



THE GLOBAL ALLIANCE MOVES AHEAD

All 34 participants at the December 2002 meeting of the *ad hoc* Strategic Planning Workshop in Liverpool, England, realized the great importance of working together toward the goal of global elimination of lymphatic filariasis. The second meeting of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF2) in New Delhi in May 2002, gave this workshop its direction, recognizing "...the conclusions of the Working Groups as a guide to further exploration of how to develop an active Alliance with the strong participation of endemic countries, with particular need for the urgent establishment of an Alliance Task Force on Advocacy and Resource Mobilization and for other ways to complete the business arising from the working groups between meetings of the Alliance".

Despite the dark clouds and damp December weather, the warm camaraderie and newly established friendships prompted candid and open discussions that led to fruitful conclusions. With 18 attendees from endemic countries serving as country representatives and chairs of the Regional Programme Review Groups (RPRG) and regional advisers participating, it was clear that community and field realities were given serious consideration during the deliberations.

The challenges remain considerable – a US\$ 95 million gap in resources needed to cover an at-risk population

of 350 million with mass drug administration (MDA) by 2005; complete mapping of all countries with ongoing MDA; increased political commitment and partnerships at the national level; implementing social mobilization and scaling-up interventions for disability prevention; researching, and then defining and measuring, progress indicators - all formidable yet achievable goals. With reassurance from the key donors, pharmaceutical partners, LF support groups and all others present at the meeting, the field implementers remain hopeful and optimistic.

Nevertheless, the "nuts and bolts" of the organization and management of the Global Alliance remain to be settled – and a number of agreements were indeed reached. The "buzz words" were: cost-efficiency, transparency, low bureaucracy, high accountability, and leadership. To complement the Task Force on Advocacy and Fundraising and the Task Force on Communication

and GAELF3, the Global Alliance Secretariat was created.

The Government of Egypt, through the Ministry of Health and Population, kindly agreed to host GAELF3 in March 2004. The journey to the global elimination of lymphatic filariasis remains long and arduous but the first right steps have been taken. Since its birth in 2000 in Santiago de Compostela, the Global Alliance has moved to a new and exciting developmental stage. It is directing its strength towards building logistics, communications and organizational support for the Global Programme in order to achieve the goal of a world free of lymphatic filariasis.

Dr Jaime Galvez Tan,
Chairperson, Global Alliance



THE CHALLENGE OF SCALING-UP: WHAT ARE THE PRACTICALITIES?

In May 2002, the second meeting of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF2) in New Delhi, India, highlighted for all partners the formidable challenge of scaling-up mass drug administration (MDA) campaigns in the endemic countries to cover an at-risk population of 350 million by the end of 2005.

This ambitious goal has grown from the enthusiasm, commitment and innovative participation of endemic countries over the first 3 years of the Programme to Eliminate Lymphatic Filariasis (PELF). In 2002, 32 countries implemented MDA with a reported covered population of nearly 55 million people with co-administration regimens, which exceeds the 50 million targeted by the initial strategic plan of the Global Programme drawn up in 1999.

We summarize below some of the main points raised during the *ad hoc* Strategic Planning Workshop Follow-up of the GAELF2 in Liverpool, in December 2002, which took forward some issues raised at the second meeting of the Global Alliance in New Delhi, linking them with a preliminary analysis of consolidated data from the annual reports from countries with active programmes.

- The 32 countries with active programmes account for almost 80% of the world's at-risk population, but currently can provide only 5% of them with MDA coverage. Detailed information by country of this information is presented in Table 2 on page 3.
- Any pocket of low coverage must be identified, the causes analyzed and appropriate corrective actions implemented. Thus there is an urgent need to scale-up MDA campaigns in order to cover all endemic implementation units (IU) in these countries and to maintain the momentum created so far.
- With a few exceptions, the IUs are reporting satisfactory coverage, which is a promising base for further scaling-up and to at least maintain the current coverage.
- The endemic countries are requesting increasing technical and operational support for their national elimination programmes in order to scale-up and this is particularly important given the time-limited framework of the LF elimination programmes.



