The exchange of information and experience together with the combined strength of many nations of the world backed by technical and financial support from WHO, other UN agencies and the Global Alliance would help take a giant step forward towards the goal of elimination of lymphatic filariasis, said Dr Agarwal. He too was conscious of the responsibility that India has in achieving this goal.

The available data collected over a period of several decades confirm that filariasis is a major public health problem in India. Traditionally, surveys of night blood smears are carried out in limited pockets in a district. Estimates prepared on the basis of these data are, however, not so easy to interpret. A district in India has on an average a population of around 1.5 to 2 million. Each district has urban, periurban and rural areas with vastly differing standards of sanitation and other risk factors.

Extrapolating the results to the whole population of a district, which is currently being done, could lead to vastly exaggerated estimated numbers of patients with chronic disease and microfilaria carriers. Are the numbers quoted in relation to India acceptable? Are there approximately 23 million patients and 31 million carriers with 473 million living in at-risk areas, or are the numbers one-half or even one-third of these estimates? There is an urgent need to explore ways and means of obtaining more accurate estimates.

Developing diagnostic tools which are specific, sensitive, easy to use and affordable is the greatest need of the hour. Conventional methods of collection of night blood smears for the detection of microfilariae are still used. The procedure is time-consuming, tedious, and requires home visits at an inconvenient time.
The Director-General urged the Global Alliance and scientists from the ICMR to flag this as a problem area needing urgent resolution.

THE PAST AND THE PRESENT AND THE FUTURE

India established the National Filariasis Control Programme (NFCP) in 1955. The objectives of NFCP were to:

- Map affected districts
- Implement control measures in the affected districts
- Conduct training programmes for human resource development.

Currently 206 control units, 198 filaria clinics and 27 survey teams are functioning under NFCP. The filaria control units have different categories of health personnel. The survey units have been actively engaged in conducting night blood surveys, although because of the large number of districts and the vastness of the geographical area to be covered, repeat surveys in the same area are carried out only after a period of several years.

The NFCP was independently assessed four times between 1960 and 1995 by the ICMR. The first Assessment Committee recommended reorganization of control units on the basis of population of each town, continuation of antilarval measures, withdrawal of mass DEC administration and indoor spraying of insecticides and establishment of new control units. The second Committee recommended selective DEC therapy and mapping of endemic areas. The third recommended treatment of clinical filariasis cases through primary health care system and control of B.malayi filariasis. The fourth Committee emphasized the need for integrated vector control measures, mapping of rural areas as a priority, new detection methods, increased central assistance, health education and human resource development.

The work of the units and survey teams under NFCP has over the years provided valuable data. Based on the information collected under NFCP, 261 districts, or roughly one-third of the country, is presumed to be endemic. Surveys by these teams as well as the national institutes have confirmed that 15 states covering 133 million population are free of filariasis.

Although valuable work was being done under NFCP, it was very limited in scale and thinly spread. Its impact could not be well assessed. Funding for this programme has decreased slightly over time. However, personnel posted under NFCP still constitute a considerable human resource. In addition, trained personnel are also available under the National Anti-Malaria Programme and can be mobilized for periodic activities. Each state has senior health professionals and experts with many years of experience of organizing campaigns conducting scientific and operational research studies and evaluating programmes.

BUILDING ON SUCCESS

Tamil Nadu recently organized the mass administration of DEC alone and DEC + albendazole in 13 endemic districts in the state, covering a total population of 28 million,
which is more than the total population of several endemic countries. Such mass campaigns have also been organized in Orissa and Kerala, although on a scale smaller than in Tamil Nadu.

By 2002, 27 districts in 7 states with a combined population of about 68 million had completed one or more rounds of DEC alone or in combination with albendazole. Plans have now to be drawn up and resources found for another 234 districts with a population of about 380 million. Many of these districts have relatively inadequate health infrastructures and a heavy burden of other diseases, including malaria. The need for training health personnel in IEC activities for creating awareness and promoting community participation cannot be over-emphasized. The messages should be culturally acceptable and suited to local needs. Such activities should be recurring and sustainable and their operational costs and funding sources need to be adequately reflected in the budget for filariasis elimination.

There has been some concern voiced by experts in India regarding the documented evidence related to the advantage of adding albendazole with DEC administration. India is a big country and needs large size studies on the combination. In India DEC alone or DEC+albendazole has been given to millions of people under pilot projects. Dr Agarwal urged scientists who are monitoring these projects to urgently compile data to find out whether the co-administration strategy is more effective.

AN INTEGRATED APPROACH TO ELIMINATE LF

The rationale of mass drug administration is to reduce the transmission of the infection, which is a public health goal. There is no immediate visible positive impact so far as the community is concerned. To gain public acceptance and also to alleviate the suffering of patients with elephantiasis, it is proposed to make morbidity management as accessible to the community as possible by training health personnel of the peripheral health facilities, NGOs, family members and patients themselves. The experience in Brazil and in India’s branches of National Institute of Communicable Diseases is very encouraging. There is, however, a large group of nonspecific symptomatic patients as well as patients with acute symptoms of the disease, and guidelines are being prepared so that patients receive appropriate care through routine health services.

