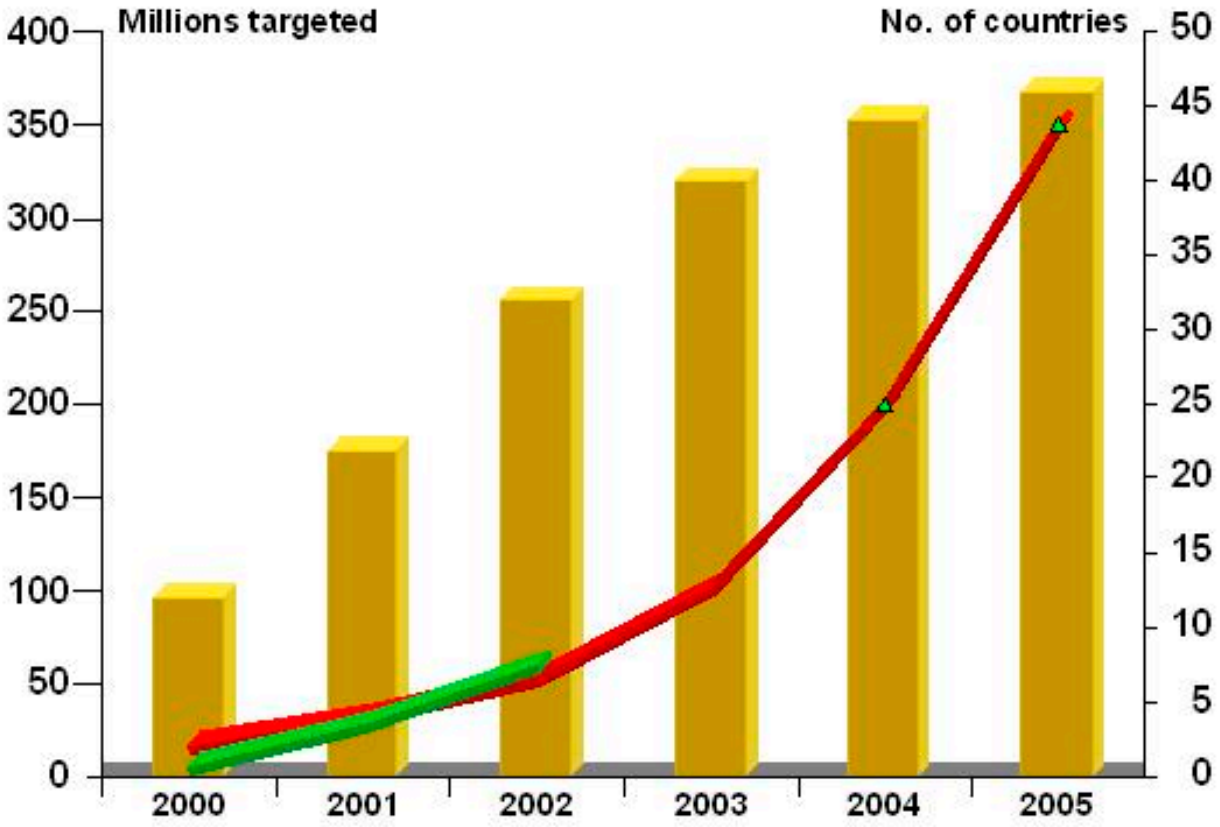
GLOBAL PROGRAMME FOR THE ELIMINATION
OF LYMPHATIC FILARIASIS

Strategic Plan 2003–2005
Challenges of scaling up



World Health Organization
Geneva

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GLOBAL PROGRAMME FOR THE ELIMINATION OF LYMPHATIC FILARIASIS

Strategic Plan 2003–2005

Challenges of scaling up

Programme to Eliminate Lymphatic Filariasis
Department of Control, Prevention and Elimination
Communicable Diseases, World Health Organization
Geneva, 2004

This Plan, which has been approved in outline and content by the Technical Advisory Group on Lymphatic Filariasis at its meeting in March 2003, is intended to provide strategic guidelines as a basis for Regional Programme Review Groups and Country Programme Managers to finalize the specific implementation plans appropriate to their regions and countries. Its content may also be used, in appropriate form, for advocacy and promotional purposes by the Global Alliance to Eliminate Lymphatic Filariasis (GAELF).

Contents

Goal and overall assumptions

The goal of the Global Programme to Eliminate Lymphatic Filariasis (GPELF) is defined as "**the elimination of lymphatic filariasis as a public health problem by 2020"**.[1] The Strategic Plan of 1999[2] identified four major elements of the GPELF and two aims:

- ➢ the interruption of transmission
- ➢ the prevention of disability.

This Strategic Plan for 2003–2005 for scaling up is exclusively programmatic and assumes the availability of adequate funding for GPELF. Detailed planning for the acquisition of funding is being done by the Alliance Task Force on Advocacy and Fundraising.

Scope

Endemic countries - strategy to interrupt transmission of lymphatic filariasis

Mass drug administration (MDA) to entire "at-risk" populations can effectively interrupt transmission of lymphatic filariasis (LF) by reducing the number of parasites in the blood to levels below which the mosquito vectors can no longer transmit infection:

- ➢ Use of once-yearly treatment with single dose of two drugs given together (albendazole plus either ivermectin or diethylcarbamazine (DEC)) for 4–6 years.[3]
- ➢ Exclusive use of DEC-fortified table or cooking salt for 1–2 years.

Preventing disability caused by lymphatic filariasis – lymphoedema and hydrocele

- ➢ Community home-based self-care for lymphoedema through support services.
- ➢ Access to surgery for LF patients with hydrocele.

[1] World Health Assembly resolution 50.29.

[2] *Building partnerships for lymphatic filariasis: strategic plan*. Geneva, World Health Organization, 1999 (WHO/FIL/99.198).

[3] The number of annual rounds of MDA required is dependent on the MDA coverage. The lower the coverage the greater is the number of rounds that may be required. A minimum coverage of 65% of the total population of the implementation units is considered to be effective.

Strategic operational principles

Regionalization

While much has been achieved in the area of regionalization, GPELF must continue to focus closely on action that is region- and country-specific so as to respond in the most appropriate and practical way to particular characteristics and needs. Such focus should also help in finding the most cost-effective approach to problems and needs in the various regions. Regional Programme Review Groups (Regional PRGs) need to be strengthened to enable them to perform a greater steering and supporting role in respect of the country programmes.

Strengthening existing health systems

It is clear from experience that large-scale programmes such as GPELF must be implemented through existing health systems – otherwise the programmes become external and "top-down" and impose considerable additional demands on scarce resources. Working through existing systems offers the dual advantage of increasing local and national capacity and promoting the sustainability of GPELF. Sector-wide approaches demand a critical role in planning and allocation of resources at district levels (which largely coincide with LF implementation units). National programmes should start MDA only in provinces or districts that have incorporated ELF activities into their plans of action through the local health systems (which is also essential step to secure synergies with other public health programmes).

Synergies with other disease control or elimination programmes

In terms both of cost and of management and operational efficiency, the PELF, like other large programmes, must seek to synergize as far as possible with other relevant national or sub-national programmes and activities, such as those dealing with onchocerciasis, helminthiasis, schistosomiasis, or malaria in Africa. In most cases, the channels of treatment and national or local management are likely to be the same, and inter-programme synergy creates greater efficiency, effectiveness, and economy. Vector control programmes – bednets in Africa, dengue control in the Pacific, for example – provide important entry points for the LF programme (and vice versa).

Embedding ELF in primary development strategy

If PELF is to be successful and effectively implemented over the required period of time, governments of the affected countries must make a strong commitment to the programme within their own national development priorities. While there is a clear need for action to eliminate LF, the demand (in social, political, and economic terms) for such programmes cannot be generated by WHO or other external partners alone. A strong political commitment and policy priority on the part of the governments of LF-endemic countries will ensure sustainable implementation at national and local levels and encourage external partners to provide the financial and technical support that may be needed.

Creating national partnerships

The main focus of action must be concentrated at national and sub-national levels. A major instrument for supporting such action is the creation of national partnerships, including the ministry of health, WHO, other national ministries, local and international nongovernmental development organizations (NGDOs), and local representatives of the private sector and of aid agencies. For operational support, it is particularly important to make full use of the potential of NGDOs present in the area.

Strategic objectives

2003–2005

- ➢ Complete mapping of implementation unit within countries where LF transmission occurs.
- ➢ Scaling up of the programme to 46 countries and 350 million people.
- ➢ Establishment of disability prevention programmes in at least 23 countries.
- ➢ Measuring impact and demonstrating success of MDA.

2006–2010

- ➢ All implementation units to have initiated MDA by end 2010.
- ➢ Scaling up to 80 countries and all endemic populations.
- ➢ Verifying interruption of transmission in 10 countries.
- ➢ Disability programmes established in all endemic countries.

2011–2020

- ➢ Transmission interrupted in all endemic countries by 2015.
- ➢ Surveillance of children born after end 2015 in place in all countries.
- ➢ Home-based self-care for all patients with lymphoedema or hydrocele.

Short-term plan 2003–2005

Objectives and priorities

Objectives (as established by the Second Meeting of the Global Alliance to Eliminate LF, New Delhi, February 2002):

1. Scale up MDA to cover 350 million people at risk in 46 countries towards interruption of transmission.
2. Establish strategies for disability prevention in at least 50% of the endemic countries that have initiated PELF.

3. Develop technical and management capacities in each Regional Programme Group and national health system to adequately support ELF activities.
4. Establish assessment, monitoring, and evaluation framework and measure impact of MDA strategies in 15 countries.
5. Secure resources to scale up programme.

