

# Wrap-Up, Highlights, & Perspectives

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*Dr. Eric Ottesen, Emory Lymphatic Filariasis Support Center (LFSC)*  
*Dr. José Luis Garcés F., Ministry of Health (MoH), Costa Rica*

## **Dr. Eric Ottesen**

### **Introduction**

At the Regional Program Managers Meeting (RPMM) meeting in 2003, I called my wrap-up “the year of the happenings,” because everything seemed to be happening, starting right, and coming together. But this year I think we have “the year of realizations,” with “realization” meaning two things: actually having things completed, and becoming aware of other things we need be thinking about. I think we understand a lot more now than we did two years ago.

### **COSTA RICA**

In terms of highlighting these realizations, the focus will be on the meeting proceedings for Day 1, with the first presentation from Costa Rica, a real success story. And in these days of hearing about the threat of bird flu we need to publicize the good stories. The Ministry in Costa Rica can take pride in what they’ve done and celebrate the fact that there was an infectious disease that has been eliminated.

This success follows a long history of endemicity (defined as the period of “identification and treatment of mf-positives in the late 1970s”; see Table 1), vector control initiatives that began or were

intensified in 1987, and antigenemia confirmation of the absence of infection (see Table 2). It’s really a good story, and it’s a very clear story. So I think that was a wonderful way to start our meeting. The key is that it was emphasized from the start that there be a commitment to develop a surveillance strategy, a laboratory backup, a mechanism for reportable cases, to make ensure lymphatic filariasis (LF) stays away.

### **Achievements**

- Long endemicity
- Identification and treatment of mf-positives (1976–80)
- Vector control initiatives (intensified in 1987)
- Antigenemia confirmation of absence of infection

### **Commitment to developing surveillance strategy, laboratory back-up, reportable cases**

- Do not let this success slip away!
- Celebrate and advertise this success!

**Table 1. Distribution by area of 6,155 persons from the City of Puerto Limón, Costa Rica (1976–1980)**

Areas	Nº. of cards	Positives	
		Nº.	%
Roosevelt	406	14	3.4
Cuartel	275	3	1.1
Cementario	159	3	1.9
Pueblo Nuevo	302	5	1.7
Cristóbal Colón	743	26	3.5
Santa Eduvigés	533	12	2.2
Limón Centro	914	8	0.9
Barrio Quinto	689	7	1
Volunteers (various areas)	938	16	1.7
Census Manzanas Positives	1,196	39	3.2
TOTAL	6,155	133	2.2

**Table 2. Distribution by schools of persons examined for *W. bancrofti* antigenemia in the City of Puerto Limón (2002–2003)**

School	Area	Persons examined		
		No.	%	Results
Balvanero Vargas	Cieneguita	349	11	Negative
Tomas Guardia	Limón centro	486	16	Negative
Rafael Iglesias	Limón centro	434	14	Negative
San Marcos	Limón centro	248	8	Negative
Olimpia Trejos	Bo Trinidad	145	5	Negative
Atilia Mata	Bo San Juan	447	15	Negative
Limoncito	Limoncito	665	22	Negative
Santa Eduvigés	Santa Eduvigés	180	6	Negative
Los Lirios	Los Lirios	90	3	Negative
TOTAL		3,044	100	Negative

## DOMINICAN REPUBLIC

The Dominican Republic (DOR) program was also on target, with the mass drug administration (MDA) successfully scaled up over the years, with highly improved coverage—a great social success. The key in the DOR (see Figure 1) is what is supposed to be happening with the mf and antigenemia at the sentinel sites: The progressive expansion of the MDA in the southwest focus (see Figures 2–4); the fact that immunochromatographic testing (ICT) prevalence has fallen from 21.5% to 3% at the mid-term, and, after the two rounds of treatment, the rate of mf has dropped from 4% to 0% at the same sentinel site; and similarly impressive drops elsewhere of 36 to 10% and 14 to 0.9% (see Table 3). These accomplishments are fantastic; this is exactly what we ought to be achieving, so we should be very pleased with the program in the DOR, which is really a model of inter-institutional collaboration, particularly with the IDCP (Dermatology Institute; *Instituto Dermatológico*

*de Cirugía de la Piel*) regarding lymphedema management. And we heard more extensively how the UNAPs (Primary Health Care Units; *Unidades de Atención Primaria*) are now well-integrated and working closely with the LF program. And we know the DOR team is anxious to complete its mapping exercises (see Figure 5).

