Thirteenth Meeting of the Western Pacific Regional Programme Review Group on Neglected Tropical Diseases

Manila, Philippines
19 July 2013
MEETING REPORT

THIRTEENTH MEETING OF THE WESTERN PACIFIC REGIONAL PROGRAMME REVIEW GROUP ON NEGLECTED TROPICAL DISEASES

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
19 July 2013
NOTE

The views expressed in this report are those of the participants in the Western Pacific Regional Programme Review Group on Neglected Tropical Diseases and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the Western Pacific Regional Programme Review Group on Neglected Tropical Diseases, which was held in Manila, Philippines on 19 July 2013.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>FBT</td>
<td>foodborne trematodiasis</td>
</tr>
<tr>
<td>ICT</td>
<td>immunochromatographic</td>
</tr>
<tr>
<td>MDA</td>
<td>mass drug administration</td>
</tr>
<tr>
<td>NTD</td>
<td>neglected tropical disease</td>
</tr>
<tr>
<td>RPRG</td>
<td>Regional Programme Review Group</td>
</tr>
<tr>
<td>SAE</td>
<td>severe adverse event</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>Regional Office for the Western Pacific</td>
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Keywords:  
Neglected diseases - epidemiology, prevention and control / Trachoma / Brugia /Schistosomiasis / Helminthiasis / Filariasis
The Regional Programme Review Group (RPRG) Meeting was held on 19 July 2013 at the Regional Office for the Western Pacific (WPRO) in Manila, Philippines. Experts on neglected tropical diseases (NTDs), representatives of pharmaceutical companies supporting the drug donation programme, and NTD staff of WHO Headquarters and Regional and Country Offices participated in the meeting. The meeting followed the 3-day meeting of the Regional NTD Programme Managers. The number of RPRG members has increased from 11 to 14, adding experts on trachoma, resource mobilization and helminthiasis. The RPRG was renamed the “Western Pacific Regional Programme Review Group on Neglected Tropical Diseases.”

In his opening remarks, the Regional Director for the Western Pacific, WHO, outlined the objectives of the RPRG and lauded its role in providing technical expertise to the Region’s NTD control/elimination programmes. Then, the Chairperson noted that the countries and areas lagging behind should be given full support to achieve the NTD control/elimination goals by 2020.

The Team Leader, Malaria, Other Vectorborne and Parasitic Diseases, WPRO, presented the Action Taken Report. The meeting reviewed the newly introduced virtual review process of joint requests for preventive chemotherapy medicines and made it clear that the RPRG will continue to play a major role in the review process. The meeting reviewed and approved the requests made by endemic countries and areas for preventive chemotherapy medicines, such as albendazole, diethylcarbamazine and mebendazole.

The members reviewed the lymphatic filariasis elimination programmes of the Region, particularly those of Wallis and Futuna, Tuvalu and Federal States of Micronesia, and gave recommendations for future courses of action. The RPRG also reviewed the lymphatic filariasis elimination verification reports submitted by three countries, Niue, Palau and Vanuatu. The success story of these countries was lauded by the members.

The meeting reviewed the incident of severe adverse events that occurred in the Lao People’s Democratic Republic following administration of praziquantel. It was felt that information related to reasons for the events should continue to be sought to pinpoint the exact reasons behind such events. The meeting also discussed the global and regional status of the trachoma burden and elimination, and expressed confidence that the Region will make progress in overcoming trachoma. Finally, the meeting assessed the steps taken on laboratory quality assurance.

During the discussion on resources mobilization, it was agreed that the NTD profile of the Region should be raised by publicizing the success stories and unprecedented progress made so far and identifying the resource gaps and the steps to fill the gaps.
1. INTRODUCTION

The Regional Programme Review Group (RPRG) Meeting, held on 19 July 2013 at the World Health Organization (WHO) Regional Office for the Western Pacific (WPRO) in Manila, Philippines, was scheduled at a critical time, coinciding with the World Health Assembly passing a historic resolution on neglected tropical diseases (NTDs). Also, for the first time, the RPRG has more experts on NTDs, suggesting the resolve of the Region to address all NTDs prevalent in its countries and areas.

The meeting focused on the review of lymphatic filariasis elimination verification reports submitted by three countries, newly introduced virtual review process for joint requests for preventive chemotherapy medicines, incidence of severe adverse events (SAEs) following administration of some preventive chemotherapy medicines, and enhanced efforts to control and eliminate trachoma.

1.1 Objectives

1) To review country requests for NTD drugs;

2) To analyse key challenges in achieving the NTD elimination and control goals in the Region;

3) To propose concrete steps to address these challenges, including massive scaling up of interventions and sustainability efforts; and

4) To provide specific recommendations for each endemic country and area to address NTD-related key challenges.

1.2 Opening remarks

Dr Shin Young-soo, Regional Director for the Western Pacific, WHO welcomed the RPRG members to Manila. He stated that he appreciated the members’ contribution to the preceding 3-day meeting of the programme managers, and that their expertise and experience gave a better understanding of the state of NTDs across the Region. Thanks to them, integrated national plans for the elimination of lymphatic filariasis and other NTDs are now in better focus. The programme managers came out of the sessions invigorated, with a fresh sense of Regional solidarity. The Regional Director noted that their knowledge must be made into workable and adequately funded plans that will carry the world towards its global NTD roadmap and regional NTD action plan goals.

He enumerated the four objectives of the RPRG meeting, and then stated that he appreciated the role that the RPRG has played in the remarkable progress towards eliminating lymphatic filariasis in the Region. He recalled that the RPRG was formed in 2001 as two groups for subregional programme review: one group was for the Mekong area and the other for Pacific island countries and areas. In 2011, the two RPRGs were merged to form one RPRG for the Region. Then, their functions were expanded to include not just lymphatic filariasis but other key NTDs as well. To add to the group's skills, a trachoma expert was brought on board in 2012.
and an expert on advocacy in 2013. The RPRG now consists of world-renowned experts in NTDs, vector control and advocacy, as well as representatives from various national programmes.

The Regional Director then noted that among all of the bodies that help WHO in its work, the RPRG has emerged as one of the most skilled and insightful. Its observations and recommendations have played a vital role in WHO’s belief that it can, at last, master NTDs.

In closing, he thanked those who came together in such a concerted manner to help tackle NTDs. To the companies that made drug donations through memoranda of understanding with WHO Headquarters, he extended a deep sense of gratitude and expressed that without their commitment, the Region would never have made the progress that it has made. He also thanked partners for their hard work and support, as no single organization can handle the NTD control task alone. Globally, financial resources have grown significantly in recent years, so he thanked partners for their continued generosity. He also thanked the governments of the Region, including the programme managers present during the week for rallying to the cause of NTDs.

The Chairperson, Professor Dato C. P. Ramachandran, then extended a warm welcome to all members. He highlighted that the RPRG has expanded, and its terms of reference have been broadened. He detailed that WPRO mainly focuses on two control programmes and five elimination programmes, and that the RPRG has a lot of work to do to strengthen the NTD control/elimination programmes. He stated that the regional NTD action plan is the Region’s roadmap and is a link between the global NTD roadmap and the Region. It is in line with the objectives that are envisaged to achieve Millennium Development Goals.

He also stated that while the Region is heading in the right direction and is well poised to control/eliminate NTDs, the lack of progress in Papua New Guinea is a cause for concern. It is a major player in the Region, but its involvement in NTD control activities is minimal. He reiterated that the RPRG has a major role to play in implementing national NTD control plans, and then thanked the Regional Director for his support of NTD control/elimination programmes.

2. PROCEEDINGS

2.1 Recommendations of the Regional Programme Review Group 2012

Dr Eva Christophel, Team Leader, Malaria, Other Vectorborne and Parasitic Diseases, WPRO, presented the objectives of the meeting and actions taken on the recommendations of the previous meeting.

The actions taken on the recommendations of the 2012 meeting are as follows.

2.1.1 Severe adverse events reporting following deworming in the Lao People’s Democratic Republic

WPRO requested that the Center for Malaria, Parasitology and Entomology and the Ministry of Health in the Lao People’s Democratic Republic use appropriate SAE reporting forms for recording each SAE. They were also advised to use the same forms to report the SAE to the concerned pharmaceutical company. Thus, the Ministry of Health is now using the
recommended forms to record SAEs. Recently occurred SAEs, following the administration of praziquantel for the treatment of foodborne trematodiases, were recorded on the recommended forms.