Priorities within specific objectives:

1. Complete mapping in all known endemic countries, initially giving high priority to supporting those that have already begun the mapping exercise.
2. Where MDA has begun, ensure its continuity with special focus on areas where coverage is not yet effective;[1] using social mobilization to ensure sustained high coverage will be an essential component of strategy.
3. Measure coverage achieved and adjust strategies to increase coverage where necessary (social mobilization, etc.).
4. Ensure the rapid expansion of MDA in areas/countries which it has already been initiated so as to cover the entire at-risk population rapidly.
5. Begin MDA elsewhere only after mapping has been completed for an entire country and a comprehensive national plan (including scaling up) has been developed.
6. Integrate strategies for disability prevention into programmes at national and sub-national levels.
7. Identify and meet training requirements at national and sub-national levels, with emphasis on training at the level of implementation units.

Activities and outputs

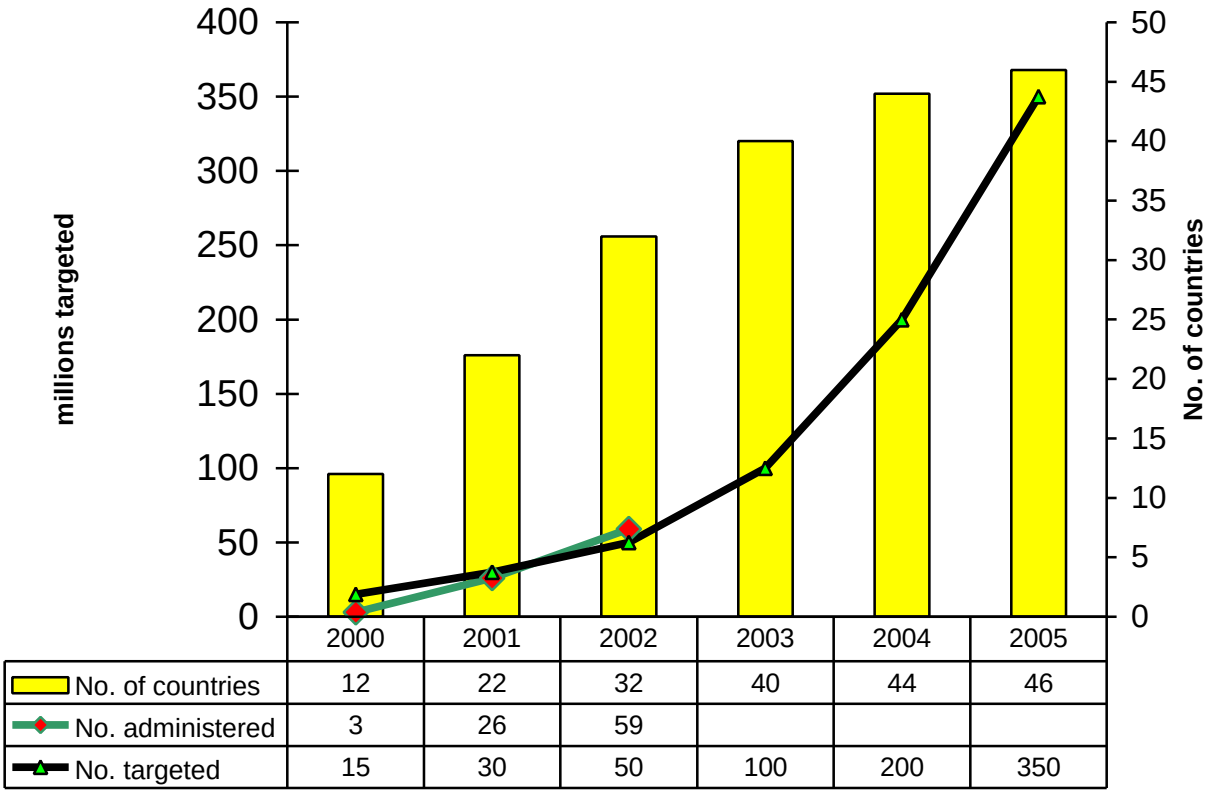
Completion of mapping (Objective 1)

Mapping is the fundamental platform from which ELF implementation can be launched. The methodology for the initial assessment and mapping is available. A standardized operational guideline for Africa is in use. A geographically coordinated approach should be used in implementation and planning. Training workshops should ensure standardization and survey results should be independently validated. There should be an adequate supply and quality assurance of user-friendly rapid diagnostic tools and rapid detection kits.

Scaling up of MDA coverage (Objective 1)

There should be effective coverage with recommended drug co-administration in all implementation units in endemic countries; such coverage should be maintained until microfilaraemia levels are reduced to levels at which recrudescence will cease to occur. To achieve the short-term target of covering 350 million people at risk by the end of 2005, at least 100 million should be covered in 2003 and 200 million in 2004.

[1] Simulation models indicate that interruption of transmission requires a minimum effective coverage of 65% to be achieved.



	2000	2001	2002	2003	2004	2005
No. of countries	12	22	32	40	44	46
No. administered	3	26	59			
No. targeted	15	30	50	100	200	350

Drug supply, logistics, and quality control (Objective 1)

The quality of donated supplies of albendazole and ivermectin is assured and sustainable. In a Memorandum of Understanding with WHO, GlaxoSmithKline has committed to provide the entire supply of albendazole that may be required to eliminate LF. Merck & Co., Inc., has also committed to supply ivermectin in those African countries where LF and onchocerciasis are co-endemic. Supplies of quality DEC are still unregulated. To achieve adequate supplies of good-quality DEC, GPELF should ensure that at least five manufacturers of DEC formulations and two of raw DEC are pre-qualified by 2005. To ensure that DEC tablets or the DEC active pharmaceutical ingredient (API)for DEC-fortified salt meet the current United States Pharmacopeia standards and pass the test for piperazines in the International Pharmacopoeia 1996, procurement should be centralized. Countries procuring independently should use the list of WHO pre-qualified manufacturers that can be obtained from WHO. Standards for the manufacture and quality assurance of DEC-fortified salt need to be developed to help countries that choose DEC-fortified salt as the treatment strategy.

Role of vector control (Objective 1)

Vector control has traditionally been one of the mainstays of LF control programmes but has had varied impact. In the Solomon Islands, for example, LF was eliminated as a

collateral benefit of malaria vector control activities, and improved general sanitation through overall development resulted in the elimination of LF from Japan and from most of the Republic of Korea; however, no similar results were obtained through vector control and selective chemotherapy programmes designed to control *Culex*-transmitted bancroftian filariasis in endemic areas. Resources for LF elimination should therefore be used judiciously for vector control activities. A window of opportunity exists in Africa where the target is to cover 60% of malaria-endemic populations with insecticide-treated nets by 2005; synergy between this intervention and PELF activities in LF-endemic areas is likely to benefit both.

Establishment of disability prevention strategies and programmes (Objective 2)

Access to the knowledge necessary for self-care of lymphoedema and to hydrocele surgery should be made available to all patients with these LF-related clinical manifestations and disabilities in all of the implementation units covered by MDA. This element should be included, in specific terms, in all national plans for LF elimination. The most difficult challenge is to provide support for development and implementation activities at the level of the implementation unit. Simple tools for the training of the informal care-givers and home-based self-management of lymphoedema have already been produced. Further needs include: technical and operational support to provide guidelines on disability prevention for at least half of the national programmes; pilot projects in a few implementation units followed by scaling up to cover at least 50% of the units by 2005 and establishment of operational links with the community home-based treatment of other chronic conditions to ensure sustainability of the LF-related disability prevention measures.

Capacity-building and training (Objective 3)

In-country programme management training will remain an essential component of the training effort. While skills at national level are important, the challenge remains to develop adequate capacities at lower operational levels.

➢ *National level:*
- Revision of the training module for ELF programme managers.
- Training package for planning and implementing social mobilization in the ELF programme; a generic package to be adapted at country level.

➢ *District level:*
- Training module for district managers on implementing ELF.
- Training module for health personnel at district level involved in ELF monitoring and evaluation.
- Production of generic training packages for home-based self-care and for surgical treatment of hydrocele at the secondary level of the health systems, and guidelines for their adaptation at country level; technical guidelines for the district health team for planning and implementing interventions to prevent LF disabilities (Objective 3).

Creation of national partnerships (Objective 3)

Regional PRGs should provide guidance and advocacy to national programmes on creation of national-level partnerships (including ministry of health, WHO, other sectors of national government, local aid agencies, local and international NGDOs, local academic and research institutes, the private sector). Such partnerships can play a crucial role in promoting regionalization, strengthening existing national health systems, creating synergies with other disease control or elimination programmes, and encouraging a strong national commitment to LF elimination within national development priorities. National task forces can be instrumental in fostering synergy, developing partnerships, obtaining resources, and furthering essential cooperation at national and sub-national levels.

Integration of social mobilization into basic programme planning (Objectives 1–3)

Social mobilization is now recognized as extremely important in encouraging the behavioural change required to achieve effective drug coverage and disability prevention. For maximum effectiveness, the social mobilization component must be included at the initial phase programme planning phase at both national and sub-national (implementation unit) levels. The societal and political support of stakeholders at higher decision-making levels, as well as in the communities, is crucial for effective coverage and for the overall sustainability of the time-limited ELF programme.

Programme monitoring and evaluation (Objective 4)

Monitoring and evaluation systems in each national programme should be established, applied and maintained. Define and standardize the assessment and monitoring framework for country programmes. Implement periodic independent evaluations in countries. Enable inter-programme exchange of information and experience. Demonstrate the impact of MDA in achieving reduction of microfilaraemia to levels at which further recrudescence will not occur; if required, validate the intervention strategy. Implementation units and countries that approach the criteria for stopping MDA, e.g. Egypt in 2005, the Pacific islands in 2005, Sri Lanka in 2006, should be closely monitored for any recrudescence after stopping MDA. (Objectives1, 2 and 3). Review and adjustment of treatment strategies to achieve success in various epidemiological settings requires information to be gathered at regional and global level . The Healthmapper and HealthAtlas software developed by WHO are to be utilized as a part of the global information system with links to other health care/disease control programmes.