### On target!

- MDA scaled up successfully
  - Great social success
  - 80–90% coverage
- Effective decrease in mf+ and ICT+ at sentinel sites
- Model of inter-institutional collaboration
  - IDCP (lymphedema management)
  - UNAPs
- Mapping to be completed this year

Figure 1. DOR political-administrative regions

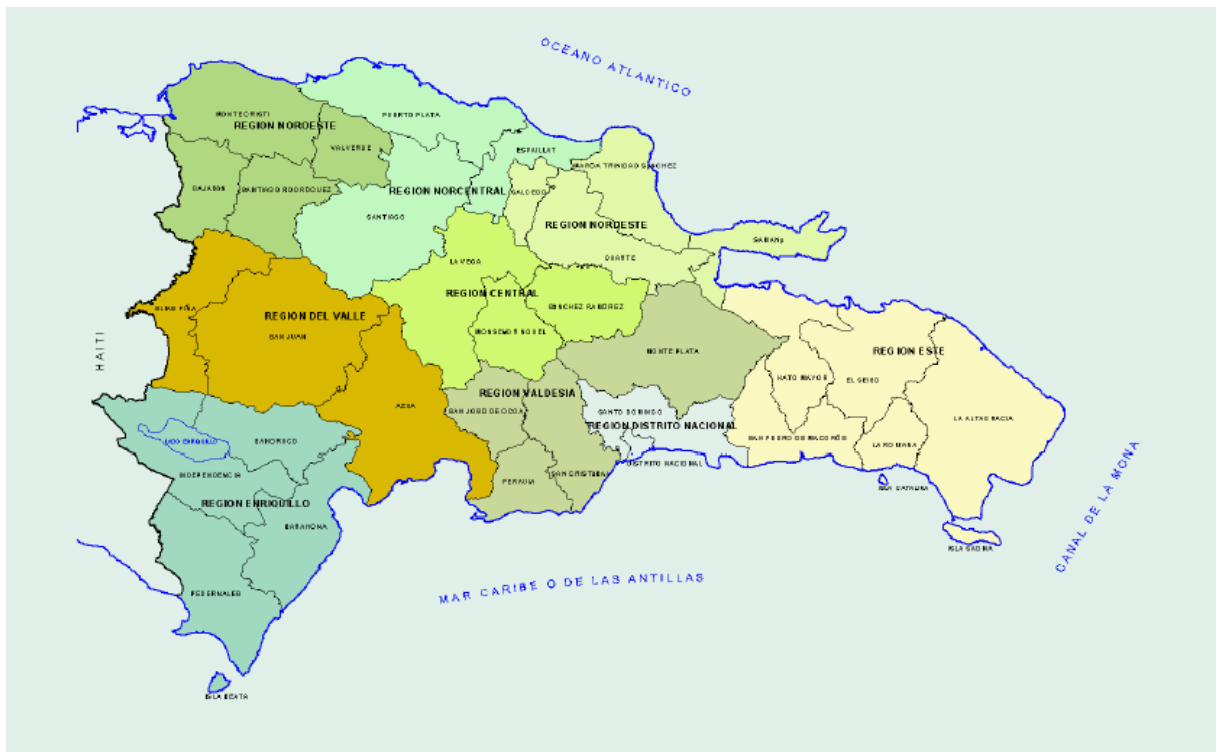


Figure 2. MDA 2002

