

Report of the Ninth Workshop for Pacific Lymphatic Filariasis Programme Managers



Nadi, Fiji
20-21 June 2007

(WP)MVP/PIC/CPC/1.2/001-E

Report Series Number: RS/2007/GE/20(FIJ)

English only

REPORT

**NINTH WORKSHOP FOR PACIFIC LYMPHATIC FILARIASIS
PROGRAMME MANAGERS**

Convened by:

WORLD HEALTH ORGANIZATION
Western Pacific Region

Nadi, Fiji
20-21 June 2007

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

January 2008

The views expressed in this report are those of the participants in the Ninth Workshop for Pacific Lymphatic Filariasis Programme managers and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Western Pacific Region for governments of Member States in the Region and for those who participated in the Ninth Workshop for Pacific Lymphatic Filariasis Programme Managers, held in Nadi, Fiji from 20 to 21 June 2007.

CONTENTS

Page

ABBREVIATIONS

EXECUTIVE SUMMARY

1. INTRODUCTION	1
1.1 Objectives	1
1.2 Participants and resource persons	1
1.3 Organization	1
1.4 Opening ceremony	1
2. PROCEEDINGS	2
2.1 Global updates	2
2.2 Overview of the Bill and Melinda Gates Foundation grant to the Global Alliance to Eliminate Lymphatic Filariasis (GAELF)	4
2.3 Liverpool LF Support Centre (LFSC) and GAELF update	5
2.4 Partnership in the Global Programme to Eliminate LF	5
2.5 James Cook University LF Support Centre	6
2.6 Current challenges facing the Pacific Programme to Eliminate LF (PacELF)	6
2.7 Update on the Papua New Guinea ELF programme	7
2.8 Morbidity control in the Pacific: Key elements to be incorporated into national plans	8
2.9 Draft five-year surveillance plan for the Pacific	10
2.10 Review and recommendations from PacCARE	11
2.11 Group work	11
2.12 Presentation of two-year plans of action and budget estimates by PICs	13
2.13 Closing ceremony	20

ANNEXES

Annex 1	- PROVISIONAL AGENDA
Annex 2	- LIST OF PARTICIPANTS
Annex 3	- REGIONAL DIRECTOR'S SPEECH
Annex 4	- WELCOME ADDRESS

ABBREVIATIONS

COMBI	Communication for Behavioural Impact
DEC	Diethylcarbamazine citrate
GAELF	Global Alliance to Eliminate Lymphatic Filariasis
GPELF	Global Programme to Eliminate Lymphatic Filariasis
GSK	GlaxoSmithKline
ICT	Immunochromatographic test
ITN	Insecticide-treated bednet
JCU	James Cook University
LF	Lymphatic filariasis
LFSC	Liverpool Lymphatic Filariasis Support Centre
MDA	Mass drug administration
Mf	Microfilaria/microfilaremia
NGO	Nongovernmental organization
NTD	Neglected tropical disease
PacCARE	PacELF Programme Review Group
PacELF	Pacific Programme to Eliminate Lymphatic Filariasis
PIC	Pacific island country

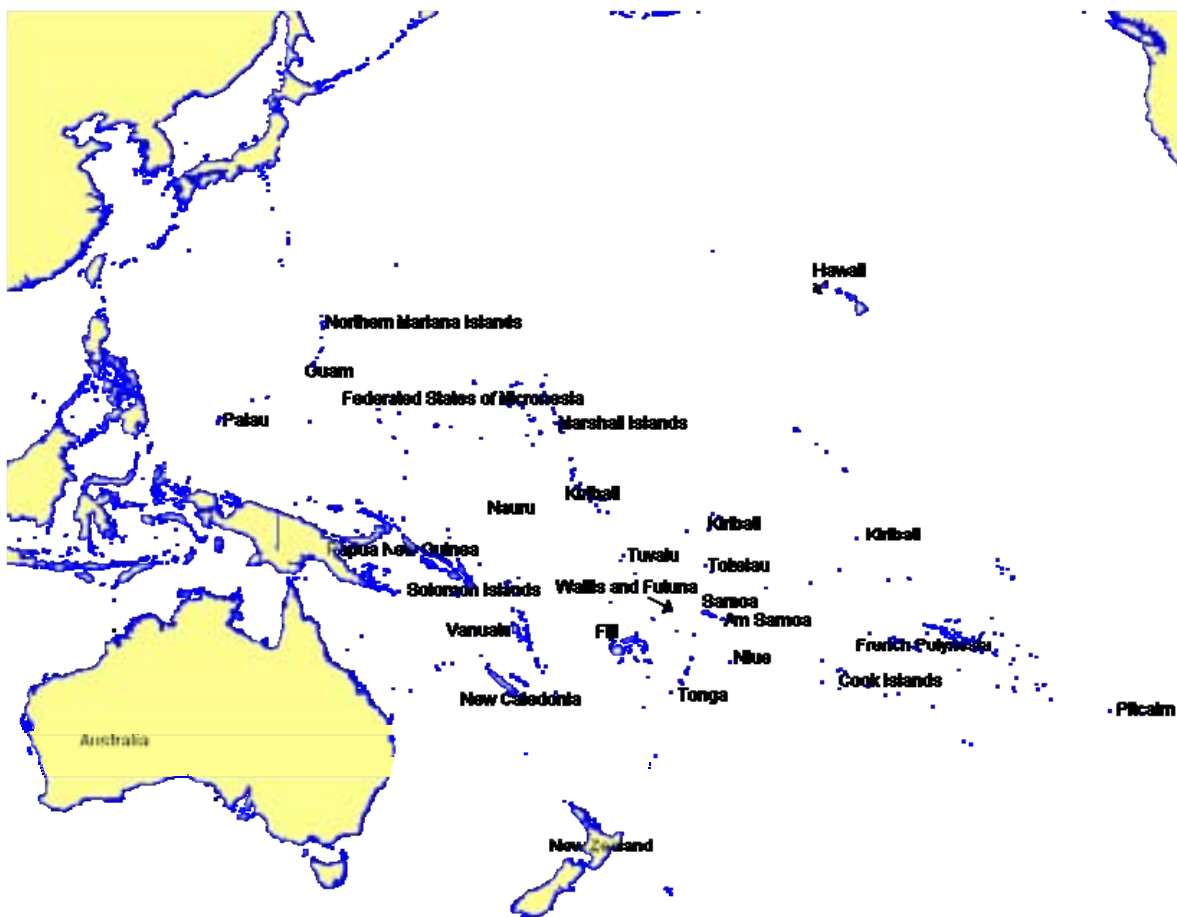
EXECUTIVE SUMMARY

The Pacific Programme to Eliminate Lymphatic Filariasis (PacELF) began with 22 countries, of which 11 were endemic for lymphatic filariasis (LF). Three of these countries have now reduced their LF prevalence rates to below 1%, with the other eight continuing activities to eliminate the disease.

In June 2007, PacELF national managers, with the support of WHO and others, met in Nadi, Fiji, to review the progress of national elimination programmes and build skills and knowledge for future actions. Issues and topics covered during the two-day programme included a review of the Global Programme to Eliminate Lymphatic Filariasis (GPELF), an update on the activities of various partners, identification of the current challenges to eliminating LF from the Pacific region, morbidity control, and a five-year surveillance plan for the Pacific.

During the latter half of the programme, group activities were conducted with the aim of preparing two-year action plans for each country. The action plans included a list of key activities and budget estimates. Each country presented its two-year plan to the rest of the group.

Figure 1: Map of the Pacific islands



1. INTRODUCTION

WHO estimates that over 120 million people worldwide are affected by lymphatic filariasis (LF), and 40 million to date have been severely disfigured and incapacitated as a result of infection. At present, over 1 billion people are at risk of being infected, in 83 countries throughout the world. When the Pacific Programme to Eliminate Lymphatic Filariasis (PacELF) began, 11 of its 22 Pacific island members were endemic for the disease. Following a programme of mass drug administration and prevalence monitoring, three of those 11 endemic countries have reduced their LF prevalence rates to below 1%. The remaining countries continue to actively implement activities to eliminate LF.

The main partners contributing to LF control in the Pacific region are the Australian Agency for International Development (AusAID), the United States Centers for Disease Control and Prevention (US-CDC), Emory University LF Support Centre, GlaxoSmithKline (GSK), Institut Louis Malarde, James Cook University, the Government of Japan, the Japan International Cooperation Agency (JICA), Liverpool Lymphatic Filariasis Support Centre, the Ministry of Health Fiji, the Secretariat of the Pacific Community, United Nations Volunteers, Voluntary Service Overseas (VSO) and WHO.

1.1 Objectives

By the end of the meeting, participants would have,

- (1) identified the challenges that have prevented some countries from achieving the elimination target level of less than 1% prevalence and collaborated on identifying and developing next steps;
- (2) reviewed the status of national lymphatic filariasis elimination programmes and finalized plans of action for the next 12 months; and
- (3) been updated on key technical matters, including monitoring, evaluation, social mobilization and disability control and alleviation activities.

1.2. Participants and resource persons

Programme managers from nine Pacific island countries and areas (PICs) attended the meeting. In addition, there were six temporary advisers, six observers and ten WHO secretariat members.

The agenda and the list of participants are attached as Annexes 1 and 2.