Lymphatic filariasis is transmitted by a mosquito that is notoriously difficult to control. Selective vector control measures are being applied under the National Anti-Malaria Programme which includes the use of bednets, larvivorous fish and other antilarval measures and indoor residual spraying of insecticides. The Indian government is promoting integrated vector control measures against filaria and other vector borne diseases.

In conclusion, it is possible to eliminate lymphatic filariasis with the known strategy and availability of effective drugs and insecticides. The task will be easier as new drugs and diagnostic tools are developed and more funds are mobilized for implementing the strategies in the field. This will be possible only with the cooperation of communities as well as all stakeholders in public and private sectors, especially all the partners of the Global Alliance to Eliminate Lymphatic Filariasis.
Certificate of Achievement

presented to the World Health Organization
by GlaxoSmithKline Mayenne for their collaboration
in donating the first **100 million** Albendazole tablets
for the Global Programme to Eliminate Lymphatic Filariasis

Marc Santesmases - Site Director
Mayenne 14th June 2002

GlaxoSmithKline
World Health Organization
EFFECTIVE PUBLIC PRIVATE-PARTNERSHIPS
Dr J.P. Garnier, Chief Executive Officer, GlaxoSmithKline

Highlighting the value of diversity in the Global Alliance to Eliminate Lymphatic Filariasis, Dr Garnier acknowledged that such diversity of partners also posed a difficult challenge when it comes to decision-making. He praised the programme managers as the "architects of success" but stressed that this is a 20-year effort and that to attain the programme's targets success should be seen every 5 years.

GlaxoSmithKline's billion dollar commitment over the next 20 years reflects that the company were "in for the long run". The Global Alliance is an important forum beyond the discovery of new drugs. Although GlaxoSmithKline is not a philanthropic organization it is committed to neglected diseases and to ensuring access to drugs regardless of patients' ability to pay. LF forms a large part of the company's efforts in putting patients first.

The 120 000 employees of GlaxoSmithKline are extremely interested in the programme and find it very motivating to help countries to fight this disease. GSK also supports volunteers and acts as a catalyst for scientific work such as tailoring drug regimens and specificity of countries.

After stating, "I am impressed with the progress of the LF programme and thank WHO for being tremendously effective", Dr Garnier expressed three wishes about the meeting:

1) That it be action-orientated and pragmatic
2) That it concentrate on agreement and forget disagreement
3) That it focus on results, reminding participants that the responsibility was grave and that they could not afford to fail – the LF programme was far more visible than they realize.

TECHNICAL STATEMENTS
Dr B. G. Bagnall, Director of Lymphatic Filariasis Programme, Global Community Partnerships, GlaxoSmithKline

From the beginning in January 1998, GSK's policy has been clear – donating one of the preventive drugs (albendazole) alone would not be enough, said Dr Bagnall. "We committed therefore to become an active and involved partner of the elimination programme."

He took the opportunity to announce that GSK has just completed the first 100 millionth donated treatment and acknowledged that although this was a major milestone it represented only 2% of the projected 20-year commitment. Realizing the enormous challenge of the partnership, GSK has provided a small team of professionals to support a wide variety of activities whose sole job will be to help fight lymphatic filariasis while there is a window of opportunity to do so.

"We are passionate believers that the private sector can play a key role in major global public health efforts in disease control. We can offer more than being a remote donor. We think that we can go beyond just philanthropy so that our joint goals become integrated with yours, working together at many levels."
Through the partnership represented in the Global Alliance, there is a good basis for the Mectizan® Donation Program to take on the challenge of LF elimination.

He hoped the meeting would build a stronger Global Alliance so as to attract and obtain major donors and supporters. The Global Alliance needs a compelling and unique identity, a powerful and united vision as well as a vibrant membership. He pointed to the lessons that the Global Alliance can learn from the experience of how the tuberculosis and poliomyelitis campaigns have organized and promoted their goals.

Lastly Dr Bagnall pointed out that when Dr Brundtland became Director-General of WHO she challenged all to build innovative public-private partnerships. The Global Alliance is an opportunity to deliver on this promise for lymphatic filariasis.

Mectizan® Donation Program
Dr B. Thylefors, Merck & Co., Inc.

On behalf of Merck & Co., Inc., Dr Thylefors began by congratulating the countries on their strong commitment to embark on the challenge of eliminating one of the world’s most disabling diseases. It was very topical that the greater part of the meeting was to be devoted to the building of national programmes and further development of the Global Alliance.

The year 2002 marks the 15th anniversary of the Mectizan® Donation Program currently operating in 35 onchocerciasis-endemic countries. In line with the commitment of Merck & Co., Inc. to support LF elimination, the Donation Program has now begun to tackle lymphatic filariasis in the African countries where onchocerciasis and LF coexist. Through the partnership represented in the Global Alliance, there is a good basis to take on the challenge of LF elimination.

The following strategic issues are of major importance for the Mectizan® Donation Program:

► Intensified efforts to make rapidly available the human and financial resources needed to complete the mapping process in Africa. This is of particular significance to the Mectizan® Donation Program as it will be supporting LF activities in Africa.

► Urging and drawing attention to the potential gains of integration as a tool to streamline and manage LF field operations. Models for linking LF mass drug administrations with other activities such as onchocerciasis control must also be developed.

