

Special Topic: Reports from Key Partners in the Americas

Chair: Dr. Celsa Sampson, PAHO/WHO, Brazil

Rapporteur: Dr. D. Fermin Arguello, Centers for Disease Control and Prevention (CDC)/Atlanta



GPELF: An Overview of the Global Program for the Elimination of LF: Progress, Financing, & Directions

Dr. Steven K. Ault, Regional Advisor, Communicable Diseases, PAHO/WHO

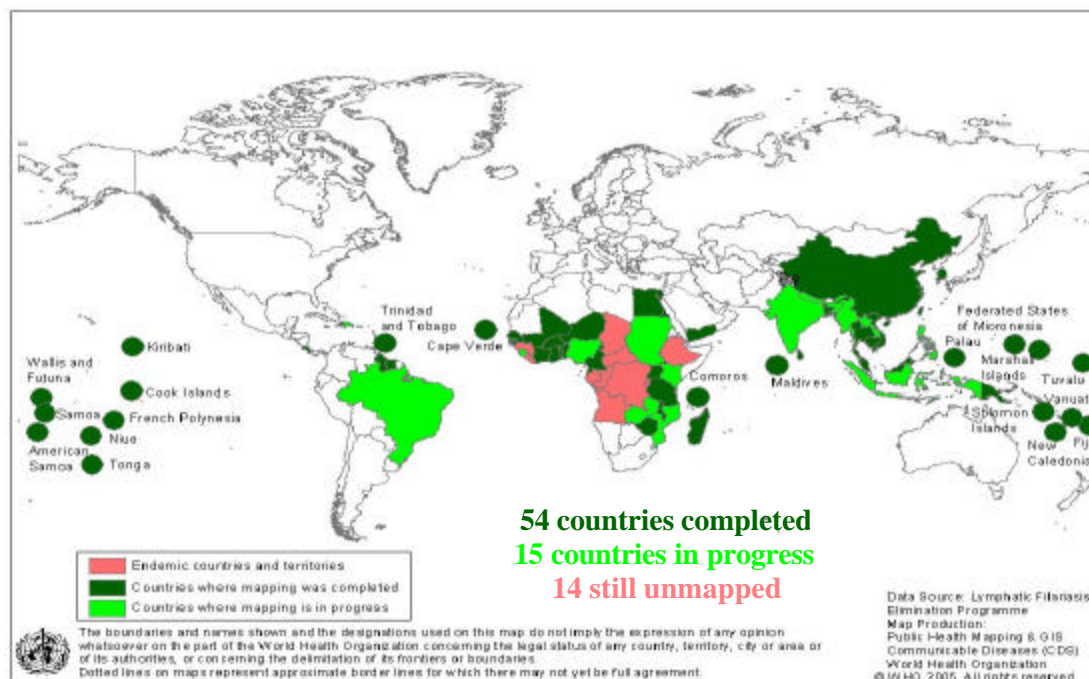
Introduction

This update was presented by Dr. Steven Ault on behalf of the WHO Global Program for the Elimination of LF (GPELF) and other colleagues who could not attend the meeting due to commitments at other meetings occurring simultaneously. It includes a brief overview of GPELF, which is coordinated by World Health Organization (WHO) through its Office in Geneva and works with the six Regional Offices of WHO, including the Regional Office for the Americas, known as the Pan American Health Organization (PAHO).

Overview

Mapping of the global distribution of lymphatic filariasis (LF) is an ongoing task in all regions, including the Americas, where both Brazil and the Dominican Republic (DOR) are continuing their efforts in mapping and in re-mapping. There are about 83 countries worldwide with known LF transmission. Of these, 54 have completed mapping 15 are in the process of mapping, and 14 countries, mostly, if not entirely, in the African continent, have not yet begun the mapping (indicated in Figure 1 in dark green, light green, and pink respectively).

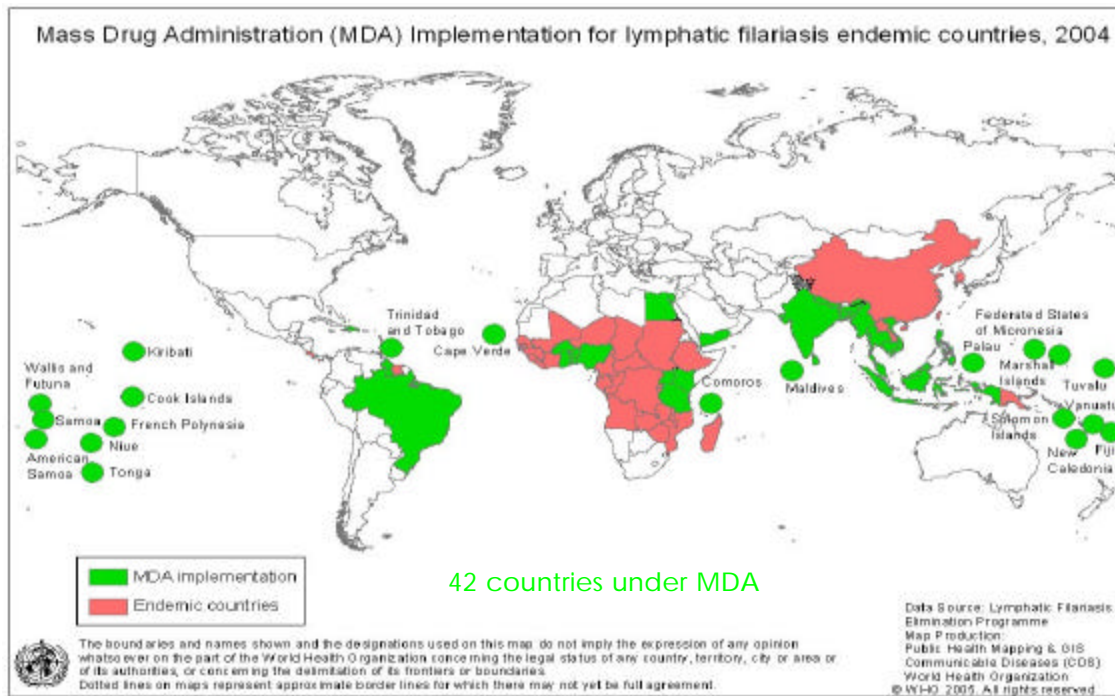
Figure 1. Mapping LF distribution in endemic countries