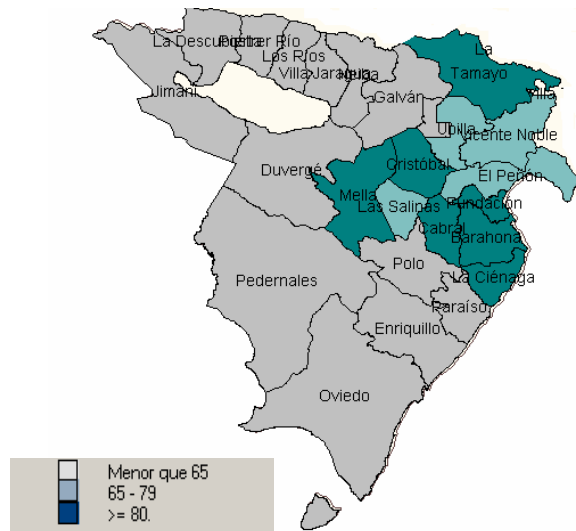


Figure 3. MDA 2003

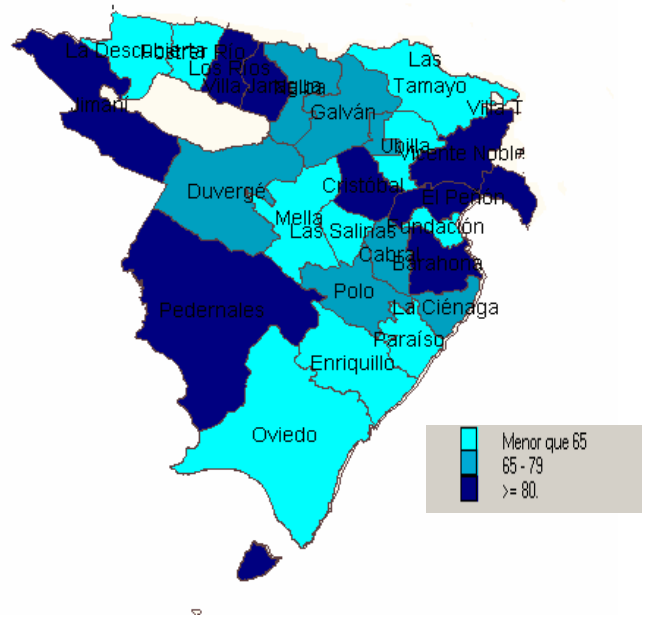
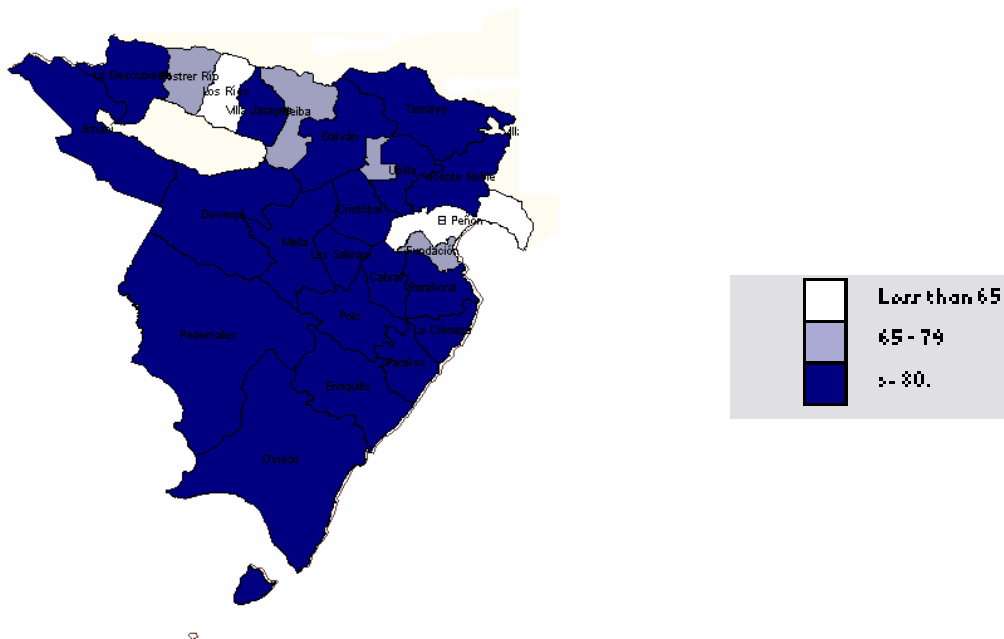


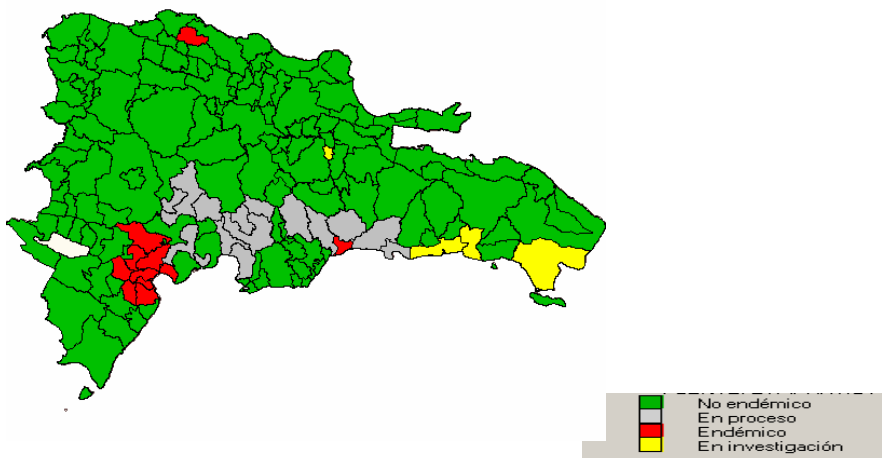
Figure 4. MDA 2004



**Table 3. Sentinel site monitoring**

Sentinel sites	2002		2004	
	ICT%	Mf%	ICT%	Mf%
Bo. Pueblo Nuevo	21.5	4	3	0.0
Batey No. 7	36	14	10	0.9
La Sombra	9.4	4	2	0.2

