendazole - Dr Andy Wright, GSK
- 12.10 hrs Supply and quality of DEC – Dr Gautam Biswas

Agenda XII: Group Work II

- 13.30 hrs Group Work II – To discuss & identify a) national level alliance for
ELF , and b) constraints and suggested solutions to overcome them

Agenda XIII: Synchronizing MDA with STH de-worming rounds

- 14.45 hrs Synchronizing MDA with STH de-worming rounds –
Dr EA Padmasiri
- 15.05 hrs Health Mapper Version 4 – Dr Gautam Biswas

Agenda XIV: Recommendations and closing remarks II

- 15.30 hrs Formulation of recommendations
- 16.00 hrs Closing remarks

Annex 4

STEPS FOR STOPPING MDA

- (1) Mf prevalence survey (~500 people) in sentinel (2) and spot-check sites(2) in each IU must be conducted just prior to 5th MDA
 - If >1% mf prevalence, continue MDA
 - If <1% mf prevalence, proceed toward stopping MDA
(This minimizes suppressive effect of last round (4th MDA) on mf levels)
 - Include ICT testing of 2-4 year old children at same sites at same time

- (2) Test 5-10 additional high risk sites in same fashion for mf prevalence in adults/older children
 - if >1%, continue MDA
 - If <1%, proceed toward stopping
 - for ICT prevalence in children (2-4 yrs) -if there are positives, explore implications
(Provides an intermediate less expensive (than LQA) step for detecting areas most likely to have persistent transmission)

- (3) Complete 5th MDA round

- (4) Following 5th MDA round, perform LQA-cluster ICT survey of 300 children 2-4 year old children in high risk areas
 - If no positives (i.e., <1% prevalence), proceed toward stopping MDA
 - If there are positives, explore implications
(This additional intermediate step presumes that with programme success, 2-4 year old children will not have been exposed, and thus should be ICT negative)

The following log diagram shows the steps before stopping the MDA:

