**Lessons Learned in LF Dossier Development Webinar: March 2026**

*Frequently Asked Questions*

Impact Assessments

- *Q: If MDA has been suspended for a year or two due to budget problems or the security situation, and I want to resume them, what do you advise? Should previous rounds before the stop be counted?*
  A: Yes. The prior rounds can be counted. EMS can be planned to monitor the epidemiological situation as warranted when the total number of MDA rounds with effective coverage has been met.

- *Q: What is the difference between transmission assessment surveys (TAS), IDA impact surveys (IIS), and impact surveys?*
  A: We use the term impact surveys when referring to the surveys used in the 2-step strategy to determine when MDA can stop. This is now the EMS plus either the TAS, in areas using one- or two-drug regimens, or IIS, in areas using the IDA drug regimen.

- *Q: Do programmes need to conduct TAS3 or IIS3 first before submitting a dossier?*
  A: The WHO guidance on post-MDA surveillance is to complete two successive TAS/IIS every 2 years after stopping MDA. Ideally, programmes can implement a TAS2/IIS2, two years after stopping MDA followed by a TAS3/IIS3 conducted two years after passing TAS2. This ensures close monitoring of infection since MDA has stopped. In this scenario, TAS3/IIS3 provides the evidence documenting that infection remains below target thresholds 4 or more years after stopping MDA. All endemic evaluation units (EUs) in the country must meet this requirement for validation.

  In some exceptional circumstances, programmes may have been unable to implement TAS2/IIS2 within the recommended time period for various reasons such as COVID or insecurity. In this case, if the second TAS/IIS is implemented no sooner than 4 years since MDA stopped, this second TAS/IIS effectively serves the purpose of the TAS3/IIS3. Therefore, for such exceptional EUs, the validation criterion is documented with only the one post-MDA TAS/IIS.

- *Q: If you wait more than 4 years to conduct a TAS2, can it count as a TAS3 instead?*
  A: In some exceptional circumstances, programmes may have been unable to implement TAS2/IIS2 within the recommended time period for various reasons. In this case, if the second TAS/IIS is implemented no sooner than 4 years since MDA stopped, this second TAS/IIS effectively serves the purpose of the TAS3/IIS3. Therefore, for such exceptional EUs, the validation criterion is documented with only the one post-MDA TAS/IIS.

- Q: *Are there WHO recommendations for integrating other infection prevalence protocols into a* TAS?
  A: WHO has guidance on how to integrate soil-transmitted helminthiases (STH) surveys with TAS and a newly published manual on how to integrate onchocerciasis surveys with TAS. This guidance provides a new baseline for these NTDs if LF MDA stops and helps with making treatment decisions.

- *Q: Why did Uganda carry out remapping in certain districts?*
  A: Uganda carried out remapping in districts that met the one of the following criteria: i) had reported clinical cases, ii) had borderline antigenemia rapid test results (0.8-0.99% positive) in the original mapping, or iii) had been redistricted into areas without original mapping/sentinel sites.

Morbidity management and disability prevention (MMDP)

- *Q: What tools are available to estimate the number of lymphoedema and hydrocele patients?*
  A: Annex 5 of the WHO Situation Analysis Tool for MMDP includes a list of various methodologies for estimating patients.

- *Q: What is the unit cost of hydrocele surgery? How are programmes managing hernia co-morbidity?*
  A: Sawers et al (2020) found the budgetary cost of hydrocele surgery in Malawi to be US$68; previously reported costs have ranged from US$80-$360. In 2016, Togo evaluated the average cost to be $204. Hydrocele surgery is one of the essential surgical procedures that should be available at the district hospital and part of routine health delivery. Whenever possible, hydrocelectomy should be referred to these facilities which would be able to manage hernia. Provision of hydrocelectomy is the responsibility of health care system. The NTD programme should document the availability of surgery for hydrocele in the dossier and advocate with the appropriate department to ensure hydrocele and hernia surgery are integral components of primary health care.

- *Q: How did Uganda manage the co-endemicity of podoconiosis with LF in the dossier MMDP data?*
  A: Podoconiosis mapping was just completed in Uganda and only a few districts have an overlap with LF. Only LF-related lymphoedema cases will be included in the dossier. However, training on lymphoedema management can also apply to podoconiosis management.

- *Q: What is the best technique for estimating for MMDP in countries for Brugia spp., since there are fewer lymphoedema patients than in countries endemic for Wuchereria bancrofti?*
  A: Annex 5 of the WHO Situation Analysis Tool for MMDP includes a list of various methodologies for estimating patients. Countries with robust health management information systems that include indicators for lymphoedema could use those estimates as a data source.

- *Q: When should you implement the direct inspection protocol (DIP) to assess quality of lymphoedema services?*

A: Ideally, the DIP should be implemented 2 years before the dossier submission to include how any gaps in services were addressed. However, if the DIP is being implemented after TAS3 are complete, it should not delay dossier submission and the measures for addressing the gaps should be included in the dossier.

- *Q: What if a programme implemented the direct inspection protocol (DIP) more than two years before dossier submission?*
  A: This is not a problem. You should present what has been done to address the gaps since the assessment. Some validated countries implemented the DIP post-validation to continue to improve the quality of care available to persons that remain with lymphoedema.

- *Q: Do you need to include in the dossier the evidence that gaps in quality MMDP services have been filled?*
  A: If you have that evidence, it should be included in the dossier. You can also report what measures you have planned to address the gaps.