2.1.2 Use of GlaxoSmithKline-provided albendazole in neglected tropical disease control/elimination programmes in the Philippines

The Ministry of Health in the Philippines had expressed a preference to use locally procured drugs. As per the government’s decision, albendazole is now locally procured and used in accordance with the guidelines of the Department of Health.

2.1.3 Incineration of expired albendazole in Papua New Guinea

To ensure safe disposal of expired drugs, the National Department of Health in Papua New Guinea was advised to incinerate the stock of expired diethylcarbamazine and albendazole tablets. Dr Bieb Sabauk from Papua New Guinea, a member of the RPRG, stated that the drugs were incinerated as per the recommendation.

2.1.4 Introduction of virtual review process

To expedite the approval process of joint preventive chemotherapy drug requests by Member Countries, a virtual review process developed by WHO Headquarters was put in place and tested. Further, the country programmes were informed of changes in packaging of albendazole tablets, as well as GlaxoSmithKline’s change from 100-tablet to 200-tablet containers.

2.1.5 Lymphatic filariasis mass drug administration in Papua New Guinea

Towards initiating and strengthening NTD control activities in Papua New Guinea, an action plan was prepared with details of mass drug administration (MDA) implementation against lymphatic filariasis in two districts in New Ireland Province. However, MDA was not implemented in 2012.

2.1.6 Test and treat strategy

The RPRG, in 2012, recommended that Kiribati discontinue its test and treat strategy and instead implement two more rounds of MDA in the Line Islands. Accordingly, Kiribati implemented the first of the recommended two rounds in 2012, and the second round is slated for 2013. Fiji, which has also been following the test and treat strategy in some islands, was also advised to continue only if the programme can afford it. Fiji discontinued the test and treat strategy from the second quarter of 2013, taking into account the costs and logistics involved.

2.1.7 Lymphatic filariasis survey in New Caledonia

New Caledonia has yet to assess its lymphatic filariasis situation. WPRO, with the Pacific Island Country and Area NTD Focal Point, advised the Territorial Directorate of Health and Social Affairs to combine the lymphatic filariasis surveys with the planned nationwide arbovirus surveys. The survey commenced in June 2013.
2.1.8 Lymphatic filariasis transmission assessment survey results

Many countries and areas of the Region have stopped MDA against lymphatic filariasis and progressed to post-MDA surveillance activities, in which transmission assessment surveys are a major activity. Information on survey results is crucial to understand the progress of the countries, areas and Region towards elimination of lymphatic filariasis. Hence, as recommended by the last RPRG, Malaysia, as well as other countries and areas, were requested to incorporate survey results into their annual reports and have followed suit.

2.1.9 Transmission assessment surveys in Samoa

After implementing several rounds of MDA, the lymphatic filariasis situation in Samoa was assessed through transmission assessment surveys in the three evaluation units. Of the three, two evaluation units passed the transmission assessment survey while one failed. The Ministry of Health was advised to implement further MDA and to monitor the situation in the failed evaluation unit.

2.1.10 Follow-up of contacts in Tonga

The RPRG noted the progress made by the lymphatic filariasis elimination programme in Tonga, including the prevalence of the lymphatic filariasis antigen below the threshold level. Thus, the RPRG felt that it is no longer necessary to follow up with the contacts (i.e. family members of lymphatic filariasis-positive persons) with antigenaemia assessments. This was conveyed to the Ministry of Health, which is planning to perform the final transmission assessment survey in 2014.

2.1.11 Spot-check site surveys in Tuvalu

Tuvalu is close to stopping its MDA, but was advised to conduct two spot-check surveys first. They were conducted in 2013, showing prevalence of the antigen above the threshold level of 1%.

2.1.12 Regional Programme Review Group

As the RPRG’s mandate was expanded to include all NTDs, it was recommended that a trachoma expert be included in the RPRG. Accordingly, a trachoma expert has been appointed to the RPRG for a 3-year period. It was also agreed that the RPRG will be renamed the “Western Pacific Regional Programme Review Group on Neglected Tropical Diseases.”

The RPRG noted that country programmes should provide annual work plans to enable it to contextualize review of reports and reapplications, under the new joint application and review process. Accordingly, all of the countries and areas were advised to provide annual work plans along with annual reports. Also, the new virtual review process introduced by WHO envisages the development of annual plans and providing them along with Joint Reporting Forms and Joint Requests for Selected PC Medicines.

2.2 New virtual review process of Joint Requests for Preventive Chemotherapy Medicines

Dr Albis Gabrielli, Department of Neglected Tropical Diseases, WHO Headquarters, Geneva, detailed the introduction of a new set of forms (to replace the previous set of forms) to effectively deal with programme reporting challenges and accelerate the expansion of preventive
chemotherapy through hassle-free procurement of drugs by Member Countries. These forms include the (1) Preventive Chemotherapy Joint Reporting Form, (2) Form for Joint Request for Selected PC Medicines and (3) Annual Work Plan Form.

The forms are reviewed through a virtual process, involving two mechanisms. Under the first, WPRO will send the completed forms from Member Countries to WHO Headquarters, which will then share the forms with a global virtual review panel. The global panel includes, apart from other experts, some RPRG members. This global virtual review process is flexible in that the review process can be delegated to the RPRG if it includes experts in all relevant NTDs. Under the second mechanism, review will be done by the RPRG, with WPRO as secretariat. The forms with the RPRG recommendations will then be submitted to WHO Headquarters. In both mechanisms, the forms can be reviewed virtually and throughout the year.

Dr Mark Bradley, GlaxoSmithKline, suggested that the review facilitated by WHO Headquarters will have the advantages of having a single platform and uniformity in screening of applications from different Regions.

Professor C. P. Ramachandran stated that the RPRG and WPRO are responsible for guiding the programmes in the Region. They are also well aware of the regional NTD situation. Hence, they should have the primary role of screening the applications and forwarding them to WHO Headquarters.

It was concluded that the RPRG will, from now on, virtually review the forms, and send the review outcomes to WHO Headquarters through WPRO.

Recommendation: The virtual review process of joint reporting and joint applications should be done regionally. The RPRG should review them and make recommendations. WPRO, with the Country Offices, should coordinate this, and after review and clarification, send the forms and recommendations to WHO Headquarters for sharing with donors.

2.3 Review of drug applications and annual reports

WPRO received Joint Requests for PC Medicines from eight countries. The RPRG reviewed and approved the requests, as shown in Tables 1 and 2.

Table 1. Preventive chemotherapy medicines approved for 2013 by the Regional Programme Review Group for Member Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Drug</th>
<th>Disease</th>
<th>Quantity Requested (no. of tablets)</th>
<th>Quantity Approved (no. of tablets)</th>
<th>When Needed</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>ALB</td>
<td>LF</td>
<td>386 515</td>
<td></td>
<td>August 2013</td>
<td>The quantity is to be rechecked and clarified based on the RPRG recommendations.</td>
</tr>
<tr>
<td></td>
<td>DEC</td>
<td>LF</td>
<td>966 288</td>
<td></td>
<td>October 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALB</td>
<td>STH</td>
<td>238 171</td>
<td></td>
<td>October 2013</td>
<td></td>
</tr>
<tr>
<td>Kiribati</td>
<td>ALB</td>
<td>LF</td>
<td>8711</td>
<td>8711</td>
<td>August 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DEC</td>
<td>LF</td>
<td>21 778</td>
<td>21 778</td>
<td>August 2013</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALB</td>
<td>STH</td>
<td>39 469</td>
<td>39 469</td>
<td>August 2013</td>
<td></td>
</tr>
</tbody>
</table>
Table 2. Preventive chemotherapy medicines approved for 2014 by the Regional Programme Review Group for Member Countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Drug</th>
<th>Disease</th>
<th>Quantity Requested (no. of tablets)</th>
<th>Quantity Approved (no. of tablets)</th>
<th>When Needed</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>ALB</td>
<td>LF</td>
<td>386 515</td>
<td></td>
<td>August 2014</td>
<td>The quantity is to be rechecked and clarified based on the recommendations.</td>
</tr>
<tr>
<td></td>
<td>DEC</td>
<td>LF</td>
<td>966 288</td>
<td></td>
<td>August 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALB</td>
<td>STH</td>
<td>238 171</td>
<td></td>
<td>August 2014</td>
<td></td>
</tr>
<tr>
<td>Kiribati</td>
<td>ALB</td>
<td>STH</td>
<td>39 469</td>
<td>39 469</td>
<td>August 2014</td>
<td></td>
</tr>
<tr>
<td>Lao People’s Democratic Republic</td>
<td>ALB</td>
<td>LF</td>
<td>250 344</td>
<td></td>
<td>December 2014</td>
<td>The quantity needs to be revised and resubmitted.</td>
</tr>
<tr>
<td></td>
<td>PZQ</td>
<td>SCH</td>
<td>73 317</td>
<td>73 317</td>
<td>December 2014</td>
<td></td>
</tr>
<tr>
<td>Papua New Guinea</td>
<td>ALB</td>
<td>LF</td>
<td>529 742</td>
<td>529 742</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DEC</td>
<td>LF</td>
<td>2 648 742</td>
<td>2 648 742</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vanuatu</td>
<td>ALB</td>
<td>STH</td>
<td>90 000</td>
<td>90 000</td>
<td>January 2014</td>
<td></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>ALB</td>
<td>STH</td>
<td>9 274 445</td>
<td></td>
<td>May 2014</td>
<td>The number of rounds needs to be clarified.</td>
</tr>
</tbody>
</table>