Operational research (Objectives 1–4)

Operational research will be a continuous requirement of the programme, addressing issues as they evolve. Issues that are specific to the local or country level or that are more global in nature need to be identified and prioritized. Countries should be encouraged to strengthen their capacity to be able to identify and address the country-specific operational research needs. Links should be set up with local or regional academic and research institutions. Broader operational research at regional and global level may be addressed by WHO Collaborating Centres. A pivotal role will be played by TDR – the

UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases – but other members of the international scientific community will be engaged, particularly such bodies as the Bill and Melinda Gates Foundation, national institutes of health, The Wellcome Trust, the European Union, and the Medical Research Council, United Kingdom.

Medium-term plan 2006–2010

Objectives and priorities

1. All implementation units to have initiated MDA by the end of 2010.
2. Implementation units that have completed five rounds of MDA are assessed to verify the reduction of microfilaraemia to a level where transmission no longer occurs.
3. Disability prevention activities are in place in all national ELF programmes

Long-term plan 2011–2020

Objectives and priorities

1. By the end of 2015, all LF-endemic countries should have reduced infection levels to the point at which new infection does not occur.
2. All endemic countries should maintain surveillance of children born after the end of 2015 to assess whether new infection is taking place.
3. All patients with lymphoedema should have access to information and training on home-based self-care to prevent disability. All patients with simple hydrocele should have access to surgery within the primary health care system.
4. Verification of interruption of transmission of LF should be carried out.

Resource requirements

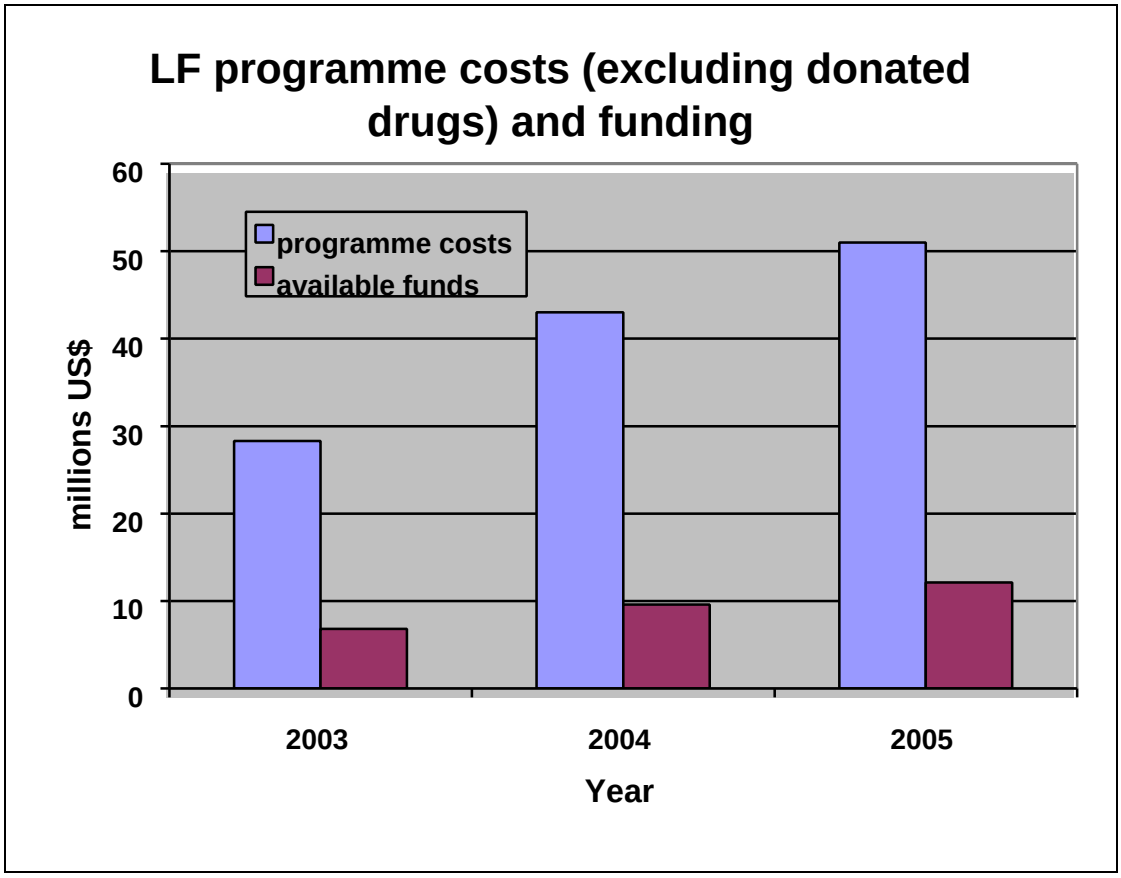
Short-term plan 2003–2005

➢ *Drugs*
Estimated requirements for albendazole, ivermectin (Mectizan®), and DEC are shown in the following table.

