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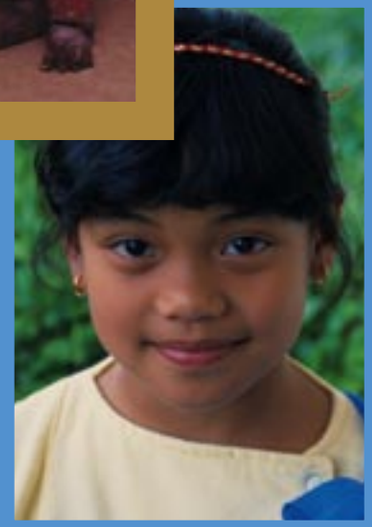
AFUTUREFREEOFLF
GlobalAlliance

Freeing the World of LF: A Call to Action

Third Meeting of the Global Alliance to Eliminate Lymphatic Filariasis

23-25 March 2004
Cairo, Egypt



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ACKNOWLEDGEMENTS

The Third Meeting of the Global Alliance to Eliminate Lymphatic Filariasis was supported by the Bill and Melinda Gates Foundation, GlaxoSmithKline, the Mectizan® Donation Program and Merck & Co., Inc.

The organisation and smooth management of the meeting was possible only through the assistance, dedication and hard work of many voluntary contributors:

- *His Excellency, the Hon. Minister of Health and Population in Egypt, Dr. Mohammed Awad Tag El-Din* and the *1st Under-Secretary*, *Dr. Magda Ali Rakha*

- *The Cairo Local Organising Committee* - Dr. Maged El-Setouhy (Ain Shams University Professor – Chair), Dr. Hussein Kamal (Ministry of Health), Mrs. Jehane Sayed Khadr (EMRO), Dr. Hussein El Arini, Ms. Suzan Hashem and Mrs. Aysen Osman (GlaxoSmithKline), Mr. Yehia Abbassy (Merck Sharp & Dohme).

- *Mr. Hossam Younes* (EMRO) responsible for production of the CD of the meeting.

- *Students of Ain Shams University*

- *Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine* – Professor David Molyneux, Mrs. Joan Fahy, Ms. Lisa Bluett, Mr. Michael Brown, Ms. Nathalie Haleber and Ms. Margaret Fraser.

- *GlaxoSmithKline* – Dr. Brian Bagnall, Dr. Mark Bradley, Mr. Andy Wright

For more information about the Global Alliance to Eliminate Lymphatic Filariasis, please visit www.filariasis.org

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Foreword

BACKGROUND

More than 1 billion people are threatened by lymphatic filariasis (LF), a devastating parasitic infection spread by mosquitoes. LF – caused by thread-like parasitic worms that damage the human lymphatic system – is usually contracted in childhood, often before age five. One of the world's most disabling and disfiguring diseases, LF afflicts the poorest of the poor. The disease currently infects over 120 million people, leaving more than 40 million incapacitated or disfigured with swelling of the limbs and breasts (lymphoedema) and genitals (hydrocele), or swollen limbs with dramatically thickened, hard, rough and fissured skin (elephantiasis). LF prevents the afflicted from experiencing a normal working and social life, furthering the cycle of poverty.

The Global Programme to Eliminate Lymphatic Filariasis was established in 1998 under the leadership of the World Health Organization (WHO), following a 1997 landmark resolution by the 50th World Health Assembly to eliminate LF as a public health problem by 2020. In 1998, SmithKline Beecham (now GlaxoSmithKline) and Merck & Co., Inc. each announced their commitment to donate drugs – albendazole and Mectizan® (ivermectin) – for as long as necessary to eliminate LF as a public health problem, and they were joined by many other partners around the world.

The Global Alliance to Eliminate Lymphatic Filariasis, launched in 2000, is a broad partnership that unites national Ministries of Health and more than 40 diverse public and private partners including WHO, companies within the private sector, international development agencies and foundations, non-governmental organisations, research institutions, and local communities, all committed to a world free of LF. The Arab Fund for Social & Economic Development, the Bill & Melinda Gates Foundation, the Department for International Development (UK) and the Japan International Cooperation Agency contributed critical seed money that helped accelerate LF elimination efforts dramatically.

Four years after the formation of the Global Alliance, remarkable progress has been made to mobilise political, financial and technical expertise to rid the world of LF. The third meeting of the Global Alliance to Eliminate LF (GAELF), held March 23-25, 2004, in Cairo, Egypt, brought together approximately 200 people from 33 countries to discuss progress and challenges associated with eliminating LF at the country, regional and global levels.

MEETING OBJECTIVES

The key objectives of the third meeting of the Global Alliance were as follows:

- To recognize the Global Programme's remarkable progress;
- To communicate key achievements and challenges of country programmes;
- To enhance the profile of LF elimination;
- To establish secure funding for country programmes;
- To agree to the Global Alliance's future structure and governance.

Meeting Highlights

This meeting report includes key highlights from the third meeting of the Global Alliance to Eliminate Lymphatic Filariasis (GAELF). For a more comprehensive review, visit www.filariasis.org.

GROWTH & PROGRESS

Overview

Dr. Lee Jong-wook, Director-General of the World Health Organization (via video) commended the Global Alliance on its commitment and progress since the last meeting in New Delhi in May 2002.

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"The Global Programme to Eliminate Lymphatic Filariasis was launched in 2000. At that time it covered a modest 3 million people with the recommended mass drug administration. By 2003 it had reached over 70 million. The Global Alliance to Eliminate Lymphatic Filariasis has played a major role in putting this disease on the public health map…however much remains to be done. We all welcome the Alliance's determination to continue its effort to increase support for eliminating this disease and to link up with other global initiatives." – Dr. Lee Jong-wook

Dr. Mohammed Awad Tag El-Din, His Excellency, the Hon. Minister of Health and Population, Egypt, welcomed attendees to the historic city of Cairo, and described Egypt's dramatic success in virtually eliminating LF – one of the country's most ancient endemic diseases – through its successful collaboration with the GAELF, political commitment, involvement of the medical community, widespread community mobilisation, public awareness, and four consecutive mass drug administrations (with a fifth planned for September 2004) that achieved coverage of more than 96% of the eligible population.