- *Q: When reporting the estimated number of individuals with hydrocele and lymphoedema in the dossier, should the estimated number include individuals who have had hydrocelectomy, or just the number of people still waiting to have a hydrocelectomy done?*
  A: The estimated number of patients should include all hydrocele patients. You can also report in the narrative the number of patients that have had hydrocele surgery and the remaining backlog.

Post-validation surveillance (PVS)

- *Q: Are rapid diagnostic tests such as FTS or QFAT available to programmes for PVS?*
  A: The tests are commercially available if countries are able to procure them. From WHO, the priority for providing tests is to countries that still need to complete EMS/TAS/IIS or remapping. In certain cases where a country is trying to pilot or establish PVS, WHO can consider providing limited amounts of tests.

- *Q: What mechanisms can be planned for post-validation surveillance (PVS) to prevent reintroduction of transmission?*
  A: In Chapter 10 of the 2025 WHO manual on monitoring and epidemiological assessment of lymphatic filariasis, WHO provides guidance on the platforms to be used for post-validation surveillance. These platforms include i) health facility screening, ii) integration with standardized surveys, iii) molecular xenomonitoring, and iv) targeted surveys. WHO is about to launch a planning toolkit entitled "Integrated post-validation and post-verification surveillance for neglected tropical diseases" to help determine where to prioritize areas for PVS.

- *Q: What are the elements of entomological surveillance?*
  A: In Chapter 10 of the 2025 WHO manual on monitoring and epidemiological assessment of lymphatic filariasis, WHO provides details about molecular xenomonitoring, the direct assessment of parasites in vector mosquitoes by PCR techniques, and required responses.

- *Q: How did the Togo programme decide where and when to implement testing of people migrating seasonally?*
  A: The first step was collecting information about migrating populations with the local health staff such as NTD focal point support in each endemic district. The second step was to conduct a risk assessment to identify the population with high risk and how to access them, and the final step was to schedule your field investigation.

- *Q: Has Uganda identified a post-validation monitoring framework and started implementing it as recommended?*
  A: Not yet, but national LF programme has begun discussions with the malaria programme about integrated xenomonitoring and has started training lab technicians in microscopy in preparation for health facility screening.

Dossier content and template

- *Q: Is there space to discuss cross-border situations in the dossier narrative template?*
  A: Yes. This information can be added in section 2.2. regional context or section 7. Special issues.

- *Q: For countries that went through the dossier development process, what are some of the recommendations you would give to those countries who are planning to start this process soon? I would particularly like to know about any challenges around the identification, collection, and analysis of the data that provides a full picture of your elimination journey.*
  A: The data are scattered in different files and formats. It is very challenging to access and arrange all the data systematically. So data access and arrangement are very important. Also, hardly any documents are available on implementation processes and there is often turn-over of NTD program staff, so documenting MDA and survey implementation while these activities are ongoing is important.

- *Q: What measures did you take to ensure accuracy and completeness of data reported?*
  A: In Togo, most of the interventions were undertaken with research institutions and resulted were published in medical journals, thus those were used as the most accurate source. In programmes supported by Dr Ramaiah, they focused on completeness by first developing a matrix of MDA and various surveys (baseline, mid-term, pre-TAS, TAS and PVS) by IU/EU and year. Then for each IU/EU and for each year, data was accessed and compiled. For accuracy, if there were variations in the data compiled from multiple sources or multiple data points, the data were compared with the reports submitted to WHO or the data in WHO PCT databank and then the data were finalized. If any data were found to be missing or have unresolvable data points (which was rare), this was noted in the dossier narrative document.

Dossier submission and review process

- *Q: Do you need a national committee to approve the dossier?*
  A: It is not required. However, a national committee could be very helpful in a first technical review of a draft dossier. Some countries have established committees and require a national 'approval' before submitting to WHO.

- *Q: What is the flow to submit the dossier draft for informal review?*
  A: National programmes can submit the dossier to the WHO country office, who will liaise with the WHO NTD staff at regional level and Geneva for informal review. This is not a mandatory step. It is intended to help programmes who may be concerned that not enough evidence is available. The advantages are that this is an informal, no-stress, pre-review to assist programmes. The dossier does not have to be perfect and the information review can identify items that may need strengthening. Having a pre-review also increases probability that no issues will be found during the official review by the regional dossier review groups.

- *Q: How long did it take for the review of dossiers once submitted to WHO?*
  A: It depends upon region and if WHO has advance notice that a dossier will be submitted. Once the dossier review committee is convened, it usually takes 6-8 weeks.

- *Q: Will you be sharing examples of successful dossiers?*
  A: Some executive summaries of dossiers have been published in scientific literature. Programmes can send requests to their focal point at Regional Offices to request copies of validated dossiers.

- *Q: When a disease has been declared eliminated, it is often difficult to maintain the efforts of staff and partners; how is this challenge addressed at all levels (country, AFRO)?*
  A: This challenge is important. At country-level, advocacy within the Ministry of Health to help other departments understand post-validation surveillance and sustainable clinical care needs and find resources should begin early. In addition, NTD can design innovative and integrated activities using other endemic NTDs or health programmes such as malaria as a platform for interventions, particularly with support from operational research. Advocacy and collaboration with research institutions, universities, and local non-governmental organizations can also help address this issue.