**Figure 5. Filariasis situation**



## **BRAZIL**

The other successes that need to be celebrated are those that have occurred in Brazil. Brazil has made some terrific achievements, functioning like a federation of independent programs under centralized guidance, an unusual situation, but one that can obviously work very effectively. The most striking data came from Maceió, where prevalence dropped to zero in 2005 (see Figure 6). This is a vast improvement since 2003. The other striking achievement was in Belém, with all the antigenemia work. The curve, which was negative in 2002 and presented in 2003 is even more firmly routed here in zero (see Figure 7). Another commendable achievement is the rapid upscaling in Recife, with total target population coverage anticipated by 2008. This program's upscaling has been increasing every year. There has also been a very strong focus on active morbidity assessment and individual health care of those affected by LF. Much of this care can be accommodated by a very strong public health services. This is a very important concept: to do a great job in the detailed assessment management of morbidity but to also try to work it into the health services system. On the other hand, one important challenge highlighted in group presentations and discussions is the need to investigate formally endemic areas, especially Salvador, in the State of Bahia, where re-occurrences seem to be identified.

- Maceió: LF eliminated
- Belém: LF eliminated
- Pernambuco: rapid upscaling (total target population coverage anticipated by 2008)
- Active morbidity assessment and individual care (provided by strong public health system)
- Need for investigation of formally endemic areas (e.g., the case of Salvador)

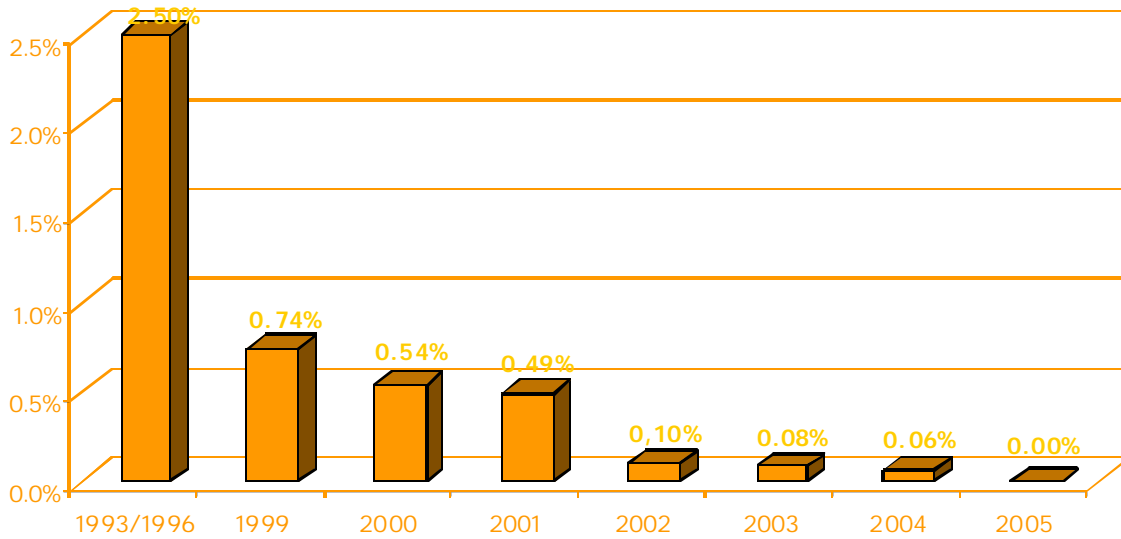
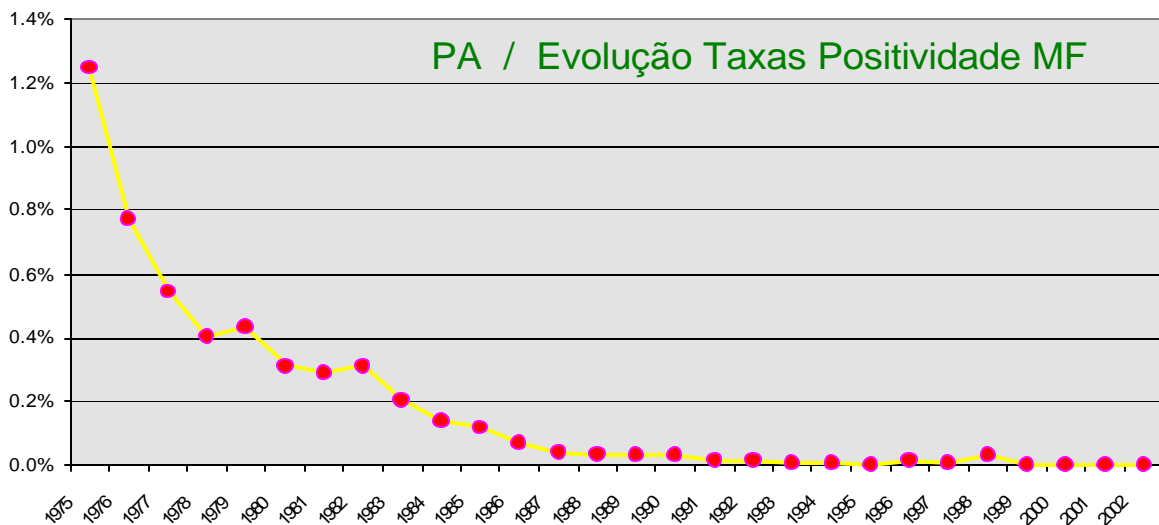


