

## TEMPLATE FOR THE DOSSIER DOCUMENTING ELIMINATION OF LYMPHATIC FILARIASIS AS A PUBLIC HEALTH PROBLEM

This template was designed to help managers of national lymphatic filariasis programmes prepare a dossier with supporting evidence for presentation to WHO, requesting validation that lymphatic filariasis has been eliminated as a public health problem. The information presented in the dossier will provide the context necessary to help reviewers understand programme achievements and supporting epidemiological evidence. However, the minimum information necessary to support the claim of elimination as a public health problem include the following elements:

1. Description and supporting data of how endemic and non-endemic areas were classified as such;
2. Interventions implemented to combat lymphatic filariasis; data of the interventions (treated population, coverage, etc.)
3. Monitoring data of the conducted interventions, including microfilaraemia and/or antigenaemia at the sentinel and spot-check sites
4. Results from stop-mass drug administration (MDA) and surveillance surveys from endemic areas;
5. Reported and/or estimated number of patients with lymphoedema and (in *Wuchereria bancrofti* areas) hydrocele;
6. Data indicating availability and provision of the essential recommended package of care to manage patients with lymphoedema or hydrocele.

## 1. BACKGROUND

### 1.1 DEMOGRAPHIC AND DEVELOPMENT CONTEXT (OPTIONAL)

- *In narrative form*, summarize (1–2 pages) the overall demographic and economic features of the country, referencing the population census, Demographic and Health Survey and other relevant documents.
  - Where possible, provide indicators and/or maps on poverty, development, and household access to water and sanitation in both rural and urban areas.
  - Define and quantify the administrative units in the country and explain the related health structure (total number of states, districts, etc.; State Health Bureau, District Health office).
  
- Complete the Excel dossier data annex.

### 1.2 HEALTH SYSTEM (OPTIONAL)

- *In narrative form*, provide a brief (up to 1 page) overview of the health system, including the following:
  - Health system structure including the delivery of primary healthcare services
  - Major infectious diseases, neglected tropical diseases (NTDs) and any chronic diseases prevalent in the country relevant to the lymphatic filariasis (LF) elimination programme

### 1.3 LF PROGRAMME OVERVIEW (REQUIRED)

#### BACKGROUND EPIDEMIOLOGICAL INFORMATION

- *In narrative form*, describe the LF programme in the country including the following (please reference relevant publications):
  - Historical documentation of the disease
    - parasite species. For areas with *Brugia malayi*, discuss evidence (or lack of) for reservoir hosts for filariasis
    - description of LF vectors in the country including vector breeding habits, resting and biting behaviour, abundance and vector efficiency. If available, information on transmission levels (annual transmission potentials, vector infection and infectivity rates, etc.) may be included
    - historical evidence of clinical cases, including geographical distribution
    - co-endemicity with onchocerciasis, including maps
  - Any interventions against LF prior to launch of current national programme

#### LF PROGRAMME STRUCTURE

- *In narrative form*, describe the LF programme in the country including the following:
  - National programme goals and objectives, and dates of programme establishment
  - Organizational chart and responsibilities
    - for planning and implementation of MDA, supervision of the programme, and response to serious adverse events
    - include the organizational chart for morbidity management and disability prevention (MMDP) activities
  - How the LF programme is integrated/coordinated with NTD programmes or other health programmes, if any integration/coordination is conducted

- The data collection and management system used by the programme, including how MDA, integrated vector management, MMDP and other data and information are reported and transmitted from community to national level

## 2. DELINEATION OF ENDEMICITY

### 2.1 DATA USED TO CLASSIFY IMPLEMENTATION UNITS AS ENDEMIC OR NON-ENDEMIC (REQUIRED)

- Insert maps of endemicity, differentiating the areas that were determined to be endemic (needing MDA) and non-endemic (not needing MDA)
- *In narrative form*, describe:
  - The implementation unit (IU) used in the country and, if different, the geographical unit used for mapping; include the following information:
    - the total number of IUs (endemic and non-endemic) at the start of the programme
    - the current number of IUs and a description of any change in the total number since the start of the programme, e.g. due to redistricting
  - Methodology followed to determine endemicity or non-endemicity, e.g., confirmatory mapping protocol, including:
    - age group(s) sampled
    - target sample size
    - how sites were selected
    - how participants were selected, e.g. all residents, random selection of households, convenience sample at community gathering point
    - diagnostic methods used
  - Procedures for training field teams
  - Quality control
  - Supervision
  - Response to positive results
  - Issues encountered during implementation of surveys that may have affected methods or results, e.g., difficulties reaching sample size, insecure areas that were unable to be sampled
  - If the endemicity status of certain IUs was reassessed during the programme, please describe why and how the IUs were reassessed
- Complete the Excel dossier data annex.

### 2.2 REGIONAL CONTEXT (OPTIONAL)

- *In narrative form*, briefly describe the occurrence of LF and the current status of LF elimination efforts in neighbouring countries and whether neighbouring countries are considered a risk to the achievements of the national programme.
  - Data can be found in the PCT databank (<https://www.who.int/teams/control-of-neglected-tropical-diseases/data-platforms/pct-databank> )
- If possible, include the status of LF in surrounding countries on the endemicity map (see section 2.1)



### 3.2 SUPPLEMENTAL INTERVENTIONS (REQUIRED)

- *In narrative form*, summarize any supplemental interventions that could have affected the transmission of LF.
  - Integrated vector management efforts carried out by the LF programme or other programmes, e.g. malaria, including:
    - activities conducted
    - estimated coverage of interventions (if available)
  - Environmental or economic improvements
  - Screening, testing and treating positive cases of microfilaraemia or antigenaemia outside of MDA, including test-and-treat activities
  - Preventive chemotherapy for soil-transmitted helminth infections or onchocerciasis:
    - type of medicines distributed
    - years of implementation
    - target age group
    - whether the intervention is expected to continue in the future
  - Distribution of DEC-fortified salt

## 4. EPIDEMIOLOGICAL MONITORING AND EVALUATION OF INTERVENTIONS

### 4.1 SENTINEL AND SPOT-CHECK SITES (REQUIRED)

- *In narrative form*, summarize sentinel site (SS) and spot-check site (SC) assessments including a detailed description of:
  - Composition and population size of EUs
  - Ratio of SS and SC per evaluation unit (EU) and per population
  - Map of the distribution of the SS and SC in the EUs, if available
  - Methodology followed, e.g., pre-transmission assessment survey (pre-TAS) or epidemiological monitoring survey (EMS), including:
    - age group(s) sampled
    - target sample size
    - how sites were selected
    - how participants were selected, e.g. all residents, random selection of households, convenience sample at community gathering point
    - diagnostic methods used
  - Procedures for training field teams
  - Quality control
  - Supervision
  - Response to positive results
  - Issues encountered during implementation of surveys that may have affected methods or results, e.g., difficulties reaching sample size, insecure areas that were unable to be sampled
- *Insert a table* in the narrative with data from EUs with SS and SC assessments with results over threshold.
- Complete the Excel dossier data annex providing sentinel and spot-check site information.

## 4.2 SURVEYS FOR STOPPING MDA (REQUIRED)

- *In narrative form*, summarize the epidemiological surveys implemented to decide whether to stop MDA (reference any publications), including a detailed description of:
  - Composition and population size of EU (if different than 4.1)
  - Methodology followed, e.g., transmission assessment surveys (TAS), IDA impact surveys (IIS), PacELF C surveys, including:
    - age group(s) sampled
    - target sample size
    - how sites (communities/schools) were selected
    - how participants were selected
    - diagnostic methods used
  - Procedures for training field teams
  - Quality control
  - Supervision
  - Response to positive results
  - Response in EUs that did not “pass” TAS or other epidemiological surveys
  - Issues encountered during implementation of surveys that may have affected methods or results, e.g., difficulties reaching sample size, insecure areas that were unable to be sampled
  
- *Insert a table* in the narrative with results of targeted treatment from clusters with positives in TAS1 or IIS1 (if applicable) including geographical area covered, population denominator, population treated and coverage. *In narrative form*, briefly explain:
  - Medicine used
  - Distribution strategies
    - when, who and how delivered
    - directly observed
    - supervision structure
  - Eligible population
  - Social mobilization strategy implemented
  - Training
  
- Complete the Excel dossier data annex with data from stopping-MDA surveys.

## 5. SURVEILLANCE

### 5.1 CROSS SECTIONAL SURVEYS, INCLUDING POST-MDA TAS (REQUIRED)

- *In narrative form*, summarize the epidemiological surveys implemented during post-MDA surveillance that determine infection levels remain below elimination targets including the following information:
  - Description of the methods TAS, IIS or other
    - clearly indicate whether the same methods were used for stopping MDA surveys
    - note any differences in age group sampled, site or participant selection, or diagnostic tools used
  - Protocol for response to each positive case identified
  - Description of positive cases (age range, gender, ethnic group, residence history, etc., to help determine whether cases were local or imported)
  
- *Insert a table* in the narrative with data from EUs with surveillance surveys with results over threshold.
  
- *Insert a table* in the narrative with results of targeted treatment in clusters with positives in TAS2-3 or IIS2-3 (if applicable) including geographical area covered, population denominator, population treated and coverage. *In narrative form*, briefly explain:
  - Medicine used
  - Distribution strategies
    - when, who and how delivered
    - directly observed
    - supervision structure
  - Eligible population
  - Social mobilization strategy implemented
  - Training
  
- *In the narrative*, if targeted treatment was implemented after TAS3 or IIS3, briefly describe the surveys conducted after the second round of targeted treatment, including:
  - Age group sampled
  - How participants were selected
  - Diagnostic methods used
  - Quality control
  
- Complete the Excel dossier data annex with surveillance survey, e.g. TAS2 and TAS3, data.

### 5.2 ONGOING SURVEILLANCE (REQUIRED)

- Summarize any ongoing surveillance activities, including a description of the following:
  - When (frequency), where (endemic and non-endemic IUs, geographical distribution of tested persons), who (teams/technician and target population) and how (sample selection, assay performed/indicator) data are collected
  - Response to positive cases identified
  - Profile of positive cases (age range, gender, ethnic group, residence history, etc., to help determine whether cases were local or imported)

- Describe national programme commitment to sustain surveillance activities post validation, including:
  - o Which platforms are being or planned to be used (health facility screening, standardized surveys, molecular xenomonitoring, and/or surveys targeted to high-risk areas or high-risk groups)
  - o What diagnostic tests are being or planned to be used
  - o How frequent the surveillance activities are being or planned to be conducted
  - o Who is responsible for conducting post-validation surveillance activities
  - o Who is responsible for responding to signals in post-validation surveillance activities
- Attach any surveillance reports with the detailed description of the surveillance activities and positive cases in the annex.

### 5.3 ENTOMOLOGICAL MONITORING (OPTIONAL)

- *In narrative form*, summarize entomological monitoring activities that occurred to look for evidence of infection in vectors, including answering the following questions:
  - o Who had responsibility for implementing entomological monitoring? From what level were these activities managed and/or coordinated?
  - o How were sites picked?
  - o What sampling methods were used, e.g. traps, human biting?
  - o (If applicable), what species of mosquito were included?
  - o What methodology was used, e.g. dissection, PCR, L3 PCR, etc.?
  - o Which indicators were monitored, e.g. vector infection/infectivity rate, monthly/annual transmission potential, etc.?
  - o How were the results used?
- If applicable, attach entomological monitoring reports with the detailed description of the surveillance activities, the indicators monitored and interpretation of the results in the annex.

## 6. MORBIDITY MANAGEMENT AND DISABILITY PREVENTION (MMDP)

### 6.1 DATA ON NUMBER OF PATIENTS WITH LYMPHOEDEMA OR HYDROCELE (REQUIRED)

- *In narrative form*, briefly describe the methodology used to identify the number of patients with lymphoedema and hydrocele, including year of estimates.
- If possible, include a map showing prevalence of filarial clinical disease by clinical condition. Depending on burden, this could be just those IUs with cases and those IUs without cases, or IUs could be grouped by number of cases. Such information could be combined with the map showing endemicity status of IUs in section 2.1.
- Complete the Excel dossier data annex presenting the number of patients.

### 6.2 AVAILABILITY OF TREATMENT FOR LYMPHOEDEMA AND HYDROCELE (REQUIRED)

- *In narrative form*, summarize existing data related to readiness of health facilities to provide quality treatment for lymphoedema and hydrocele, including the following:
  - o Description of where lymphoedema and adenolymphangitis (ADL) services are provided within the health system:

- number of designated health facilities providing services for lymphoedema and ADL (*minimum recommended 1 per IU with known patients.*)
- Description of where hydrocelectomies are provided within the health system:
  - number of health facilities providing hydrocelectomies (*each IU with known cases should be served by at least 1 facility*)
- Methods used to collect data on number of facilities providing services
- Number of facilities surveyed to assess quality of care for lymphoedema and ADL management and/or hydrocelectomy (*Assessment of at least 10% of designated facilities providing each service [lymphoedema management or hydrocelectomy] nationwide is preferred*)
- Methods used to collect data on quality of care
- Results of the assessments and planned programme response:
  - if using direct inspection protocol, include average scores per health facility and per indicator

**Table 6.1. National overview of facilities providing morbidity management and disability prevention services**

Indicator	Lymphoedema/ADL	Hydrocele
Number of IUs with known patients		
Number of IUs with no known patients		
Number of IUs with at least 1 facility designated to provide recommended basic package of care		
Number of patients		
Number of health facilities providing service		
Number of health facilities surveyed to assess quality of care		

- Complete the Excel dossier data annex with number of designated facilities providing services per IU.

## 7. SPECIAL ISSUES (OPTIONAL)

- *In narrative form*, please provide the following:
  - Description of any special circumstances that have affected the implementation, monitoring and evaluation of the programme. This could include, but is not limited to, the following:
    - stability or security issues in the country
    - immigration from LF-endemic countries
  - Description of any effort to investigate infections and/or intervention coverage in difficult-to-reach populations (i.e. nomadic populations or seasonal workers).

## 8. RESOURCES AND PARTNERSHIPS (OPTIONAL)

- *In narrative form*, briefly describe the human resources involved in implementing the programme and estimate the financial resources utilized.
- Complete the following table to describe the partnerships of the national programme:

**Table 8.1. Role of partners in the national programme**

Partner name	Activities supported	Geographical area of support
<i>e.g. WHO</i>	<i>Financial and technical assistance for TAS</i>	<i>Region A</i>

## 9. BIBLIOGRAPHY (REQUIRED)

- Include a bibliography of all data sources used to develop this dossier, including:
  - o Ministry of Health records
  - o published studies
  - o academic theses and dissertations
  - o other
- Notate the key articles and reports. These should be kept on file in the national programme office.

## 10. ABBREVIATIONS (OPTIONAL)

- Provide a list of definitions for all abbreviations used in the dossier.