Treatment

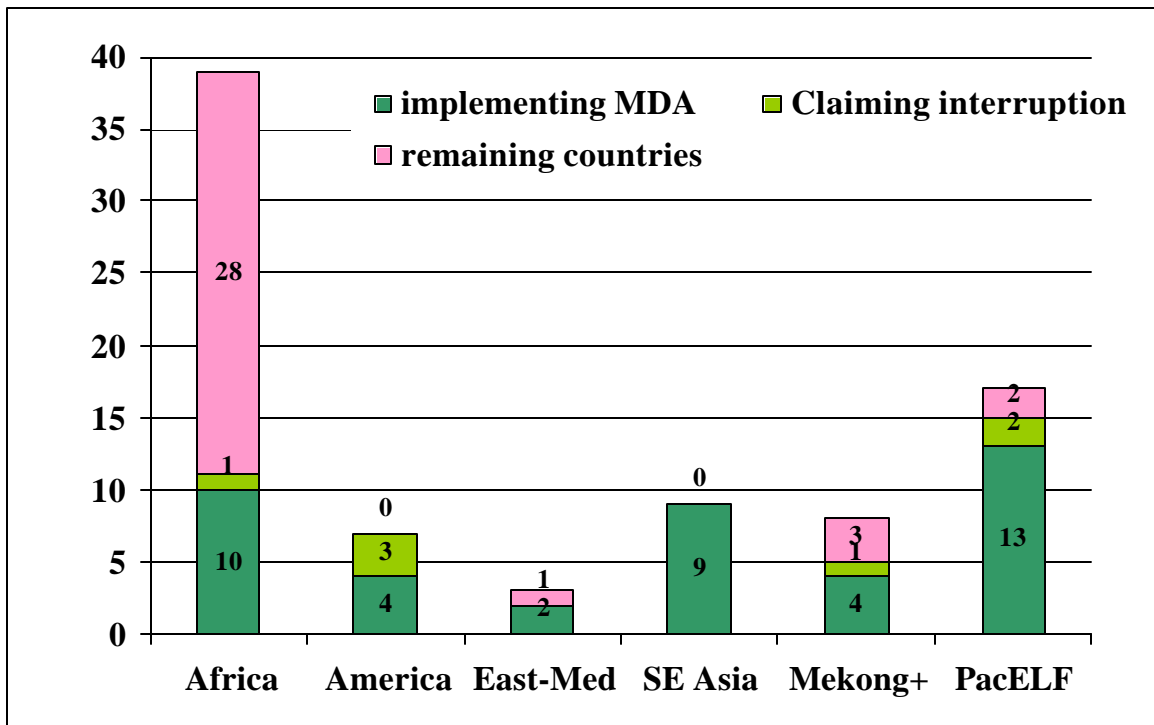
Currently, WHO is reporting 42 countries worldwide that are conducting mass drug administration (MDA) (see Figure 2). Most are using a combination of albendazole with diethylcarbamazine citrate (DEC), but some are using strictly DEC, as in the case of India and Brazil. Some endemic countries have not yet undertaken MDA, but a number of countries in the South Pacific, the Americas, North Africa and other parts of Africa, Sri Lanka, India, and parts of Southeast Asia are very active and organized in this effort.

Figure 2. MDA implementation



The global effort aims to scale up MDA where it is being implemented, but this is a slow process in some cases, especially in countries with resource limitations. However, the Global Program's goal is to continue to promote upscaling by obtaining resources to help countries implement their campaigns. Figure 3 shows the proportion of endemic countries with MDA programs under way. In Africa, 10 countries are implementing MDA, one country is claiming interruption, and 28 remain in the initial stages of their MDA programs. The Americas region has made much better progress. It has four countries working with MDA, and three countries claiming interruption. In the Middle East, only three countries are involved in this process, two of which are implementing MDA. All afflicted countries in Southeast Asia are implementing MDA. In the Mekong-plus region, the eastern part of Southeast Asia, four countries are implementing MDA, and in the Pacific Region, which consists of a number of small island nations, 13 countries have initiated MDA, two are claiming interruption of transmission, and two will begin MDA in the near term. In terms of coverage and drug intake (see Table 1), the total population in the implementation units (IUs) targeted by MDA in 2004 was 435.9 million people worldwide. In the Americas, an estimated 2.7 million people were targeted. Of that population, about two-thirds are reported to have ingested the drugs. In the Americas, actual coverage was very close to the target set by the countries of 2.7 million.

Figure 3. Proportion of endemic countries with MDA programs



In India, there has been a great increase in MDA in terms of geographic expansion (see Figure 4). Most states involved in the program are using DEC exclusively (as is Recife, Brazil, in the Americas region), although some are using a combination of DEC and albendazole. Figure 5 shows global coverage by MDA with either the 2-drug strategy or DEC-fortified salt. In general, from 2000 to 2004, both MDA coverage and IUs were expanded.

Table 1. Population covered and reported drug intake per RPRG in 2004

	Pop. in IUs targeted by MDA	Pop. reported to have ingested drugs
Africa	29.6 million	21.2 million
America	2.7 million	1.5 million
East Mediterranean	2.9 million	2.7million
South-East Asia	384.8 million	214.0million ++
Mekong-plus	14.5 million	9.4 million
PacELF	1.5 million	1.1 million
Total	435.9 million	250.0 million ++

Figure 4. Progress in geographical coverage by MDA in India 1996–2004

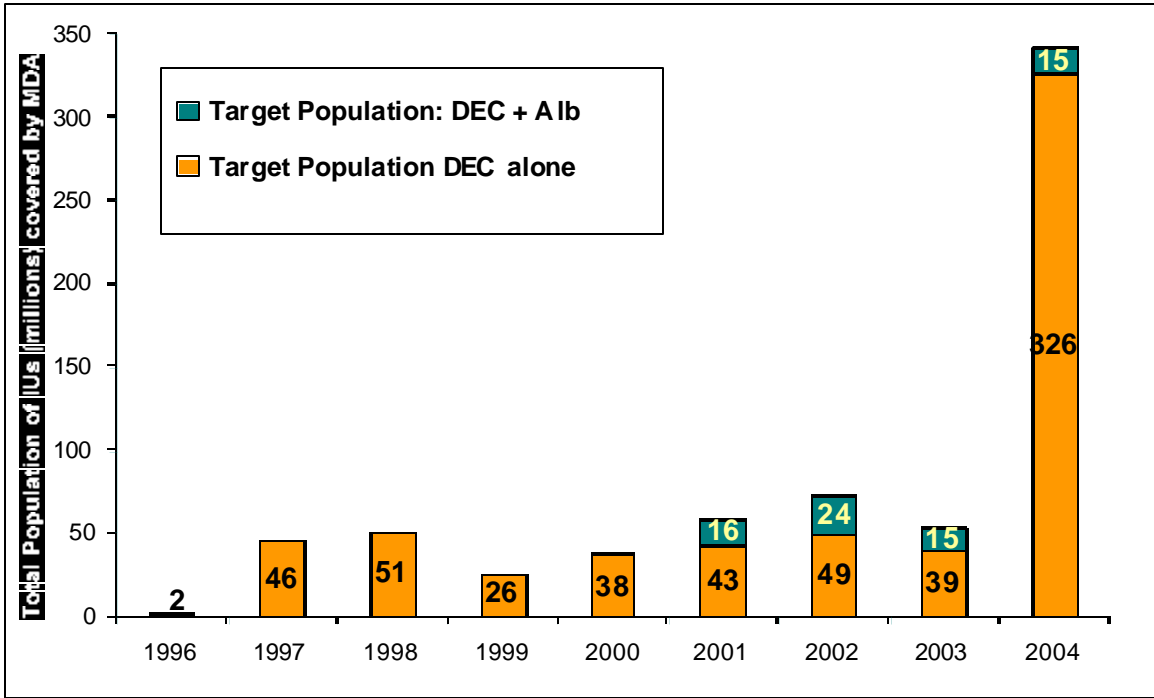


Figure 5. Progress in MDA using WHO-recommended two-drug strategy or DEC-fortified salt