It is crucial that the development and the adoption of technical and managerial tools take place in order to enhance the planning and implementation capacities at sub-national level, particularly in the IUs, through the guidance and supervision of national programme managers.

- The support required for the scaling-up of the MDA campaign varies considerably across countries and regions. More and more, the new countries coming on board are accepting the challenge to make an extraordinary effort to progress from initiating MDA to covering the entire at-risk population within an endemic country (see the success stories of Egypt and Zanzibar).

- With new energy devoted to advocacy and fund-raising for the Global Programme (see Galvez Tan editorial on page 1), the strategic allocation of resources needs to be considered at global, regional and national levels. Should countries that are scaling-up slowly receive higher priority this year? Should the Regional Programme Review Groups (RPRG) consider only those countries that have completed mapping of disease distribution and produced comprehensive national plans? These are difficult but important questions.

Ten new countries started active programmes in 2002. How many new countries will come on board in 2003? How can the Global Programme cope with the dual challenge of providing essential support to the scaling-up efforts of existing national programmes and giving adequate attention and resources to new programmes? Capacity building

is also a crucial role of the RPRGs, and with appropriate social and political support from the endemic countries we can make a difference. Nevertheless, the challenges can be met only by all the partners working together, with commitment to the Programme goals and to the sustainability of the partnership.

Dr Nevio Zagaria, WHO and Professor David Molyneux, LF Support Centre, Liverpool School of Tropical Medicine



Table 1. LF-endemic countries covered by MDA in 2002 by Regional Programme Review Groups

	Number of endemic countries	At-risk population in endemic countries (millions)	At-risk global population (%)	Number of countries started MDA	At-risk population covered in 2002 (millions)	% of at-risk population covered in 2002
Africa	39	477	38.6	9	9.9	2.08
Americas	7	9	0.7	2	0.6	6.74
Eastern Mediterranean	3	15	1.2	2	2.5	17.21
Mekong-Plus	11	214	17.3	5	11.4	5.34
Indian Subcontinent	5	514	41.6	3	29.5	5.74
PacELF	15	6	0.5	11	1.2	18.35
Total	80	1235	100	32	55.1	4.46

Table 2. Total population of all IUs for MDA with drug co-administration in 2002

Region	PRG Country	Total population of all IUs targeted for MDA in 2002	Population reported to have ingested the drugs	Drug coverage %	
				As reported by IUs	As observed in cross check sites
Africa	Burkina Faso	2,612,524	1,786,125	68.4	72.4
	Benin	289,094	224,971	77.8	nd
	Comoros	413,300	245,224	59.3	nd
	Ghana	1,650,058	1,223,122	74.1	nd
	Kenya	592,273	480,900	81.2	91.5
	Nigeria	nd	2,168,355	nd	nd
	Togo	709,455	556,974	78.5	nd
	Uganda	965,323	733,375	76.0	nd
	United Republic of Tanzania	2,017,677	1,260,049	62.5	88.4
	Zanzibar, UR of Tanzania	984,625	818,155	83.1	77.6
Americas	Dominican Republic	141,762	117,791	83.1	83.6
	Guyana		Non MDA		
Eastern Mediterranean	Haiti	510,795	434,896	85.1	nd
	Egypt	2,574,781	2,448,399	95.1	
Mekong-Plus	Yemen	109,349	79,119	72.4	nd
	Indonesia	322,250	255,144	79.2	nd
Indian Subcontinent	Myanmar	8,634,179	7,474,094	86.6	95.8
	Philippines	4,731,378	3,480,089	73.6	nd
	Thailand	130,491	118,752	91.0	64.1
	Viet Nam	88,200	76,339	86.6	nd
	Bangladesh	5,178,741	4,860,402	93.9	87.30
PacELF	India**	18,938,122	16,048,965	84.7	nd
	Maldives		Non MDA		
	Nepal		Non MDA		
	Sri Lanka	10,044,082	8,637,505	86.0	85.1
	American Samoa	57,291	28,489	49.7	nd
	Cook Islands	18,037	17,676	98.0	90.0
	Fiji	775,077	545,780	70.4	100.0
	French Polynesia	226,172	211,052	93.3	nd
	Kiribati*	84,000	13,175	15.7	nd
	Niue	1,788	1,469	82.2	82.0
32 countries under MDA	Samoa	174,140	96,301	55.3	97.0
	Tonga	90,720	82,023	90.4	100.0
	Tuvalu	9,900	nd	nd	nd
	Vanuatu	186,678	156,368	83.8	nd
	Wallis and Futuna	14,166	8,522	60.2	nd
		63,276,428	54,689,600	86.43	