► Disability prevention and alleviation, which are now becoming an integral part of the Global Programme. This also is of great significance to the social mobilization and community support that need to be generated on the issue.

► Global policy on disability alleviation must be translated into concrete action in all national programmes, including the support of interested NGOs.
Dr. B. Wabudeya, Minister of State for Health, Uganda

Although the psychosocial and real economic burden of lymphatic filariasis is not known, LF contributes significantly to loss of labour in adults and school absenteeism in children. The disease particularly affects agricultural productivity of rural communities whose mainstay is subsistence farming. At the same time treatment, surgical and palliative care of LF victims diverts resources that could have been used for economic development of the country. Elimination of LF therefore will not only remove the disease burden but also stimulate economic development and alleviate poverty.

In the light of this, Uganda gives its strong support to the LF elimination efforts spearheaded by WHO and supported by drug manufacturers and other partners and agencies. There is strong political commitment at the highest level in Uganda and the programme for the elimination of lymphatic filariasis has been the subject of cabinet discussion. The Ministry of Health has put financial, material and human resources at the disposal of the programme. However, because of the magnitude of LF and other competing health problems, Uganda is not in a position to fund the LF programme in its entirety. We will continue to seek financial and material support from our development partners such as the Global Alliance.

Dr. J. Jiya, Federal Ministry of Health, Abuja, Nigeria

The Nigerian lymphatic filariasis elimination programme will be fully energized to commence full activities starting from mapping right up to efficient delivery of mass drug administration while alleviating disability of those already affected.
Mr Maalim H. Mohamed, Minister of Medical Services, Kenya

With over 2 million of Kenya’s population at risk of infection and up to 700,000 likely infected, lymphatic filariasis deserves national attention. The commitment directed towards the elimination of this disease is encouraging and I have no doubt that through the concerted efforts of the Global Alliance, the elimination target is achievable. At this juncture I would like to assure the Global Alliance of Kenya's total commitment to the elimination of lymphatic filariasis as a public health problem.

Dr H. Mwinyi MP, Deputy Minister of Health, United Republic of Tanzania

Current estimates highlight the alarming reality that Tanzania is highly endemic of lymphatic filariasis, 15 million people are estimated to be at risk and 2 million people are already infected. The mapping of LF in Tanzania has given a better assessment of just how big the problem is. Many people affected by hydrocele and elephantiasis live in poor rural areas and the question one continually asks is how can we expect progress in these areas while over 30% of people are unable to attend to their daily activities because of filarial fevers. We have strong reasons to try and eliminate this disease and ensure that future generations do not get snared into a poverty trap that is not of their own making.

Working with the communities, building partnerships based on comparative advantages and political will are all important for the success of this programme. In my country MPs are demanding that the programme be initiated in their constituencies. This brings us to an extremely important issue, that of continuity and sustainability. Without a plan to ensure continuity and ensure all the areas at risk are covered for at least six years, the whole concept of elimination based on interruption of transmission will be invalid. This is no easy task and as governments we need to work with our partners to find the best possible way of ensuring success and sustainability. In an attempt to do all we can to ensure sustainability, we are now encouraging the districts to budget for LF activities in their annual plans.

Mr M.S. Vui, Minister of Health, Samoa

Samoa has reaffirmed and demonstrated strong political commitment at all levels. The government of Samoa, through WHO’s technical support, was the first country to launch a national lymphatic filariasis programme almost 40 years ago. LF prevalence was reduced dramatically. However, a national survey taken in 1998 showed a marked relative increase in prevalence. Much progress has since been made in Samoa with two other subsequent MDAs in 2000 and 2001. Treatment coverage for the last three MDAs averaged at 90% but will be improved and strengthened to cover the remaining 10% of the at-risk population.

We need to reaffirm commitment and dedication as national, regional and global leaders through appropriate action-oriented policies and resource allocation to ensure protection of the poor and of the population at risk from this debilitating yet preventable disease. As Minister of Health in Samoa I will do the best I can to ensure that my government continues to be fully committed to the attainment of the global and regional goals for the elimination of LF in Samoa by 2010.
Mr M. Dani-Baah, Deputy Minister of Health, Ghana

Despite the burden of other high profile diseases in Ghana there is a firm commitment to the lymphatic filariasis programme. Through the support of our partners mapping has been completed and we now know where the problem is. There are active programmes in 14 out of the 41 endemic districts and the programme has been well received by the people in these districts.

The challenge is to scale up to the remaining districts, who are also demanding that the programme be implemented in their areas. We are therefore calling on our partners to support us to reach all endemic districts. The government of Ghana will play its role in ensuring that the results are delivered. We have the expertise and are confident that we can achieve this.

SUSTAINABLE DEVELOPMENT AND THE ELIMINATION OF LF

Dr S. Stansfield, Bill and Melinda Gates Foundation

Dr Stansfield was deeply impressed by the achievements of the Global Programme. Substantial support is being given to lymphatic filariasis as the programme addresses equity with the goal of saving lives and reducing disabilities due to infectious diseases. The Bill and Melinda Gates Foundation invests in advocacy and leadership-building. The Global Programme fits into these categories and is committed to developing intervention tools to break transmission and to building global advocacy. Furthermore, continual advocacy will ensure that the resources to do the job are available.