1.3. Organization

The meeting was held in Nadi, Fiji, on 20-21 June 2007, and consisted of plenary and group work sessions (see Annex 1). A two-day and one-day Review Group (PacCARE) meeting was held either side of the PacELF meeting.

1.4. Opening ceremony

Dr Joe Koroivueta from Fiji welcomed the participants. Dr George Slama, Programme Management Officer, WHO South Pacific Office, welcomed all participants on behalf of the WHO Representative for the South Pacific and thanked the Fiji Ministry of Health for hosting the workshop.

He then read out the opening message from Dr Shigeru Omi, WHO Regional Director for the Western Pacific. The text of the Regional Director's speech is attached in Annex 3.

This was followed by an address by Dr Tui Taoi, Director of Health Services, Western Division (see Annex 4).

1.5 Appointment of Chairperson and Vice-Chairperson

Mr Manila Nosa from Niue and Dr Fasihah Taleo from Vanuatu were appointed Chairperson and Vice-Chairperson, respectively.

2. PROCEEDINGS

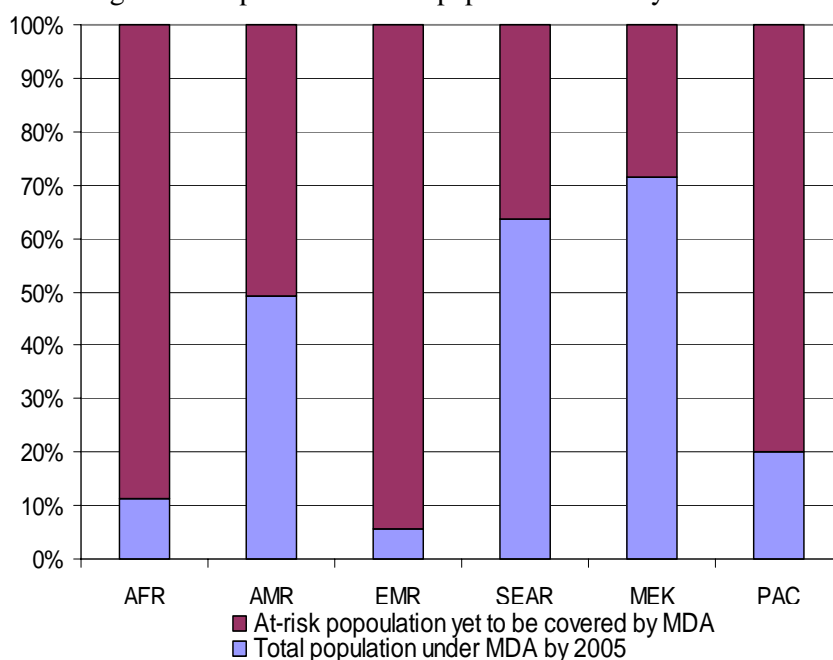
2.1 Global updates

The progress made in the Global Programme to Eliminate Lymphatic Filariasis (GPELF) was reviewed by Dr Gautam Biswas of WHO Headquarters.

Of the estimated 1300 million people at risk of lymphatic filariasis transmission, over 40% have been brought under mass drug administration strategies. However, only around 10% are following the WHO-recommended two-drug strategy. For example, India, which started its programme in 1996, began by implementing MDA primarily using DEC only. In 2007, after reviewing all the evidence from internationally and nationally conducted studies, the Indian Ministry of Health changed its strategy to the WHO-recommended two-drug combination.

Substantial progress has been made in mass drug administration according to WHO-recommended strategies. Starting from 3 million co-administered treatments in 12 countries in 2000, around 90 million such treatments were being administered in 42 countries by 2006. However, this progress has not been uniform among the different WHO regions. The African and the Eastern Mediterranean regions have lagged behind the South-East Asia as well as the Mekong area.

Figure 2: Proportion of at risk population currently under MDA



Following initial rapid scaling up, MDA coverage has somewhat stagnated at the 2004 levels, mainly due to a lack of resources and of timely availability of DEC.

The second component of the programme strategy, the prevention and management of LF-associated disabilities, has lagged behind the rapid scaling up of the mass drug administration campaigns. Presently, only half of the 42 countries that have already begun implementing MDA have also initiated disability-prevention activities. WHO held a consultation in August 2006 to finalize a manual to assist LF programme managers in planning and implementing disability-prevention programmes, as well as a protocol for the management of acute dermatolymphangioadenitis (ADLA) in the field. The manual is currently being pre-tested in a few countries.

In December 2006, a workshop was held in WHO Headquarters to review the impact of MDA on lymphatic filariasis globally. In this workshop, data, as reported to WHO in annual reports and various research studies, were reviewed. Data were available from 710 sentinel sites, of which 442 had at least two measurement points. It was concluded that the mass drug administration programme has led to a significant reduction in the public health burden of filarial infection and disease. It was also found that MDA has had a broader impact on onchocerciasis, soil-transmitted helminthiasis and scabies. Available data indicate that two to six rounds of MDA with co-administered drugs are able to reduce microfilaria prevalence below 1% in most areas. However, in some areas, more than six rounds may be necessary, since the effectiveness of the annual rounds of treatment was found to depend on the initial infection level, the treatment coverage rate and the type of mosquito vector responsible for transmission in the area. The December 2006 workshop highlighted the critical need to continue the systematic collection of data on public health impact. In addition, the workshop acknowledged the importance of the initiative towards the coordinated use of a set of drugs to tackle multiple helminth infections (preventive chemotherapy) and the opportunities this initiative provides to sustain MDAs where required.

The following operational and technical actions were identified as the way forward:

- Ensure regular and timely availability of quality anti-filarial drugs. A global drug facility is necessary.
- Ensure access to funds from within the government and from development partners at the national level.
- Complete mapping in certain remaining countries of Africa and in Indonesia.
- Develop an alternative and simplified mapping strategy.
- Develop a safe and effective MDA strategy for *Loa loa* co-endemic areas of Africa.
- Ensure the availability of affordable and field-friendly diagnostic tests.
- Strengthen monitoring and reporting as an integral part of the plans leading to decisions regarding when to stop MDA.
- Develop guidelines for post-intervention surveillance verification of non-endemicity.
- Use vector control methods (including ITNs) as a potential supplement to MDA where cost-effective.

2.2 Overview of the Bill and Melinda Gates Foundation grant to the Global Alliance to Eliminate Lymphatic Filariasis (GAELF)

Dr Eric Ottesen, acting PACare Chairperson, gave a presentation on the Bill and Melinda Gates Foundation grant. A grant totalling US\$ 11.7 million over four years was recently awarded by the Foundation to GAELF to support a project entitled “Resolving the Critical Challenges Now Facing the Global Programme to Eliminate LF,” which was developed by the LF research community. This grant is managed on behalf of GAELF by the LF Support Center in Atlanta, United States of America. Its goal is to ensure the ultimate success of the Global Programme to Eliminate Lymphatic Filariasis (GPELF) by finding solutions to the operational challenges and potential barriers it is facing.

There are eight specific objectives that support three major goals:

Goal I: Define programme end-points and determinants of success

Objective 1: identify best measure of impact on LF transmission

Objective 2: identify key indicators of programme success

Objective 3: identify most effective surveillance strategies

Objective 4: assess potential impact of non-compliance

Goal II: Identify effective and cost-effective supplemental measures

Objective 5: define optimal role and strategies for vector control

Objective 6: assess effectiveness of increased drug dosage and frequency schedules for the current LF regimens

Goal III: Develop innovative financing strategies

Objective 7: carry out financial situation analysis for LF/neglected tropical diseases (NTDs) in selected countries

Objective 8: bridge gap between available international development funds and LF or NTD programmes in ministries of health.

To accomplish the first of these objectives, a comprehensive and highly-standardized multi-centre study will be carried out at sites in nine countries (representing the principal epidemiological differences in LF) to compare the effectiveness of eight available diagnostic tools in demonstrating the absence (or persistence) of LF transmission after multiple rounds of MDA (see Table 1). Two of these countries will be from the PacELF region (French Polynesia and Tuvalu). The result will be of particular importance and relevance to the PacELF countries, because it will guide the selection of tools and criteria for deciding when to stop MDA and how to carry out the necessary post-MDA surveillance.

The LF community is extremely fortunate to have this means of carrying out operational research, essential for GPELF success, but the continued cooperation and input of the entire LF community will be necessary to take full advantage of this unique opportunity.

Table 1: Tool-testing study design (objective 1).