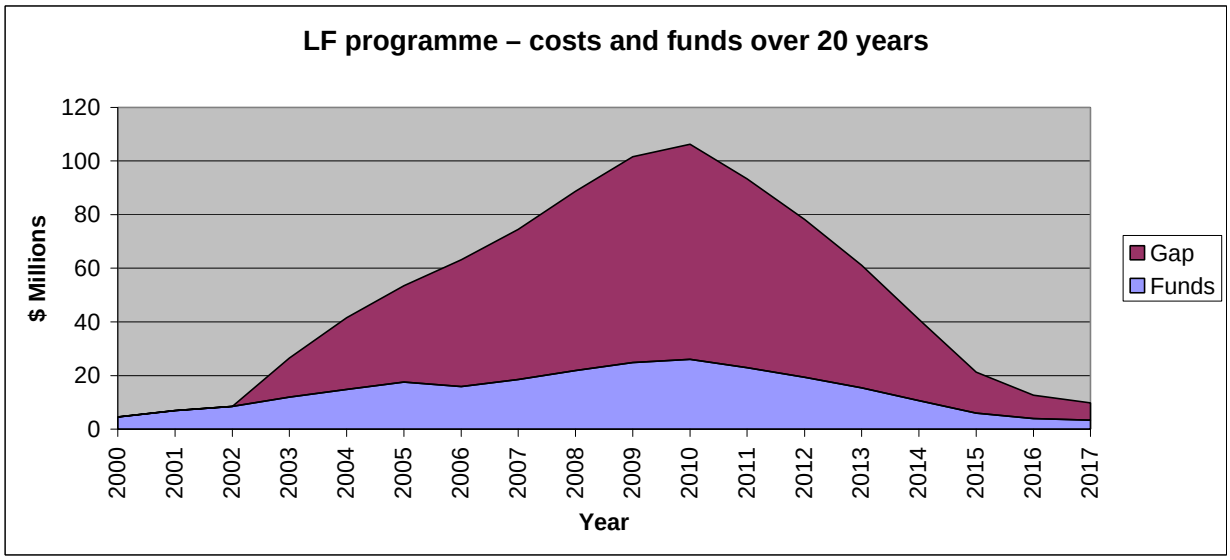
Year	Countries in programme	Drug requirements (millions of tablets)		
		Albendazole	Ivermectin	DEC
2003	40	100	84	180
2004	44	200	144	380
2005	46	350	223	689

➢ *Supplies (ICT cards)*
It is estimated that at least 25 000 ICT cards will be required per quarter to complete the mapping. A total of 300 000 will therefore be required during 2003–2005.

➢ *Funding*
For the period 2003–2005, there is an estimated shortfall of US$ 100 million between the programme costs and available funding (including that from donors, existing commitments, and contributions by health ministries and national partners).



Medium- and long-term plans 2006–2020



LF Programme governance

The Global Programme to Eliminate Lymphatic Filariasis is the culmination of the national programmes being implemented by the LF-endemic countries.

Country organization

National programmes

- ➢ Ministries of health and sub-national health authorities should implement the programmes through the existing health systems.
- ➢ A national coordinator/manager should be designated to run the elimination programme.
- ➢ Each programme should have a national task force/coordinating body – a multidisciplinary body to guide the programme in establishing objectives, policies, and national partnerships, and in generating political will.

National partnerships

- ➢ Local public–private sector partnerships needs to be created to support the national programme.
- ➢ The national task forces and its members are expected to be key in forging these local partnerships.
- ➢ The WHO country office maintains the link between WHO/HQ, the Regional Office and the national programme. The country office maintains the logistics for

importation of donated drugs and diagnostic supplies and provides resources. In countries where the burden of LF disease is large, country offices need to be strengthened with local professional staff to provide technical support and monitoring of the national programme to identify technical or financial resource needs.

Regional organization

A Global Programme Review Group (Global PRG) was set up under the Memorandum of Understanding with GlaxoSmithKline; its task was to review applications from national ministries of health for LF programmes. With the rapid increase in programme activities, it became clear that programmes could be reviewed more efficiently at regional level.

The seventh meeting of the Global PRG, at WHO headquarters, Geneva, on 26–27 February 2001, agreed on terms of reference for the six proposed Regional PRGs. For the South-East Asia and Western Pacific regions, interregional and sub-regional groups of countries were created, rather than basing the Regional PRGs strictly on the WHO regions; this was done in recognition of the epidemiological distribution of LF in these regions. The six Regional PRGs
are:

African Programme Review Group
Eastern Mediterranean Programme Review Group
American Programme Review Group
Indian Subcontinent Programme Review Group
Mekong-Plus Programme Review Group
PacCARE Programme Review Group

The Regional PRGs need to be further supported in their role of providing advocacy and guidance to the regional and national programme initiatives.

The WHO Regional Offices serve the RPRG Secretariat and interact with the Technical Advisory Group (TAG) and implement the latter's recommendations.

Global organization

World Health Organization

WHO provides expertise to support national programmes in preparing national plans, mapping disease distribution, training health personnel in both drug distribution and disability prevention and control activities, social mobilization, and monitoring and evaluation.