ALB = albendazole, DEC = diethylcarbamazine, LF = lymphatic filariasis, PZQ = praziquantel, RPRG = Regional Programme Review Group, SCH = schistosomiasis, STH = soil-transmitted helminthiases.

Note: As of 19 July 2013.

Additional requests for preventive chemotherapy medicines for 2013 and 2014 are expected, and these requests will be reviewed virtually by RPRG members on an ad hoc basis via e-mail.

2.4 Technical issues

Technical issues pertaining to Pacific island countries and areas were presented by Dr Kim Sung Hye, NTD Focal Point for Pacific Island Countries and Areas, Fiji.
2.4.1 Wallis and Futuna

This French overseas territory consists of 23 islands, with a population of 14 900. Some of the islands were endemic for lymphatic filariasis caused by subperiodic *W. bancrofti*, with *Aedes polynesiensis* as the vector species. An antigenaemia prevalence survey was conducted in 2001 in all endemic areas, using the immunochromatographic (ICT) card test. This survey showed an antigenaemia prevalence of 0.8% (CI 0.3–1.6). This was followed by at least two rounds of MDA, one each in 2002 and 2003, with treatment coverage of 60.2% and 65.3%, respectively. Antigenaemia surveys were again performed in 2005 and 2006. A transmission assessment survey was conducted in 2012 (Table 3).

Table 3. Results of various antigenaemia surveys carried out in Wallis and Futuna

<table>
<thead>
<tr>
<th>Year</th>
<th>Diagnostic Method</th>
<th>Sampling Method</th>
<th>Number Sampled</th>
<th>Number Positive for Antigenaemia</th>
<th>Antigenaemia Prevalence % (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>ICT card test</td>
<td>Convenience</td>
<td>792</td>
<td>6</td>
<td>0.80 (0.3–1.6)</td>
</tr>
<tr>
<td>2002</td>
<td>MDA 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>MDA 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>ICT card test</td>
<td>6–12-year-old children survey</td>
<td>878</td>
<td>0</td>
<td>0.0 (0.0–0.3)</td>
</tr>
<tr>
<td>2006</td>
<td>ICT card test</td>
<td>Village cluster survey</td>
<td>1539</td>
<td>6</td>
<td>0.40 (0.1–0.9)</td>
</tr>
<tr>
<td>2012</td>
<td>ICT card test</td>
<td>All children of all elementary classes in all schools (13) (TAS)</td>
<td>1014</td>
<td>1+2</td>
<td>0.32 (3.935)</td>
</tr>
</tbody>
</table>

ICT = immunochromatographic, MDA = mass drug administration, TAS = transmission assessment survey.
Note: In 2012, the positive child was a 7-year-old girl from Futuna. There were two dubious/faint positives.

Recommendation: The surveys performed in 2005 and 2006 and the transmission assessment survey performed in 2012 revealed an antigenaemia prevalence of less than the threshold level, which suggests interruption of transmission. This provides an opportunity to stop MDA. The available information, however, suggests that MDA was continued during the last 5 years, although the details as to when the last MDA was implemented are not available. The RPRG recommends that the programme should conduct the final transmission assessment survey after the waiting period of 3 years.

2.4.2 Tuvalu

Tuvalu consists of nine inhabited islands with a population of 10 837. The country is endemic for subperiodic *W. bancrofti*, transmitted by *Aedes polynesiensis*. The baseline antigenaemia prevalence, measured in 1999, was 22.3%. Five rounds of annual MDA were implemented during 2001–2005, and treatment coverage rates of more than 75% were reported in four out of five MDAs. During 2007–2008, all people in the nine islands were targeted for blood tests, and the antigenaemia-positives were treated. The antigenaemia prevalence was 6.3%, a level much lower than the baseline level, but higher than the threshold level to stop MDA. From 2008 onwards, a test and treat strategy was implemented. In 2013, two spot-check surveys were conducted in two communities, sampling 500 persons in each site. Although these surveys suggest a declining antigenaemia trend, its prevalence continues to be higher than the threshold level of 1% (Figure 1).
Figure 1. Mass drug administration coverage and prevalence of antigenaemia during different years in Tuvalu

ICT = immunochromatographic, MDA = mass drug administration.

Recommendation: As the antigenaemia prevalence observed in 2013 is higher than the threshold level, at least two more rounds of MDA should be conducted before re-checking the antigenaemia prevalence.

2.4.3 Federated States of Micronesia

The Federated States of Micronesia consist of 607 islands with a population of 106,918. There are four states in the country: Yap, Chuuk, Pohnpei and Kosrae. Historically, the four states were endemic (Table 4). At the beginning of the Pacific Programme to Eliminate Lymphatic Filariasis, Yap was the only state that was considered endemic among Pacific island countries.

Table 4. Prevalence of microfilaria and antigenaemia in different states of the Federated States of Micronesia, 1953–2012

<table>
<thead>
<tr>
<th>Year</th>
<th>Yap</th>
<th>Chuuk</th>
<th>Pohnpei</th>
<th>Kosrae</th>
</tr>
</thead>
<tbody>
<tr>
<td>1953a</td>
<td>12.6</td>
<td>22.5</td>
<td>3.2</td>
<td></td>
</tr>
<tr>
<td>1992a</td>
<td></td>
<td></td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>2000–2001</td>
<td>2.0 (19/971)</td>
<td>0.2 (4/2186)</td>
<td>0.0 (0/716)</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>34.0 (91/266)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007–2008</td>
<td>0.1 (1/720)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.0 (0/735)</td>
<td>1.69% (16/946)b</td>
<td>0.0 (0/1077)</td>
<td>0.0 (0/468)</td>
</tr>
</tbody>
</table>

*aMicrofilaria prevalence values for the other years pertain to antigenaemia prevalence, assessed using the immunochromatographic card test.
*bOf the 16 positives in Chuuk, 15 (n = 446) were detected in the outer islands, and 1 (n = 500) was detected in Weno.

In 2012, surveys were conducted in children attending grades 9–12 in Yap and Kosrae and grade 9 in Chuuk and Pohnpei as per the previous RPRG recommendation to test 1000 students in each state. Three out of four states showed 0% antigenaemia prevalence. In the fourth state, Chuuk, the antigenaemia prevalence in the outer islands, except Weno, was 1.69% (Table 4), which is slightly higher than the threshold level.
Recommendation: As the number of children detected with antigenaemia in Chuuk exceeds the threshold number, at least two more rounds of MDA should be conducted followed by a transmission assessment survey.

2.4.4 Lao People’s Democratic Republic

The country has detected two persons with antigenaemia in a village in one of the four districts in Attapeu Province, which adjoins the endemic province of Champasak and is, so far, been considered to be nonendemic.