Country	# of MDA cycles	Vector genus	Target Filaria	Pop. All ages	Sch Entry child	# ict	# mf	# og4c3	# Bm14	# Bmr1	# urine	# Q-PCR: blood pools	# Q-PCR: Vector pools
French Polynesia	5	Aedes	Wb	1000	350	1350	1350	1350	1350	0	1350	150	500
PICT-?	5	Aedes	Wb	1000	350	1350	1350	1350	1350	0	1350	150	500
Ghana	5	Anoph	Wb	1000	350	1350	1350	1350	1350	0	0	150	500
Indonesia (Alor)	5	Anoph	Bt	1000	350	0	1350	0	1350	1350	0	150	500
Nigeria	4	Anoph	Wb	1000	350	1350	1350	1350	1350	0	0	150	500
Zanzibar	5	Culex	Wb	1000	350	1350	1350	1350	1350	0	1350	150	250
Haiti	6	Culex	Wb	1000	350	1350	1350	1350	1350	0	1350	150	250
India	Various	Culex	Wb	1000	350	1350	1350	1350	1350	0	1350	150	250
Malaysia	5	Mansonia	Bm	1000	350	0	1350	0	1350	1350	1350	150	500
TOTALS						9450	12 150	9450	12 150	2700	8100	1350	3750

2.3 Liverpool LF Support Centre (LFSC) and GAELF update

This update was presented by Ms Joan Fahy, Programme Coordinator, Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine, United Kingdom. The activities of LFSC and the overlap of its work with that of GAELF were presented. LFSC is the secretariat of GAELF and Professor David Molyneux, Director of LFSC, is the Executive Secretary of GAELF. LFSC provides funds for MDA to Bangladesh, Burkina Faso, Ghana and Tanzania, as well as support for operational research, evaluation and morbidity control, which can be channeled wherever needs are identified. The strategy for and current position of LFSC's advocacy and fundraising initiatives were described, with an assurance that there is an awareness of the needs of the PacELF region. Details of the GAELF meeting to be held in Arusha, Tanzania, from 1 to 3 April 2008, were provided.

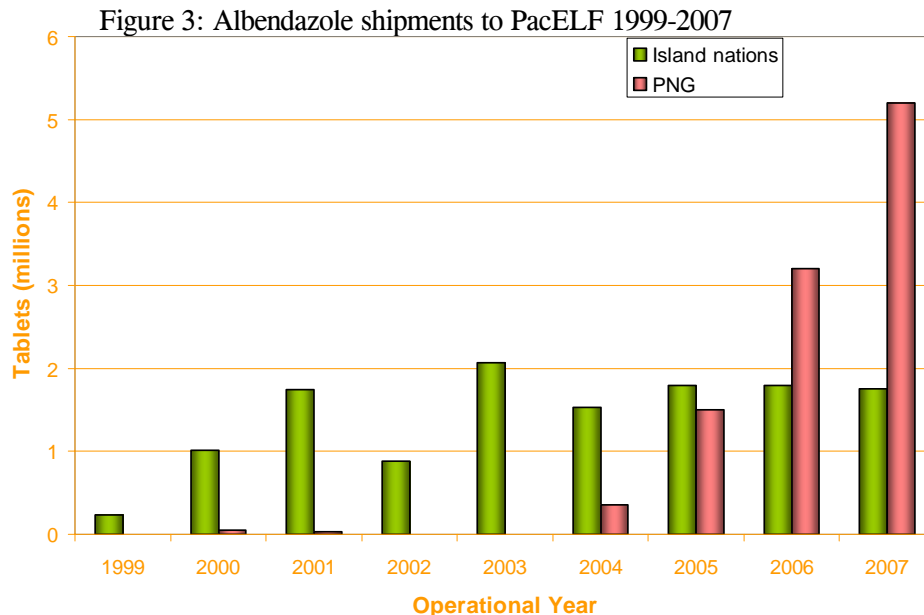
2.4 Partnership in the Global Programme to Eliminate LF

The GlaxoSmithKline (GSK) representative provided an update on several notable events that had occurred in the Global Programme since the last PacELF meeting in 2006:

- All albendazole production has been transferred from France to Cape Town, South Africa.
- India has adopted the WHO-recommended two-drug therapy, with implications for tablet supply.
- Following the untimely and tragic death of Dr J.W. Lee, former Director-General of WHO, the new Director-General, Dr Margaret Chan, has firmly positioned WHO to address neglected diseases.
- The Bill and Melinda Gates Foundation is funding GAELF to address critical challenges facing GPELF.
- The President of Pharmaceutical Operations GSK visited Nigeria with President Carter, attended the partners meeting in WHO Headquarters and reaffirmed GSK's commitment to global public health.

- There has been a change in the Global Community Partnerships department at GSK: Mr Andy Wright is now Director of coordinated public health initiatives.

The GSK representative also presented an update on the company's albendazole donation to the Global Programme, specifying that 626 million treatments had been donated to 44 countries as of the end of April 2007. Of this total, 16.3 million were donated to the programme in the Pacific, including Papua New Guinea (see Figure 3). GSK reiterated the company's commitment to the Pacific programme, indicating that the supply of albendazole will continue until regional elimination has been achieved. In addition, GSK will continue to provide financial assistance to the PacELF programme and the LF Support Centre at James Cook University.



2.5 James Cook University LF Support Centre

Dr Wayne Melrose, Director, WHO Collaborating Centre for Control of Lymphatic Filariasis, James Cook University, Townsville, Australia, outlined how the James Cook University LF Support Centre supports PacELF and Mekong Plus by providing technical support and training and by conducting operational, applied and basic research. Current activities are focusing on Papua New Guinea, Tuvalu and Timor-Leste. The major source of operational funding is GSK. The main constraints facing the Centre involve personnel and funding.

2.6 Current challenges facing the Pacific Programme to Eliminate LF (PacELF)

Dr Capuano, the newly appointed coordinator of PacELF, described the main challenges facing Pacific island countries as they move towards the elimination of LF. An in-depth review of the current epidemiological situation in each PIC, carried out in October 2006, acknowledged the progress made and identified a number of issues in relation to programme implementation: disparities in (1) MDA distribution strategies; (2) treatment regimens; (3) methods of reporting coverage; (4) compliance; (5) collection of data; (6) implementation of morbidity control; (7) plans for stopping MDA; and (8) plans for continued surveillance.

The review focused particularly on: (1) obtaining data on the current LF situations in all of the Pacific countries and areas by early 2008; (2) developing and implementing a surveillance plan for the PICs; and (3) developing and implementing a morbidity-control strategy. In this exercise, Papua New Guinea was considered separately from the other PICs in view of its high infection rates and its limited progress in implementing a national elimination programme until recently, due to economic,

political and technical problems. A workshop was conducted in April 2007 in Port Moresby to review the situation in Papua New Guinea and come up with a revised strategy for elimination for the period from 2007 to 2020. The revised strategy is now in place. A summary of this strategy and future plans for Papua New Guinea are reported under item 2.7 of this report by Mr Leo Makita, the LF Programme Manager for Papua New Guinea.

In summing up the challenges facing Papua New Guinea and the other Pacific island countries and areas, Dr Capuano suggested and recommended that the way forward for the next five years towards successful implementation of LF elimination would require:

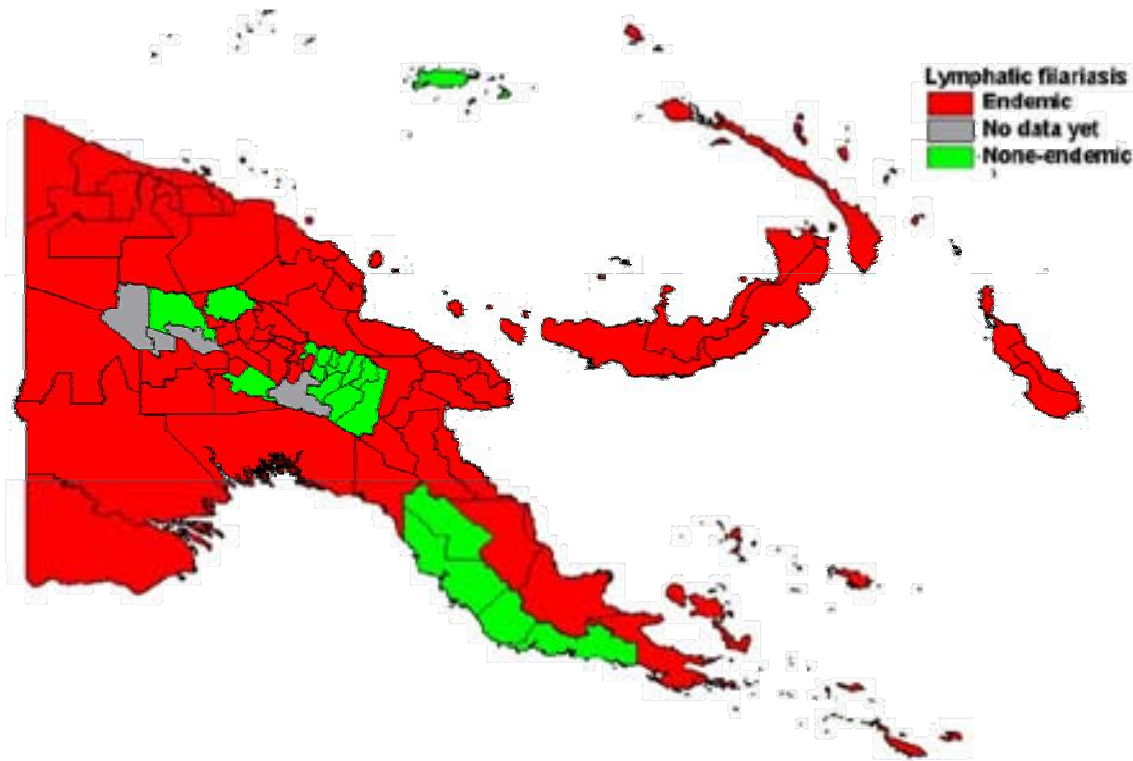
- strong technical and financial support to all PICs for the development of survey protocols, data analysis and report writing; and
- development of surveillance plans for all countries, followed by their implementation.

