Lymphatic filariasis (LF) is one of the leading causes of permanent disabilities causing socioeconomic problems. Since the launch of the global programme to eliminate LF in the South-East Asia Region in 2000, by 2011 the nine endemic countries had made significant progress. Since more and more implementation units (IUs) in the SEA Region are completing minimum required mass drug administration (MDA) rounds with a declining microfilarial rate to below 1%, it is essential to plan Transmission Assessment Surveys (TAS) in LF elimination programme as per the WHO manual for national elimination programmes 2011.

WHO-SEARO organized a capacity-building workshop at the Vector Control Research Centre (VCRC), Pondicherry, India (WHO Collaborating Centre) to enhance the knowledge and skills of the LF programme managers on planning and implementation of TAS. The workshop had 11 modules. The pre- and post-test questionnaires were designed to assess how far knowledge and skills of the participants improved after completing training. The participant’s pre-test knowledge score was 13.1 of the 27 scores and post-test score was 24 of the 27 scores which indicated that the workshop was productive. The participants agreed to develop a country plan of action where TAS is to be implemented and submit these to WHO-SEARO.
Lymphatic Filariasis Elimination Programme in the South-East Asia Region

Report of the regional capacity-building workshop on Transmission Assessment Survey
Pondicherry, India, 10 – 13 July 2012

World Health Organization
Regional Office for South-East Asia
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## Annexes

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Executive summary

The Global Programme to Eliminate Lymphatic Filariasis (GPELF) was launched in 2000 and was gradually expanded to 53 of the 72 endemic Member States requiring mass drug administration (MDA) by 2011. Of them, 13 countries have stopped MDA and are under surveillance. Effective monitoring and evaluation is necessary to take a decision regarding stopping or continuing further rounds of MDA. Having implemented the MDA programme following WHO guidelines, the programmes should be able to assess whether interventions have succeeded in lowering the level of infection (measured by microfilarial (Mf) rate or by antigenaemia (Ag)) to a point so that transmission cannot be sustained. A WHO manual for the national LF elimination programme for monitoring and epidemiological assessment of MDA in 2011 is being shared with the programmes. This is a revised version of the WHO guidelines of 2005. Transmission Assessment Survey (TAS) is a decision-making tool to stop MDA in this manual and a protocol is designed to assist the LF programmes to determine whether implementation units (IUs) have reached the critical threshold of infection and do not require further rounds of MDA. Results from a TAS provide evidence for taking the decision to stop or continue MDA. Hence, training of programme managers or focal points dealing with LF is required to plan and implement TAS systematically and uniformly.

Nine out of 11 countries in the South-East Asia Region (SEAR) are endemic for LF, and the GPELF launched in these countries is in different stages of implementation and evaluation. Since more and more IUs in the Region are completing the minimum required MDA rounds with a declining microfilarial rate to below 1%, it is essential to plan a TAS exercise as per the WHO manual 2011. WHO-SEARO organized a capacity-building workshop in collaboration with the Vector Control Research Centre (VCRC), Pondicherry, India, and the Centres for Disease Control and Prevention (CDC), Atlanta, United States, from 10 to 13 July 2012 aiming to: (i) update the progress of the national LF elimination programme in each country; (ii) enhance knowledge and skills of the LF programme managers or focal points on planning and implementation of TAS; and (iii) develop a plan of action (PoA) for implementing TAS in countries.
This capacity-building workshop was based on 11 modules. The faculty included experts in the respective fields from WHO-SEARO, and VCRC.

The pre- and post-tests were designed to assess how far knowledge and skills of the participants had improved after completing training. This also assisted faculty members to improve training methodologies. The participant’s pre-test knowledge score was 13.1 of the 27 possible scores and the post-test score was 24 of the 27 scores which indicated that the workshop was quite productive. The participants agreed to develop country plans of action where TAS is to be implemented and submit then to WHO-SEARO.