* Incomplete data.

**India: 35.7 M covered with DEC alone not included.

nd = no data (data not included in annual report).

Table 3. Number of people covered by MDA since 1999

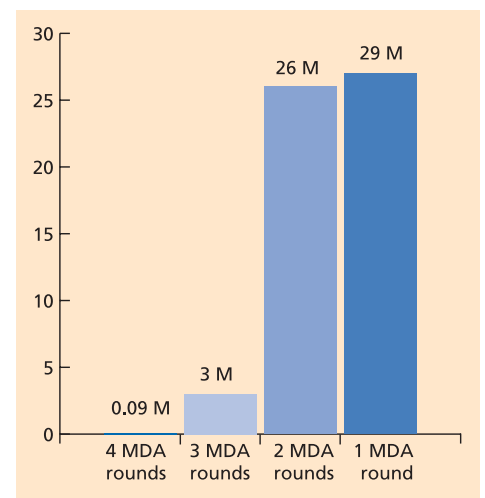
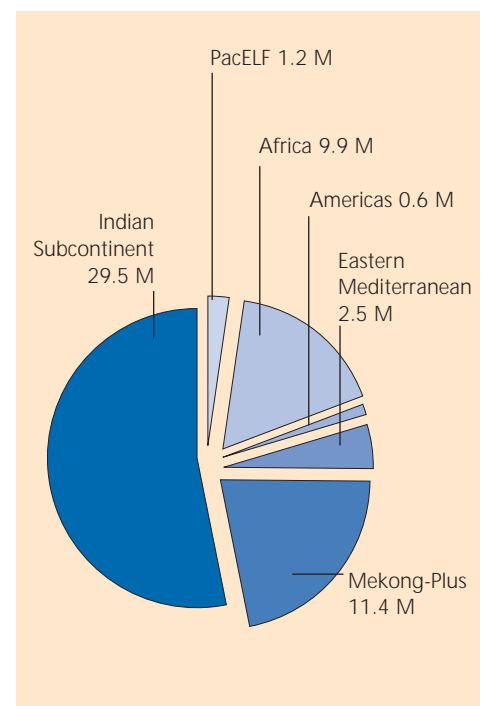


Table 4. At-risk population covered by RPRG in 2002 (millions)



PRG ACHIEVEMENTS OF 2002 AND FUTURE SCALING-UP

AMERICAN PRG

Immuno-chromatographic test (ICT) cards have enabled the countries in the Region to re-assess the epidemiological situation of LF. Current evidence strongly suggests that Costa Rica, Suriname and Trinidad & Tobago no longer have transmission. Belém, one of three foci in Brazil, may also no longer have transmission. Guyana is about to launch MDA based on the DEC-fortified salt regimen.

The potential of integrating control programmes into other ongoing public health initiatives in the Region is good, as are the prospects of implementing the programmes in a cost-effective, socially responsible manner through links with other programmes. There has been significant progress in re-assessing the status of infection and disease in the seven endemic countries and this important knowledge will allow the Region to redefine the at-risk population, the treatment targets and the implementation units (IU).