Dr Capuano indicated that programme managers should discuss and agree on these new plans of action. She said that financial sustainability and political commitment at the national level are critical to achieve PacELF's goals.

2.7 Update on the Papua New Guinea ELF programme

The Papua New Guinea ELF update was presented by Mr Leo Makita, the national LF Programme Manager. Filariasis is highly prevalent in Papua New Guinea (see Figure 4), with local prevalence of microfilaria antigen ranging from 10%-98%. It is estimated that more than 1 million people are infected, with another 3 million people at risk of infection. In a population of 5.8 million people, this risk is very high for the whole country.

Figure 4: Distribution of LF in Papua New Guinea



The programme for the elimination of LF was initiated in Papua New Guinea with support from the PacELF office in Fiji in 2004. After the preparatory phase in 2004, the first round of MDA was conducted in Milne Bay province in 2005. In 2006, the second round of MDA was conducted in

Milne Bay province and another five provinces conducted their first MDA. Baseline surveys for the provinces prior to MDA showed ICT-positivity rates ranging from 15% to 40%. The plan is to add several more provinces to the programme each year until the whole country is covered. There are 20 provinces in the country and each province is an implementation unit.

To date, coverage has been variable in the implementation units conducting MDA, varying depending on the resources available. In its initial plan, Papua New Guinea opted for door-to-door delivery of the drugs for MDA using the existing health infrastructure. However, MDA implementation has taken a very long time due to use of this method by the health service in each village.

After the first National Meeting, conducted in April 2007, the original implementation plan for 2004-2012 was revised to reflect global strategies and the constraints being faced by the programme. The revised strategic plan for 2007-2020 addresses MDA, monitoring and evaluation and disability-control issues, and includes strategies for implementation. The new plan also considers alternatives to MDA, such as DEC-fortified salt or tinned fish to address the logistical problems of drug delivery.

The programme in Papua New Guinea is currently facing many challenges that may affect its continuation. These challenges include:

- a lack of human resource capacity at the national level;
- a lack of sustainable funding support for the programme;
- a need to find alternative strategies for delivery of drugs;
- the fact that filariasis elimination is not a national priority; and
- insufficient funding for activities.

The issues that need to be addressed urgently include:

- investigation of sustainable funding sources (donor agencies, development banks, etc.);
- investigation of possible alternative intervention methods (DEC-fortified salt/tinned fish);
- investigation of alternative methods of drug delivery (mobilizing communities, church groups, NGOs, etc.);
- lobbying for the prioritization of the LF programme and inclusion of a recurrent budget line for the programme in the government budget;
- review of the areas that were indicated as being non-endemic in the initial mapping exercise;
- survey and registration of persons living with disabilities; and
- communication and education (very important for good coverage).

2.8 Morbidity control in the Pacific: Key elements to be incorporated into national plans

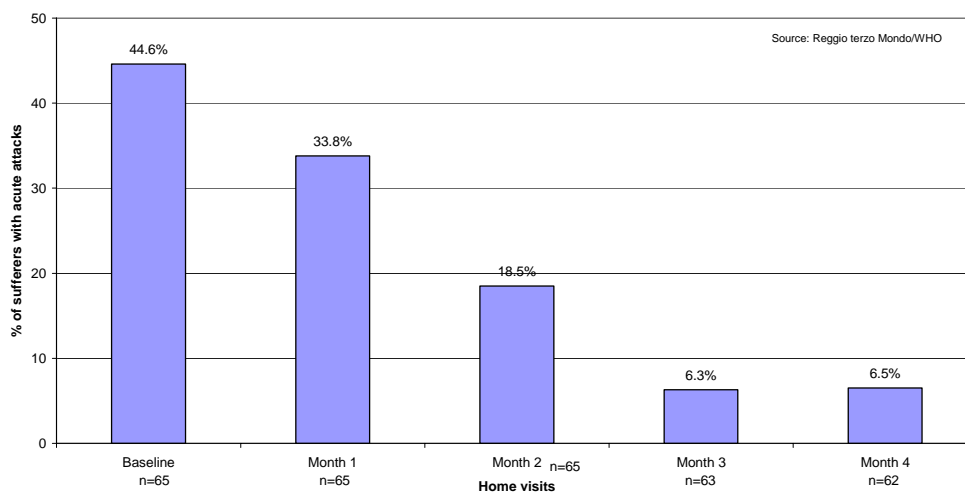
Dr Ottensen discussed the key elements of morbidity control. The goal of the Global Programme is to prevent LF disability—first, by preventing acquisition of infection (through MDAs) and second, by preventing disabilities in those already infected from getting worse.

Figure 5: Disability-prevention activities



The new, simple approaches to managing LF disability are based on solid clinical science. Since the major cause of progression of lymphoedema to elephantiasis is recurrent inflammation, careful attention to hygiene and local limb care (elevation, washing, etc.) is an effective clinical strategy to reduce the progression of the disease (see Figure 6). For hydrocoeles, the principal treatment approach is surgery, which is simple, quick and effective.

Figure 6: Report of acute attacks in lymphoedema sufferers after introduction of foot care in Madagascar.



Since much progress has already been made in decreasing the transmission of LF, attention must now be turned to creating or strengthening morbidity management in national programmes. The key elements in establishing morbidity components are to:

- identify and contact affected LF patients;
- develop a sustainable care/support system, including the training of patients, families, health workers, nurses and doctors;
- enable patients to manage lymphoedema themselves;
- increase access to safe, affordable hydrocelectomy;
- provide LF patients with psychosocial support and motivation; and
- improve the socioeconomic inclusion of LF patients.

Fortunately, WHO has prepared excellent documents and supportive materials to assist in establishing these programmes, and it is very feasible for morbidity management to become a key goal for all national PacELF programmes during the next two years of programme activity.

2.9 Draft five-year surveillance plan for the Pacific

Dr Clare Huppatz was recruited as a WHO consultant from 8 to 23 June 2007 to develop and finalize a draft LF Surveillance Strategy for the Pacific, which she presented.

By the end of 2007, several Pacific island countries will be in the final stages of their LF elimination programmes. There is an urgent need to offer them advice about surveillance to ensure that interruption of transmission has occurred and is maintained in all areas. No other region in the world has commenced widespread ongoing surveillance for LF. As a result, there are no existing strategies on which to base a Pacific surveillance programme.

The task of developing a Pacific surveillance strategy began with a consultation process. Opinions from recognized LF experts were sought and collected regarding issues of diagnostics, treatment, sampling, reintroduction, clinical surveillance, vector behaviour and control. This information was used to write a preliminary draft surveillance strategy. During the consultation process it was determined that there are some issues surrounding LF surveillance for which no evidence exists, making precise recommendations problematic.

In order to gain a detailed overview of the Pacific LF elimination activities completed thus far, a comprehensive review of data from all Pacific island countries and areas was performed. Where possible, an attempt was made to gauge the progress, or otherwise, of each country's participation in the LF elimination programme to date. Analysis of these data was used to inform the surveillance strategy. An in-depth discussion followed with Dr Capuano and other members of the WHO/SP LF Elimination Programme team. Each country's situation was reviewed in detail and the information was used to further modify the draft surveillance strategy.

The proposed strategy uses a primary surveillance strategy, called the Child Transmission Survey (CTS). This is a modification of the previous D Survey. Built into this new strategy is a mechanism for detecting and eliminating the source of transmission within the community. In addition, the recommended surveillance algorithms require repeated confirmation over several years that transmission has been interrupted, so that a country can be sure that transmission has stopped permanently. Two additional strategies are recommended. The first of these, termed a 'Hot Spot' Survey, was designed to augment the CTS and expand the sampling of children in areas that are thought to be of high prevalence within the country. Another strategy, termed Border Detection, is recommended as a trial in some countries to determine the risk of reintroduction that is posed by migrants and returning nationals that missed the MDAs.

The draft surveillance plan was presented at the PacCARE meeting on 19 June, 2007, and the group discussed various aspects of the plan. It was decided that a trial of the draft surveillance strategy should occur in one or two countries. During the LF Programme Managers Meeting, the draft surveillance strategy was outlined to the LF Managers as a group, and the details were discussed with those countries that are nearing completion of their elimination programme.

Several countries are facing important decision points in their LF elimination programmes. Ongoing surveillance is required to ensure that the significant gains achieved by each country to date are not lost. While several issues regarding ongoing surveillance for unanswered questions remain, it is important that the Pacific island countries and areas do not lose momentum as they near their goal. The LF Managers for Vanuatu, Tonga and Niue have agreed to trial various aspects of the draft LF surveillance strategy during the next two years. It is recommended that a trial of the CTS and 'Hot Spot' surveillance strategies occur in Vanuatu between November 2007 and May 2008, and that Niue commence a trial of the Border Detection strategy.