Dr. Jean-Pierre Garnier, CEO, GlaxoSmithKline, and **Mr. Michel Iguer**, Regional Director and Vice President, Merck & Co., Inc. both reaffirmed their companies' commitment to the Global Programme and emphasized the need for strong public-private partnerships.

"*We have now donated 250 million albendazole treatments to the global fight against LF. This is significant progress, but it is just the start. In addition to donating one of the essential medicines, we are also investing over $1 million each year to LF Global Alliance partnerships. Private-public partnerships are essential for combating diseases that will otherwise not command the resources and profile they need. I am encouraging other companies and partners to step up to the plate and get involved. LF elimination needs more partners and more funding. With greater recognition of the vital role that public-private partnerships are playing, we can more readily address the neglected diseases of the developing world." — Dr. Jean-Pierre Garnier*

"In 1998 the Mectizan Donation Program was expanded to include lymphatic filariasis, in African countries where LF and river blindness co-exist. Recently the cumulative number of tablets donated for river blindness and LF exceeded the 1 billion mark. Merck's pledge is to continue to donate Mectizan® to all who need it for as long as necessary. To date, the LF programme has had many commendable early successes, but it also faces considerable challenges. We have long recognized that we cannot find workable long-term solutions without partners – in government, NGOs, local communities and the private sector – who share our belief that if we can find the right way to work together…the right results will follow." — Mr. Michel Iguer

Professor Jaime Galvez-Tan, Global Alliance Chairman, described the meeting as a "call to action" for media, donors, ministers of endemic countries and Alliance partners to pledge full support for a world free of LF by 2020. He noted the progress in developing the Alliance; the wider appreciation of the relationship between lymphatic filariasis elimination and the Millennium Development Goals; and the link between LF and poverty.

Dr. Anarfi Asamoa-Baah, Assistant Director General, Communicable Diseases, World Health Organization, reiterated the link between LF and poverty. He noted that the Alliance had achieved its planned goals of covering over 70 million people in 36 endemic countries. He described "the way forward" at the community, national, sub-national, and international levels, with a focus on advocacy, social mobilisation, partnerships, planning, integration with other neglected diseases, country commitment, and strengthening research capacity.

Regional Progress

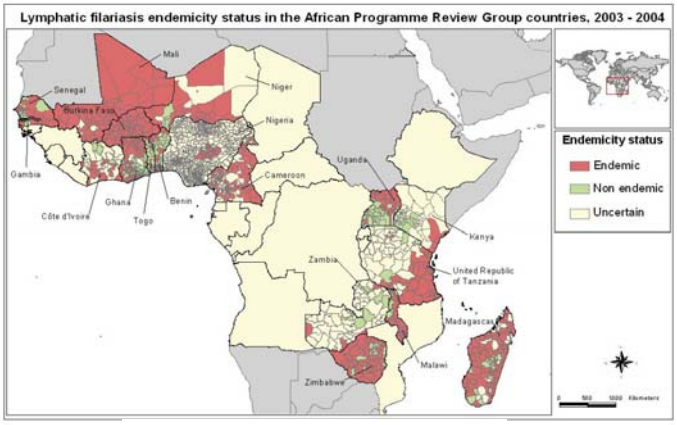
Regional Chairs of the Programme Review Groups presented progress and challenges within the Alliance's six regional groupings. Overall, progress in evaluating the impact and results of the Global Programme to Eliminate LF confirmed that:

- The current two-drug strategy is decreasing microfilaria prevalence and intensity;
- In many areas where three rounds of mass drug administration (MDA) have been completed, microfilaremia is now less than 1%;
- Overall coverage is high;
- Social mobilisation is critical to maintaining and enhancing coverage and increasing disability programmes (including access to hydrocele surgery).

Note: Data presented by Regional Chairs was prepared prior to receiving all country reports. For final data about all regions, visit www.filariasis.org to view the 2003 LF Annual Report.

AFRICAN REGION

Dr. John Gyapong, Chair, African Regional Programme Review Group



See note on maps on page 22.

OVERVIEW

At least 38% of the global burden of LF is found in Africa; 480 million people are at risk; 43 million are already infected; 4.6 million people have lymphoedema; and an additional 10 million have hydrocele.

PROGRESS

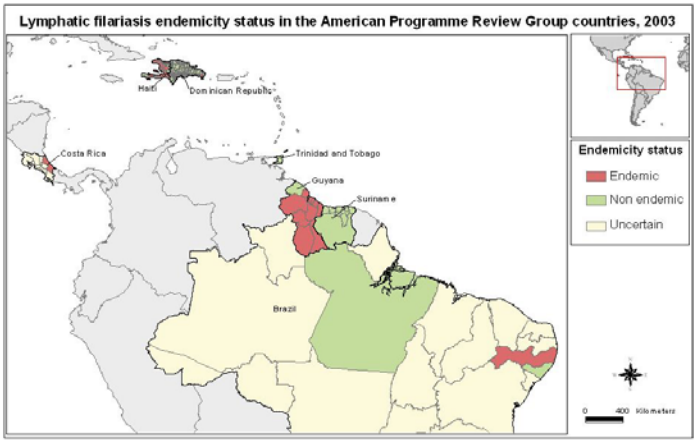
- **Mapping***:* Completed in eight countries in 2003 -- Benin, Burkina Faso, Cote d'Ivoire, Ghana, Togo, Cameroon, Mali, and Niger -- with a total at-risk population of 75.4 million. Another four countries (Gambia, Malawi, Senegal and Uganda) completed mapping recently, with seven more in progress (Kenya, Nigeria, United Rep. of Tanzania, Zambia and Zimbabwe). Mapping revealed widespread occurrence of LF in unexpected areas of Burkina Faso, Mali, Niger and Cameroon; the targeted date for completion of all mapping is 2005.
- **Mass Drug Administration:** Approximately 10 million people were treated out of 12.8 million targeted in 2002 (75%).