Recommendation: In view of detecting antigenaemia-positive individuals, mapping of adjoining districts or provinces should be undertaken. Antigenaemia-positive individuals and family members should be treated, and two rounds of MDA (i.e. one round each in 2013 and 2014) should be implemented in 10 villages around the endemic village as a precautionary measure. Technical assistance should be provided to the country as required.

2.4.5 Other countries and areas

During this session, additional country-specific recommendations were made as follows.

1) Malaysia has made significant progress towards elimination of lymphatic filariasis. Only two implementation units have antibody prevalence around 1%. Both of these provinces should provide one more round of MDA.

2) The Lao People’s Democratic Republic, Solomon Islands and Viet Nam should revise their drug requirements and submit revised application forms for preventive chemotherapy as soon as possible.

3) Samoa should submit an application form for preventive chemotherapy medicines for 2014.

4) The Philippines should be encouraged to use donated diethylcarbamazine (100-milligram tablets) for MDA.

5) The Federated States of Micronesia should conduct two rounds of MDA in its outer islands and the lagoon area of Chuuk, except in Weno, ideally in 1 year. This activity may be combined with other public health interventions such as the Expanded Programme on Immunization, to ease logistics.

6) Tuvalu should conduct two more rounds of MDA; these should be complemented by vector control, ideally long-lasting insecticidal nets, as antigenaemia prevalence is higher than the threshold level.

7) Support should be expanded and various opportunities explored to initiate the NTD control programme in Papua New Guinea to achieve the goals as envisaged in regional NTD action plan.
2.5 Review of lymphatic filariasis reports

Three Pacific island countries—Palau, Niue and Vanuatu—submitted reports for verification of lymphatic filariasis elimination, which were circulated to RPRG members. Dr Eric Ottesen and Dr Patrick Lammie presented the outcome of the review. Dr Ottesen highlighted that the role of the RPRG is to review the proposal, request an expert team to review the report as needed, advise if the report needs clarification, and make recommendations to the NTD Strategic and Technical Advisory Group at WHO Headquarters. He also noted the guidance available for the preparation of lymphatic filariasis reports.1

Dr Lammie presented the outcome of the review. He applied the following criteria for evaluation: (1) evidence for good MDA, (2) evidence for making decisions on the basis of sentinel site and spot-check site surveys, and (3) evidence for robust surveillance activities.

2.5.1 Niue

The population of Niue was 1639 in 2004. Niue was endemic for bancroftian filariasis transmitted by Aedes cooki. The baseline antigenaemia prevalence, assessed in 1999, was 3.1% (n = entire population). Five rounds of MDA were implemented during 2000–2004, and the second post-MDA survey showed antigenaemia prevalence of only 0.5% (Table 5).

Table 5. Results of lymphatic filariasis antigenaemia surveys in Niue

<table>
<thead>
<tr>
<th>Survey Type</th>
<th>Year</th>
<th>Sampling</th>
<th>Number Positive/Number Examined</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1999</td>
<td>Whole population</td>
<td>56/1794</td>
<td>3.1%</td>
</tr>
<tr>
<td>Midterm</td>
<td>2001</td>
<td>Whole population</td>
<td>22/1630</td>
<td>1.3%</td>
</tr>
<tr>
<td>Post-MDA 1 (TAS)</td>
<td>2004</td>
<td>Whole population</td>
<td>3/1285</td>
<td>0.2%</td>
</tr>
<tr>
<td>Post-MDA 2 (TAS)</td>
<td>2009</td>
<td>Whole population</td>
<td>7/1378</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

MDA = mass drug administration, TAS = transmission assessment survey.

Recommendation: The report provided adequate information and is satisfactory. Niue has a very small population, enabling the entire population to be sampled with only one person detected with antigenaemia, and he was treated. Niue has clearly reached the level of elimination of lymphatic filariasis as a public health problem. The Niue report should be forwarded to the NTD Strategic and Technical Advisory Group, WHO Headquarters for endorsement.

2.5.2 Palau

The population of Palau was 17 501 in 2012. The country was endemic for bancroftian filariasis transmitted by Culex quinquefasciatus. Evidence from literature suggests a declining trend in lymphatic filariasis prevalence from 1950s onwards.

Extensive baseline antigenaemia surveys were carried out in 2001, identifying 1 of the 15 states (i.e. Ngardmau) with a prevalence of antigenaemia higher than the threshold level. More surveys were carried out in 2002–2003. The people found with antigenaemia were treated with antifilarial drugs.

A countrywide transmission assessment survey was conducted in 2012 using random sampling. In the states of Ngardmau and Ngchesar, 100% of the households were targeted for

sampling to detect all antigenaemia-positive individuals as the historical data indicated high prevalence there. The results of the survey are summarized in Table 6. Twelve out of 13 sampled states showed 0% antigenaemia prevalence. In the 13th state, Ngardmau, two persons (n = 149) were found with antigenaemia and treated.

Table 6. Results of lymphatic filariasis antigenaemia surveys in Palau, 2012

<table>
<thead>
<tr>
<th>State</th>
<th>Number Examined</th>
<th>Number Positive (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aimeliik</td>
<td>41</td>
<td>0</td>
</tr>
<tr>
<td>Airai</td>
<td>162</td>
<td>0</td>
</tr>
<tr>
<td>Angaur</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Koror</td>
<td>1167</td>
<td>0</td>
</tr>
<tr>
<td>Melekeok</td>
<td>71</td>
<td>0</td>
</tr>
<tr>
<td>Ngaraad</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>Ngarchelong</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>Ngardmau</td>
<td>149</td>
<td>2 (1.34)</td>
</tr>
<tr>
<td>Ngatpang</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Ngchesar</td>
<td>165</td>
<td>0</td>
</tr>
<tr>
<td>Ngeremlengui</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Ngiwal</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Peleliu</td>
<td>49</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1963</td>
<td>2 (0.10)</td>
</tr>
</tbody>
</table>

**Recommendation:** While the results are satisfactory, there is a need for additional information on the steps taken to prevent the reintroduction of infection and screening of migrant workers arriving from other endemic countries. Such reintroduction is always a possibility, as 16% of the population is from another endemic country, the Philippines. The report can be reviewed further after the additional information is provided.

It was also recommended that the Ministry of Health develop a mechanism, in conformity with ethical guidelines, to screen immigrants and migrant workers, particularly those coming from endemic countries, to prevent reintroduction of lymphatic filariasis. Additional information should be provided on the steps to be taken by the Ministry of Health to prevent the risk of reintroduction of lymphatic filariasis through migrant workers.

2.5.3 Vanuatu

The population of Vanuatu was 234,023 in 2009. The country was endemic for lymphatic filariasis transmitted by *Anopheles farauti*. The baseline antigenaemia prevalence, evaluated in 1997–1998, was 4.8%. Five rounds of MDA were implemented during 2000–2004. The treatment coverage ranged from 66% to 84%, and it was directly observed treatment. The surveys post-MDA conducted in 2005–2006 showed 0.0% microfilarial prevalence and antigenaemia prevalence below the threshold level. Subsequent transmission assessment surveys (Table 7) also showed 0% antigenaemia prevalence. There is a strong malaria control programme, and bednets are distributed under the programme.
Table 7. Results of the transmission assessment survey 3 in Vanuatu

<table>
<thead>
<tr>
<th>Evaluation Unit</th>
<th>Province</th>
<th>6-7-Year-Old Population</th>
<th>Number Tested</th>
<th>Number Positive for Antigenaemia</th>
<th>Percent Positive for Antigenaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Torba Stage 1 (2010)</td>
<td>380</td>
<td>73</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Sanma Stage 1 (2010)</td>
<td>1397</td>
<td>1587</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>1777</td>
<td>1660</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>2</td>
<td>Penama Stage 3 (2012)</td>
<td>1034</td>
<td>930</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Malampa Stage 1 (2010)</td>
<td>1207</td>
<td>643</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>2241</td>
<td>1573</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>3</td>
<td>Shefa Stage 2 (2010)</td>
<td>1831</td>
<td>91</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Stage 4 (2012)</td>
<td></td>
<td>653</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Tafea Stage 2 (2010)</td>
<td>1,220</td>
<td>50</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Stage 4 (2012)</td>
<td></td>
<td>453</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>3051</td>
<td>1247</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>VANUATU TOTAL</td>
<td></td>
<td>7069</td>
<td>3374</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Recommendation: The data clearly suggest that lymphatic filariasis has been eliminated. The report included all required information, but, the data should be more effectively presented. A more robust report should be prepared and submitted to WPRO, which should facilitate its review by an expert and circulate the review results to RPRG members.