2.10 Review and recommendations from PacCARE

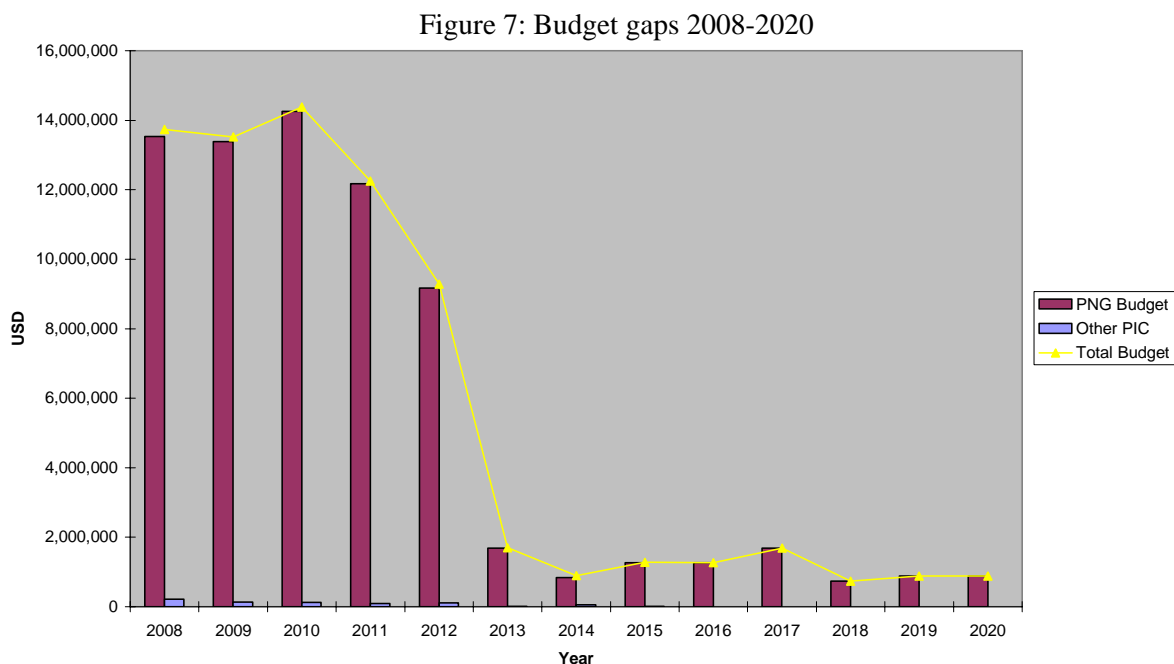
Dr Ottesen, presented the outcomes of the PacCARE meeting, held on 19 June 2007.

PacCARE examined, country by country, the status, problems and plans for all 22 PacELF countries following the October 2006 review, and identified gaps in the group's understanding of the current situation at the country level. It was decided to take advantage of the programme managers' presence during the LF Managers Meeting to clarify issues and identify opportunities for support. PacCARE debated the draft protocol for LF surveillance in the Pacific. The group focused special attention on the challenges and opportunities for Papua New Guinea.

The current and past financial situation of PacELF and the projected costs for 2008-2020 were discussed (see Figure 3). The group agreed on:

- the need to ensure resources for post-MDA surveillance in the Pacific; and
- the need to take advantage of international development fund opportunities, especially for the challenges of Papua New Guinea.

The group reaffirmed its commitment to providing technical and resource support to all PacELF countries.



2.11 Group work

The meeting participants were split into four groups, countries being grouped according to the current stage of their LF elimination programmes, as follows:

Group 1: Papua New Guinea

Group 2 (Child Transmission Surveys): Niue, Tonga, Vanuatu

Group 3 (C Surveys): Fiji, French Polynesia, Kiribati, Tuvalu

Group 4 (Repeat C Surveys): Cook Islands, Samoa

The country participants first met without facilitators to freely raise and discuss their concerns. The facilitators then joined the groups and each country participant was requested to prepare a pragmatic, achievable and realistic two-year plan of action (see Table 2 for a summary).

The following material was provided to assist each group:

- A list of points for discussion, relevant to each group.
- A summary of activities to be reviewed, and modified/completed if necessary.
- Budget estimates up to 2020 for the PICs.
- A folder containing all documents currently available at the WHO/SP Office for each country. Each participant was requested to review the content of his/her country file and to inform the secretariat about any document available at country level not contained in the WHO/SP folders.
- A PowerPoint presentation template to report the final two-year plan in a standardized format.

Table 2: Summary of 2008-2009 workplans

Country	2008	2009
Cook Islands	<ul style="list-style-type: none"> • D survey • Surveillance 	<ul style="list-style-type: none"> • Verification
Fiji	<ul style="list-style-type: none"> • Analysis of C survey • Development of recommendations for future action 	<ul style="list-style-type: none"> • Dependent on results of C survey
French Polynesia	<ul style="list-style-type: none"> • C survey • Possible D survey • Training for morbidity control 	<ul style="list-style-type: none"> • Dependent on results of C survey, but may include MDA, targeted MDA, or surveillance • Follow up morbidity control
Kiribati	<ul style="list-style-type: none"> • Following results of 2007 C survey, either CTS or MDA integrated with deworming (April) • Continue morbidity programme 	<ul style="list-style-type: none"> • Second C survey if MDA in 2008 • Morbidity programme.
Niue	<ul style="list-style-type: none"> • Implement system for border detection 	<ul style="list-style-type: none"> • Continue border detection • Surveillance plan
Samoa	<ul style="list-style-type: none"> • Dependent on results of 2007 C survey 	
Tonga	<ul style="list-style-type: none"> • Morbidity survey (Jan) 	<ul style="list-style-type: none"> • Repeat CTS • Follow up treatment of ICT positives
Tuvalu	<ul style="list-style-type: none"> • Dependent on results of 2007 C survey 	
Vanuatu	<ul style="list-style-type: none"> • CTS “hot spot” survey • Follow-up and treatment of ICT positives • Data entry and analysis 	<ul style="list-style-type: none"> • Consider border surveillance.
Papua New Guinea	<ul style="list-style-type: none"> • MDA in each of the four province groups • B survey in Group 2 	<ul style="list-style-type: none"> • MDA in each of the four province groups • B survey in Group 3 • C survey in Group 1

2.12 Presentation of two-year plans of action and budget estimates by PICs

Cook Islands (presented by Mr Charlie Ave, National Filariasis Coordinator)

Two-year plan:

2007 Carry out C survey, follow up and treat ICT-positives.

2008 Carry out D survey and continue LF surveillance.

2009 Prepare for verification.

Discussion:

Dr Capuano asked for more information about the surveillance plan and the follow up of positive individuals. Mr Ave explained that a first treatment will be given on the spot when an individual is identified as positive. An updated record will be kept for follow up and further treatment every six months.

Fiji (presented by Dr Mike Kama, Acting Senior Medical Officer, Fiji Center for Communicable Disease Control, Ministry of Health)

Three-year plan A (Additional MDA):

- 2007 Conduct sixth MDA with vector control, social mobilization and morbidity control.
Recruit and train a Programme Coordinator.
Hire consultants to (1) conduct a review of the present national ELF plan and determine the resource costs required for effective MDA and (2) develop a COMBI plan and provide technical assistance for its implementation.
- 2008 Implement the consultant's recommendations.
Carry out analysis and documentation for sixth MDA.
Conduct seventh MDA with vector control, social mobilization and morbidity control.
- 2009 Carry out C survey with vector control and morbidity control.
Continue LF surveillance.

Three -year plan B (C survey):

- 2007 Carry out C survey (stratified cluster sampling).
- 2008 Conduct analysis of C survey.
Make decision on next set of actions and plan for maintenance of elimination status (additional MDAs and/or LF surveillance).
- 2009 Conduct additional MDA.

Discussion:

Dr Kama expressed a preference for plan A (COMBI followed by additional MDA). Prof C.P. Ramachandran cited the 11.4% ICT prevalence found by the latest B survey at sentinel sites (2005) and expressed concern that a C survey (plan B) would not be helpful in deciding whether or not to conduct additional MDA. He also expressed concern regarding Fiji's lack of a Programme Coordinator. He pointed out that clinical data from the MDAs, such as records of adverse reactions to

the drugs, appear to be missing, and emphasized that reported coverage and actual coverage need to be well defined. Finally, he asked for clarification of the plan for distribution in urban centres. Dr Koroivueta, Medical Superintendent, Tamavua/Twomey Hospital, Fiji, explained that, in towns, the teams would go door to door and set up booths at public events. He acknowledged that these methods are not very effective and identified problems with the transportation of nurses in urban areas. Dr Koroivueta said that the immediate plan is to write officially to the Ministry of Health to recommend additional MDA. He asked WHO for support on this.

French Polynesia (presented by Ms Laurence Renou)

Two-year plan:

- 2007 Conduct eighth MDA (completed) and morbidity control (update data on LF cases).
- 2008 Carry out C survey (stratified cluster sampling) and training for morbidity control.
If ICT prevalence <1% throughout all C survey sites, carry out D survey.
- 2009 Conduct ninth MDA (national or targeted, based on C survey results) using the door-to-door strategy, with proper evaluation of coverage.
If a D survey is conducted in 2008, continue LF surveillance.
Conduct morbidity control (follow up of LF cases).