Figure 6. Microfilaria (mf) prevalence in Maceió (1993–2005)

Figure 7. Mf prevalence in Belém (1975–2002)



## HAITI

Haiti also had a good record of achievement. The MDA reached 1.2 million last year with more than 80% coverage. Mf and vector infection are progressively decreasing at the sentinel sites. The mapping is complete, and surgical facilities and other aspects of morbidity control are still very active. There have also been collateral de-worming benefits. Also, the diethylcarbamazine citrate (DEC)-salt strategy utilized in Guyana thus far may be extended and instituted (in somewhat different ways from Guyana and in limited areas).

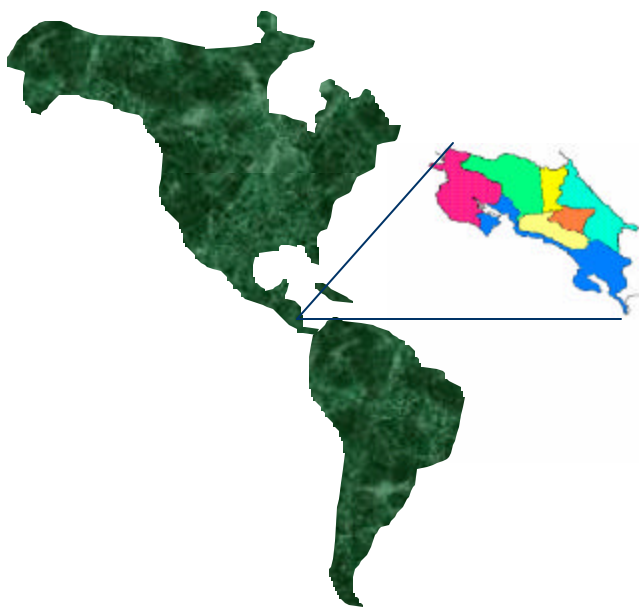
### Achievements

- Progressive program expansion
  - MDA reached 1.2 million last year—80+% coverage!
  - Mf, vector infection progressively decreasing at sentinel sites
  - Mapping complete
  - New clinics, surgical facilities, Hope Clubs opening
- Collateral “de-worming” benefits well documented
- Salt strategy to be instituted this year in limited area

## REGION

The Programs to Eliminate Lymphatic Filariasis (PELFs) in the Americas region (see Figure 8) have a great opportunity to conduct the most needed operational research. The intellectual capacity and academic support in the Americas is extraordinary. Every program in the Americas could make major contributions to the Global Program (GPELF) as well as other country programs in the region. Increased regional operational research would also present opportunities for additional funding for the Americas.

Figure 8. RPELF–Americas



### Challenges

#### *Travel constraints*

The storm prevented the participation of key program colleagues from Guyana, Haiti, Suriname, and Trinidad & Tobago, eliminating the possibility of first-hand stories from most of those countries, and from some partners from the UK and the United States.