Work remains to be done to assess the disability status and to develop a proper response to tackle this problem. Some of the programmes face obstacles, including the lack of both human and financial resources and, at times, political commitment. Thus, the alliance is confronted with the challenge of conducting intensive advocacy among those capable of effective action, including the ministries of health, NGOs, bilateral agencies and the United Nations system.

Among the biggest challenges are the need to implement MDA as soon as possible and to scale-up efforts in those countries where MDA activities have begun. Among the most important assets sustaining the regional LF elimination efforts are the partnerships and alliances that have evolved among the countries, the international community, the private sector and nongovernmental organizations (NGO). Our regional initiative must quickly consolidate a rational disability prevention and rehabilitation programme in order to retain the interest of our partners and sponsors.

AFRICAN PRG

The Programme to Eliminate Lymphatic Filariasis (PELF) implementation efforts began in endemic countries in 2000. In 2001, the African Programme Review Group (PRG) mandated a review of new applications for support of national programmes, and evaluated re-applications from established programmes for additional support. To accomplish this, 11 people were appointed in their individual capacities.

Two meetings have been held to date, the first in October 2001 in Cotonou, Benin, and the second in October 2002 in Kampala, Uganda. At the first, the PRG adopted a proposal to hold two meetings per year, which was seen as necessary for processing national applications and re-applications particularly in view of the scaling-up of the programme. Meetings in 2003 are planned for April and October.

The African PRG has achieved the following:

- Four countries have completed epidemiological disease mapping, and an additional 14 countries have acquired the skills for disease mapping and are at different stages of the process.
- Two countries began mass drug administration (MDA) in 2002, making a total of nine countries that have started MDA since 2001.
- The start of MDA by one new programme (Côte d'Ivoire) was approved; two countries (Mali and Niger) have developed country plans of action and submitted applications for MDA, which will be considered at the next African PRG meeting in April.
- Twelve countries have been assisted to create and use the lymphatic filariasis database in their national programmes.

The African PRG is working towards accomplishing the following:

- Completing the goal of disease mapping by 2005.
- Scaling-up MDA, both within the nine countries where it has already begun and in new countries recruited into the programme.
- Broadening the capacity of the Regional Office by decentralizing technical support to countries: by establishing subregional offices in western, central and southern Africa; by recruiting a staff member responsible for administrative and logistic issues as a means of improving

responsiveness to country needs and requests; and by strengthening disability prevention by recruiting staff specialized in this area.



PacELF PRG

The 4th Annual PacELF Meeting of Programme Managers was held in Raratonga, Cook Islands, in 2002, and its resolutions and recommendations were widely distributed to all PacELF Member countries, donors, and PacELF partners and collaborators. The PacELF PRG met twice in 2002.

The Liverpool LF Centre provided funding for two technical assistants based at the PacELF office in Suva, Fiji, for 1 year. In addition, five Japanese volunteers are now helping Fiji (2), Samoa (1), Tonga (1) and Vanuatu (1) to support PacELF country programmes under the Japanese Overseas Cooperation Volunteers Scheme. Members of PacELF PRG have been appointed by WHO Regional Director for the Western Pacific Region, in accordance with the composition guidelines clearly defined in the PacELF Terms of Reference.

Scaling-up of LF elimination programmes has reached maximum level for the region; scaling-down in the region will start in 2004, by which time Samoa will have completed five rounds of mass drug administration (MDA). However, when Papua New Guinea is on board, significant scaling-up for its national programme will be needed. Eleven countries have now implemented MDA, with Fiji undertaking its first round in 2002. New Caledonia plans implementation in 2003. The mid-term evaluation in Samoa and Vanuatu indicated a microfilarial reduction of 90%. In all, 42,500 ICT cards and 12,850,000 DEC tablets (provided by the Government of Japan through the Japanese International Cooperation Agency) and 1,442,300 albendazole tablets (provided by GlaxoSmithKline) were distributed to endemic countries.

The PacELF website was launched in September 2002 (<http://www.pacelf.org>).