Discussion:

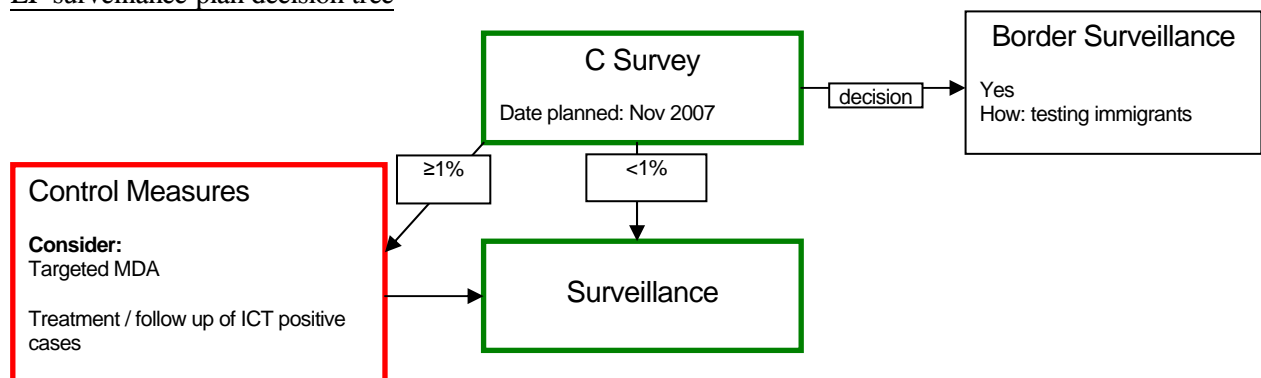
Dr Bradley, GSK, clarified that an estimated 20% of the infected population were covered by door-to-door delivery during the 2007 MDA in French Polynesia, and that this percentage was not an intended target as such. Dr Capuano noted that this was actually an excellent outcome. She visited French Polynesia only six weeks prior to the commencement of the 2007 MDA and made the recommendation for pilot testing of door-to-door and directly observed treatment strategies. To have covered 20% of the treated population via door-to-door delivery is very encouraging considering the short notice and the initial resistance to the recommendation.

Niue (presented by Mr Manila Nosa)

Two-year plan:

- 2007 Conduct a C survey (whole population), plan for border detection.
- 2008 Implement a system for border detection.
- 2009 Continue border detection, implement surveillance plan.

LF surveillance-plan decision tree



Discussion

Dr Biswas suggested that it may not be necessary to repeat a C survey as one was already carried out in 2004, and Dr Ramachandran suggested focusing only on children. Dr Bradley raised a question regarding possible ongoing surveillance and how to implement it. Dr Capuano proposed further discussion of the case of Niue during the upcoming PacCare meeting.

Papua New Guinea (presented by Mr Leo Makita)

Activities in 2007:

1. Conduct MDA in six provinces: Milne Bay Province, Bougainville, New Ireland Province, East New Britain Province, West New Britain Province and Oro.
2. Carry out a coverage survey in the above six provinces.
3. Conduct a mid-term assessment for Milne Bay Province (conducted first MDA in 2005).
4. Carry out a baseline survey for the five new provinces.
5. Liaison with church groups:
 - coordinate the inclusion of the five new provinces for 2008 MDA; and
 - discuss the feasibility of joint action to secure the continuity of MDA in the current six provinces (listed above).
6. Consider MDA alternatives (DEC salt or DEC fish): hire a consultant to conduct a situation analysis of the feasibility, plan, negotiation, etc.
7. Follow up on the budget line with the Government.
8. Ensure all activities are included in the annual plan of the Department of Health; coordinate with the Planning and Monitoring Unit of the Department of Health.
9. Carry out a re-mapping survey to clarify LF prevalence in the three provinces classified as “uncertain”.
10. Implement disability control and patient registration.

Activities in 2008:

1. Conduct MDA in six current provinces and five additional provinces.
2. Carry out coverage surveys in six current and five additional provinces.
3. Decide on MDA vs. an alternate strategy (e.g. DEC salt) and plan accordingly.
4. Conduct a mid-term assessment for five provinces (Bougainville, NIP, EBP, WBP and Oro)
5. Plan according to pending confirmation of three uncertain provinces:
 - If positive, include above under #1; and
 - if negative, maintain LF surveillance (based on plan to be developed).

6. Implement disability control: home based self-care, surgery.

Current timeline for MDA implementation by province:

Group and name of provinces			Year							
Group 1 (1 province)	1	MBP								
Group 2 (5 provinces)	2	Oro								
	3	NIP								
	4	ENB								
	5	WNB								
	6	NSP								
Group 3 (5 provinces)	7	Gulf								
	8	Morobe								
	9	Madang								
	10	ESP								
	11	WSP								

Discussion:

Dr Biswas emphasized the importance and resource-demanding nature of the Papua New Guinea programme and suggested linking with other programmes to take advantage of existing logistics. Mr Makita indicated that this possibility has been the subject of continuing discussion. He mentioned possible coordination with World Vision deworming efforts. He also suggested mobilizing churches, which reach all communities, to assist in drug delivery. He said that there are no NGOs that would reach enough people.

Dr Ramachandran pointed out the importance of securing resources to complete additional rounds of MDA in those provinces that have already begun MDA, so that gains that have been made will not be lost. Mr Makita acknowledged the importance of this task and said that MDA will begin in new provinces only when resources are sufficient to continue MDA in the current six provinces. Therefore, the addition of new provinces may have to be moved back several years pending immediate efforts to secure resources.

Dr Ottesen requested clarification on the targeted population figures. Mr Makita explained that 1.5 million people are targeted for MDA in 2007. If five provinces are added in 2008, it is expected that 3.5 million would be covered that year. Reaching the 3.5 million population by 2008 would require US\$ 3.7 million over the two years.

Samoa (presented by Ms Iokapeta Mailei, Senior Vector Control Officer, Ministry of Health)

Two-year plan:

- 2007 Carry out a C survey (stratified cluster sampling) with an integrated morbidity survey. Conduct targeted MDA for men*.
- 2008 If necessary, conduct additional targeted MDA, followed by a third C survey in targeted areas.

2009 Carry out a D survey.

** The planned 2007 targeted MDA was removed on the advice of Dr Biswas, as described in the discussion below.*

Discussion:

Dr Biswas raised a concern regarding the trend lines in the data. He pointed out that the data cannot be compared and that this was also an issue in previous meetings. Dr Biswas asked why MDA targeted at men was planned if the ICT prevalence from the 2007 C survey were found to be less than 1%. Ms Maiava explained that the Ministry of Health planned to conduct the targeted MDA simultaneously with the second C survey, since the previous C survey had shown a high prevalence among adult males. Dr Biswas suggested conducting the targeted MDA after the second C survey, so that the most recent survey results could be used to accurately identify priority areas where intervention is needed.

In response to a question from Mr Ave regarding morbidity, Ms Maiava said that, at the moment, Samoa does not have complete data on morbidity. A need for a morbidity register was identified. Dr Melrose brought up the issue of conducting a survey for hydroceles, which is prone to underreporting. Dr Capuano suggested a strong awareness campaign to promote the surgical treatment of hydroceles through success stories and a focus on the simplicity of the procedure, to encourage affected males to actively seek care from the health system. Dr Ottesen noted that, in the Dominican Republic, treatment awareness led to better reporting of hydroceles. Dr Bradley cautioned that the health system must be prepared, with trained surgeons and a budget, before offering and promoting treatment.

Dr Koroivueta mentioned that the Pacific Leprosy Foundation recently made a commitment to assist with morbidity control and management. He suggested a possible system for sending LF cases from the PICs to Fiji for treatment; the Foundation would pay for airfares and accommodation. He was unsure how much such support the Foundation could provide, but Dr Capuano indicated that she had been in contact with the Foundation and that they are interested in helping. Dr Ehrenberg said that the extent of the morbidity control task will have to be evaluated in order to know how much support will be necessary prior to setting up a new system.

Kiribati (presented by Ms Teiti Bwenawa, Principal Nursing Officer, Filariasis Programme)

Two-year plan:

2007 Carry out a C survey (stratified cluster sampling), implement a morbidity control programme.

2008 If ICT prevalence <1% in all C survey sites, carry out CTS.
If ICT prevalence \geq 1% in certain areas, conduct targeted MDA integrated with deworming.
Continue the morbidity control programme.

2009 If MDA is conducted in 2008, carry out a second C survey.
Continue the morbidity control programme.

Discussion:

Mr Ave brought up the issue of data analysis, noting that it poses problems for most LF managers. Dr Capuano reiterated WHO's commitment to providing technical support to country programmes based on the needs identified during the meeting. She said that WHO will continue to

keep in touch with programme managers after the meeting to discuss what specific assistance can be provided.

Ms Maiava said that data management tends to be difficult and is a weakness in many country programmes. She requested that training in data management be arranged, possibly during the annual PacELF workshop, so that representatives from each country can be updated on this aspect of the programme.