CHALLENGES

- **Funding:** Insufficient funding remains the major constraint. Strong evaluation data is critical, and all efforts must be made to obtain it.
- **Demand:** Enthusiasm is high among endemic countries, but demand far outweighs resources. This lack of resources prolonged the mapping of the distribution of LF prevalence (even in countries where MDA is underway) and reduced the rate of scaling up, thus creating a stagnation in the number of active programmes.
- **Partnerships and synergies**: Country ownership of the programmes, partnership-building at local, regional and global levels, as well as creation of synergies between disease control programmes, must be highly encouraged.

AMERICAS REGION

Dr. Guillermo Gonzalvez, Chair, Americas Regional Programme Review Group



See note on maps on page 22.

OVERVIEW

With a population of 854 million (2002), the total population at risk of LF in the Americas is 8.9 million, or about 1% of the global burden.

PROGRESS

- **Verification:** Three countries are seeking to verify interruption of transmission (Costa Rica, Suriname and Trinidad & Tobago).

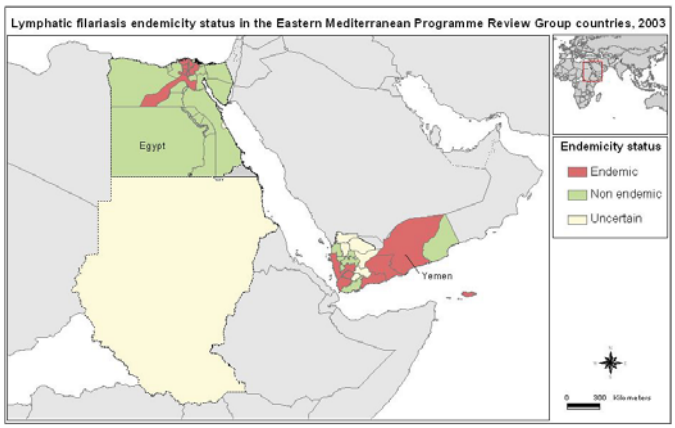
- **Active national programmes:** Four active programmes exist with both drug treatment (including one based on DEC/salt in Guyana) and morbidity prevention/control components.
- **LF elimination possible:** Guyana could eliminate LF by 2006.
- **Hydrocele surgical capacity:** Surgery capacity has been established in Brazil, Dominican Republic, Guyana and Haiti.

CHALLENGES

- **Resources**: The major challenges facing the Americas are the lack of financial and human resources, and at times, political commitment. Some countries have only part-time coordinators for the Programme to Eliminate Lymphatic Filariasis, and all have small country budgets.
- **Rapid scale up**: Among the biggest challenges is the rapid scaling up of efforts in countries where mass drug administration activities have begun.

EASTERN MEDITERRANEAN REGION

Dr. Maged El Setouhy, Chair, Eastern Mediterranean Regional Programme Review Group



OVERVIEW

In the Eastern Mediterranean region, Egypt, Sudan, and Yemen have ongoing LF transmission. In Sudan and Yemen the disease co-exists with onchocerciasis (river blindness). In Djibouti, Oman, Pakistan, Somalia, and Saudi Arabia, LF transmission is uncertain, although clinical cases have been reported in all but Djibouti.

See note on maps on page 22.

PROGRESS

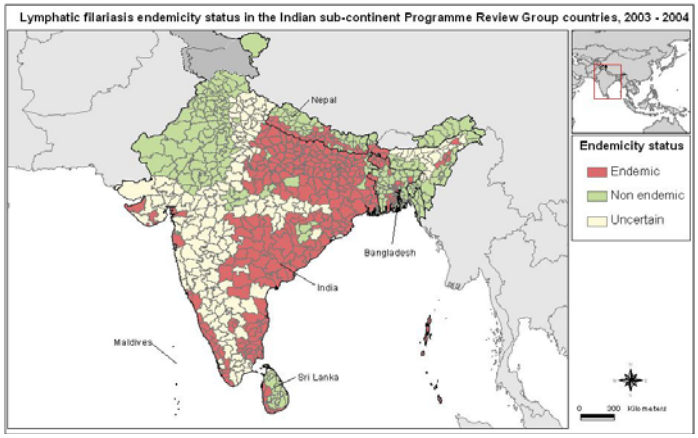
- **Mapping:** Mapping has been completed in Yemen, and is planned for Oman, and Saudi Arabia.
- **Mass Drug Administration:** In Egypt, about 2.5 million people living in 179 villages were covered in the fourth round mass drug administration in September 2003. A recent study in four localities revealed that overall MF prevalence decreased by 75% (from 8% to 2%). In Yemen, MDA began in most areas.

CHALLENGES

- **Implications of success:** Challenges in Egypt are related to the programme's success; specifically, how should the Technical Advisory Group's recommendations for stopping MDA be implemented, how should a "mop up" phase be conducted; and how can management of elephantiasis cases be scaled up to a national level as soon as possible.
- **Political obstacles:** Political problems in Sudan have hampered mapping, an essential first step in eliminating LF. A pilot survey in four states documented several LF endemic areas, which should be extended to map other endemic areas.

INDIAN SUBCONTINENT REGION

Professor Mahroof Ismail, Chair of the Indian Subcontinent Regional Programme Review Group



See note on maps on page 22.

OVERVIEW

Nearly 50% of the world's LF burden exists in the Indian Subcontinent Region. In India, 450 million people are at risk of LF, followed by Bangladesh (49.9 million), Nepal (13.9 million), Sri Lanka (9.8 million), and Maldives (8 of 200 islands are endemic).