PRG ACHIEVEMENTS OF 2002 AND FUTURE SCALING-UP

EASTERN MEDITERRANEAN PRG

The Eastern Mediterranean PRG adopted a plan of work for 2002 during its first meeting in Cairo, Egypt, on 23–24 December 2001.

The Chairman of the Eastern Mediterranean PRG visited Saudi Arabia in March 2002 to train local officers in performance of the immuno-chromatographic (ICT) card test and to assist in planning surveys of LF status. Another member of the Eastern Mediterranean PRG visited Oman and helped national authorities to interpret completed questionnaires and to plan the mapping out of surveys using ICT cards.

A planned mission to Sudan by an Eastern Mediterranean PRG member to conduct a mapping workshop and to assist in planning of surveys to assess national LF was delayed by the lack of ICT cards. These activities have been postponed until 2003.

Members of the Eastern Mediterranean PRG assisted the national programme of Egypt with the implementation, monitoring and evaluation of activities related to the training of drug distribution teams, preparation of health education materials, monitoring the coverage of drug distribution, and organization of microfilarial surveys in sentinel sites. The Eastern Mediterranean PRG also worked closely with the national GlaxoSmithKline office to raise financial support for social mobilization activities.

Via e-mail, members of the Eastern Mediterranean PRG reviewed and approved the annual report and re-application form submitted by Yemen in June 2002. As a result, the national programme in Yemen received the requested quantity of drugs in time to complete MDA in 11 implementation units in 2002.

The second meeting of the Eastern Mediterranean PRG was held in November 2002, and was attended by national managers from all endemic countries as well as health officials from countries of uncertain LF status. Plans have been made to scale-up mapping activities in Yemen and to initiate such activities in Oman, Saudi Arabia and Sudan in 2003. Mapping activities will be conducted in Djibouti, Pakistan and Somalia in 2004.



INDIAN SUBCONTINENT PRG

Almost half of the world's at-risk population live in the endemic countries of the Indian Subcontinent PRG. In 2002, Bangladesh, India and Sri Lanka continued the mass drug administration (MDA) they had initiated the previous year, while Nepal postponed its first MDA until 2003. Bangladesh scaled-up to cover 4.86 million people, a six-fold increase from 2001. Sri Lanka targeted the at-risk population in all endemic areas with MDA and covered 8.63 million people, a five-fold increase from 2001. With the implementation of the COMBI (Communication-for-Behavioural-Impact) strategy for social mobilization, Sri Lanka increased MDA coverage from 65.4% in 2001 to 86% of the total at-risk population in 2002. In the same year, India covered 37.5 million people with DEC alone, and 16 million in Kerala, Orissa and Tamil Nadu with the DEC plus albendazole combination.

Mapping of the distribution of lymphatic filariasis cases has already been completed in Sri Lanka and will be completed in all endemic countries of the Subcontinent by 2005,

despite problems with the stability and availability of ICT cards. All of the programmes use night blood and disability surveys for mapping purposes.

At the Bi-Regional Programme Managers Meeting in Bali, 22–25 July 2002, the PRG discussed how to scale-up the community home-based prevention of disability due to LF. Lymphoedema management services are offered to LF sufferers through health institutions, as well as at the community and household level, in many locations in Bangladesh, India and Sri Lanka. Surgical hydrocelectomy is offered to patients through general health services in India and Sri Lanka and also through special programmes in Bangladesh and the Indian state of Kerala. Bangladesh has trained 60 doctors in hydrocelectomy and there are plans to expand the training next year.

In May 2002, India hosted the GAELF2 meeting in New Delhi. The first and second Indian Subcontinent PRG meetings also were held during 2002, the second back-to-back with the Mekong-Plus PRG meeting – enabling members of the two groups to meet and exchange views and to discuss geographical and cross-border issues. The Indian Subcontinent PRG reviewed and made recommendations on LF elimination activities in all five endemic countries and annual reports and re-applications from Bangladesh, India and Sri Lanka contributed significantly towards LF elimination in the region.