2.5.4 Overall recommendations on reports

Members expressed that the reports submitted by the three countries are commendable success stories, and the report submission process should be expedited.

Recommendations:

1) All three reports should be submitted via the Monitoring and Evaluation Working Group to the NTD Strategic and Technical Advisory Group, WHO Headquarters. The reports should contain morbidity information.

2) WHO Headquarters should clarify the process of verification of elimination (including the need for post-verification surveillance depending on the prevalent mosquito vector) and produce guidelines.

3) The RPRG should continue to provide technical assistance in preparing adequate reports. Assistance for reports is time-consuming and possibly involves country visits. Funding should be raised for this investment.

2.5.5 Other issues

Dr David Addiss inquired whether any report included details on morbidity management programmes. Dr Patricia Graves reported that Vanuatu noted a total of about 100 cases in 2003. Overall, very minimal information was included on morbidity management issues in the reports.
Dr Ichimori clarified that there are plans to make a morbidity management programme part of the report.

2.6 Severe adverse events

Dr Padmasiri Eswara Aratchige, Technical Officer, WPRO, presented details on the 2012 incidence of SAEs in communities treated with praziquantel in MDA against foodborne trematodiasis (FBT) in Champasak Province in the Lao People’s Democratic Republic. Three people, who took treatment under the MDA programme, died within a few days after the MDA.

Praziquantel tablets have been used in the province since 1996 in the campaign to control and eliminate schistosomiasis. This is the first time SAEs were reported from the country. Following the report of SAEs, the FBT MDA programmes were stopped in Cambodia, the Lao People’s Democratic Republic and Viet Nam, because they all used the same source of praziquantel.

A joint team, comprising staff from the Ministry of Health of the Lao People’s Democratic Republic, WHO Headquarters and WHO Country Offices, investigated the SAEs. The team visited the affected communities and conducted a verbal autopsy of the affected individuals. The drugs used in the programme were subjected to conformity tests in two laboratories, a WHO reference laboratory in Viet Nam and a laboratory in Portugal. Toxicity, tested in mice, was inconclusive. The investigations concluded that all samples of praziquantel met stated compendial standards. The actual cause of the deaths could not be explained, because no post-mortems were conducted on the diseased. One person was suspected to have had neurocysticercosis.

Recommendation: To better understand the risk of SAEs during FBT campaigns with praziquantel, prevalence of human cysticercosis should be assessed (using antibody tests) in areas targeted for MDA.

2.7 Response to adverse events

Dr Padmasiri presented on the issue of surveillance of SAEs. He gave the definition for SAEs and cited the WHO publications that give information on monitoring SAEs. He listed the components of minimal pharmacovigilance for the NTD endemic countries and areas, and drew attention to the one followed in the Expanded Programme on Immunization. He emphasized the need for simple mechanisms for reporting, investigating and responding to SAEs and data management.

Recommendation: Pharmacovigilance systems in all endemic countries and areas should be established and/or strengthened. Preventive chemotherapy medicines should be covered in the national pharmacovigilance system, and national capacity should be built for both regular reporting of SAEs from preventive chemotherapy MDA programmes and for causality analysis and decision-making for appropriate action. In countries and areas where very limited expertise exists for causality analysis and risk determination, a regional expert advisory group (ad hoc or regularly established) may provide the needed technical advice. With WHO Headquarters and the Working Group on Capacity Strengthening for Control of NTDs, adverse event surveillance systems should be explored and established at national and regional levels, similar to the Expanded Programme on Immunization model for surveillance of vaccine-related SAEs.


2.8 **Way forward on trachoma**

Dr Hugh Ringland Taylor presented the trachoma global burden and the scenario in the Region. Globally, 325 million people living in 53 countries and areas are at risk of trachoma, and 21.3 million children are affected with trachomatous inflammation, follicular and 7.3 million with trachomatous trichiasis. Improvements in living conditions and control efforts have led to a decrease of active trachoma cases from an estimated 400 million–500 million in 1971 to 40.6 million in 2007, and blindness from 6 million–7 million in 1981 to 1.6 million in 2003.

The target date to eliminate trachoma in the Region is 2020. The elimination criteria are trachomatous inflammation, follicular prevalence of less than 5.0% in children ages 1–9 years, trachomatous trichiasis of less than 0.1% and corneal blindness of less than 1 per 10 000. Political commitment and resources are essential to achieve trachoma elimination by 2020.

WHO recommended implementation of the SAFE strategy in 1993. There is a tremendous need to scale up surgery for trachomatous trichiasis to clear the backlog, and scale up antibiotic treatment in the next few years. If the scale-up takes place as expected, the antibiotic treatment can be scaled down from 2017 onwards.

Although trachoma disappeared from most of Australia 100 years ago, it continues to be a problem in Aboriginal children. Thus, the Prime Minister announced $16.0 million in 2009 and a further $16.5 million in 2013 for trachoma elimination. Health education and social marketing of the SAFE strategy are the key components of the elimination programme in Australia. These, combined with increased community screening and treatment coverage, have led to a marked decline of trachoma prevalence after 2009.

In a study of trachoma prevalence in Pacific island countries and areas, Dr Anu Mathew examined the situation among children of ages 1–10 years for active trachoma and all adults age 40 years and above for trichiasis and scarring. These surveys were conducted in schools, through door-to-door visits and/or via central meeting places.

Current activities in the Pacific include mapping (2012–2013) in Fiji, Kiribati, Solomon Islands and Vanuatu. The mapping exercise is funded by the Australian Agency for International Development and the Avoidable Blindness Initiative.

Table 8: Prevalence rate of trachoma in selected Pacific island countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Trachomatous Inflammation, Follicular Prevalence (%)</th>
<th>Trachomatous Trichiasis Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiji</td>
<td>15.4</td>
<td>8.0</td>
</tr>
<tr>
<td>Kiribati</td>
<td>16.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Solomon Islands</td>
<td>21.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Data not available</td>
<td>Data not available</td>
</tr>
</tbody>
</table>

Solomon Islands may start an MDA programme to bring down its prevalence rate. Prevalence surveys are being conducted in selected provinces, funded by Lions Club International with WHO Headquarters input, and an impact assessment is planned in selected districts with funding from the United States Agency for International Development (USAID). Similarly, the Lao People’s Democratic Republic and Cambodia are planning prevalence surveys with support from USAID to assess progress and for planning future courses of action.
Dr Taylor also clarified that mapping is not yet complete in the Region. For example, there is no information on trachoma status in New Caledonia or Nauru. He highlighted that there are a lot of commonalities and synergies in intervention activities against trachoma and other NTDs, including hygiene, morbidity management and mass treatment. The small Pacific island countries and areas have a tremendous advantage as a result of these synergies. It is important to ensure quality in the services provided and monitoring and evaluation activities.

Recommendation: Trachoma mapping should be progressed quickly so that the SAFE strategy can be started where needed. Commonalities with other programmes should be explored, especially in small Pacific island countries and areas.

2.9 Update and way forward on laboratory quality assurance

Dr Xiao-Nong Zhou presented a report on the First External Quality Assessment on NTD Diagnostic Techniques in the Region. External quality assessment is required to achieve continuous quality improvement; assess the effectiveness of all elements in quality; help set up internal and external mechanisms of assessment; and achieve internal assessment by the use of batch controls, staff competency testing and audits. The goal of the assessment is improving the capabilities of participating laboratories for parasitic diseases in South-East Asia.

The first workshop with a focus on helminth diagnostic techniques was held in China in September 2012. Personnel from Cambodia, Malaysia, Philippines and Viet Nam participated in the workshop. The quality of the morphological detection of helminth eggs using direct smear and Kato-Katz techniques and IHA and ELISA tests was assessed. The exercises in the workshop included preparation of sera panel and instructions on standard operating procedures. The results of the quality assessment showed that the accuracy rates for both morphological detection and IHA and ELISA tests were 100%. However, some participants showed low identification ability of eggs, especially with Kato-Katz slides. A follow-up training course was held in Ha Noi, Viet Nam in November 2012, in which more than 30 professionals participated. The meetings recommended that the workshops should be held annually.