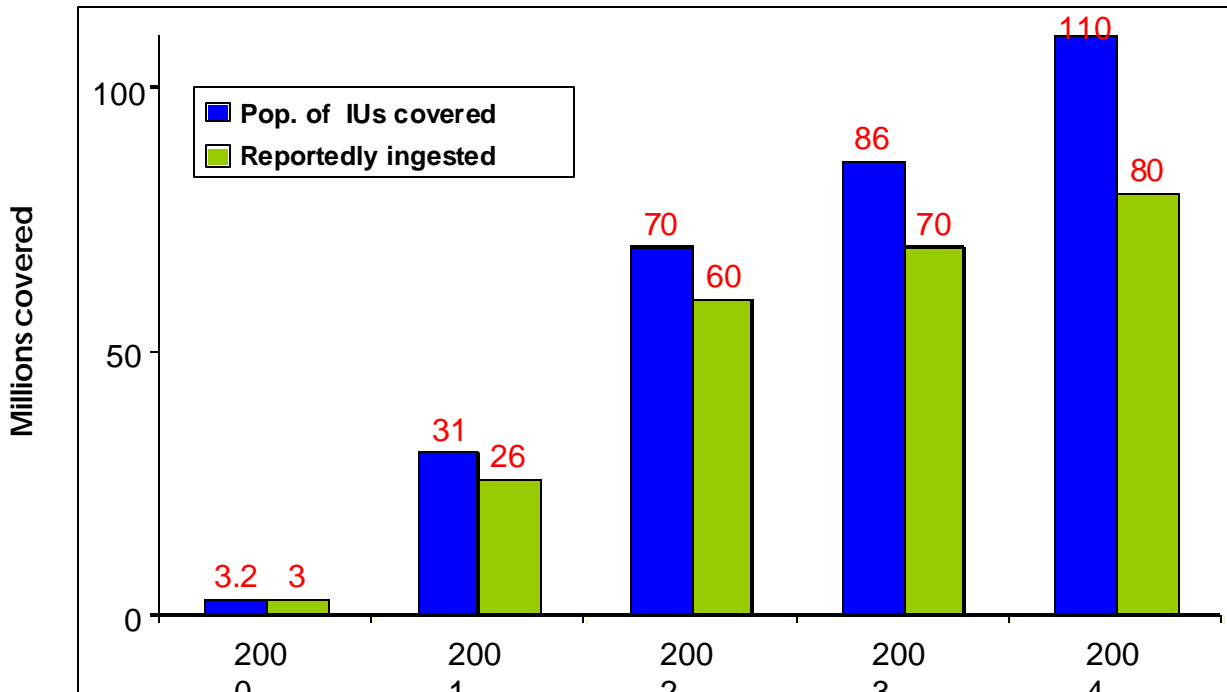


Table 2 shows cumulative targets for MDA for both the global population and the population outside of India. A global upscaling is anticipated—from a targeted population of 500 million in 2004, to 600 million for 2005, and 800 million by the year 2008. Projections for the population outside India are 150 million in 2005, increasing slowly to 350 million by 2008.

	2004	2005	2006	2007	2008
Overall	500	600	700	750	800
Outside India	100	150	250	300	350

Table 2. Cumulative targets for population covered by MDA (March 2004)

These goals and targets are used, along with other factors, to anticipate the production of albendazole and DEC that would be needed to achieve the objectives of the Global Program. This process is very dependent on the continuing actions of the national authorities, however, to ensure the MDA campaigns are safe and implemented carefully, that there is monitoring of any adverse events, and that any adverse events are investigated immediately and reported to WHO. To assist with that effort, the Technical Advisory Group (TAG) for LF disseminates recommendations and promotes drug safety at GPELF and Regional Program Manager Meetings (RPPMs) and encourages all countries to ensure they have a system in place for reporting and capturing any severe adverse events (SAEs) that require follow-up. In the case of an SAE, WHO would help coordinate an outside pharmaceutical expert to investigate. So far, no SAEs have been identified in the Americas region. If any were reported and verified, a review by an external expert would be required. Very few adverse events have been reported so far, but those that have been are recorded in a database maintained and coordinated through WHO/Geneva by Uppsala University in Sweden.

Ensuring a safe MDA campaign

- Dissemination of TAG recommendations and emphasis to program managers at PM meetings on reporting and managing severe adverse events (SAEs)
- Visit of pharmaco-vigilance expert to investigate SAEs
- Review by an external expert



- Recording all adverse events in the Uppsala University (Sweden) database

DEC supply

With respect to the supply of DEC, DEC tablets, and DEC *materia prima* (active ingredient), due to changes in the drug re-application, only one of WHO's three original suppliers of those materials remains pre-qualified for the provision of DEC tablets (as a "GMP/GLP" [good manufacturing

practices / good laboratory practices] supplier). However, the two other original companies should re-qualify once their manufacturing unit is moved to more modern facilities (which is expected to take place in late 2005). In 2006 all three original suppliers will re-apply for pre-qualification to sell or provide DEC to the countries, either through WHO or by direct purchase.

ICT cards

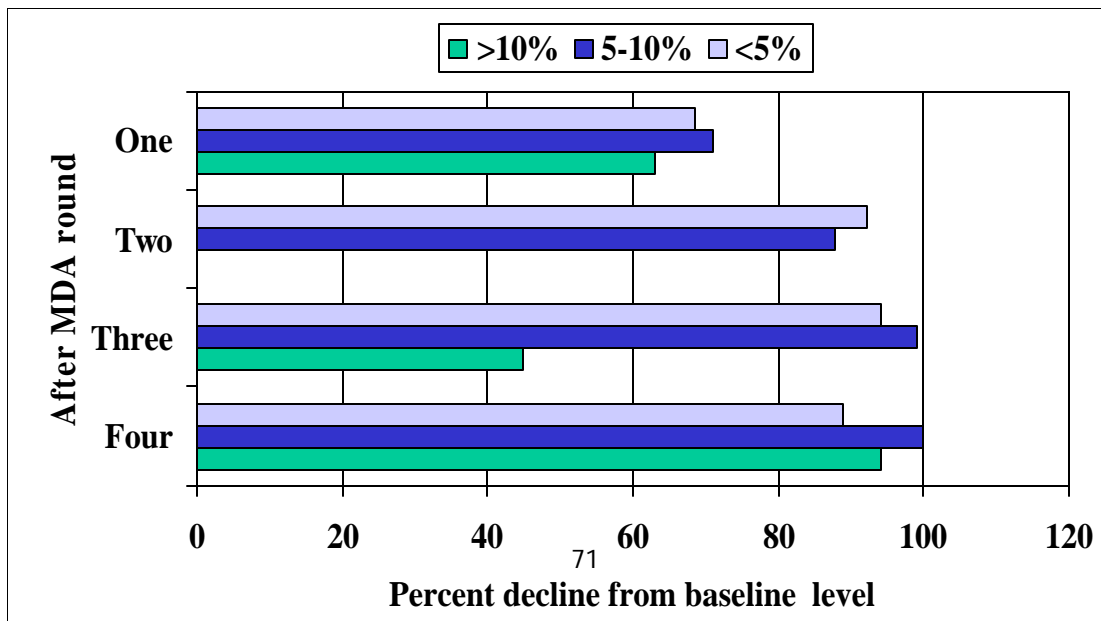
- 131,000 immunochromatographic test (ICT) cards procured by WHO for provision to countries
- Relying on just one manufacturer
- Instability of results, product recalls, interruption of production
- Shelf-life reduced to 9 months
- High cost
- Looking at alternatives

Regarding the procurement of ICT cards, GPELF must rely on just one manufacturer (Binax). There have also been some operational difficulties, including product recalls, interruption of production, and prohibitively high costs. In addition, Binax recently notified WHO that there are now claims that the shelf life of their products has been reduced from 12 to 9 months. This will

have an impact on countries with a large stock of ICT cards that are not planned for use within the next 9 months. The revised product expiration will also need to be taken into account when countries receive their next supply of ICT cards. In the Americas region, it has not been possible to obtain any ICT cards from WHO in 2005 because of limited production and the decision by WHO that they need to focus on providing cards to a list of priority countries that does not include the Americas region. So the countries in the Americas may have to look within the region for ways to procure an ICT card supply sufficient to meet their needs via purchases through PAHO, WHO, or some other mechanism. The high cost of the cards is another ongoing constraint, and WHO is looking at alternative solutions.