Technical Advisory Group (TAG)

The TAG advises WHO on key issues (policy, strategy, and operation) relevant to implementation and to monitoring the progress and success of the elimination effort. It

also identifies research questions that need to be addressed to enhance the acceptability and sustainability of the programme.

Global Alliance to Eliminate Lymphatic Filariasis (GAELF)

GAELF, for which WHO serves as the secretariat, is a free, non-restrictive partnership forum for the exchange of ideas and coordination of activities, with membership open to all interested parties. Its functions includes sharing of information on progress and challenges, coordination of activities, fund raising, and advocacy. To date GAELF includes, in addition to the ministries of health of the endemic countries, 39 organizations from public and private sectors, academia, government bodies, and NGDOs.

GAELF was officially formed during a meeting at Santiago de Compostela, Spain, in May 2000. Discussion at this first meeting focused on support (including funding) for effective country action, communication and information needs, the role of NGDOs in national LF elimination programmes, critical elements for successful programmes, and maximizing regional cooperation.

➢ *Partnership*

GAELF has been forged among many organizations, all with different mandates but sharing a common goal – to tackle the wide-ranging and complex process that will result in the elimination from the world of LF as a public health problem.

Early support for the task of elimination came from the health ministries of the endemic countries and from a number of international organizations, including the Arab Fund for Economic and Social Development, the United States Centers for Disease Control and Prevention, and the United Kingdom Department for International Development.

In 1998, the coalition was given a powerful boost when GlaxoSmithKline (at the time SmithKline Beecham) announced its commitment to forming a unique public–private partnership with WHO and support GPELF by supplying the drug albendazole, free of charge, for as long as necessary. The two organizations pledged to work together closely to undertake this massive international public health effort. Subsequently, Merck & Co., Inc., pledged to extend its existing Mectizan® Donation Program for onchocerciasis to cover treatment of LF with ivermectin in all African countries where the two diseases occur together. These donations enable countries that are in need but that lack the necessary resources to acquire the drugs and pursue their national elimination programmes.

➢ *Secretariat – terms of reference*

Acting on behalf of the GAELF, the Secretariat shall:

1) Set the objectives for the GAELF3 meeting.

2) Maintain regular information-sharing and consultation with GAELF partners.
3) 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.
4) Represent the Alliance externally, including active participation in fund raising and advocacy.
5) Develop and recommend alternative GAELF governance/management structures (including supporting financial mechanisms) for discussion and ratification by GAELF3.
6) Review key issues as they occur and take appropriate actions.

The Secretariat will function until the third meeting of GAELF (GAELF3).

➢ *Task Force on Communications*

Following the Lymphatic Filariasis Global Alliance Ad Hoc Strategic Planning Workshop held in Liverpool, England, in December 2002, a Task Force on Communications and GAELF3 was established. It was composed of representatives from WHO, the Emory LF Support Center, the Regional PRGs, the NGDO sector, and pharmaceutical donors.

➢ *Task Force on Advocacy and Fundraising*

Following the Lymphatic Filariasis Global Alliance Ad Hoc Strategic Planning Workshop held in Liverpool, England, in December 2002, a Task Force on Advocacy and Fundraising was established. It was composed of representatives from WHO, Emory LF Support Center, LF Support Centre, Liverpool, England, Mectizan® Donation Program, and Regional PRGs.

Annex 1

Summary report of GPELF progress 1999–2002

Interruption of transmission

Interruption of transmission is achieved through mass drug administration (MDA) covering the entire at-risk population, which reduces the number of microfilariae in the blood to levels below which the mosquito vectors can no longer transmit infection. This reduction is effected either by once-yearly MDA with single doses of ivermectin or diethylcarbamazine (DEC) co-administered with albendazole over 4–6 years or by use of DEC-fortified table or cooking salt over 1–2 years.

By the end of 2001, 38 countries had begun plans for LF elimination programmes and 22 had initiated MDA of a total at-risk population of 30 million with reported drug coverage of 26 million (86.67%). The second meeting of the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF2) in May 2002 therefore recommended that GPELF be scaled up to cover 350 million at-risk people by the end of 2005.[1] By the end of 2002, some 59 million persons in 32 countries had been covered by MDA with co-administered drugs.[2] Another 40 million were covered by DEC alone in India in 2002.

Prevention of disability[3]

The strategy to prevent disability is designed to encourage home-based self-care (regular skin care, exercise, and appropriate footwear) for patients with lymphoedema, and to increase access to surgery in peripheral health facilities for people with hydrocele. Despite training of programme managers in a number of LF-endemic countries, there has been little significant progress in disability prevention. Basic principles for implementing disability prevention were developed in collaboration with partners and discussed by the TAG and with endemic countries. A new training package (based on pilot projects in Burkina Faso and Zanzibar) has been developed for community home-based self-care. Similar pilot projects will be undertaken during the first half of 2003 in Myanmar and Sri Lanka, promoting long-term home-based self-care for a variety of chronic conditions, including those related to LF. This inclusive approach is new and should be a key element in the sustainability of prevention of both LF-related disabilities and other chronic conditions.