Recommendation: External quality assurance of NTD laboratory diagnosis should be continued. National NTD laboratory capacity should be strengthened.

2.10 Raising the profile of neglected tropical diseases in the Region

Ambassador Michael Marine suggested that the RPRG members and WPRO maintain the excellent momentum generated to overcome the burden of NTDs. He suggested that the first task for RPRG and WPRO is to identify the needs of the programmes, the needs of the affected countries and areas, and the source(s) of support to address the needs. Everyone should start thinking about 2020, the target date to achieve control and elimination of NTDs. Also, there is need to identify countries and areas that can be pitched to donors, as donors would like to know the progress of the programmes and what is being done to reach the targets. Evidence is needed for success.

He suggested that the Government of Australia is in a position to support a trachoma elimination campaign. However, a pipeline of services and capacity-building must be created, including improving quality control. Needs for research and monitoring and evaluation as well as surveillance should also be identified. The Global Network for Neglected Tropical Diseases is in a position to support the Region’s needs to maintain the momentum.
The members supported his remarks and agreed that there are good success stories from the Region, which should be publicized.

Recommendation: Funding gaps for 2015–2016 should be identified now. Countries and WHO should call for this support from key donors, aggressively, in finite pieces, but broadly (i.e. not just for preventive chemotherapy). Each RPRG member should actively engage in mobilizing resources for NTD control. Support should be found to record the many success stories of the Region.

2.11 Other issues

2.11.1 Vector status of lymphatic filariasis endemic countries

Members expressed that in some countries, the mosquito vector species for lymphatic filariasis has not yet been identified. Steps may be taken to identify the species responsible for lymphatic filariasis transmission in these places.

2.11.2 Buffer stock of drugs for Pacific island countries and areas

Members discussed the possibility of having a buffer stock of preventive chemotherapy drugs for the Region. However, it has been expressed by many members that the maintenance of warehouses and buffer stock is cumbersome and may not be viable. Hence, members suggested that the countries and areas should be advised to better estimate the drug requirements for NTD control/elimination programmes, including buffers, and prepare the joint requests well in advance to facilitate procurement of drugs early.

2.11.3 Operational research priorities for neglected tropical diseases

Members expressed the need for a periodic review of operational research needs of the programme. The Region, countries and areas should participate in research activities. International organizations should take WPRO into confidence when planning and implementing research studies in the Region.

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

1) Countries and areas that have so far not identified lymphatic filariasis vectors must take action to determine and document this information.

2) While the role of antigenaemia detection, using the ICT card test, is being tested widely for ceasing MDA and transmission assessment surveys, the value of the Brugia Rapid test in transmission assessment surveys needs to be studied and standardized.

3) The literature on the incidence and causality of SAEs following MDA for control/elimination of schistosomiasis must be reviewed.
3.2 Recommendations

1) The RPRG should be renamed the “Western Pacific Regional Programme Review Group on Neglected Tropical Diseases”; the changed name and the finalized terms of reference should be attached as an annex to the minutes of the RPRG meeting.

2) The virtual review process of joint reporting and joint applications should be done regionally. The RPRG should review them and make recommendations. WPRO, jointly with Country Offices, should coordinate this, and after review and clarification, send the forms and recommendations to WHO Headquarters for sharing with donors.

3.3 Technical issues in countries and areas

1) The Lao People’s Democratic Republic has detected two individuals with lymphatic filariasis antigenaemia in a village in one of the four districts in Attapeu Province. The province adjoins the endemic province of Champasak and has so far been considered nonendemic. In view of detecting antigenaemia-positive individuals, mapping of adjoining districts/provinces should be undertaken. Antigenaemia-positive individuals and family members should be treated, and two rounds of MDA should be implemented, i.e. one round each in 2013 and 2014, in 10 villages around the endemic village as a precautionary measure. Technical assistance should be provided to the country as and when required.

2) Malaysia has made significant progress towards elimination of lymphatic filariasis, as only two implementation units have antibody prevalence around 1%. Both of these provinces should provide one more round of MDA.

3) The Lao People’s Democratic Republic, Solomon Islands and Viet Nam should revise their drug requirements and submit revised request forms for preventive chemotherapy medicines as soon as possible.

4) Samoa should submit an application for preventive chemotherapy medicines for 2014.

5) The Philippines should be encouraged to use donated diethylcarbamazine (100-milligram tablets) for MDA.

6) The Federated States of Micronesia should conduct two rounds of MDA in the outer islands and the lagoon area of Chuuk, except in Weno, ideally in 1 year. This activity may be combined with other public health interventions such as the Expanded Programme on Immunization to ease logistics.

7) Tuvalu should conduct two more rounds of MDA; these should be complemented by vector control, ideally the use of long-lasting insecticidal nets, as antigenaemia prevalence is higher than the threshold level.

8) All support should be extended to initiate the NTD control programme in Papua New Guinea to achieve the goals as envisaged in the Regional NTD action plan.

9) To better understand the risk of SAEs during FBT campaigns with praziquantel, the prevalence of human cysticercosis should be assessed (using an antibody test) in areas targeted for MDA.
10) Pharmacovigilance systems in all endemic countries and areas should be established and/or strengthened. Preventive chemotherapy medicines should be covered in the national pharmacovigilance system, and national capacity should be built for both regular reporting of adverse events from preventive chemotherapy MDA programmes and for causality analysis and decision-making for appropriate action. In countries and areas where very limited expertise exists for causality analysis and risk determination, a regional expert advisory group (ad hoc or regularly established) may provide the needed technical advice. With WHO Headquarters and the Working Group on Capacity Strengthening for Control of NTDs, SAE surveillance systems should be established at the national and regional levels, similar to the Expanded Programme on Immunization model for surveillance of vaccine-related adverse events.

11) Trachoma mapping should be progressed quickly so that the SAFE strategy can be started where needed. Commonalities with other programmes, such as integration of yaws mapping into trachoma mapping, should be explored, especially in Pacific island countries and areas.

12) An azithromycin noninferiority trial for dose recommended for trachoma should be carried out against yaws.

13) External quality assurance of NTD laboratory diagnosis should be continued. National NTD laboratory capacity should be strengthened.

14) Funding gaps for 2015–2016 funding gaps should be identified now. Countries, areas and WHO should call for this support from key donors, aggressively, in finite pieces, but broadly. Each RPRG member should actively engage in mobilizing resources for NTD control. Support should be found to tell and record the many success stories this Region has to show.

3.4 Lymphatic filariasis reports

1) Additional information should be provided in the Palau report on steps to be taken by the Ministry of Health to prevent the risk of reintroduction of lymphatic filariasis through migrant workers.

2) The Vanuatu report included all required information, but it was not presented effectively. A more robust report should be prepared and submitted to WPRO, which should facilitate its review by an expert and circulate the review results to RPRG members.

3) All three reports should be submitted via the Monitoring and Evaluation Working Group to NTD Strategic and Technical Advisory Group, WHO Headquarters.

4) The reports should contain morbidity information.

5) 3.4.5 WHO Headquarters should clarify the process of verification of lymphatic filariasis elimination (including the need for post-verification surveillance depending on the prevalent mosquito vector) and produce guidelines.
6) The RPRG should continue to provide technical assistance in preparing adequate reports in the future. Assistance for reports is time-consuming and possibly involves country visits, so funding should be raised for this investment.
Western Pacific Regional Program Review Group (RPRG) on Neglected Tropical Diseases (NTD)

Terms of Reference

The Regional Program Review Group will function as an independent group of experts to advise WHO on:

1. Technical issues related to the planning, implementation and assessment of national lymphatic filariasis elimination programmes.
2. Requests for medicines and diagnostics supplied by donation programmes such as Glaxo SmithKline, Merck, Eisai and Johnson & Johnson.
3. Applications by countries for verification of elimination of NTDs.
4. Technical issues related to the planning, implementation and assessment of control/elimination programmes for other neglected tropical diseases of public health importance in the Region.
5. Operational research related to neglected tropical diseases.
6. Advocacy and support for resource mobilization for LF and other NTD programmes.

Meetings

The RPRG will meet at least once a year at a place and time to be determined by the Secretariat.

Secretariat

The WHO Regional Office for the Western Pacific will serve as the Secretariat.