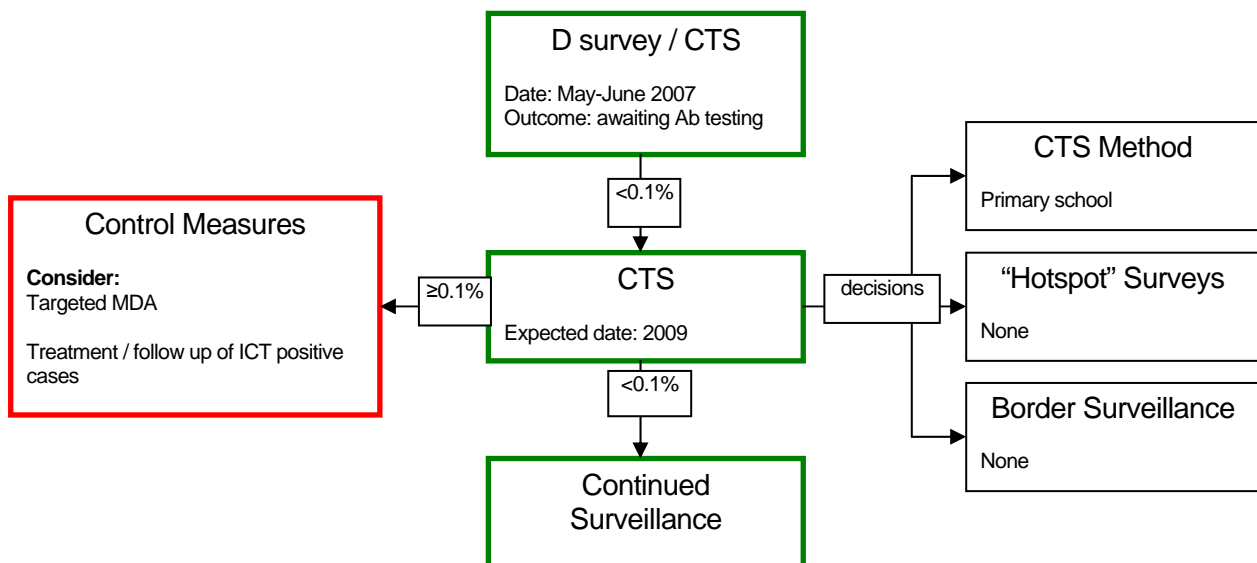
Dr Melrose indicated that the LF Support Centre in Townsville, Australia, could help with data management, but requests for such help would have to come through Dr Capuano.

Tonga (presented by Dr Louise Fonua Senior Medical Officer in charge of Communicable Diseases, Ministry of Health)

Two-year plan:

- 2007 Finalize and report the results of CTS.
Plan for a morbidity survey (possible need for WHO assistance).
- 2008 Conduct a morbidity survey, input and analyse data, plan for follow up (e.g. train nurses and community health care workers).
- 2009 Carry out a second CTS, follow up and treat ICT-positives.

LF surveillance-plan decision tree:



Discussion:

Dr Biswas noted that, during the 2006 C survey, one of the clusters was found to have a high prevalence and he requested clarification on the follow-up activities. Dr Fonua indicated that everyone in the area was treated during the MDA and that, during the D survey, all previously positives were re-tested. All were then found to be negatives.

Dr Bradley mentioned that positive test sera are available to help clear up doubts regarding the validity of ICT results.

Mr Ave asked Dr Capuano if an Excel template is available to analyse data from a D survey. Dr Capuano explained that the existing template for C survey data is not applicable to D surveys but mentioned that WHO/SP can provide support to countries that need help in data analysis.

Dr Ramachandran inquired about what would be done if all of the antibody tests submitted during the D survey were found to be negative. Dr Melrose said that the exact significance of antibody testing is not yet known, but he remains optimistic that completing the tests on samples from Tonga can yield information to determine whether programmatic decisions can be made based on the test. Dr Fonua indicated that Tonga would plan to conduct a CTS in 2009 to continue surveillance.

Tuvalu (presented by Ms Falealili Feagai, Senior Environmental Health Officer, Princes Margaret Hospital)

Planned 2007 activities:

1. Carry out a C survey (whole population) using ICT and Mf, with technical assistance from JCU Implement immediate treatment of ICT-positives.
3. Make a decision on future MDA based upon results of survey (will need the assistance of PacELF).

Discussion

Dr Melrose clarified that the budget indicated was given in local currency, not United States dollars.

When asked about the capacity to conduct Mf testing in Tuvalu, Ms Feagai confirmed that there is a laboratory technician in Tuvalu who can read Mf slides. In addition, Dr Melrose said that a laboratory technician from JCU will be in Tuvalu to assist with the Mf slides.

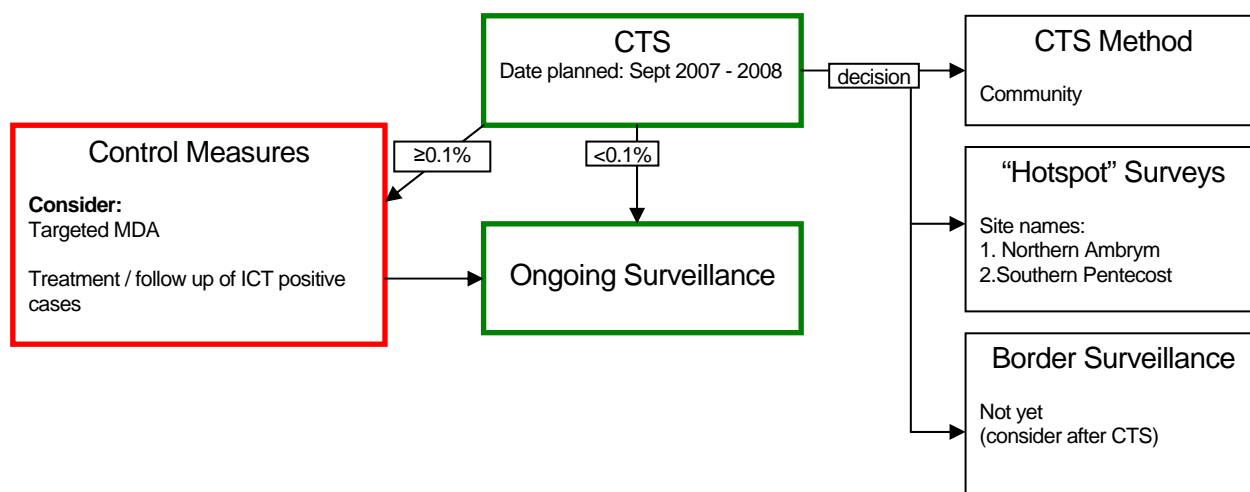
Prof Ramachandran noted that a mid-term survey showed ICT prevalence rates as high as 17% in certain areas. Dr Melrose said that, at the time of that survey, problems with the ICT tests led to numerous false positives, therefore the mid-term survey results are not reliable. He emphasized the importance of the 2007 survey in light of this lack of reliable data.

Vanuatu (presented by Ms Fasihah Taleo, National Filariasis Coordinator)

Two-year plan:

- | | |
|------|--|
| 2007 | Carry out CTS (community method) and Hot Spot surveys.
Update the morbidity register. |
| 2008 | Follow up and treat ICT-positives.
Conduct data entry and analysis of CTS. |
| 2009 | Consider border surveillance. |

LF surveillance-plan decision tree:



Discussion:

Ms Taleo confirmed that no clusters were found to have ICT prevalence above 1% during the 2005 C survey. Dr Melrose commended the success of the Vanuatu programme, which did tremendous work with little outside support. He said that this success deserves global attention. Dr Melrose also identified a possible need to set up a reference laboratory in the Pacific to handle any additional antibody testing, since his laboratory may not be able to cope with the increased load.

2.13 Closing ceremony

The Chairperson thanked participants for their contributions and acknowledged the practical and useful outcomes of a very successful meeting. He then passed the floor to Dr Capuano for her closing remarks.

Dr Capuano thanked the country participants, the Chairperson and all the other participants. There is now a clear vision, and pragmatic plans of action have been developed for at least the next two years. At the next LF managers meeting in 2008, the country participants will be requested to report on the plans of action and estimated budgets they have developed. The objective of this meeting was to focus on the endemic countries as they had burning questions and issues that needed clear and specific answers. However, the non-endemic and 'partially-endemic' countries were not forgotten. During the PacCARE meeting on Tuesday 19 June 2007, recommendations were made for them as well. WHO is committed to continuing to provide technical support to countries and discussions will continue after the meeting with each individual country to review needs and identify ways to address them.

Dr Ehrenberg thanked all the participants for their active participation and acknowledged the financial support received from the Government of Japan over the past few years. He congratulated Dr Capuano and her team for a well-managed and very successful workshop and for the open spirit that prevailed during this meeting. He remarked that, despite a very tight agenda, the outcomes are excellent and he expressed confidence that much can be achieved in the next few years. Integration of LF with other NTD should also be kept in mind and further developed whenever possible. Dr Ehrenberg officially closed the meeting.

