



Current (2005) WHO Guidelines for Monitoring & Epidemiological Assessment of the PELFs at the Implementation Level

Patrick Lammie, Centers for Disease Control and Prevention (CDC)/Atlanta

Overview

The new monitoring and evaluation (M&E) guidelines developed by the World Health Organization (WHO) for the Programs to Eliminate Lymphatic Filariasis (PELFs) have an increased emphasis on coverage surveys and how to conduct them (e.g., they include very specific instructions for conducting cluster surveys). They also include a different procedure for stopping mass drug administration (MDA) (see Figure 1), which should be reviewed by all PELFs. The content of these updated guidelines is a work in progress, however, so they will change over time. This is very important, especially for the people in the Americas region, where the use of new tools is crucial. The key for programs in the Americas region is to apply these new tools, learn from their use, and share the information so the guidelines can be adapted accordingly. One major omission in the guidelines is the lack of any information on surveillance. So it is absolutely critical to apply any new tools in a way that allows surveillance to be conducted in a more meaningful way.

Issues

- Need for high coverage to interrupt transmission
- Importance of understanding patterns of compliance
 - Persistent reservoir of infection created by noncompliant persons

M&E

- New guidelines
 - Provide detailed instructions for cluster surveys

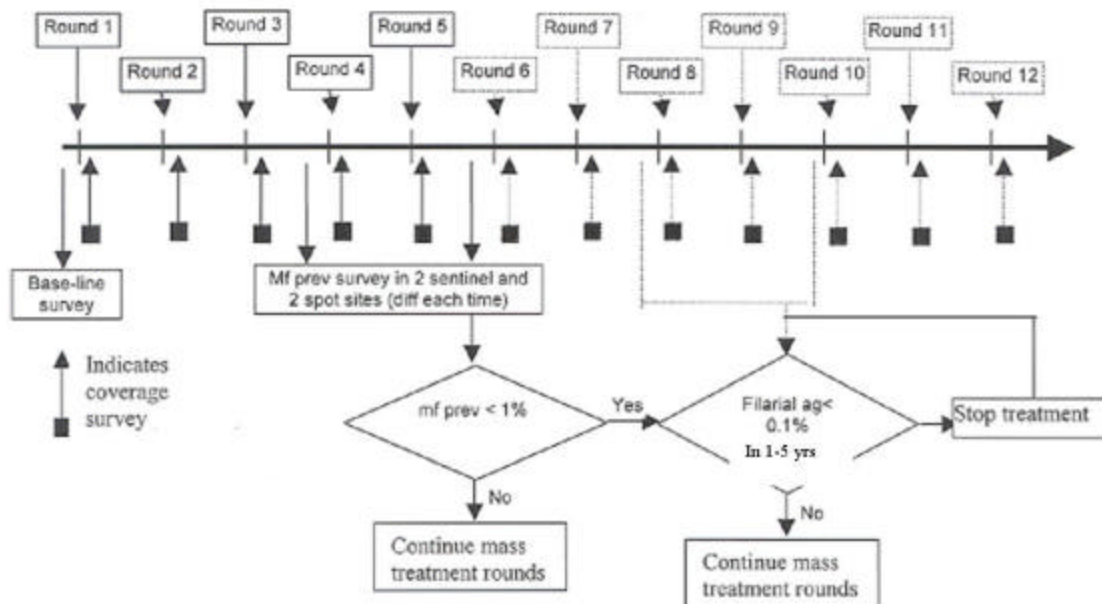
Impact assessment

- New tools
 - antigenemia
 - antibody responses
 - vector infection

Recommendations

- PELF staff should learn how to apply impact assessment tools in program settings.
 - PELF scientists and programs are excellent and should contribute their skills.
 - The Americas region should lead the effort.

Figure 1. Stopping MDA (previous PMG meeting)



New approaches to stopping MDA

• Intermediate Steps

- Provide quicker, cheaper, alternative strategies to identify any persistent infection and to avoid stopping MDA too soon.
 - Steps initiated early enough to be completed in time to avoid the 6th round¹ of MDA if no persistent infection is found

• Summary Steps

- Changes/additions
 - Mf prevalence survey (~500 people) at sentinel sites (2) and spot-check sites (2) in each implementation unit (IU) (just prior to 5th MDA)
 - If >1% mf prevalence, continue MDA
 - If <1% mf prevalence, proceed toward stopping MDA
 - ✓ Minimizes suppressive effect of last round (4th MDA) on mf levels
 - Immunochromatographic testing (ICT) of 2–4 year olds at same sites at same time
 - Provides additional information before going immediately to large costly sample
 - Easy to add testing of 2–4 year-olds, and any positives² should raise concern

¹ “rounds of MDA” refers to the years during which coverage was thought sufficient to stop transmission.

² All “positive” ICT cards must be “true positives” (an algorithm is available to assist in evaluating rare positives).

- Test 5–10 additional high-risk sites in the same fashion
 - for mf prevalence in adults/older children
 - ✓ if >1%, continue MDA
 - ✓ if <1%, proceed toward stopping
 - for ICT prevalence in children (2–4 year-olds)
 - ✓ if positives, explore implications
 - *Provides an intermediate, less expensive (than LQA³) step for detecting areas most likely to have persistent transmission*
- Following 5th MDA round, perform LQA-cluster ICT survey of 300 children 2–4 years old in high-risk areas⁴
 - If no positives (i.e., <1% prevalence), proceed toward stopping MDA
 - If positives, explore the implications
 - ✓ This additional intermediate step presumes that with program success, 2–4 year-olds will not have been exposed and thus should be ICT-negative
- Current PMG
 - Conduct LQA survey for ICT positivity in 3,000 school *entrants* representative of the entire IU
 - If positives are not found, stop MDA
 - If positives are found
 - ✓ carry out 6th round of MDA
 - ✓ repeat LQA school entrants survey following 6th round

Conclusions

- These guidelines are a “best guess” and will be modified based on experience.
- Guidelines still need to be developed for surveillance.

Better tools make better guidelines.

³ Lot Quality Assurance

⁴ To ensure the accuracy of the LQA model, sampling requires random selection of children.