Figure 7 illustrates the reduction in mf prevalence at sentinel sites worldwide, based on the number of rounds of MDA. A decline of more than 10% in mf prevalence at sentinel sites after MDA is shown in green. A decline of between 5 and 10% appears in dark blue, and a decline in prevalence of less than 5% is shown in light blue. In general, results indicate that good progress has been made, with the number of areas that are seeing a 5 to 10% decline in prevalence growing, after each round of MDA. Generally, as the number of MDA rounds increases, there is a drop in mf prevalence at the sentinel sites.

Figure 7. Percent decline in post-MDA mf prevalence at sentinel sites

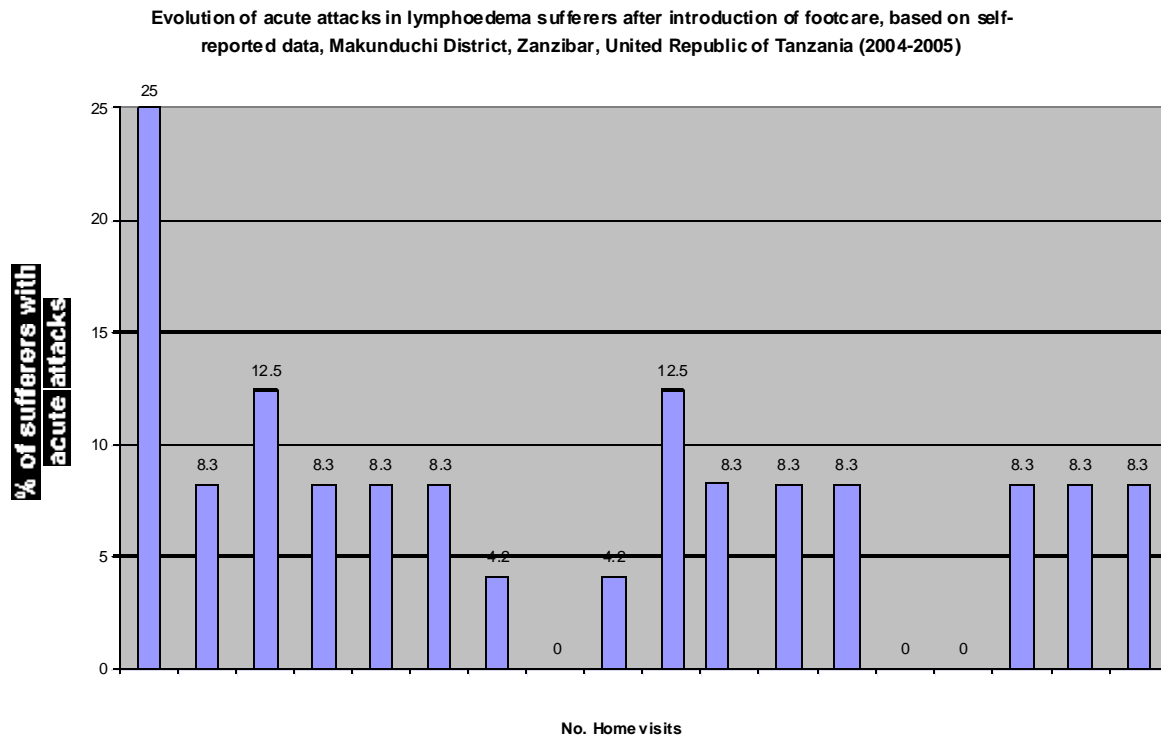


Community and home-based care programs for lymphedema management have been very active in working toward the prevention of LF-related disabilities, particularly in the Americas region (e.g., Brazil, Guyana, Haiti, and the DOR). Figures 8–10 indicate the advantages and successes of home-based treatment programs, with a decrease in the proportion of lymphedema sufferers who experience adenolymphogitis (ADL) attacks in the months following the start of home-based care. In general, there is a fairly large decrease fairly early on in the course of home-treatment regarding attacks of ADL. This data is encouraging and should be conveyed to the program managers as well as others (e.g., potential donors of antibacterial and antifungal creams) to demonstrate the importance and successes of the home-based self-care model.

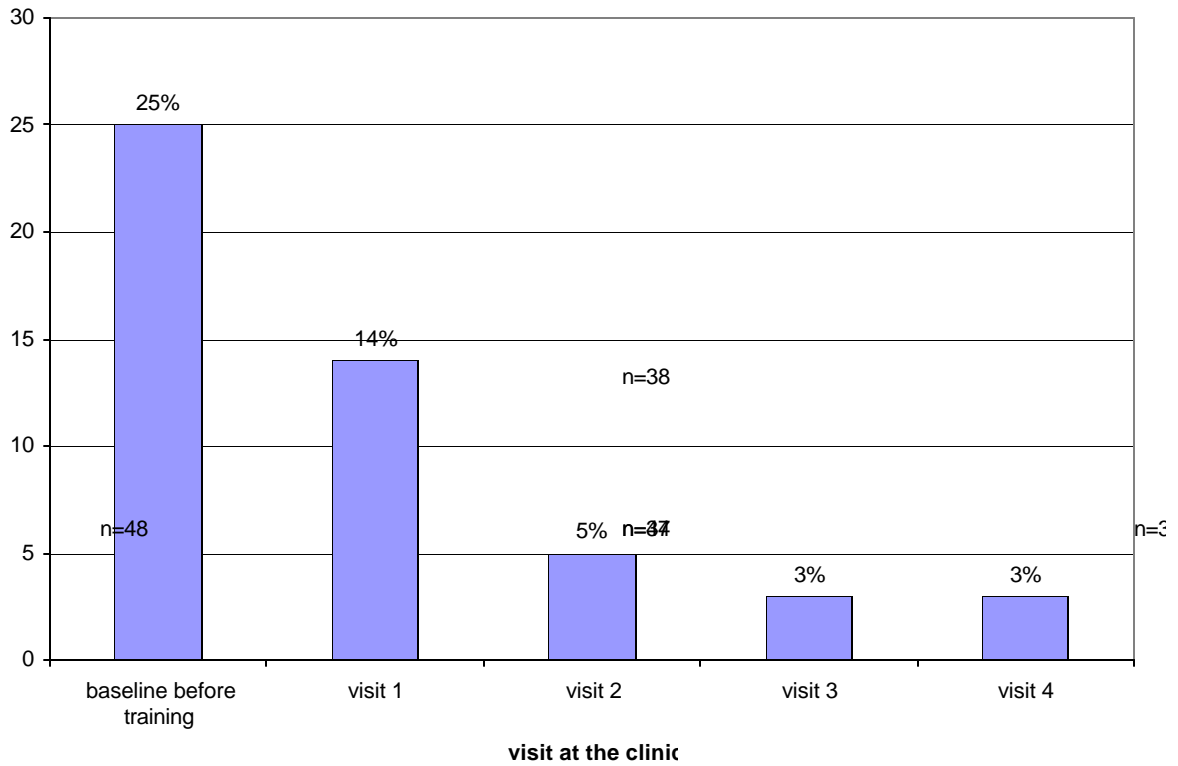
Projects on prevention of LF-related disabilities

- Community- and home-based care for lymphedema management
 - Brazil, Burkina Faso, DOR, Guyana, Haiti, Madagascar, Sri Lanka, and Zanzibar (United Republic of Tanzania)
- Operational research to increase access to hydrocele surgery and to follow up on operated cases for complications and recurrence
 - Burkina Faso, Madagascar, and Zanzibar