PROGRESS

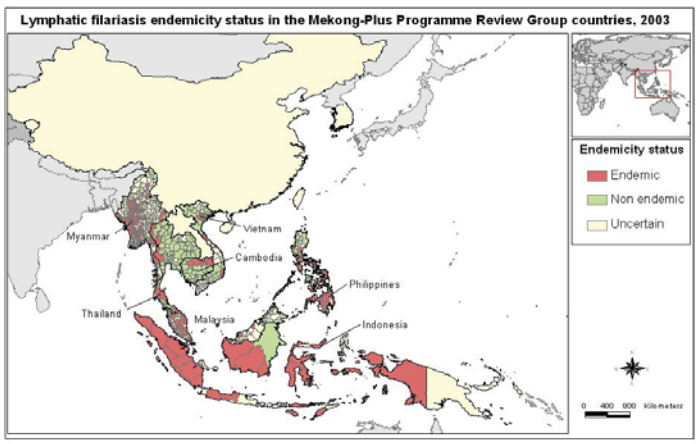
- **Mapping:** Mapping was completed in Maldives in 2002. In Nepal, mapping in 37 endemic districts was completed in 2001; mapping of 38 districts remains to be undertaken.
- **Mass Drug Administration:** In Bangladesh, MDA in 2003 covered 6.7 million people and 10.1 million are targeted for 2004. India conducted MDA in 2001-2002, and again in 2003, targeting 31 districts with a population of 71 million. In 2003, 50 million people in 20 districts received DEC, while 21 million in 11 districts received a combination of DEC and albendazole. India's coverage in 2003 ranged from 67-100% in most districts. India plans to treat 200 districts with DEC alone in June 2004. MDA began in Maldives in 2003. Sri Lanka began MDA in 2002, targeting its entire endemic population of 9.5 million. A comprehensive social mobilisation campaign in Sri Lanka achieved coverage of more than 80%.
- **Improved health care:** In Bangladesh, medical officers have been trained in hydrocele surgery, and a hospital was established with Japanese aid. Doctors saw more than 2,000 patients in 2003 and performed more than 30 hydrocele surgeries. A community home-based morbidity control plan is in place for India, and pilot programmes are planned for Bangladesh and Sri Lanka. Health staff training is planned for Maldives, Nepal and Sri Lanka. Clinics will be established in Nepal and will be improved in Sri Lanka.

CHALLENGES

- **Funding:** Insufficient funding remains the major challenge facing the Indian Subcontinent region.

MEKONG-PLUS REGION

Professor Dato C.P. Ramachandran, Chair of the Mekong Plus Regional Programme Review Group



See note on maps on page 22.

OVERVIEW

The Mekong-Plus Region includes 12 countries: Brunei, Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Korea, Thailand, Timor Leste, and Viet Nam. The countries at greatest risk for LF transmission are Indonesia (57 million people at risk), followed by Myanmar (over 33.5 million at risk), and the Philippines (over 21 million at risk).

PROGRESS

- **Mapping:** Mapping has been completed in Cambodia, Lao PDR, Malaysia, Myanmar, Thailand, and Viet Nam. Mapping in Indonesia is planned for completion in 2008.

- **Mass Drug Administration:** MDA programmes began in 2001 in Myanmar and the Philippines; followed by Indonesia, Thailand, and Viet Nam in 2002; Malaysia in 2003; and Cambodia in 2004. China is no longer at risk of LF transmission, due to aggressive efforts to combat the disease that began in the 1950s. Thailand has had an extensive programme since the 1950s.

- **Strategies:** The strategies utilized by the Mekong-Plus region to build successful programmes are: integration with other disease programmes, promotion of social mobilisation, operational research, monitoring and evaluation, development of partnerships, and fundraising and training commitments.

CHALLENGES

- **Funding:** Despite substantial efforts, current funding gaps are hampering full implementation of LF elimination activities. MDA, accounting for 64% of the total budget, will cost more than $31.5 million (U.S. dollars) for all countries in the Mekong-Plus Region from 2004 through 2010.

PACIFIC REGION (PacELF)

Dr. Joe Koroivueta, Chair, Pacific Regional Programme Group

OVERVIEW

PacELF, the first regional filariasis elimination programme, is a network of the 22 island countries and territories in the Pacific for the purpose of eliminating filariasis in the Pacific by the year 2010 – 10 years ahead of the global elimination target date. LF is endemic in 16 of 22 Pacific countries.

PROGRESS

Mass Drug Administration: Eleven of the endemic countries have implemented MDA programmes, treating 1.67 million people, with a 73% coverage rate. Samoa has completed five rounds of MDA. Five countries have completed four rounds (American Samoa, Cook Islands, French Polynesia, Niue and Vanuatu); three countries have completed three rounds (Kiribati, Tonga and Tuvalu); and two countries (Fiji and Wallis and Futuna) have completed their second round. New Caledonia and Papua New Guinea will start their MDAs in 2004. Further investigations continue in countries where the status of LF is doubtful or partially endemic. Non-endemic countries, such as Guam, Nauru, Solomon Islands and Tokelau will soon be conducting final surveys to verify interruption of transmission. With many countries completing all five rounds of MDA in the near future, the next step for PacELF is to implement activities that evaluate the post-MDA situation to assess if sustained elimination of transmission has occurred.

CHALLENGES

- **Integration:** Integration with other disease programmes, including soil-transmitted helminthiasis, dengue, malaria, and the Healthy Islands Initiative;
- **Advocacy and political commitment:** Working through groups such as Pacific Ministers' meetings;
- **Operational research:** Answering questions in areas including entomology, morbidity surveys, and the social aspect of LF;
- **Surveillance:** Includes refining monitoring and evaluation strategies and post-MDA efforts.