Dr Stansfield said the Bill and Melinda Gates Foundation was delighted at the progress made at country level and proceeded to explain why they invested in the LF programme:

► The inequitable burden of disease is intolerable and LF should happen to no one
► Success is a non-event. What should be made clear is what the burden would have been had we not done anything. The cost of inaction exceeds the cost of action.

She further outlined key opportunities for the Global Programme:

► The need to increase community partnerships as well as political partnerships
► Strengthening and supporting national and regional operational plans
► Mobilizing more international resources.

Mr K. Leitch, Health and Population Department, Department for International Development (United Kingdom)

Mr Leitch began by citing the Global Programme as a successful programme mainly because it is flexible and innovative. He said it enhances sustainable systems and has a significant health impact. For these reasons it fits into the portfolio of Department for International Development (DFID) and is targeted for support.

The Global Programme has proven to be cost-effective and provides tangible health gains. It addresses barriers which prevent the poorest people from accessing services. Many country examples show that investing in LF strengthens health systems. The LF programme reflects an excellent example of public-private partnerships and DFID is pleased at the support given to country-level work through the programme as well as with the capacity-building gains made through the involvement of NGOs.

Treatment coverage for the last three MDAs in Samoa averaged at 90% and is going to be strengthened to cover the remaining 10% of the population at risk.
The Elimination of Lymphatic Filariasis as a Strategy for Poverty Alleviation and Sustainable Development – Perspectives from the Philippines.
Dr. J.Z. Galvez Tan MD, MPH

I. High poverty and the double burden of illness

In the year 2002, the Philippines, although classified by international agencies as a lower middle-income country, is still saddled with a national poverty incidence of 39.4%, up by 2.6% since 1997. In other words a total of 30 million people out of a total population of 76.4 million in 2000 are poor.

There are wide disparities in poverty incidence between urban and rural areas as well as between regions and provinces. With a high population growth rate, the economic growth rate of 3.4% in year 2001 has hardly been felt by the poorest of the poor in the country.

The double burden of disease is evident as the Philippines is currently in epidemiological transition with diarrhoea, pneumonia, bronchitis, influenza and tuberculosis being the leading infectious diseases. In addition there are the degenerative diseases such as heart disease, stroke, pneumonia, cancer and accidents.

Poverty and lymphatic filariasis: The endemic areas of lymphatic filariasis are also the areas with high incidence of poverty. Out of 79 provinces in the Philippines, 30 have a higher poverty incidence than the national poverty incidence. Seventy seven percent of these 39 high poverty incidence provinces are endemic for lymphatic filariasis.

II. Poverty Alleviation

Poverty in the Philippines is manifested mainly by inequities and disparities in the economic, political, social and cultural spheres of society. In the sphere of health, poverty is manifested by the lack of access and opportunities, inequities and disparities in access to health knowledge, health promotion and the prevention of diseases, primary health care services, essential drugs, emergency medical and obstetric care, disability and rehabilitation services and the maintenance of health, well-being and productivity.

Since 1986, the Philippine government has had a Social Reform Agenda which particularly aims at poverty alleviation and reduction in the poorest provinces of the country. A National Anti-Poverty Commission (NAFC), headed by a secretary of cabinet rank, has been functional ever since. For the urban poor, a Presidential Commission for the Urban Poor (PCUP) has also been established. The Aquino (1986 – 1992) and Ramos (1992 – 1998) administrations were successful in lowering the incidence of poverty in the country. However, during the Estrada administration (1998 – 2001), the incidence of poverty has increased.

A behaviour survey on how people dealt with health held in 1993 showed that across income groups, self-care was the most prevalent ranging from 40% in the richest quartile to 56% in the poorest quartile. A more recent survey in 2001 showed that the bottom 30% expenditure class use mostly the traditional healer, followed by the village
health station and government hospital, while the top 40% expenditure class use private clinics and hospitals the most and the government health centres and traditional healers the least.

Other sobering indicators show that 45 out of 100 Filipinos still die without any medical attention and that 44 out of 100 babies are delivered by untrained hands.

These surveys show the lack of access to basic health services for the poorest and the disparities between the poor, the middle class and the rich as well as between urban and rural.

III. Elimination of LF as a means to poverty alleviation

Knowing that the provinces endemic for lymphatic filariasis are also the provinces with the highest poverty areas, the elimination of lymphatic filariasis in these areas is a golden opportunity to reduce both poverty and inequities in health. An analysis of the services offered by elimination of lymphatic filariasis shows that indeed elimination of lymphatic filariasis is a means to poverty alleviation.

1. LF surveys and mapping using ICT and community reporting of hydrocele and elephantiasis increase the poor’s access to health knowledge, health information, epidemiological data as well as access to diagnostic services.

2. Mass drug administration with DEC + albendazole increases access to essential drugs and ensures universal coverage of the treatment of LF and soil transmitted helminths, thus improving nutrition, reducing iron deficiency anaemia due to hookworm and reinforcing sanitation campaigns.