Membership

1. Appointment of Members

Members are appointed for 3 year terms by the WHO Regional Director based on the recommendation of the MVP Team Leader. Membership can be extended for one additional period of 3 years subject to approval by the Regional Director.

Members will be chosen based on their areas of expertise:
- 2 experts on lymphatic filariasis
- 1 expert on soil transmitted helminths
- 1 expert on foodborne trematodes
- 1 expert on schistosomiasis
- 1 expert on trachoma
- 1-2 experts on other neglected tropical diseases such as yaws and echinococcosis
- 1 expert on disease vector control
- 1 expert on monitoring & evaluation or epidemiology
- 1 expert on communications
- 1 expert on fund raising
- 1-2 National NTD Programme Manager/s.

2. **Chair and Vice Chair**

   The WHO Regional Director for the Western Pacific will appoint a Chairperson. The group will select from among the members the Vice Chairperson. Both will serve for a period of three years.

3. **Observers**

   Other experts or representatives of partner agencies may be invited by the WHO Regional Director to attend the annual meetings as resource persons or as observers.
### Agenda

**Meeting of the Western Pacific Regional Programme Review Group on Lymphatic Filariasis and other Neglected Tropical Diseases**  
**July 19, 2013**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Name</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 - 8:30</td>
<td>Registration</td>
<td></td>
<td>0:30</td>
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<tr>
<td>8:30 - 8:40</td>
<td>Welcoming remarks by the Regional Director</td>
<td>Dr. Shin Young-soo</td>
<td>0:10</td>
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<tr>
<td>8:40 - 8:50</td>
<td>Welcoming remarks by the RPRG Chairperson</td>
<td>Prof. Dato CP Ramachandran</td>
<td>0:10</td>
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<tr>
<td>8:50 - 9:00</td>
<td>Self-introductions</td>
<td>Participants</td>
<td>0:10</td>
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<tr>
<td>09:00 - 09:30</td>
<td>Group photograph &amp; Coffee break</td>
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<tr>
<td>09:30 – 10:15</td>
<td>Objectives of the meeting, and actions taken on the recommendations of the last RPRG meeting</td>
<td>Dr. Eva Christophel</td>
<td>0:15</td>
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<tr>
<td>10:15 - 12:15</td>
<td>Review of drug applications and annual reports</td>
<td>Dr Muth Sinuon/ Dr Hiroshi Ohmoe</td>
<td>0:15</td>
</tr>
<tr>
<td>10:15 - 12:15</td>
<td>Summary of previous review</td>
<td>Dr Patrick Lammie/ Prof Zhou Xiao-nong</td>
<td>0:15</td>
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<tr>
<td>10:15 - 12:15</td>
<td>Summary of previous work and plan for implementation</td>
<td>Dr Eric Ottesen/ Prof CP Ramachandran</td>
<td>0:15</td>
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<tr>
<td>10:15 - 12:15</td>
<td>Summary of previous work and plan for implementation</td>
<td>Dr Patricia Graves/ Dr Bieb Sibau</td>
<td>0:15</td>
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<tr>
<td>10:15 - 12:15</td>
<td>Summary of previous work and plan for implementation</td>
<td>Prof Juerg Utzinger/ Dr Bieb Sibau</td>
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<tr>
<td>10:15 - 12:15</td>
<td>Summary of previous work and plan for implementation</td>
<td>Dr. Wayne Melrose/ Dr Patrick Lammie</td>
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<td>10:15 - 12:15</td>
<td>Summary of previous work and plan for implementation</td>
<td>Prof Zhou Xiao-Nong/ Dr Muth Sinuon</td>
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<tr>
<td>12:15 - 12:15</td>
<td>Technical issues (continued)</td>
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<tr>
<td>13:15 - 13:30</td>
<td>Technical issues (continued)</td>
<td>Dr. Kim Sung-hye</td>
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<td>13:30 – 14:00</td>
<td>Technical issues (continued)</td>
<td>Dr. Eric Ottesen/ Dr. Patrick Lammie</td>
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<td>14:00 - 14:30</td>
<td>Technical issues (continued)</td>
<td>Prof. Dato CP Ramachandran</td>
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<td>14:30 - 14:45</td>
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<td>14:45 - 15:30</td>
<td>Technical issues (continued)</td>
<td>Dr Padmasiri Aratchige</td>
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<td>15:30 - 16:00</td>
<td>Technical issues (continued)</td>
<td>Dr Padmasiri Aratchige</td>
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<td>16:00 - 16:30</td>
<td>Technical issues (continued)</td>
<td>Prof Hugh Taylor</td>
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<td>16:30 - 17:00</td>
<td>Technical issues (continued)</td>
<td>Prof Zhou Xiao-nong</td>
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<td>16:30 - 17:00</td>
<td>Technical issues (continued)</td>
<td>Amb. Michael Marine</td>
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<td>16:30 - 17:20</td>
<td>Technical issues (continued)</td>
<td>Prof Dato CP Ramachandran</td>
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<tr>
<td>17:10 - 17:20</td>
<td>Technical issues (continued)</td>
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</table>

**Recommendations and conclusions**

**16:30 - 17:00** Recommendations  
**17:00 - 17:10** Closing remarks  
**17:10 - 17:20** Vote of Thanks
INFORMATION BULLETIN NO. 2

LIST OF TEMPORARY ADVISERS, REPRESENTATIVES/OBSERVERS AND SECRETARIAT

1. TEMPORARY ADVISERS

Dr Sibauk Vivaldo Bieb
Programme Manager
Disease Control and Surveillance
Department of Health
Level 3, Aopi Centre
Waigani, Papua New Guinea
Tel No. : +675 301 3703
Fax No. : +675 323 9710
E-mail : svbieb@gmail.com

Dr Patricia Graves
Senior Principal Research Fellow
Faculty of Medicine, Health & Molecular Sciences
School of Public Health, Tropical Medicine & Rehabilitation Sciences
James Cook University
Cairns, Queensland, Australia
Tel No. : +61 7 404 21088
Fax No. : +61 7 404 21216
E-mail : patricia.graves@jcu.edu.au
Dr Patrick Lammie
Senior Scientist
Division of Parasitic Diseases and Malaria
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, Georgia
United States of America
Tel No. : +1 404 718 4135
Fax No. : +1 404 718 4193
E-mail : pjl1@cdc.gov

Ambassador Michael Marine
Chief Executive Officer
Global Network for Neglected Tropical Diseases
Sabin Vaccine Institute
2000 Pennsylvania Avenue
NW, Suite 7100
Washington, D.C.
United States of America
Tel No. : +1 202 842 5025
Fax No. : +1 202 842 7689
E-mail : michael.marine@sabin.org

Dr Wayne David Melrose
Adjunct Associate Professor
Anton Breinl Center
James Cook University
38 Stuart Street
Townsville, Queensland, Australia
Tel No. : +61 7 47 816 175
Fax No. : +61 7 47 815 254
E-mail : nmelrose5@bigpond.com

Dr Muth Sinuon
Programme Manager of Helminthiasis
National Center for Parasitology, Entomology and Malaria Control
Ministry of Health
No. 322 Monivong Boulevard
Phnom Penh, Cambodia
Tel No. : +855 12 926 266
E-mail : sinuonm@cnm.gov.kh
Dr Hiroshi Ohmae  
Head  
Laboratory for Parasitic Diseases in the Tropics  
National Institute of Infectious Diseases  
1-23-1 Toyama  
Shinjuku-ku  
Tokyo 162-8640, Japan  
Tel No. : +81 3 5285 1111  
Fax No. : +81 3 5285 1173  
E-mail : h-ohmae@nih.go.jp

Dr Eric Ottesen  
Director  
'Envision'  
The Task Force for Global Health  
325 Swanton Way  
Decatur, Georgia  
United States of America  
Tel No. : +1 404 687 5604  
Fax No. : +1 404 371 1138  
E-mail : eottesen@taskforce.org

Professor Dato Dr C. P. Ramachandran  
Private Consultant  
Tunku  
Bukit Tunku 50480  
Kuala Lumpur, Malaysia  
Tel No. : +60 3 2698 7275  
Fax No. : +60 3 2698 6152  
E-mail : ramacp@hotmail.com