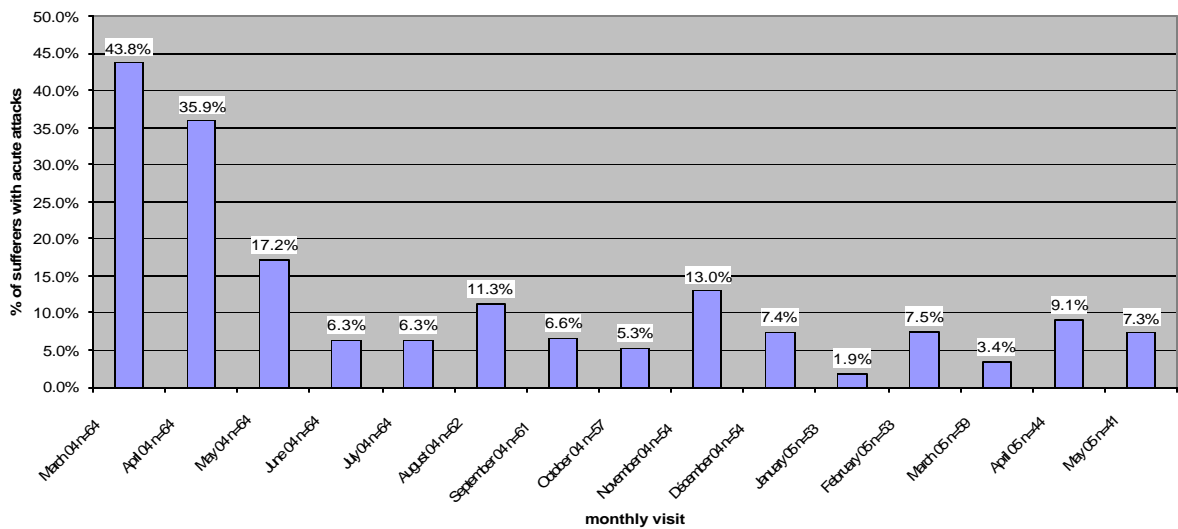
Figures 8–10. Decrease in proportion of lymphedema sufferers experiencing ADL attacks during month following start of home-based self-care



**Acute attacks evolution in lymphoedema after implementation of fox
Kalutara District, Sri Lanka**



**Evolution of acute attacks in lymphoedema after introduction of home-based lymphoedema
management and DEC single dose treatment, based on self reported data, Antaimoro region,
Madagascar, March 2004 - May 2005**



Funding GPELF implementation

One of the difficult issues, not only in the Americas region, but globally, including the WHO program in Geneva, is the challenge of funding. The same problems will likely be experienced in the PAHO Regional Office. Although central funding¹ is diminishing, there has been some success in obtaining funding at the country level, as summarized below, and in Table 1, through various interventions and/or activities.

- National funding for entire program in India, Malaysia, Thailand, and others
- JICA (Japanese International Cooperation Agency) support extended for five years to PacELF countries (DEC and volunteers for Bangladesh)
- ADB (Asian Development Bank) has included LF among disease control and elimination efforts it's supporting in the Mekong Delta Area. This is a large program, about US\$20 to 30 million (a portion of which will be dedicated to LF elimination efforts in that region).
- Funds from the UK's DFID (Department for International Development) through the Liverpool School of Tropical Medicine (LSTM) for identified countries for five years
- AusAID (Australian Agency for International Development) funding to Indonesia, Timor-Leste, Philippines, and Papua New Guinea
- Merck's Mectizan® Donations Program (MDP) is continuing in Africa.
- Ongoing support from GlaxoSmithKline (GSK) for drug issues and, in some countries, epidemiological assessment.

There is still a large gap, however, between the identified needs of countries and current funds and other available resources.

Synergy with other programs

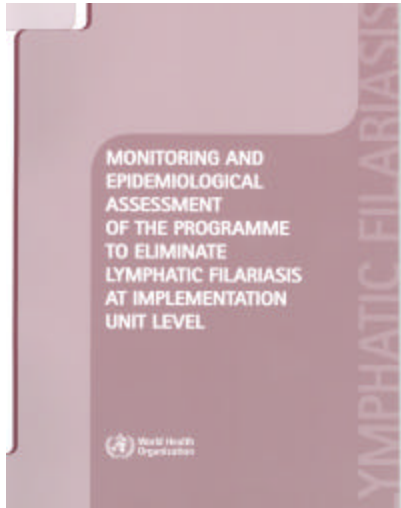
Programmatic

- Berlin meetings to generate an overall consensus on moving forward with neglected tropical diseases
- Ministries of Health (MoHs) are moving toward coordinated, synergistic program links with CDC and other partners
- Full session on LF at TAG Meeting

One way to partially bridge this gap is to look for opportunities to synergize the work of LF elimination with other neglected diseases, and, in some cases, to attempt to sell a package of interventions. For instance, selling LF treatments such as fortified salt (DEC-salt) to reduce the incidence of intestinal helminthes to donors, and even selling the idea within the MoHs to obtain additional funding for LF programs by combining them with programs that offer opportunities for cooperation in prevention, surveillance, and control. This is a result, in part, of a series of two meetings held in Berlin over the last three years in which there was consensus in the public health tropical medicine community to package certain types of neglected tropical diseases, including LF, to help increase access to funding, among other anticipated outputs. MoHs have also moved toward more coordinated, synergistic approaches in building stronger links with the CDC and other partners. And as discussed above, a full meeting session was devoted to the question of synergy at the last TAG meeting in Geneva.

¹ The term "central funding" refers in this case to funding from WHO/Geneva

Monitoring & evaluation (M&E)



In regard to M&E, current output includes

- production and distribution of new WHO guidelines for managers on how to conduct monitoring and epidemiological assessment (see icon)
- technical assistance provided to countries nearing or completing five rounds of MDA
- technical assistance provided to China for verification of interruption of transmission
- ongoing development and testing of WHO DAS-S (Short Disability Assessment Schedule) as an evaluation tool for interventions against disability.

Miami meeting (November 2004)

An informal consultation was held in Miami in 2004 held to address issues arising after five years of program implementation, including

- program goals and how to measure their achievement
- how to increase intervention impact to achieve program goals.

Conclusions

- Current World Health Assembly (WHA) resolution still holds
- PELF can be divided into three phases:
 - initial implementation demonstrating rapid reduction of mf
 - scaling up interventions
 - moving toward interruption of transmission.
- Use of two-tiered programmatic goal structure
 - Level 1 (when prevalence of filarial infection is below the level of initiating interventions)
 - Level 2 (when parasitological indices are at levels that are not conducive to recrudescence on stopping interventions)

Recommendations

- Establish protocols for assessing whether transmission threshold has been achieved.
- Test protocols in countries completing four to five rounds of MDA.
- Apply protocols using several different tools in different settings.
- Investigate questions related to tool development and performance in prospective studies.
- Investigate larger public health benefit and impact on health system and Millennium Development Goals (MDGs).

Challenges

- Scaling up program interventions
- Ensuring high quality of program interventions
- Generating data and experience to better define "endpoints" (i.e., when to stop MDA)

- Simplifying program monitoring guidelines
- Post-MDA surveillance and how to detect early resurgence
- Ensuring regular supply of diagnostic tests and DEC for the program
- Funding for most countries to implement PELF
- Implication and opportunities of integration for PELF

Strategies

- Consolidation
 - Ensure "effective" MDA in ongoing areas
 - Ensure countries complete five rounds of MDA in following M&E criteria
 - Scaling up in countries with MDA to minimize total duration of program interventions
 - Start MDA in already-mapped countries vs. mapping the remaining central African countries

DISCUSSION

Question. WHO is encouraging the upscaling of programs, which requires a certain level of resources [to support access to DEC, the tablets, etc.]. Can we guarantee the countries will have a sufficient supply of DEC to meet their treatment needs?