Technical support

Technical support has been provided by WHO and other GAELF partners.

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[1] See: *Report of the second meeting of the Global Alliance to Eliminate Lymphatic Filariasis*. Geneva, World Health Organization, 2002.

[2] See: *Global Programme to Eliminate Lymphatic Filariasis: Annual report 2001* and *Annual report 2002*. Geneva, World Health Organization, 2001 and 2002.

[3] The term "prevention" is inclusive of primary, secondary, and tertiary prevention.

Review and documentation of the safety of the co-administered drugs

Independent pharmacovigilance experts from within and outside WHO reviewed the outcome of studies in both controlled clinical settings and community-based distributions. By the end of 1999, the experts had endorsed the large-scale use of the recommended co-administered drugs. The use of co-administered drugs is regularly reviewed by the safety review committee.

Technical Advisory Group

The TAG has 14 members and was set up to provide recommendations to WHO and GPELF. It has met four times and the main issues for discussion have been:

- indicators for GPELF monitoring
- disability prevention strategy
- LF as a childhood disease
- ensuring supplies of good-quality DEC
- verifying absence of infection or achievement of the interruption of transmission
- safety monitoring of drug combinations
- vector control and xenomonitoring
- building the evidence base for GPELF
- social science issues in LF
- diagnostics
- treatment policies and age of eligibility
- monitoring and evaluation.

Regional programme review

The Global Programme Review Group was created in 1998 to formulate guidelines and requirements for the donation of albendazole. In anticipation of the scaling up of programme activities, six Regional Programme Review Groups were established in 2001. The terms of reference of these groups now include recommendation for free supplies of albendazole and ivermectin, review of national plans and their implementation, and identification of operational research issues.

Capacity building

Intercountry workshops were held for senior health personnel and for LF programme managers of the Indian Subcontinent and Mekong-Plus countries. National-level training for drug distributors was conducted in all regions. Workshops on social mobilization were held in India. National LF elimination programme teams were trained in various countries of Africa and south-east Asia. The training materials that were produced include:

- Preparing and implementing a national plan to eliminate lymphatic filariasis – guidelines for programme managers
- Training module for drug distributors

- Fact sheet for drug distributors
- Four-part training package on community home-based prevention of disability due to lymphatic filariasis.

Programme monitoring and evaluation

Procedures for establishing baseline data and monitoring and evaluation of LF elimination programmes were outlined in the 1999 report of a WHO Informal Consultation[1] and in two documents[2] published in 2002. In March 2002, on the recommendation of the Technical Advisory Group (TAG), a working group on monitoring and evaluation was set up with members from WHO, its collaborating centres and the Emory and Liverpool LF Support Centres. The first meeting, in June 2002, focused on assessment of drug coverage and optimization of sampling methods, sentinel site data collection, guidelines for stopping MDA, verification of absence of transmission, needs for specific research and support materials. In February 2003, the second meeting of the group made recommendations to the TAG on MDA coverage, when to stop MDA, verification of absence of transmission, and monitoring and evaluation applied research needs.

Operational research

In association with TDR, GPELF has promoted research into:

- drug delivery strategies for achieving high and sustained coverage
- integrated drug delivery strategy
- long-term transmission studies
- community-based management of adenolymphangitis (ADL) strategies and tools for monitoring and evaluation
- rapid assessment method for identifying risk of *Loa*-associated encephalopathy
- safety of albendazole and ivermectin co-administration
- pharmacokinetics of the two-drug regime
- filarial genomes.

[1] *Report of a WHO Informal Consultation on Epidemiologic Approaches to Lymphatic Filariasis Elimination: Initial Assessment, Monitoring, and Certification. Atlanta, Georgia, USA, 2–4 September 1998*. Geneva, World Health Organization, 1999 (WHO/FIL/99.195).

[2] *Preparing and implementing a national plan to eliminate lymphatic filariasis (in countries where onchocerciasis is not co-endemic)*. Geneva, World Health Organization, 2000 (WHO/CPE/CEE/2000.15).

Preparing and implementing a national plan to eliminate lymphatic filariasis (in countries where onchocerciasis is co-endemic). Geneva, World Health Organization, 2000 (WHO/CPE/CEE/2000.16).

Annex 2

List of acronyms

DEC	Diethylcarbamazine citrate
ELF	Elimination of Lymphatic Filariasis
GAELF	Global Alliance to Eliminate Lymphatic Filariasis
GPELF	Global Programme to Eliminate Lymphatic Filariasis
ICT	Immuno-chromatographic test
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
NGDO	Nongovernmental Developmental Organization
PacCARE	PacELF Coordinating and Review Group
PELF	Programme to Eliminate Lymphatic Filariasis
PRG	Programme Review Group
RPRG	Regional Programme Review Group
TAG	Technical Advisory Group
UNDP	United Nations Development Programme
WHO	World Health Organization