3. Identification of people with disabilities due to LF for eventual morbidity reduction services will increase access to health services and rehabilitation especially for those who have lived as outcasts carrying society’s stigma for such disabilities. This will also mean the poor can return to productive economic work and active social life. Eventually, the community will have more economically and socially productive members and improve its overall health, well-being and quality of life.

4. Access to other health services will be increased with the integration of additional health services during the MDA such as bednets distribution, immunization, growth monitoring and promotion, vitamin A and iodized salt distribution and sanitation and hygiene education. The Filariasis Fair in the Philippines, organized by local governments, creates a festival out of the MDA, offering additional services to attract more people to take DEC and albendazole.

IV. Elimination of LF as a means to sustainable development

The installation of the mechanisms for elimination of lymphatic filariasis will be a means to sustainable development at national, local and community levels. With the devolution of health services in the Philippines since 1993, there has been a great need for health systems development especially at local levels. National and local governments will therefore be given through elimination of lymphatic filariasis the opportunity for health systems development in the following areas: (1) health planning tech-
nologies; (2) health logistics system with the procurement of DEC, receipt of albendazole and their distribution, inventory and accountability; (3) health research systems development with epidemiological research, basic health research, health social science research, health systems research, evaluation research, operational research and participatory action research; (4) development of health management information systems using the latest information technology (GIS, FilSim remote sensing); (5) social marketing and social mobilization methodologies; (6) setting up of health referral systems especially using the adverse drug reaction reporting system; (7) vertical and horizontal integration system with elimination of lymphatic filariasis and primary health care; (8) human resource development through scientific and programme updates; (9) international and regional networking for technical assistance and resource mobilization; (10) a venue for leadership in health to shine and to be proven worthy.

Furthermore, the elimination of LF will spur an increased investment in health. Whether in the form of a north-south partnership, or a reallocation of national budgets for health or an increase in local budgets for health by local governments or resource mobilization from the private sector or community health financing or all of the above, elimination of lymphatic filariasis will definitely move more resources for the health of the poorest.

V. Vision and mission for 2020

The strategy for the elimination of LF is a 20-year strategic plan for the world community. With the vision, mission and commitment to ensure the delivery to all LF endemic countries of quality technologies and human services to eliminate lymphatic filariasis worldwide through a multi-stakeholder Global Alliance, the opportunities for greater world peace and development are once more at hand.

"The global goal of elimination of lymphatic filariasis is great. Let us seize this magnificent moment for partnerships and solidarity for a better world – a world with less poverty and a world with sustainable development and finally free from the scourge of lymphatic filariasis."
The Global Alliance to eliminate Lymphatic Filariasis:
80 endemic countries and more than 30 partners

National Programmes to eliminate Lymphatic Filariasis
Endemic Communities

WHO acts as Secretariat of Global Alliance

Legend
- Communications/Co-ordination/Advice Links
- Operational Links

CCC: GSK/WHO Collaborating Coordination Committee
EMEC: Expanded Mectizan® Expert Committee
Commitment to elimination of lymphatic filariasis should be reflected in the national health policy and also by a specific provision in the budget.

Countries represented in the Global Alliance to Eliminate Lymphatic Filariasis have all begun elimination of lymphatic filariasis activities and have thus committed themselves to this programme. The commitment and ownership of countries is reflected by:

- Adoption of the World Health Assembly resolution on eliminating lymphatic filariasis;
- Formation of a national task force
- Formulation of action plans and allocation of a budget for programme activities.

The organization and implementation of the programme of lymphatic filariasis elimination requires a designated programme manager at the national and the subnational levels who should have support from personnel with expertise in public health, advocacy, social mobilization and other areas. The programme should have a long-term perspective and be implemented through the existing health infrastructure.

Commitment to elimination of lymphatic filariasis should be reflected in the national health policy and also by a specific provision in the budget. The programme should be planned as long-term with sufficient funding to carry out campaigns in the affected areas.
areas. However, the achievement of the goal will be dependent on the allocation that can be made from the national budget for filariasis elimination. This can be strengthened by creating an adequate database and collecting information on disease burden in order to generate political commitment and support.

External participation should be locally sensitive and appropriate. External partners can help by providing technical and financial support to fill gaps identified by the national task force for elimination of lymphatic filariasis. To ensure efficient and optimal utilization of the external funds, the funds should be provided for items reflected in the national plans. The use of external funds should be decided in consultation with the national task force for elimination of lymphatic filariasis, rather than as individual activities taken up independently at the local level.

Conditions for external participation should be conducive to mutual collaboration. Short-term resource-intensive activities by individual organizations should be discouraged as, in the long term, they may be counterproductive to the functioning of the routine health services. To promote transparency of programme operations, partners such as NGOs and academic institutions should be included in evaluation activities.

GROUP 2: ELIMINATION OF LYMPHATIC FILARIASIS, POVERTY ALLEVIATION AND SUSTAINABLE DEVELOPMENT – POLICIES AND STRATEGIES FOR RESOURCE MOBILIZATION

What policy framework should the Global Alliance and its members use in approaches to donors?

The overall policy framework should be that of poverty alleviation and sustainable development, since poverty alleviation interacts with disease elimination. The ministry of health should work together with the ministries of finance and of education to create an integrated approach to lenders. The ministry of health particularly needs to use economic or financial language to show return on investment.