Response 1. It's not certain that the companies that manufacture DEC can guarantee a sufficient supply without clear data from the countries on the projected demand. The factories of the three main manufacturers may have the technical capacity to produce a sufficient amount of DEC tablets. There is a need for reliable forecasts of demand, and WHO needs to continue to negotiate good price schemes for this. There is a temporary problem in doing that, as two of the three manufacturers previously qualified under the WHO guidelines are not qualified now. But they should be re-qualified by the end of the year. So hopefully, by 2006, all three companies will be able to supply DEC tablets. But WHO is not in a position to distribute DEC tablets for free, so there will be some cost to the national programs for purchases are coordinated through WHO.

Response 2. The most important issues in terms of forecasting have all been touched on, but it all comes down to one thing: money. If there was a steady supply of money, the manufacturers would have been able to meet the demand for DEC forecast by the countries; it would not be a problem. For example, JICA ordered all of the DEC forecast for the Pacific Island countries; they put their money on the table, and the manufacturers made the DEC and sent it to them. There is a decrease in production capacity at the moment, but that's probably not the real limiting step. The limiting step is that the programs are living hand-to-mouth every drug cycle, regardless of whether there is a good supply system. That doesn't mean it's hopeless, it just indicates where the focus should be to ensure the programs get adequately financed. With money, and good forecasting, there will be plenty of drugs.



GAELF: Global Alliance for the Elimination of Lymphatic Filariasis: Update from Global Alliance Executive Group

Dr. Patrick Lammie, CDC/Atlanta, on behalf of Ms. Joan Fahy,² GAELF Secretariat and Liverpool LF Support Centre, UK

Overview

The Global Alliance To Eliminate Lymphatic Filariasis (GAELF), also known as the Global Alliance, is a free, non-restrictive partnership forum consisting of the member countries, and organizations from public and private sectors, academia, and governmental bodies for

- the exchange of ideas and sharing of information
- the coordination of activities
- raising awareness of lymphatic filariasis (LF)
- gathering of support for the Global Program to Eliminate Lymphatic Filariasis (GPELF), which comprises the national programs of all endemic countries and is coordinated by World Health Organization (WHO), with the goal of eliminating LF by 2020.

Structure

The Global Alliance is a consortium of partners that exist to support the Global Program. It's an informal structure devoted to the exchange of information, advocating for the LF program as a public health activity. The key issue is using advocacy to increase the support available for the program. Through the Alliance, at the last meeting in Cairo, the members of the Executive Group (EG) were selected.

Executive Group

The EG is meant to meet on a regular basis to make decisions about support, advocacy, communications, and strategies for the Global Program and the Global Alliance. This group exists to serve the people at the country level

through the Representative Contact Group (RCG). The EG includes five individuals. These people serve at the discretion of the Global Alliance for a period of two years. Current members include John Condozzi, the Chair, and representatives from WHO, CDC, Merck's Mectizan® Donations Program (MDP), and GlaxoSmithKline (GSK). The EG guides the development and implementation of

- communication and advocacy strategies for the Global Alliance
- partnership development strategies to support the Global Program and endemic countries
- engagement and maintenance of communications with major donors and partners
- preparation for the next meeting of the Global Alliance.

The EG also maintains regular contact with the RCG regarding the direction and progress of ongoing efforts. Current EG members include

- Yankum Dadzie, Chair
- Patrick Lammie, CDC
- Francesco Rio, WHO
- Bjorn Thylefors, MDP
- Andy Wright, GSK.

EG activities since GAELF3 (GAELF 2003 Annual Meeting in Cairo) include

- regular teleconferences and face-to-face meetings
- Action Plan with timelines developed from the outcomes of GAELF3 Working Group recommendations

² Unable to attend the meeting due to travel constraints caused by Hurricane Wilma

- Alliance newsletters (2) and *EG Updates* (6)
- advocacy and fundraising activities
- planning for GAELF4 (to be held in Fiji).

Regional Contact Group

The RCG comprises members of the country programs and representatives from the major partners of the Global Alliance, including the drug companies, NGOs, universities, and major research institutions. It serves as the conduit between the EG and the countries and partners. The RCG should also be in the position to provide support to country activities. It also has a number of other functions, including electing the EG every two years. At this point, RCG members only meet and communicate electronically. Tasks of group members, who include 30 representatives selected by the different partner groups at the business session at each GAELF meeting, include

- appointing members of the EG at the business session of the GAELF meeting
- serving as a link between the EG and the Alliance partners
- translating the vision, policies, and recommendations of the Alliance into a work plan with priorities for the EG
- selecting Global Alliance President
- overseeing communication with constituency groups/countries regarding Global Alliance and Executive Group initiatives
- actively supporting the implementation of GAELF fundraising and advocacy efforts as formulated by the EG.

Financing

The EG meets at least once per month by telephone and about every three to four months face-to-face. It focuses on the number-one issue: how to get more money to the country programs. Newsletters and emails are sent to members to keep them abreast of some of the activities. A number of different fundraising activities have been carried out with the help of a team of fundraisers based in Atlanta, Europe, and the Philippines, so fundraising activities have a regional focus. Fundraising is led by Pam

Wuichet and includes Becky Castle, P.J. Hooper, and Molly Brady (United States); Tasha Boerner (Europe); and Sandra Libunao (International).

A number of different areas were targeted initially. Getting money means going where the money is, and largely this means major international donors, banks, etc. The support that has been raised so far has been relatively limited. However there are some indications of positive activity outcomes. Poverty reduction monies may become available for some countries, and other countries have had limited success in accessing Global Fund (Global Fund to Fight AIDS, TB, and Malaria, or GFATM) monies through partnerships with malaria or tuberculosis (TB) programs. There are a number of other activities with specific donors as well as advocacy efforts (e.g., one of the program's major activities is to raise the visibility of LF and other neglected disease within the U.S. political system).

Donors

Current donors (see Table 1) include the UK Department for International Development (DFID), which provides country support (predominantly for Tanzania, Ghana, Burkina Faso, and Bangladesh), along with the Izumi Foundation, which provided support for MDA for Zanzibar. There are also some other limited sources of money for focal point projects. A major donor during the first four to five years of the GPELF was the Bill & Melinda Gates Foundation.

Gates Foundation

The region has benefited tremendously from the Bill & Melinda Gates Foundation for the last four to five years through direct support for the national programs in Haiti, Guyana, and the Dominican Republic (DOR). These monies have supported MDA, morbidity activities, and diethylcarbamazine citrate (DEC)-salt fortification efforts. Unfortunately, the Gates funding has essentially ended as of this year. There have been a number of changes at the Gates Foundation, and it's important to understand what they are in order to appreciate the changes and to determine how funds might be accessed in future.