NINTH WORKSHOP FOR PACIFIC
LYMPHATIC FILARIASIS
PROGRAMME MANAGERS

WPR/PIC/CPC/1.2/001/MVP(2)/2007.1A
14 June 2007

Nadi, Fiji
20-21 June 2007

ENGLISH ONLY

PROVISIONAL AGENDA

1. Opening ceremony
2. Recent Gates Foundation Grant to the Global Alliance
3. Global programme to eliminate lymphatic filariasis
4. Liverpool School Lymphatic Filariasis Support Center/Global Alliance to Eliminate Lymphatic Filariasis (GAELF)
5. Partnership in the global programme to eliminate lymphatic filariasis: Focus on the Pacific
6. James Cook University Lymphatic Filariasis Support Center
7. Current challenges of the Pacific programme to eliminate lymphatic filariasis
8. Update on the Papua New Guinea's programme to eliminate lymphatic filariasis
9. Draft five-year surveillance plan for the Pacific
10. Morbidity control in the Pacific: key elements to be incorporated into national plans
11. Review and recommendations from PacELF* Programme Coordinating and Review Group (PacCARE)
12. Guidelines for preparing the national five-year plans of action
13. Presentation on group work and objectives
14. Country presentations: five-year plan of action and budget estimates
15. Discussions
16. Closing ceremony

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Speech by Dr Shigeru Omi, Regional Director
WHO Western Pacific Regional Office at the
Ninth Workshop for Pacific
Lymphatic Filariasis Programme Managers
Nadi, Fiji, 20 and 21 June 2007

FRIENDS AND COLLEAGUES, ladies and gentlemen,

Lymphatic filariasis has been known for centuries and depictions of people afflicted with elephantiasis are found in old civilizations. Today, WHO estimates that 1 billion people in 80 countries are at risk with over 120 million already affected and 40 million severely disfigured and incapacitated. Even when no clinical symptoms are present, hidden lymphatic pathology and kidney damage exists.

The consequences of the disease, such as elephantiasis and hydrocele, are not only disabling but can also drag entire families into poverty. The social and economic burden, as well as the suffering of affected individuals, is enormous.

New diagnostic tools and a more effective combination of drugs now make elimination an attainable goal.

In 1997, the World Health Assembly adopted resolution WHA50.29 to eliminate lymphatic filariasis as a public health problem. The strategy has two components:

- To interrupt transmission of lymphatic filariasis.
- To address and alleviate associated morbidity, including residual morbidity even after interruption of transmission has been achieved.

A generous pledge in 1998 by GlaxoSmithKline or GSK, then, SmithKline Beecham, to collaborate with WHO concentrated on the donation of albendazole for as long as necessary to ensure success of the elimination programme. In addition, the company continues to support other key elements of the programme such as the regional programme review groups. The Global Alliance, of which GSK is a member together with other key partners, has helped strengthen the regional initiative and increase chances for success.

The Pacific Programme to Eliminate Lymphatic Filariasis was launched in 2000 under the auspices of WHO. However, several countries and areas in the Pacific such as Cook Islands, French Polynesia, and Samoa have a long history of fighting the disease.

Among the 22 countries covered by the Pacific Programme to Eliminate Lymphatic Filariasis, 16 countries are endemic. It is estimated that about 7.9 million people are at risk, most of them in Papua New Guinea.

Since 2000, great efforts have been made to eliminate lymphatic filariasis in the Pacific area in partnership with the Pacific countries, the Government of Japan and other stakeholders. Great progress has been achieved. So far, 14 countries have conducted mass drug administration and 11 of these have completed at least five rounds.

However, we can not drop our guard. The morbidity component must be fully tackled and programmes for verification of elimination need to be completed. Since 2000, 1.5 million people have been reached by mass drug administration in the Pacific. Although some countries have achieved high treatment coverage rates, mass drug administration coverage of at-risk people in this area - except for Papua New Guinea - has so far been 59%. If Papua New Guinea is included, this proportion drops to 19%. Clearly, these issues are an important challenge to the elimination of lymphatic filariasis.

Various partners are now joining forces to provide adequate support for proper monitoring and evaluation of the Papua New Guinea's programme. This is an important milestone that is expected to have an impact on the entire Pacific Programme to Eliminate Lymphatic Filariasis.

This meeting is critical as it addresses the next steps and strategies for the coming five years. With only 13 years left before the global target of 2020, there remains much to be done. Elimination of lymphatic filariasis in the Pacific islands is feasible but will require continuous support and strong commitment from all partners.

I would like to take this opportunity to express my deepest appreciation to Governments of the Pacific Island Countries for their efforts and achievements, the Japanese Government for its generous financial support and donation of drugs and test cards, GlaxoSmithKline for its donation of drugs and financial support, and for all other partners and stakeholder's support in the global war against lymphatic filariasis.

I wish you a successful workshop and look forward to its positive outcomes.

Speech by Dr Dr Tui Taoi, Director of Health Services, Western Division at the opening
ceremony of the
Ninth Workshop for Pacific
Lymphatic Filariasis Programme Managers
Nadi, Fiji, 20 and 21 June 2007

Foremost I wish to convey to our WHO, donor partners, and stakeholders our utmost gratitude and appreciation from the Ministry of Health for your enormous support that is quite visible, tangible and continuing. You have made profound impact to health services here in Fiji and surely the same could be said for my Pacific neighbors. May I thank you most sincerely for that and to thank WHO again for having confidence in hosting the 9th Annual Meeting of PacELF programme managers here in Fiji amidst times of challenges.

This critical interphase in time is to recognize Pacific Island Countries that have completed 5 rounds of Mass Drug Administration with DEC and Albendazole and pursuing mopping up of endemic foci of infection in their countries. The successes and challenges will be discussed in greater detail during the course of the meeting and for that Fiji looks forward to receiving your deliberations so that we will be able to learn from that and apply its practicality to better LF programme implementation here in Fiji. Certain things need mention here. Countries like Samoa have committed their people and their government to this national undertaking. They have walked the many miles, sailed the rough seas and sweated the terrains primarily to reach the community for drug distributions. The passion of the Pacific countries for the betterment of health for their people cannot be overemphasized.

Last year this meeting was scheduled to prelude the 4th Meeting of the Global Alliance to Eliminate LF at the Warwick International Hotel. Fiji hosted the Global Alliance Meeting on behalf of our Pacific member countries and yourselves. Glad to say that the meeting was a true success and wish to thank you all for all your support and valued assistance. The PacELF flag should rise high despite the many challenges we face at programme and at country level. We will do things conceived the PacELF way and we should not lose sight of our community obligations.

Today will be remembered as a time that you will reflect on the status of your national elimination programmes within the PacELF initiative, exchange information of LF and related issues, share your experiences in the elimination initiatives and more to that to celebrate the PacELF successful achievements amidst many challenges such as our smallness and diversity within the global village.

All is not over yet as we embark on prevalence surveys to guide the next sets of actions. Fiji is committed as always to this meeting and looks forward to harmonizing that with the 5th Global Alliance Meeting to be convened in Africa next year. Our commitment goes further to the days when LF is eliminated from Fiji and the Pacific Shores.

We have experienced interesting public health emergencies here in Fiji. We had a measles outbreak; we also had an outbreak of acute hemorrhagic conjunctivitis in 2006 and like you too preparing for an influenza pandemic. Building capacities for International Health Regulations and its implementation in 2007 pose urgent attention to all of us. These are just a few. Within all these initiatives, the PacELF has taught us many lessons that regional initiatives need to learn from.

The strong leadership of WHO needs commendation in time as we take stock of the interesting times we sailed through. Clearly the LF eliminative is embedded in the Ministry of Health Strategic

Plan 2007-2011. We have challenged ourselves that by 2008 we have eliminated LF and measles in Fiji. There is still hard work to do given existing factors that affect the health system deliveries, human resource developments and technical capacities.

We, the Pacific Island Countries need to learn and apply strategic public health principles undertaken in this regional elimination initiative. Your full participation and ongoing attentiveness to resurgence of LF and control should be enshrined in our implementation strategies and actions. Let us be remembered as the passionate professionals of the Pacific that worked tirelessly to eliminate a neglected tropical disease: Lymphatic Filariasis.

As a developing country with restricted resources and capacities, I pledge herewith that evidence based practices should be our guiding pillars in the elimination. Our system therefore will have to be assisted, supported and more so refurbished to ensure that we also are in par with all endemic countries worldwide.

Our country continues to look forward to your collaboration, support and advise as we address cross border transmissions and spread. Elimination of LF calls for collective and collative work. It calls for team efforts and working together as a team, like what PacELF champions.

Barriers and bureaucracies further harm the affected communities who are in dire need of assistance and support. I urge you all to work with great serenity and dignity whereby you could craft a national sense that will touch affected individuals and communities in our beloved Pacific.

As health professionals and partners, we are critically looked upon by our people to provide sound and effective interventions to minimize disease impacts and more so continue to prevent re-emergence of LF. Given the enormous efforts put into your own national programmes and the mode we are in now, preparedness at all levels cannot be overemphasized.

Fiji looks to you with respect, trust and hope that what you continue today will assist our communities in the elimination of LF. Fiji has gained some tangible products from the LF programme which ranges from technical capacity building, operational support, equipment and supplies, and more so making connections for health.

I will be looking forward towards the deliberation and outcomes of this very important meeting in due course. May I wish the forum the very best in your deliberations and hope that good sense and understanding will prevail to enable you to meet the outcomes and outputs of the meeting.

Last but not least, let us never forget the very people we are obligated to serve. They have placed their trust and hope in us. Let us not diverge from that in our business of health delivery. Let me close by saying this quote:

Small minds talk about people.
Average minds talk about events.
Great minds talk about ideas.

May great ideas be encouraged and translated to actions.

With those few words, I now take the privilege to officially declare the Ninth Workshop of the PacELF Programme Managers officially open.

Thank you very much, Vinaka Vaka levu and Baat Dhanbard.

May God Bless us all.”