In the health sector framework, LF is a disease of poverty. To achieve improved quality of life, the disease must be addressed. LF elimination fits well into the sector-wide (sub-district, health centre and community levels) approach to support primary health care (e.g. promote good basic hygiene and skin care). The elimination of LF is already embedded into the national health systems. Examples range from the Pacific to sub-Saharan Africa. Moreover, disease control programmes strengthen the capacity of health system in areas such as surveillance, information systems, delivery systems, social mobilization, logistics and capacity building. Health systems development has already been assisted by LF work and past experience since intervention incorporates best practice from other disease control programmes. Significant advantages of assisting in ELF include:

- Focus on primary prevention – MDA and cheap drugs available
- Impact can be determined in short timeframe
Improved productivity and decreased disability

Interventions that particularly help the poor, women and children.

In terms of information or analyses needed to support approaches to donors, the following issues were identified:

- Need for quantification of cost of investment
- Cost of action vs the cost of inaction
- Economic studies to quantify cost of acute disease and chronic disease
- LF as a disease of children
- Cost of ineffective interventions
- Return on investments: cost-effectiveness studies
- Quality of life and change in productivity due to control
- Costs of investment in programme-related operational research
- Measurement of costs of acute episodes in the community
- Benefits of hydrocele surgery and morbidity management in giving back productive life years
- Social and economic costs on individuals, households and communities
- Impact on household income
- Coping strategies and support mechanisms.

Potential sources of funding:

All original donors (private, bilateral, foundations) expect more funds to be leveraged for the programme. There is a need for an action plan for advocacy and fundraising in the next 6-9 months. Such a plan would address:

- WHO's capacity to seek support from bilateral and multilaterals
- Capacity of different World Bank sources
- Recognition of regional success in funding, e.g. PacELF, Government of Japan, EMRO and the Arab Fund for Social and Economic Development
- Effective country partnerships in several countries involving NGDOs, bilaterals etc.

The Working Group recommended that an Advocacy Working Group be established to continue development of the Action Plan and resource mobilization, recognising that there may be a need for regional organization and ownership.

Advocacy: key messages for donors need to be created

- Compelling themes
Images and materials

Ruthless pursuit of success stories

Match donor priorities with needs of LF activities e.g. specific countries, children, education, disability.

LF is a “wrappable problem”; we can package the message in different ways without distorting the substance.

Donors are not monolithic; they have different missions, cultures, priority themes and geographical areas – these must be taken into account.

Points for further consideration:

• Channels in USA: World Bank and a not-for-profit LF NGO in the United States of America specifically for receipt of donations from within the USA.

• The need for a resource mobilization officer should be examined (whether central or regional)

• In the Americas, possibilities include NGDOs at country level, Rotary, Lions and UNICEF (for salt, iodine, fluoride and DEC)

• Country partnerships should be strengthened, with particular emphasis on the role of the endemic country in such a partnership

• LF advocacy and fundraising need to be coordinated globally

• GSK will support activities to tap American private donor base. The USA-based Global Alliance members are considering options which include church groups, cooperation with operations in LF countries, foundations, service organizations, research institutions and individual donors. All have different missions and priorities which must be understood.

• World Bank support is moving away from projects, stressing country ownership of funds; local advocacy is required between ministries of health, finance and of education; in the claim on resources available for sector reform, the poverty-related agenda must be emphasized; part of World Bank funding is subject to the internal decision of country; a certain percentage of IDA funds will soon become grants; look at regional approaches and post conflict fund sources

• LF should be a base indicator of development progress; if LF is not eliminated, the effectiveness of developmental loans is damaged

• In the European Commission, there are major amounts of unallocated development funds (euro 14 billion).

Final comment: It is now time to proceed further and to equip the Global Alliance with a structure which can effectively support operations, service its constituency and generate resources. It is time to review the Global Alliance structure in the light of the recommendation for an Advocacy and Resource Mobilization working group.
GROUP 3: THE GLOBAL PARTNERSHIP

1. What is the rationale for a partnership?
   ▶ No single organization can do it alone
   ▶ The goal demands a partnership
   ▶ Importance of working together
   ▶ Global advocacy; need for a common voice
   ▶ Strategic planning

2. Challenges to be addressed
   ▶ Requirements of a data-driven programme
   ▶ Certification issues
   ▶ Uniformity of methodologies and standard operating procedures
   ▶ Resource mobilization and sharing; financial-global approach
   ▶ Human resource development
   ▶ Epidemiological need; interrupt transmission; cooperation between countries and regions; migration; cross-border issues
   ▶ Networking
   ▶ Operational research needs
   ▶ Sharing of experiences and information

3. What is the Global Alliance?
   ▶ An equality of partners?
   ▶ An alliance to support WHO’s programme for LF elimination or an alliance for elimination of LF?
   ▶ There is a need for a clearer agenda as to who does what.
   ▶ How does it work in between meetings?