Table 1. Fundraising and advocacy

<i>Current activities</i>	
Foundations & companies	Fundraising team led by Pam Wuchet Becky Castle, PJ Hooper, Molly Brady (United States); Tasha Boerner (Europe); Sandra Libunao (International)
HIPC (Highly Indebted Poor Poor Countries Initiative) funds	World Bank visits to Ghana and Tanzania to lobby for LF. Burkina Faso visit planned.
DFID	New five-year grant awarded to Liverpool for support centre plus funding for Tanzania, Ghana, Burkina Faso, and Bangladesh
Izumi Foundation	Support to Zanzibar
Annie Casey Foundation	Support to CDC for treatment of immigrants in United States
Country-level advocacy	Sandra Libunao, collaboration with Red Cross, Benin, Kenya, Nigeria, Mali, milk production companies, Niger, and others
<i>New prospects</i>	
Gates Foundation	LOI (level of investment) submitted
Global Health Council	Advocacy for neglected diseases
Organization of the Petroleum Exporting Countries (OPEC) Fund for International Development	Proposals about to be submitted
Open Society Initiative (OSI)	Proposals about to be submitted
Starr Foundation	To submit proposal by December
Global Fund (GFATM)	Proposals submitted following workshop held in Lome for five African Francophone countries services
Bilaterals	Approaches made to Austria, Belgium, and France
Kiwanis and Rotary Clubs	Cultivating relationship

The original grant was awarded back in 2000, when the Gates Foundation was interested in catalyzing public health activities; a number of grants were made simultaneously to support activities in tropical diseases (e.g., the GPELF, the Schistosomiasis Control Initiative, the International Trachoma Initiative, Partners for Parasite Development [for de-worming], and a number of others). The hope of the Foundation at that stage was to provide programs with resources until they could be self-sustaining. The GPELF used the funds in the regions for MDA and other global activities, and WHO used them to fund activities such as the purchase of ICT (immunochromatographic test) cards and DEC (diethylcarbamazine citrate). As the funding started to wind down, however, and initial discussions with the Gates Foundation were conducted regarding opportunities to renew it, it became clear a number of changes had occurred at the Foundation, including their focus and use of funding.

Their new focus is on basic research and tool development, especially innovative tools (vaccines, drugs, etc). There is much less interest in programmatic activities, and there is very little interest in what they call implementation. Unfortunately, most of the Foundation's funding for the GPELF is earmarked for scaling up and maturing (i.e., implementation). So it has become more difficult to identify a niche for the LF program within the current Gates Foundation portfolio.

There is still a possibility for the GPELF to continue some activities with the Foundation, but any future relationship with them will mainly entail critical operational research conducted to support the Global Program, as per their current interests. An initial proposal, or Letter of Inquiry (LOI) has been submitted to the Foundation describing a number of operational research topics (the response is pending). There should be some good opportunities in the region to participate in those activities and compete for those monies, and the GPELF hopes to use any operational research money it may receive to leverage additional program funds.

Prospective donors

As experienced in GPELF's activities at the country level, it can be very difficult to get donors to listen to discussions about LF. The major focuses in many countries—HIV, TB, and malaria—are also the focus of many major donors, a situation that presents a particular set of challenges. Given the current climate, the idea that a single donor can be found to pay for all program activities for one or several countries seems to be a false hope. Therefore, several potential donors must be identified to support programmatic activities.

These types of fundraising activities mainly begin at the country level. Country representatives know who is operating in their countries, and who the donors are. For example, the Inter-American Development Bank (IADB) may have some new activities focused on poverty reduction, or there may be an opportunity to receive GFATM funds by linking LF activities to TB drugs, malaria treatment, or distribution of bed-nets. These approaches to seeking funding must be as proactive and creative as possible or the country programs are going to continue to flounder. The possibility that MDAs may have to be skipped because of a lack of funding is a sobering thought. Funds for DEC and ICT cards are especially critical. The era of sending in a request to WHO and four weeks later receiving a supply of ICT cards or DEC has come to an end. Raising money for these types of commodities is one of the program's biggest challenges. It is something that must be focused on in order to project into the future and ensure regional supply needs are stabilized.

An enormous amount of effort has been put into identifying potential donors (see Table 2), but no major funding has been identified at this stage. The money is there, at the country level, but the national programs must help identify the possibilities. If the program managers know of a potential donor, and need assistance in writing a proposal, the EG and other members of the RCG can help (e.g., in the provision of templates for grant application). Fundraising efforts must be approached collectively.

Table 2. Donors

North America	Europe	International
Foundations		
Anne E. Casey Foundation	Aga Khan Foundation	Africa Medical and Research Foundation (AMREF)
American India Foundation	Bernard van Leer Foundation	Aga Khan Foundation (Kenya)
Bill & Melinda Gates Foundation	Fondation de France	Charles Stewart Mott Foundation
Catholic Foundation of Northern Georgia	Fondazione Medikinale International Parma Prix	East African Association of Grantmakers
CDC Foundation	Leonardo	Ford Foundation – East Africa
Dikembe Mutombo Foundation	France Libertés – Fondation Danielle Mitterrand	Nippon Foundation
Ellison Medical Foundation	Global Fund (GFATM)	OSI for Southern Africa
Ford Foundation	Gulbenkian Foundation	Rockefeller Foundation
Geronimo Fund	John Ellerman Foundation	(Eastern and Southern Africa Program)
Izumi Foundation	New Philanthropy Capital	Rotary Club (Kenya)
Katherine J. Murphy Foundation	Nuffield Trust	SAGA (Strategies and Analyses for Growth and Access)
Kiwanis International	OPEC Fund for International Development	W.K. Kellogg Foundation
Rockefeller Foundation	The Health Foundation	
Rotary International (& Atlanta club)		
Starr Foundation		
The African Grantmakers' Affinity Group		
The Atlantic Philanthropies Inc.		
Woodruff Foundation		
Private sector		
Citigroup Foundation	ABN–Amro Bank N.V.	Celtel International (Burkina Faso, Kenya)
Corporate Council on Africa	BP International	Coca-Cola Africa Foundation
GE Foundation	British Airways plc	Diageo Guinness (Ghana, Kenya)
Honeywell Specialty Materials	Celtel International	Fasoplast (Burkina Faso)
Johnson & Johnson Corporate Giving	Coca-Cola Foundation	GSK (East Africa, Kenya)

Levi Strauss & Co. Contributions	Fasoplast	Hemas Holding Ltd (Sri Lanka)
Merck & Co., Inc.	Fondation d'Entreprise du Groupe Air France	Holcim Ltd (Sri Lanka)
New England Biolabs	GSK	Nation Media Group Ltd. (Kenya)
Terason	Heineken International	Nestle (Kenya)
U.S. Council for International Business	Marks & Spencer	Phoenix Industries (Sri Lanka)
	Novartis Foundation	Shell International (Kenya)
	Shell International	Standard Chartered Bank (Kenya)
	Standard Chartered Bank	Tourism Promotion Services (Kenya)
		Unilever (Ghana, Kenya)
		Industrial Promotion Services/Plastics & Rubber Industries Ltd. (Kenya)
<i>Bilaterals</i>		
Belgian Embassy Economic Affairs	DFID (UK)	
Canadian International Development Agency (CIDA)	Directorate General for Development and Cooperation, Belgium	
NIH/Fogarty International Center	French Ministry of Foreign Affairs	
UNICEF	GTZ (German Technical Cooperation)	
USAID	Norwegian Agency for Development Cooperation (NORAD)	
World Bank	Royal Danish Embassy	

DISCUSSION

Question. How should members of the RPRG be chosen to represent this region?

Response 1. To ensure regional representation of the Americas at the meeting in Fiji in 2006, this [meeting] group should select a representative (e.g., someone who has the time, and who would be an effective spokesperson for the region). The representative(s) should be nominated and their names given to the meeting Chair (Dr. João Batista Vieira).

Response 2. Discussion of the RCG is an agenda item in the RPRG Meeting. So it can be decided in that meeting, with the program managers present, which individuals should represent the region. [The Secretariat] will then seek funding to allow for their participation in Fiji.



GSK: Contributions & Challenges

Mr. Larry M. Mulligan-Gibbs, Director of International Communication, LF Elimination Program, GSK/USA

Introduction

Mr. Mulligan-Gibbs thanked the group for inviting GSK (GlaxoSmithKline) to give his presentation, which focused on shipments of albendazole tablets in the Americas, general issues and challenges for GSK and the program, and the company's new manufacturing unit in Cape Town, South Africa.