Ministers Reaffirm Commitment

During a Ministerial session, the Alliance welcomed Honourable Ministers of Health and other representatives from countries including Burkina Faso, Egypt, Ghana, Samoa, Sudan, Tanzania, Thailand, Togo, Uganda, and Zanzibar. All reviewed the progress of their programmes and renewed their commitment to – and advocacy for – the Global Programme to Eliminate LF as an important component of their health policies. Among their comments:

EGYPT

- ***"The Lymphatic Filariasis Elimination Programme began in 2000, with eight governorates*** *identified as endemic…after the four mass drug administrations, prevalence in most endemic villages was less than 1%. It is not an easy mission. Television must be used to persuade people; programmes shown on TV helped bring about a 92% response. With the Egyptian will, it is hoped that this debilitating disease will be overcome."*
  – Hon. Hussein Ahmed Kamal, Ministry of Health and Population, Egypt

GHANA

- ***"The Government of Ghana will remain committed*** *to the goals of lymphatic filariasis elimination, and will work with the programme to raise the needed funds to ensure that the achievements made so far are sustained."*
  – Hon. Moses Dani Baah, Deputy Minister of Health, Ghana

SAMOA

- *"**Samoa was the first country to implement a new mass drug administration campaign** in 1999 using DEC and albendazole. It is now the first country to complete five rounds of MDA…I wish to acknowledge the help and support of the PacELF committee, WHO, and other contributory partners. Our ultimate goal should be the elimination of LF from the beautiful island of Samoa."*
  – Hon. Mulitalo Siafausa Vui, Minister of Health, Samoa

TANZANIA

- ***"LF elimination has been integrated into the local government health system*** *and other control programmes, and there is an active research component, as well as strong support from the Tanzanian government. We will continue to pay the salaries of LF workers, and provide direct support amounting to $100,000 (U.S.), which is approximately 25% of costs in 2003, and $150,000 (U.S.) in 2004. Local governments will continue to contribute funding in their respective districts. The biggest challenge is scaling up the programme, for which we need financial support."*
  - Hon. Hussein Mwinyi, Deputy Minister of Health, Tanzania

TOGO

- ***"Control of morbidity concerns all the country.*** *There is a progressive plan to cover transmission zones with MDA, and a pilot project in one district in 2002 and 2003 provided useful lessons. Monitoring and evaluation included training, supervision, control of funds, study of treatment coverage and impact. An integrated approach was adopted, with the development of community-based activities for the campaign against malaria, schistosomiasis, onchocerciasis and guinea worm. Eliminating LF in Togo will happen very soon, as long as partnerships continue."*
  – Hon. Suzanne Aho, Minister of Health,Togo

UGANDA

- ***"Our achievements include successful implementation of the pilot MDA in Katakwi and Lira districts in August 2002,*** *with coverage of 74% in 664 villages in the Katakwi district, and 76.7% of the total population treated in 1,885 of the 2,266 villages in the Lira district. (The rest were not covered because of insecurity.) Our challenges include scaling up MDA in the face of inadequate resources, implementation of MDA in the presence of insecurities, linkages with other programmes, initiation of the disease control component of the programme and conducting operational research against the background of lack of funds and expertise."*
  – Hon. Alex Kamugisha, Minister of State for Health, Uganda

CHALLENGES & OPPORTUNITIES

While the Global Alliance to Eliminate LF has experienced spectacular growth since its launch, it also faces numerous challenges and opportunities -- particularly in the areas of **advocacy and fundraising**, **communications**, **financing**, and **research and health system issues.** During the meeting, key issues were addressed by task forces and experts, including the Task Force for Communications, the Task Force for Advocacy & Fundraising, and the Technical Advisory Group (TAG). Among key messages and discussion points:

ADVOCACY & FUNDRAISING
Dr. Brian Bagnall, Chair, Advocacy and Fundraising Task Force

- **Fundraising is everybody's job:** The Task Force has set up a framework, but cannot make the direct, repeated contact needed for success with a broad range of donors. We must all take responsibility for fundraising.

- **There is no centralized "Global Fund" for LF:** Increasingly, donors want to target their funds to particular activities and regions, and often – as in the case of bilaterals – to receive proposals directly from countries. We need to put countries at the centre of fundraising efforts, supporting them with training, materials, and advice about which donor agencies are likely to offer the best chances of funding. We need to find creative ways to link with other disease programmes, such as malaria.

- **Successful fundraising requires significant time and resources:** Much effort is required to understand donor interests and priorities, and establish dialogues that will lead to successful funding requests. This work is labour-intensive – requiring donor-specific strategies, visits, documentation and coordination – and takes both time and resources to put in motion.

COMMUNICATIONS
Professor David Molyneux, Chair, Communications Task Force

- **Engage the media in telling the LF story:** Our success to date, and country successes of mass drug administration and disability alleviation, must be documented and promoted to raise the profile of LF.

- **Publicity is gradually increasing:** The GAELF is an unrecognized success story, but publicity is gradually increasing. The dissemination of the new GAELF logo, and other communications materials, is also contributing to public awareness.

- **BBC-commissioned documentary will air May 28:** A BBC documentary on lymphatic filariasis as part of a series entitled *Kill or Cure* focuses on Ghana and Egypt, and will reach a global audience. (For a copy of the documentary, email gaelf@liv.ac.uk)

- **Share our story with others:** The LF community must communicate the pro-poor and cost-effective aspect of drug delivery, its impact and relevance to Millennium Development Goals, and its substantial public health benefits. LF information and materials should be shared with different constituents such as the media, influential individuals (within and outside the health sector) and particularly politicians.

FINANCING ENVIRONMENT
Ms. Andrea Fischer, Financing Chair; Dr. Vinand Nantulya, Global Fund; Dr. John Gyapong, Country Perspective (Ghana); Ms. Sandra M. Libuano, private sector, NGDOs; Ms. Jeanne d'Arc Some, Handicap International; Mr. Nick Farrell, International Federation of Red Cross and Red Crescent Societies; Professor Bernhard Liese, World Bank, multilateral opportunities

- **Linkages with Global Fund essential**: Health is a basic human right, and the battle against LF – like the Global Fund to Fight HIV/AIDS, TB and Malaria – is a battle against poverty. There are tremendous opportunities for linkages and synergies with initiatives such as the Global Fund. Research-based policy and practice is essential, and health systems development is critical to sustain success. Partnerships are powerful when fighting diseases of poverty.