4. What should each partner give to the Alliance?
   **Endemic Countries**
   ▶ A good and effective programme
   ▶ Political commitment
   ▶ An effective programme to interrupt transmission
   ▶ Assurance of high coverage
   ▶ Uniform reporting
   ▶ Sustainability
   ▶ Strategic plan for funding (internal allocations and need for external funding)
   ▶ Shared responsibilities; countries and Alliance work together
   ▶ Allow demonstration projects to be carried out
   ▶ Participate and share research experience
   ▶ Share experience at both regional and global levels
   ▶ Sharing resources with other programmes
   ▶ Intercountry cooperation/collaboration

   **WHO**
   ▶ Should be able to assist in the process by prioritization and recognition
     ▶ Secretarial role for the Global Alliance
     ▶ Technical guidance
     ▶ Standards and guidelines for various procedures
     ▶ Methodological quality assurance
     ▶ Institutions and structures available
     ▶ Cooperation with other WHO programmes
     ▶ Use of TAG, RPRGs and collaborating centres
   ▶ Global advocacy
   ▶ Training
     ▶ In country
     ▶ Generic training material
   ▶ Promote research and strengthen evidence base
   ▶ Certification of elimination

   **World Bank and bilateral agencies**
   ▶ Play an active role for advocacy and resource mobilization
   ▶ Identify LF as an important area because of disability and socio-economic costs
   ▶ Fundraising (World Bank)
### NGOs
- Perceptions of role of NGOs
  - Networking
  - Service delivery
  - Disability alleviation
- NGO support should be in the framework of national programmes
- NGO should support infrastructure in country
- National NGOs are often grass root and usually more effective
- International NGOs should work with national NGOs
- Role in training
  - NGOs may work at central level and help in strategy planning, proposal writing, fundraising

### Scientific and academic institutions
- Expertise in training and research
- Work closely with countries
- More practically oriented, responsive to programme needs
- Provide best information and allow country to make decisions
- Engage in collaborative research
- Promote research capabilities of endemic countries
- Training
  - Strategic planning for training
  - Develop training packages
  - Coordination with WHO activities in this area
  - Capacity-building programmes; mapping, monitoring and evaluation
- Information-sharing

### 5. What can each partner expect to receive from the Alliance?

#### Endemic countries
- Advocacy at the highest level – global advocacy
- WHO technical guidance
- Some funding
- Inputs from NGOs, academic and research institutions

### WHO
- Regular reporting of activities by countries and partners
- Collaborative activities at global, regional and country level

### World Bank and bilateral agencies
- Demonstration of success/progress
- Impact assessment of programmes in quantifiable terms; monitoring and evaluation, socioeconomic impact

### NGOs
- Creative partnership in countries
- Information flow
- Interactions with other partners
- Role in evaluation of disability alleviation programmes

### Scientific and academic institutions
- Invite to attend at meetings
- Informed of progress
- Receptivity of new tools becoming available

### Drug companies and private sector
- Good and effective programmes
- Proper reporting of coverage
- Safety monitoring

### 6. Alliance use of resources
(especially between meetings)
- How does GAELF use resources between meetings?
- GAELF needs a better definition of partnership and of who does what?
- GAELF needs mechanisms for follow-up activities
**Recommendations**

- Form an executive working group, coordinated with WHO secretariat.
- Form task forces (goal-oriented) for:
  - Fundraising and advocacy
  - Strategic planning
  - Networking and strengthening the Alliance
  - Capacity-building for human resources
  - Operational research

The executive working group should be small, ensure regional representation and deal with communications to keep the Alliance informed.

- Inventory of available expertise/resources in endemic areas
- Meet the need for the Alliance to be seen in peer-reviewed journals
- Meet the need for strengthening Alliance communication; web site of the Alliance, newsletter and other channels.

**GROUP 4: NATIONAL LEVEL PARTNERSHIPS**

The major questions identified were

- How can partners be encouraged to collaborate?
- What inputs are necessary and helpful?
- How can partnerships be sustained?

The types of partnership useful to ELF at national level were

- Resource providers
  - Governments
  - NGOs
  - Private sector
- External counterparts
  - Beneficiaries
  - Communities
  - People at risk
  - Health service providers

Different levels of partners must be taken into account: external, national, regional, provincial, urban, village, household.

Basic principles of a good partnership defined as

- Shared vision
- Ownership/shared responsibility
- Recognition of strengths
- Mutual respect
- Commitment