- Guyana
- Haiti
- Suriname
- Trinidad & Tobago
- United Kingdom
- United States

## Financing

The PELFs are working, but they are starved for funds. This is a major problem. It is important to recognize how heavily the governments are contributing (Brazil, for example, is taking care of it themselves). This doesn't mean that additional funds aren't needed, because they are, but the countries are taking care of themselves. The DOR also has an increasing proportion of the funding coming straight from the government. But new strategies are needed to ensure program funding can be identified. These strategies include integrating LF in mainstream health care systems and/or packaging it with other disease-specific programs, emphasizing the public health value of the relative low-cost programs to eliminate LF (i.e., determining what other health benefits can be obtained from this relatively small investment), and documenting and emphasizing these benefits in terms of poverty reduction, improving development, etc. Different strategies would target different audience in each country—those that are potentially able to help. There is also a need to document and capture all relevant information (e.g., how healthy the people are, what has been achieved, and how much it cost) before taking the message to the donor community.

- Governments contributing heavily
- New strategies to ensure program funding must be identified, such as
  - integrating LF programs into mainstream health-care system
  - packaging LF with other disease-specific programs
  - emphasizing public health value of the relatively low-cost PELFs
  - documenting and emphasizing societal benefits of LF programs (such as poverty reduction and development facilitation), especially when integrated or packaged

## Presentation themes

### Group discussions

Groups 1, 2 and 3 looked at different ways of finding funds, strategies for morbidity control, and issues of verifying elimination.

- Funds-finding conclusions
- Morbidity control conclusions
- Verifying elimination conclusions

### Partner updates

Partner presentations included those about GlaxoSmithKline (GSK) and the Windward Islands Research & Education Foundation (WINDREF), some technical achievements, the Global Program update, integration opportunities, *HealthMapper* applications, and the story of the Belém LF elimination. Successes such as these should be written up and well advertised.

- GSK
- WINDREF
- Global Program update
- Integration opportunities
- *HealthMapper* use
- LF elimination in Belém

### Other scheduled activities

- Official recognition of program success presented to Ministries of
  - Costa Rica
  - Suriname
  - Trinidad & Tobago
- Next year's RPMM / Regional Program Review Group (RPRG) meetings to be held in Trinidad & Tobago

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The Secretariat thanked Dr. Ottesen for his wrap-up of meeting activities.

## Perspectives

### *Dr. José Luis Garcés*

I reiterate the words of the Secretariat, congratulating Dr. Ottesen for synthesizing the meeting content. In mentioning the benefits and overall advances of country programs, hopefully in the next one, two, or three years we will be celebrating with the rest of the countries or states that have concluded or fulfilled all the procedures to demonstrate interruption of lymphatic filariasis (LF).

We should not forget the questions posed by Dr. Pou regarding morbidity criteria (or the lack thereof): How are we going to define them? And how are we going to identify what represents a case of LF? For example, we know that there are many different etiologies for lymphedema. We must also focus on the clinical component to ensure that the people with the greatest experience in the programs where there is active transmission are assisting with the project management, the handling of medicine, the care of the ill, etc. These professionals can provide a good source of knowledge for the morbidity definitions.

On the other side, we must address the issue of monitoring. While there have been many congratulations about the monitoring conducted this far, the question remains: How are we going to continue doing it? In the case of Costa Rica, and possibly Suriname, Trinidad & Tobago, and Belém, Brazil, there is some uncertainty as to how to proceed. What are we going to do to guarantee that there is no reintroduction of transmission? This is where the monitoring becomes more and more important. As Dr. Ault suggested in the meeting discussions, we should consider using the SIGEPI (System of Information for Geographic Epidemiological Evaluation) program, which is versatile, multi-faceted, and easily accessible. This is already being used in the malaria program, and in an area of the Pacific in the dengue program, and it is working. The program has a significant number of features that are valuable for the analysis of epidemiological information.

Finally, what we need to do more than anything else is to resolve the challenges of financing. As mentioned, these programs are relatively simple, and cheap, but they are not free. The lack of available funding is becoming more and more important, especially as countries advance in their mass drug administration (MDA) and diethylcarbamazine citrate (DEC)-salt programs. And we are going to have problems (e.g., in the case of Haiti) if we do not identify ways to finance these programs. I think we must all make an enormous effort to try to resolve this. I don't want to comment on this in any more detail, because it has been discussed at length at this meeting, so we are all conscious of the challenge that we face in the area of resources. And this year's discussions were, at least for me, some of the more fruitful regarding various advances already occurring in some of the countries to become more self-sufficient in the area of financing, such as the states of Brazil.