- **Private sector opportunities mutually beneficial**: Private/public relationships are mutually beneficial. Private funding offers sustainability and broadens our donor base; we gain funding and expertise as well as networking, contacts and endorsements. Private companies also benefit, since they can enhance their image and employee morale, and potentially expand their market base.

- **Engaging Non-Governmental Development Organisations (NGDOs) and Non-Governmental Organisations (NGOs) a sound strategy**: Innovative synergies with NGDOs and NGOs can lead to impressive results, and often appeal to prospective donors. One example is a two-year disease alleviation project that involved the NGO, Handicap International, in Burkina Faso. The partnership yielded many tangible benefits for LF patients and health professionals, increased public awareness dramatically, and received financial support from numerous, diverse sources.

- **HIPC funding potential:** Between 1996 and 1999, the World Bank and the IMF launched the Initiative for Heavily Indebted Poor Countries (HIPC), linking debt relief to poverty reduction. To obtain HIPC funding, countries must complete a Poverty Reduction Strategy Paper (PRSP), to articulate a country's strategy for poverty reduction. PRSPs involve broad participation, and can lead to an increase in government health expenditures – including LF programmes.

RESEARCH & HEALTH SYSTEM ISSUES
Dr. Yankum Dadzie, Chair, Technical Advisory Group (TAG); Dr. Reda Ramzy, Ain Shams University, Cairo, Egypt; Mr. Khalfan A. Mohammed, Programme Manager, PELF, MOHSW, Zanzibar-Tanzania; Dr. Dominique Kyelem, Coordinator, PELF, Burkina Faso; Professor David Molyneux, Director, LF Support Centre, Liverpool; Dr. Nevio Zagaria, Coordinator, Strategy Development and Monitoring for Eradication and Elimination, WHO

- **TAG impressed by data, needs funding for research:** A report on research priorities and strategies commended countries' national programmes for submitting a wealth of data, and noted that the Global Programme to Eliminate LF has achieved substantial progress. The report also noted that research is neglected, because of the mistaken perception that "all is well" with LF elimination efforts. As a result, there is a

lack of funding for both basic and applied research. Research priorities were discussed, including applied research for effective monitoring and evaluation; studies addressing MDA challenges; and the safety of combination treatment in different settings. Strategic issues addressed in the report include scaling up, disability prevention, and social mobilisation.

- **Measuring programme costs essential:** Donors need to know that countries are committed partners, and that LF elimination is affordable and cost-effective. The Emory LF Support Center has funded nine studies to examine programme costs in Burkina Faso, the Dominican Republic, Egypt, Ghana, Guyana (DEC-salt), Haiti, India, the Philippines, and Tanzania. These studies estimate the total cost of LF programmes; the average cost per treated person; and the relative contributions of countries and external partners. The studies also project the marginal cost of continuing programmes at current levels, and scaling up. In Egypt, for example, the overall MDA cost in 2000 was about LE7 million ($2 million U.S.) to treat approximately 1.8 million people; the cost per person treated was $1.12 (U.S.); and the cost per person at risk was 95 cents (U.S.). The study also showed that the Egyptian government contributed about 75% of the resources needed.

- **District level implementation proves successful:** In Zanzibar, the district is the focal point for LF activities, including planning, MDA, and disability prevention and control. MDA coverage was 76% in 2001 (first round), 83.1% in 2002 (second round), and 83% in 2003 (third round). Home-based care for those with lymphoedema was recommended, and a training module on home-based health care was prepared for district health workers, community members, LF patients and their families. Results after one year of home-based care were extremely positive. The district also held a workshop on hydrocele surgery for 10 doctors, which is expected to result in 400 surgeries and patient follow up. The district is also collaborating with other disease control programmes for future MDAs.

- **Measuring impact of health system and LF elimination:** During a two-day meeting held in Crewe, UK, in January 2004, some members of the Global Alliance defined common, quantitative indicators that demonstrate the effect of the LF programme on health systems. They also sought to develop a template for assessing these indicators. Among the measurable indicators that emerged were: the proportion of unserved villages reached by the LF programme; the proportion of personnel trained in drug distribution; whether or not LF is embedded into district plans; and the proportion of microscopists trained to diagnose other diseases such as malaria and tuberculosis.

- **Integrating LF mass drug distribution with other neglected diseases:** A presentation about neglected diseases and neglected populations focused on how the Neglected Disease Initiative should move forward, including seeking and building synergies based on local health needs, and conducting continuous operational research to develop new strategies to simplify mapping, screening and treatment. The case should be made for neglected diseases, in terms of the burden, socio-economic impact, human rights, cost of scaling up, and interventions. LF should be included with other priorities in the poorest-of-poor populations, where health systems are very weak. Upcoming challenges include shifting the focus from neglected diseases to neglected populations; from patients to populations; and from start-up to scale-up.

MEETING OUTCOMES

The key outcomes of the meeting were as follows:

- A GAELF revised structure/governance was adopted;
- Sixteen recommendations evolved from three working group discussions and were adopted;
- The next meeting of the Global Alliance will be held in Fiji in 2006, at the invitation of the Honourable Minister of Health of Fiji.

GAELF REVISED STRUCTURE/GOVERNANCE

Professor Jaime Galvez-Tan, Chairman of the Global Alliance

- **Representative Contact Group (RCG) established**: This group is composed of country representatives from each of the regions and representatives of a number of other constituencies including the pharmaceutical industry, academic/research institutions, donors, non-governmental organisations, WHO and the World Bank. (Note: See Appendix C for contact information.)

- **Executive Group elected by RCG:** This Executive Group consists of six members with the required skills, commitment and resources to carry out the recommendations made at the Alliance meeting in Cairo. The mission of the Executive Group is to "support the Global Programme to Eliminate Lymphatic Filariasis by enhancing the effectiveness of national, regional and global fundraising, advocacy, communication and planning for the Programme." As a result of this change in structure, the Executive Group is expected to play a prominent role in promoting the future development of the Global Alliance. (Note: See Appendix C for contact information.)