**Constraints** with which to deal

- Capacity/skills
- Power relations
- Differing agendas

**Key concerns** of a successful partnership

- Coordination
- Integration
- Communication
- Sustainability
- Research
- Tools for sustaining partnerships
- Sharing responsibility
- Diversified partnerships
- Innovation and creativity
- Continuing communication and transparency
- Strategic planning
- Sharing of successes
- Timely reporting
- Building capacity
- Building capacity
<table>
<thead>
<tr>
<th>PARTNERS</th>
<th>INTEREST</th>
<th>SUPPORT NEEDED</th>
<th>INPUTS REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politicians/governments</td>
<td>People’s well-being</td>
<td>Influence (communities, administrations)</td>
<td>Information e.g. burden of disease Advocacy, lobbying</td>
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<td></td>
<td>Serving constituents</td>
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<tr>
<td>Religious groups</td>
<td>Community well-being</td>
<td>Influence, advocacy</td>
<td>Information (myths) Training packages Resources, consultation</td>
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<td>duty, responsibility</td>
<td>Information, implementation</td>
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<tr>
<td>Traditional healers</td>
<td>People’s health</td>
<td>Treatment, referrals</td>
<td>Respect Acknowledgement</td>
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<td></td>
<td></td>
<td>Sharing knowledge and practice</td>
<td></td>
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<tr>
<td>Professional groups (medical, paramedical)</td>
<td>People’s health</td>
<td>Treatment, referrals, data</td>
<td>Information Training Materials</td>
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<td>Compliance protocols</td>
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<td></td>
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<td>Implementation, IEC</td>
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<tr>
<td>Households/families</td>
<td>Health and well-being of members</td>
<td>Cooperation</td>
<td>Information, consultation Affirmation, empowerment through the above</td>
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<td></td>
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<td>Participation</td>
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<td></td>
<td></td>
<td>Counselling</td>
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<tr>
<td>NGOs</td>
<td>Development – health, social, economic</td>
<td>Participation; resources, Cooperation, Complementary services</td>
<td>Information: national plans, Resources, feedback, Direction</td>
</tr>
<tr>
<td>Private sector (small and medium enterprises</td>
<td>Healthy workforce</td>
<td>Resources – material, financial</td>
<td>Information: economic returns, values Training Feedback Clear expectations</td>
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<tr>
<td>&amp; multinationals)</td>
<td>Promotion of products/services</td>
<td>Lobbing</td>
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<td>Image enhancement</td>
<td>Logistics</td>
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<td>Tax benefits</td>
<td>Implementation</td>
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<td></td>
<td></td>
<td>Communication</td>
<td></td>
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<tr>
<td>Institutions, e.g. academic</td>
<td>Health care professionals</td>
<td>Research</td>
<td>Information Participation Advocacy Direction Recognition</td>
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<td>Lobbying</td>
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<td>Integration into curriculum and training</td>
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</table>
THE PARTNERS IN THE GLOBAL ALLIANCE TO ELIMINATE LYMPHATIC FILARIASIS (GAELF) ASSEMBLED IN NEW DELHI ON 2 – 3 MAY 2002:

- Express their appreciation to the Government of India for its generous hosting of the conference.
- Welcome the progress which has been made to eliminate lymphatic filariasis since the Alliance was established in Santiago de Compostela, Spain, in May 2000, with considerable progress being achieved in the areas of pharmacovigilance, integration into national health systems, regionalization and the poverty alleviation focus of the programme.
- Welcome the important achievement that, in 2001, the population in 22 countries covered by mass drug administration reached some 26 million persons – a near 10-fold increase over the number covered in 2000.
- Acknowledge the fundamentally important contribution made by the national governments of the endemic countries, particularly in terms of implementation of the programmes, and reiterates that, without such contributions and commitment, action towards the elimination of lymphatic filariasis, including operational research, disability prevention and morbidity, will not succeed.
- Note with gratitude the decisive contributions made to the programme by GlaxoSmithKline, Merck and Co., Inc. the Bill and Melinda Gates Foundation, Department for International Development (UK) the Japanese Government and the Arab Fund for Social and Economic Development.
- Note that, to maintain the momentum necessary to cover a population at risk of 350 million by 2005, further funding of at least US$ 100 million is required to supplement the continuing major contribution of endemic countries.
- Welcome the conclusions of the Working Groups as a guide to further exploration of how to develop an active Alliance with the strong participation of endemic countries, with particular need for the urgent establishment of an Alliance Task Force on Advocacy and Resource Mobilization and for other ways to complete the business arising from the working groups between meetings of the Alliance.

RESOLVE TO

- Make every effort to achieve elimination of lymphatic filariasis within the target set by the World Health Assembly resolution WHA50.29, and the Strategic Plan of the Global Alliance.

TO THAT END, THE PARTNERS PLEDGE THEMSELVES TO

- Complete mapping of the distribution of lymphatic filariasis by 2005
- Scale up the national elimination programmes to provide the high coverage required of a population at risk of 350 million people by 2005
- Remain committed to disability prevention and aim that, by 2005, 50% of the programmes will have a strategy for disability prevention in place as part of national plans
- Make every effort to obtain additional resources required for the above purposes as a supplement to the contribution of endemic countries.
ACKNOWLEDGEMENTS

The Secretariat of the Global Alliance for the Elimination of Lymphatic Filariasis would like to thank the Government of India and the World Health Organization for hosting the second meeting of the Alliance in New Delhi, India. The Secretariat also thanks the following for their contribution to the report: R. Besana, G. Biswas, T. Faizi, V.K. Kumaraswami, C. Maddock, A. Odugleh, F.A. Rio, P. Sharkey, M. Thuriaux and N. Zagaria.

Created by: K. Lyonette and N. Matsha

Design: D. Hostettler (Imagic), and N. Matsha.
This report has been produced by the Secretariat of the Global Alliance to Eliminate Lymphatic Filariasis.

For more information on the Global Alliance to Eliminate Lymphatic Filariasis, go to

www.filariasis.org

Report of the second meeting of the Global Alliance to Eliminate Lymphatic Filariasis