Professor Hugh Ringland Taylor  
Harold Mitchell Chair of Indigenous Eye Health  
Melbourne School of Population and Global Health  
The University of Melbourne  
Level 5, Bourke Street  
 Carlton, Victoria 3053, Australia  
Tel No. : +61 3 8344 9320  
Fax No. : +61 3 9348 1827  
E-mail : h.taylor@unimelb.edu.au
2. SECRETARIAT

WHO/HQ

Dr Kazuyo Ichimori
Scientist
Control of Neglected Tropical Diseases
World Health Organization
Avenue Appia 20
1211 Geneva 27, Switzerland
Tel No. : +41 22 791 2767
E-mail : ichimorik@who.int

Dr Albis Francesco Gabrielli
Project Manager
Control of Neglected Tropical Diseases
World Health Organization
Avenue Appia 20
1211 Geneva 27, Switzerland
Tel No. : +41 22 791 1876
E-mail : gabriellia@who.int
WHO/WPRO

Dr John Patrick Ehrenberg
Director
Combating Communicable Diseases
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528-9701
Fax No. : +632 521-1036
E-mail : ehrenbergj@wpro.who.int

Dr Eva Maria Christophel (Responsible Officer)
Team Leader
Malaria, Other Vectorborne and Parasitic Diseases (MVP)
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9723
Fax No. : +632 521 1036
E-mail : christophele@wpro.who.int

Dr Padmasiri Eswara Aratchige
Technical Officer (Neglected Tropical Diseases)
Malaria, Other Vectorborne and Parasitic Diseases,
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9754
Fax No. : +632 521 1036
E-mail : aratchigep@wpro.who.int

Dr Dasaradha Ramaiah Kapa
Technical Officer (Neglected Tropical Diseases),
Malaria, Other Vectorborne and Parasitic Diseases
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9416
Fax No. : +632 521 1036
E-mail : kapad@wpro.who.int
**Dr Jun Nakagawa**
Technical Officer (Tropical Disease Research),
Malaria, Other Vectorborne and Parasitic Diseases
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9721
Fax No. : +632 521 1036
E-mail : nakagawaj@wpro.who.int

**Dr Lasse Vestergaard**
Medical Officer
(Therapeutic Efficacy Studies & Operational Research)
Malaria, Other Vectorborne and Parasitic Diseases
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9061
Fax No. : +632 521 1036
E-mail : vestergaardl@wpro.who.int

**Dr Ma. Gemma Cabanos**
Medical Officer (Leprosy Elimination),
Stop TB and Leprosy Elimination,
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9710
Fax No. : +632 521 1036
E-mail : cabanosm@wpro.who.int

**Dr Andreas Mueller**
Technical Officer (Prevention of Blindness),
Noncommunicable Diseases and Health Promotion,
WHO Regional Office for the Western Pacific
Manila, Philippines
Tel No. : +632 528 9885
Fax No. : +632 521 1036
E-mail : muellera@wpro.who.int
WHO/Cambodia  
Dr Md. Abdur Rashid  
Medical Officer (Malaria)  
World Health Organization  
No. 177-179 corner Streets Pasteur(51) and 254  
Sankat Chak Tomouk, Khan Daun Penh  
Phnom Penh  
Tel No. : +855 23 216 610  
Fax No. : +855 23 216 211  
E-mail : rashidm@wpro.who.int  

WHO/Lao People's Democratic Republic  
Dr Chitsavang Chanthavisouk  
National Professional Officer  
(Neglected Tropical Diseases)  
World Health Organization  
125 Saphanthong Road, Unit 5  
Ban Saphanthongtai, Sisattanak District  
Vientiane  
Tel No. : +856 21 353902  
Fax No. : +856 21 353905  
E-mail : chanthavisoukc@wpro.who.int  

WHO/Papua New Guinea  
Dr Rabindra Romauld Abeyasinghe  
Technical Officer (Malaria)  
World Health Organization  
4th Floor, AOPI Center  
Waigani Drive  
Port Moresby  
Tel No. : +675 325 7827  
Fax No. : +675 325 0568  
E-mail : abeyasingher@wpro.who.int  

WHO/Solomon Islands  
Dr Zaixing Zhang  
Medical Officer (Malaria, Other Vectorborne and Parasitic Diseases)  
World Health Organization  
Ministry of Health Building  
Chinatown  
Honiara  
Tel No. : +677 23406  
Fax No. : +677 21344  
E-mail : zhangz@wpro.who.int
WHO/South Pacific

Dr Sung Hye Kim
Medical Officer
(Neglected Tropical Diseases)
World Health Organization
Level 4 Provident Plaza One
Downtown Boulevard
33 Ellery Street
Suva
Tel No. : +679 3 304 600
Fax No. : +679 3 234 166
E-mail : kimsu@wpro.who.int

CLO/Vanuatu

Dr Seyha Ros
Scientist (Malaria, Other Vectorborne and Parasitic Diseases)
WHO CLO Vanuatu
MOH Iatika Complex
P.O Box 177
Port Vila
Tel No. : +678 27683
Fax No. : +678 22691
E-mail : ross@wpro.who.int

4. OBSERVERS

BILL AND MELINDA GATES FOUNDATION

Mr Aryc Mosher
Programme Officer
Neglected Infectious Diseases
Bill and Melinda Gates Foundation
PO Box 23350
Seattle, WA 98102
United States of America
Tel No. : +1 206 709-3100
Fax No. : +1.206.494.7039
E-mail : Aryc.Mosher@gatesfoundation.org
CHILDREN WITHOUT WORMS

Dr David Addiss
Director
The Task Force for Global Health
325 Swanton Way
Decatur, Georgia 30030
United States of America
Tel No. : +1 404 592 1415
Fax No. : +1 404 371 1138
E-mail : daddiss@taskforce.org

EISAI PHARMACEUTICAL CO., LTD.

Dr Mitsuru Mizuno
Senior Manager
Global Access Strategies
4-6-10 Koishikawa
Bunkyo-ku,
Tokyo 112-8088, Japan
Tel No. : +81 3 3817 3016
Fax No. : +81 3 3811 4571
E-mail : m2-mizuno@hhc.eisai.co.jp

FAMILY HEALTH INTERNATIONAL

Mr James Johnson
Project Director
End Neglected Tropical Diseases in Asia
Asia Pacific Regional Office
130-132 Sindhorn Building
19th Floor, Tower 3
Wireless Road
Lumpini, Pathumwan
Bangkok 10330, Thailand
Tel No. : +66 2 263 2300
Fax No. : +66 2 263 2114
E-mail : jamjohnson@fhi360.org
GLAXOSMITHKLINE

Dr Mark Bradley
Director
Global De-worming
Global Health Programmes
London, United Kingdom
Tel No. : +44 0 208 047 5521
E-mail : mark.h.bradley@gsk.com

Ms Tijana Duric
Director
Supply Planning and Finances
Neglected Tropical Diseases Unit
London, United Kingdom
Tel No. : +44 0 208 047 4904
E-mail : Tijana.X.Duric@gsk.com

JOHNSON & JOHNSON

Dr William Lin
Director
Worldwide Corporate Contributions
New Brunswick, New Jersey 08933
United States of America
Tel No. : +1 732-524-6796
Fax No. : +1 732 5243 300
E-mail : wlin@its.jnj.com

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

Dr Marci Van Dyke
Technical Advisor
USAID Global Health Bureau
Neglected Tropical Diseases
1300 Pennsylvania Avenue NW
Washington, D.C. 20523
United States of America
Tel No. : +1 202 712 5586
E-mail : mvandyke@usaid.gov
UNITED STATES CENTERS FOR DISEASE CONTROL AND PREVENTION

Ms Kimberly Won
Health Scientist
Center for Global Health
Division of Parasitic Diseases and Malaria
1600 Clifton Road, MS D-65
Atlanta, Georgia
Tel No. : +1 404 718 4137
Fax No. : +1 404 718 4193
E-mail : kwon@cdc.gov

WORLD VISION AUSTRALIA

Dr Azadeh Baghaki
Senior Health Adviser
Policy and Partnerships
International Programs Group
1 Vision Drive
Burwood East
Melbourne, Victoria 3151
Tel No. : +614 3234 8920
Fax No. : +613 9287 2665
E-mail : azadeh.baghaki@worldvision.com.au