GAELF3 WORKING GROUPS

Meeting participants divided into three working groups to discuss future directions of communications and advocacy and fundraising (Group A); financing of national and sub-national partnerships for scaling-up (Group B); and integration as the means to an end: sustainability (Group C).

- **Future directions of communications and advocacy and fundraising**: Group A's objective was to facilitate easy access to information about LF and progress in the global elimination of the disease. Among the topics discussed were broad future directions for communications and mobilisation of resources at the national, regional, and global level.

- **Financing of national and sub-national partnerships for scaling-up:** Group B discussed topics including advocacy for the appreciation of LF as a disease of poverty, funding opportunities, scaling up, partnerships, and evidence-based decision making.

- **Integration as the means to an end: sustainability**: Group C's discussion focused on integrating LF with other programmes. The group stressed that in a time of severely limited resources, integration is critical for programme advocacy and to access funding. The group also discussed sustainability, and the need to think broadly about opportunities for integration.

GAELF3 RECOMMENDATIONS

The following recommendations evolved from the three working groups, and were discussed in open debate by all participants before being adopted.

The third meeting of the Global Alliance to Eliminate Lymphatic Filariasis recommends that:

1. **Countries make contact with Global Fund Country Coordinating Mechanisms** (CCM) to explore tangible synergistic funding opportunities between LF and the three target diseases: HIV/AIDS, TB and malaria.

2. **The Global Alliance continues to foster ongoing communication** with the Global Fund.

3. **Countries use the screening of the BBC World production** about lymphatic filariasis, entitled "Kill or Cure," to be released May 28, as an opportunity for advocacy to support LF programmes.

4. **Endemic countries and WHO work to raise the profile of LF** globally, regionally and at ministerial levels as a major debilitating and disabling poverty-related disease that is potentially eliminable.

5. **The existing email discussion list is promoted** to ensure proactive information exchange, along with the development of regional satellite LF-related websites. (CD-ROM versions should be made available where Internet use is restricted.)

6. **Academic and research institutions, particularly in endemic countries, are encouraged to support national and regional LF programmes**.

7. **The establishment of a network of LF support centres** that includes all regions is explored.

8. **A global "Lymphatic Filariasis Day" is established** to raise the profile of LF.

9. **LF support is anchored with the national poverty reduction strategy** whenever possible, to benefit from other resources such as Debt Relief and Poverty Reduction Support Credits.

10. **Scaling-up and completion of mapping is accelerated in the African region**, in recognition of the region's considerable challenges in eliminating LF.

11. **Documentation and operational research exists** to show that LF elimination has the potential to strengthen national health systems.

12. **Regular large-scale chemotherapy is promoted** as an essential component of health service delivery. (Population-based chemotherapy is a key element of other disease control strategies such as trachoma, schistosomiasis, intestinal parasites and onchocerciasis, which often occur in different combinations in the same neglected populations.)

13. **Networks of informal caregivers are created** to set up and sustain home-based long term care of LF, as well as other chronic conditions.

14. **WHO encourages endemic countries to increase the emphasis on reducing morbidity** associated with LF, in tandem with mass drug administration.

15. **WHO supports countries and non-governmental organisations** in their efforts to accelerate programmes to address acute and chronic clinical manifestations of LF.

16. **A reduction in morbidity can enhance advocacy** and resource mobilisation.

APPENDIX A

GAELF3 AGENDA
23-25 March 2004, Cairo, Egypt

Day 1
Tuesday, March 23, 2004

8:00-8:45 a.m.	**Registration**
9:00 a.m.	**Welcome:** • His Excellency the Hon. Minister of Health and Population, Egypt *(Professor Dr. Mohamed Awad Tag Eldin)* • World Health Organization (*Director General Dr. Lee Jong-wook, video message)* • GlaxoSmithKline *(CEO Dr. Jean-Pierre Garnier)* • Merck & Co. Inc. (*Vice President Middle East and Africa Mr. Michel Iguer)*
10:00 a.m.	**Coffee** *(Press Conference)*
11:15 a.m.	*OBJECTIVE: To recognize the remarkable progress of the Global Programme to Eliminate Lymphatic Filariasis* **Keynote Address** • *Professor Jaime Galvez-Tan, Global Alliance Chair*
11:30 a.m.	**Global Programme Progress** • *Dr. Anarfi Asamoa-Baah*
11:45 a.m. – 12:45 p.m.	**Reports from the Chairs of the Regional Programme Review Groups**
12:45 p.m.	**"One day," a film showing Sri Lanka's one day MDA campaign**
12:50 p.m.	**Lunch**
2:00-3:00 p.m.	*OBJECTIVE: To communicate the achievements and challenges of the country programmes to eliminate lymphatic filariasis* **Ministerial Session**
3:00-3:40 p.m.	**Reports from Global Alliance Secretariat and Task Forces, followed by questions and general debate**
3:40 p.m.	**Tea**
4:10 p.m.	*OBJECTIVE: To agree to a proposal for the future structure and governance of the Global Alliance* **Proposal and discussion on the future of the Alliance:** • *Professor Jaime Galvez Tan, Global Alliance Chair*
5:00-5:30 p.m.	**Working group establishment/appointment of chairs**

Day 2
Wednesday, March 24, 2004

9:00 a.m.	*OBJECTIVES: To enhance the profile of LF elimination as a uniquely beneficial and pro-poor public health intervention, and to establish a secure basis for funding for country programmes*.
	The financing environment *(Chair: Ms. Andrea Fischer)*
10:30 a.m.	**Coffee**
11:00 a.m.	**Research and health system issues** *(Chair: Dr. Eric Ottesen)*
1:00 p.m.	**Lunch**
2:15-5:00 p.m.	**Breakout of Working Groups** • *Group A-Communication, advocacy and fundraising* • *Group B-Financing of national and sub-national partnerships for scaling up* • *Group C-Integration as the means to an end; sustainability*