The limited availability of funds from both national governments and external resources has been a problem. LF elimination programmes in the Subcontinent were dependent on external funding for more than 80% of their costs, although several NGOs made significant contributions.



PRG ACHIEVEMENTS OF 2002 AND FUTURE SCALING-UP

MEKONG-PLUS PRG

The Mekong-Plus PRG has considerably more responsibility in 2002 due to reviewing new applications from Cambodia and Malaysia and re-applications from Indonesia, Myanmar, the Philippines, Thailand and Viet Nam. Rapid scaling-up is taking place in Malaysia, Myanmar and the Philippines, and Indonesia is making good progress after earlier trials.

A Social Mobilization and Training team from WHO/HQ, Geneva, has been assisting countries such as the Philippines by providing COMBI (Communication-for-Behavioural-Impact) training with national support. The outcome will be a complete door-to-door mass drug administration (MDA) campaign in several provinces that will be used as a model for further scaling-up next year.

National programme managers agree that, despite substantial efforts, current funding gaps will hamper full implementation of lymphatic filariasis elimination activities. However, innovative fund-raising activities are under way. For example, the Japanese government will fund Health Fairs in 2003, at which immunization will be offered to rural populations; it is hoped that this will become a model of synergy with other programmes. The Fairs will be limited to appropriate areas, however, and nationwide door-to-door MDAs will become the norm. The Chair of the Mekong-Plus PRG reports that Member States have achieved coverage of about 17% of the at-risk population of 210 million.



MEETINGS

9–10 March 2003: 3rd Meeting of Mekong-Plus PRG, Kuala Lumpur, Malaysia

25–28 March 2003: 4th Meeting of Technical Advisory Group (TAG), Annecy, France

14–15 April 2003: 3rd Meeting of Indian Subcontinent PRG, New Delhi, India

24–25 April 2003: 3rd Meeting of African PRG, Accra, Ghana

1–6 September 2003: 19th International Congress of Lymphology, Freiburg, Germany

3 September 2003: 3rd Meeting of American PRG, Maceió, Brazil

22–26 September 2003: 6th Meeting of PacELF PRG and 5th Annual Meeting of PacELF Programme Managers, Fiji

December 2003 (date to be decided): 3rd Meeting of Eastern Mediterranean PRG, Khartoum, Sudan

3–7 December 2003: 52nd Annual Meeting of the American Society of Tropical Medicine and Hygiene, Philadelphia, PA, USA

23–25 March 2004: 3rd Meeting of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF3), Cairo, Egypt

THE NEWSLETTER

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LF News is a publication of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) and is published quarterly by the Global Alliance Secretariat. Published data reflects information available at the time of print.

The editor welcomes articles of interest on public health and lymphatic filariasis for publication and suggestions of themes or issues that readers would like to see discussed or written about in LF News.



A FUTURE FREE OF LF
Global Alliance

Dear Partners,

As you can see, the second issue of LF News bears the new logo of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF). In an opinion poll to select the logo from three finalists, an overwhelming majority – 83% – of individuals chose the “pinwheel” design.

This issue focuses on three major areas. The first is the results of the *ad hoc* meeting held in Liverpool, England, in December 2002, at which the decisions were made to establish a Chair for the Global Alliance (see the editorial by Dr Jaime Galvez Tan, on page 1) the second is the practical issue of scaling-up and the third focuses on the reports from the Regional Programme Review Groups.

Starting with the third issue, an editorial board established by the Task Force on Communications and GAELF3 will be responsible for the development and promotion of the newsletter.

LF News No.2 has been printed in 3000 copies and has been widely distributed. Electronic copies can be downloaded from the Global Alliance Web site at www.filaria.org and an HTML version has been e-mailed to more than 250 people.

Your comments and suggestions for articles are most welcome and can be sent via the Web site by clicking “contact” at the upper right-hand corner on the home page of www.filaria.org.

The Editor

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