Albendazole shipments

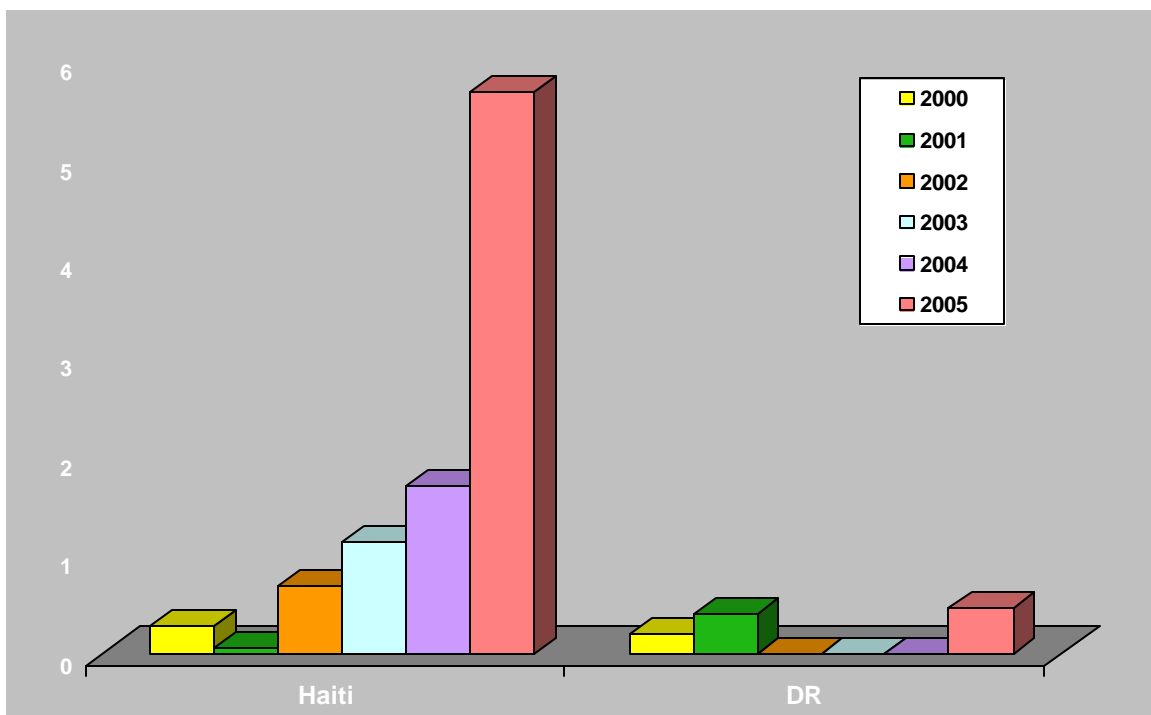
GSK recently sent a shipment of more than 5.6 million tablets to Haiti on 5 October 2005 (with an estimated delivery date of 17 October 2005). For the Dominican Republic, the company shipped close to half a million albendazole tablets, as per the national forecast of demand.



Increased demand

As shown in Figure 1, which illustrates the last five years of albendazole shipments to the Americas, there has been a steep increase in the forecast for demand of tablets, reflecting the scaling up of the program, particularly in the Dominican Republic (DOR).

Figure 1. Albendazole shipments to Americas Region



Funding

GSK recognizes the issues and concerns about funding, as discussed earlier, and World Health Organization (WHO) has requested its support in funding the supply of DEC (diethylcarbamazine citrate), which is still pending.

Mapping

The issue of mapping is important to GSK as it enables forecasts of demand, which allows the company to better prepare in order to support the demand for treatment.

Manufacturing

GSK currently produces most of its tablets in France, but some of that production load will be shifted to the new Cape Town factory. The company has invested 1.5 million British pounds at the plant (roughly US\$2 million) and is training a new production unit there. The Cape Town plant is expected to produce the majority of the albendazole tablets needed for the Programs to Eliminate Lymphatic Filariasis (PELFs) as well as supplying other needs.

DISCUSSION

Question. In the transition of production of albendazole tablets from France to Cape Town, are any delays expected in the planned shipments for the Global Program (GPELF)?

Response. There shouldn't be any delays because albendazole tablets are already being produced at the plant. Although the factory dedication is being held just this week, production has been ramping up for about a month now in anticipation of the transition. And the factory in France will not be closed. So the transition should be smooth and the production load should be balanced.

Question. What other activities and contributions GSK makes to the Global Program? GSK/Americas has been helping with a grant to allow South-South interactions here in the Americas. But it would be interesting to hear about other GPELF programs GSK supports.

Response. GSK support the provision of tablets and also donates cash to various countries to advance their tablet programs by helping with education and communication, etc. It also does needs assessment and grants other funds to support LF programs.

Shipping update

Albendazole

- Haiti: 5.69 million tablets shipped in October
- DOR: 460,000 tablets shipped in October

Achievements

- New plant now operational and contributing to global supply chain

Challenges

- Scaling up
 - Plans for completing mapping in the DOR and Haiti
- Funding (Gates Foundation, DEC)
 - Significant progress on Gates proposal (but no expectation of new funds anytime soon)
- Cape Town manufacturing plant



Update from the LF Support Centre, Liverpool School of Tropical Medicine

Joan Fahy,³ GAELF Secretariat and LSTM, UK

Goal

Eliminate lymphatic filariasis (LF) as a public health problem by the year 2020

Purpose

Support Global Alliance to Eliminate Lymphatic Filariasis (GAELF) in adding value at the international and national level to the GPELF (Global Program to Eliminate Lymphatic Filariasis) based on the strategy of mass drug administration (MDA) as part of integrated effort against parasitic diseases.

Output 1 and activity

GAELF is operating as an efficient and effective global partnership.

- *Provide Secretariat to the EG [Executive Group] of the GAELF, including support and liaison to the GAELF RCG [Representative Contact Group], the local organizing committees of GAELF meetings, and the GAELF fundraising team.*

Output 2 and activities

Country-level commitment has increased, and adequate investment in LF elimination in core endemic countries has been secured.

- *Strengthen in-country advocacy capacity to understand problems linked to LF and articulate opportunities for achievement of MDGs [Millennium Development Goals] through prioritization of LF intervention linked to other parasite disease control.*
- *Participate in and organize regional seminars and programme meetings.*
- *Provide resources for MDA in core countries to increase commitment and financial leverage at the country level from the central to district level.*

Output 3 and activities

Evidence base for WHO-recommended strategy (annual, two-drug MDA) for the elimination of LF strengthened and results disseminated to demonstrate that LF could be eliminated as a public health problem.

- *Conduct operational research activities with partners in representative post-MDA settings to assess if cessation of transmission has occurred and to explore alternative, more cost-effective strategies.*
- *Maintain and develop filariaasis.net and Filaria Journal.*

Output 4 and activities

Integrated parasitic disease control interventions and micronutrient distribution are prioritized in national health plans, with commensurate resources obtained, while strengthening health systems and increasing human capacity.

- *Work with WHO and other partners to advocate, as a priority, policies at the national and international level for intensified control of parasitic diseases (lymphatic filariasis, onchocerciasis, schistosomiasis, intestinal worms, trachoma, and micronutrient deficiency), which are closely integrated into the health system.*

Funding

- Country funding in Bangladesh, Burkina Faso, Ghana, and Tanzania.
- New 5-year contract awarded (April 2005 through March 2010).

³ Unable to attend meeting(s) due to travel constraints caused by hurricanes in the Caribbean region.