Day 3
Thursday, March 25, 2004

8:00 a.m.	*OBJECTIVE: Ensuring the success of the Global Alliance for its support of the Global Programme to Eliminate Lymphatic Filariasis*
	Reports from Working Groups, Draft for discussion
10:00 a.m.	**Coffee**
10:30 a.m.	**Discussion and endorsement of Global Alliance future structure** • *Professor Jaime Galvez-Tan*
12:00 p.m.	**Tabling of draft resolutions and recommendations; draft executive summary** • *Professor Jaime Galvez-Tan*
1:00 p.m.	**Lunch**
2:30 p.m.	**Adoption of resolutions and recommendations** • *Professor Jaime Galvez-Tan*
3:30 p.m.	**Closing Ceremony**
3:45 p.m.	**Coffee**

APPENDIX B

GAELF3 PARTICIPANTS

Note: *for a complete list of individual programme participants by name, visit www.filariasis.org and link to Third Meeting of the Global Alliance to Eliminate LF.*

COUNTRIES

Bangladesh	Benin	Brazil	Burkina Faso	Cambodia
China	Egypt	Fiji	Ghana	India
Indonesia	Kenya	Madagascar	Malaysia	Niger
Nigeria	Nepal	Papua New Guinea	Philippines	Samoa
Sierra Leone	Sri Lanka	Sudan	Tanzania	Thailand
Togo	Tonga	Uganda	Vanuatu	Viet Nam
Yemen	Zanzibar			

MINISTERS

Burkina Faso	Hon. Bedouma Alain Yoda
Egypt	Hon. Mohamed Awad Tag Eldin
Ghana	Hon. Moses Dani Baah
Samoa	Hon. Mulitalo Siafausa Vui
Tanzania	Hon. Hussein Mwinyi
Thailand	Hon. Sudarat Keyuraphan
Togo	Hon. Suzanne Aho
Uganda	Hon. Alex Kamugisha

INTERNATIONAL ORGANISATIONS

- African Development Bank
- The World Bank

PRIVATE SECTOR

- Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
- GlaxoSmithKline
- Merck & Co., Inc./Merck Sharp & Dohme
- Vestergaard-Frandsen

INTERNATIONAL DEVELOPMENT AGENCIES

- Department for International Development (DFID), United Kingdom
- Institut de la Recherche pour le Développement (France)
- Ministerio de Sanidad y Consumo (Spain)

INTERNATIONAL NON-GOVERNMENTAL ORGANISATIONS (NGOS)

- The Carter Center, Global 2000
- Catholic Medical Mission Board
- The Global Fund
- Handicap International

- Health & Development International (HDI)
- Interchurch Medical Assistance
- International Federation of Red Cross and Red Crescent Societies
- LEPRA
- Mectizan® Donation Program

GLOBAL AND REGIONAL PROGRAMME REVIEW GROUP CHAIRMEN

TECHNICAL ADVISORY GROUP (TAG) CHAIRMAN

COLLABORATING CENTRES

- Centers for Disease Control and Prevention (CDC), USA
- James Cook University, Townsville, Australia

ACADEMIC AND RESEARCH ORGANISATIONS

- Danish Bilharziasis Laboratory
- LF Support Center, Emory University
- LF Support Centre, Liverpool School of Tropical Medicine
- Michigan State University
- Tulane University
- St. George's University, Grenada
- University of Notre Dame
- Washington University School of Medicine

INTERNATIONAL JOURNALISTS

ADVISORS

WORLD HEALTH ORGANIZATION

- WHO Regional Office For The Americas (AMRO/PAHO)
- WHO Regional Office for Eastern Mediterranean (EMRO)
- WHO Regional Office for South-East Asia (SEARO)
- WHO Regional Office for the Western Pacific (WPRO)
- WHO Headquarters (HQ)

CONSULTANTS

APPENDIX C

REPRESENTATIVE CONTACT GROUP MEMBERS

CONSTITUTENCY		Represented by
Endemic countries		
Africa	Nigeria	Munirah Jinadu
	Tanzania	Esther Charles
	Togo	Suzanne Aho/Yao Sodahlon
Americas	Dominican Republic	
	Haiti	Marie Denise Milord
Eastern Mediterranean	Egypt	Hussein Kamal
	Yemen	Abdul Samid Al Kubati
Indian Sub-continent	Bangladesh	Moazzem Hossein
	India	Jotna Sokhey
Mekong Plus	Myanmar	Khin Mon Mon
	Philippines	Leda Hernandez
PacELF	Fiji	Lepani Waqatakirewa
	Samoa	Aird Hill Eti Enosa
Chairs Regional PRGs	Africa	John Gyapong
	Americas	Joâo Batista Furtado Vieira
	Eastern Mediterranean	Maged El-Setouhy
	Indian Sub-continent	Mahroof Ismail
	Mekong Plus	CP Ramachandran
	PacELF	Joe Koroivueta
Non-Governmental Organisations	Handicap International	Susan Girois
	MDP	Bjorn Thylefors
International Development Agencies	DFID	David Molyneux
	GTZ	Sybille Rehmet
Pharmaceutical Industry	GlaxoSmithKline	Andy Wright
	Merck & Co. Inc.	Ken Gustavsen
Academic/Research Institutions	KEMRI, Kenya	Njeri Wamae
	VCRC, India	PK Das
WHO		Francesco Rio
		Nevio Zagaria
World Bank		Bernhard Liese

EXECUTIVE CONTACT GROUP
(as of April 2004)

Name	***Address***
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Dr. Francesco Rio World Health Organization (WHO) Switzerland	LF Elimination Programme, World Health Organization 20 Avenue Appia CH1211 Geneva 27, Switzerland
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Dr. Bjorn Thylefors Mectizan Donation Program (MDP) USA	Mectizan Donation Program 750 Commerce Drive, Ste 400 Decatur, GA 30030 USA
Mr. Andy Wright GlaxoSmithKline (GSK) UK	LF Elimination Programme Global Community Partnerships 980 Great West Road Brentford, Middlesex, TW8 9GS UK
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Communicable Diseases (CDS)
World Health Organization