Acknowledgements

Dr V. Raman, Director of Health Services, Government of Pondicherry, and Dr T. Kalimuthu, Assistant Director (Malaria and Filariasis), Government of Pondicherry are acknowledged for their support in carrying out the school-based field demonstration of TAS using ICT. Thanks are also due to the Director of School Education and the Heads of selected schools for their cooperation in conducting the TAS.
1. Introduction

The Global Programme to Eliminate Lymphatic Filariasis (GPELF) was launched in 2000 and was gradually expanded to 53 of the 72 endemic Member States requiring mass drug administration (MDA) by 2011. Of them, 13 countries have stopped MDA and are under post-MDA surveillance. Effective monitoring and evaluation is necessary for taking a decision regarding stopping or continuing further rounds of MDA. Having implemented the MDA programme following the WHO guidelines, the programmes should be able to assess whether interventions have succeeded in lowering the level of infection (measured by microfilarial rate or antigenaemia) to a point so that transmission cannot be sustained. A WHO manual for the national LF elimination programmes entitled: Transmission Assessment Survey for Monitoring and Epidemiological Assessment of Mass Drug Administration has been developed for monitoring and epidemiological assessment of MDA in 2011. This is a revised version of the WHO guidelines of 2005. Transmission Assessment Survey (TAS) is a decision-making tool designed to help programme managers to determine whether implementation units (IUs) have reached the critical threshold of infection and do not require further rounds of MDA. Results from a TAS provide evidence for taking the decision to stop or continue MDA rounds. Training of programme managers or focal points dealing with LF is required to plan and implement TAS systematically and uniformly since it is an expensive exercise.

Nine out of 11 countries in the WHO South-East Asia Region (SEAR) are endemic for LF and the GPELF launched in these countries is in different stages of implementation and evaluation. Since more and more implementation units (IUs) are completing minimum required MDA rounds resulting in reduction in microfilarial rate to less than 1%, it is essential to plan TAS exercise as per the guidelines.

WHO-SEARO organized a capacity-building workshop in collaboration with the Vector Control Research Centre (VCRC), Pondicherry, India, and CDC, Atlanta, United States from 10-13 July 2012, with an aim of providing the knowledge and tools necessary to conduct a TAS.
There were 24 participants from nine LF-endemic countries of the Region: viz., Bangladesh (3), India (4), Indonesia (6), Maldives (2), Myanmar (2), Nepal (2), Sri Lanka (1), Thailand (3) and Timor-Leste (1) (Annex 1). The number of participants varied from two to six, depending on the number of LF-endemic districts and Implementation units in the country. The participants included programme officers in the field of Medicine (15), Public Health (4), Parasitology (2), Medical Entomology and Community Health (1). Attendance was 100% throughout the course. Eight focal points for LF of WHO country offices also attended.

The workshop was opened with a welcome address by Dr P. Jambulingam, Director, Vector Control Research Centre, Pondicherry. Dr Jambulingam highlighted the research activities that led to the development of TAS and its relevance to programme monitoring and evaluation. This was followed by opening remarks by Prof. A.P. Dash, Regional Adviser, Vector-Borne and Neglected Tropical Diseases Control, WHO-SEARO, New Delhi. Prof Dash, highlighted the objectives of the workshop and stated that as a follow-up of the workshop, participants are required to prepare a country TAS ‘action plan’ which will be reviewed and recommended by the Regional Programme Review Group (RPRG) in 2013.

Prof. Dash read the message of Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia. Dr Samlee said that as a result of effective implementation of MDA, the microfilarial rate in the South-East Asia Region declined to less than 1% in 493 out of 1100 implementation units after completing a minimum of five rounds. Dr Samlee said that Maldives and Sri Lanka had stopped MDA in 2009 and 2007, respectively, and initiated verification of elimination of LF in 2011 with WHO assistance. Stopping MDA in implementation units once they meet the criteria will result in saving of albendazole tablets and allow the programme to expand MDA to remaining implementation units to achieve LF elimination by 2020. To move forward, stopping MDA by planning and implementing TAS, and capacity-building of programme personnel in the country is essential.

2. Objectives

The objectives of the workshop were:

- to update the progress of the national LF elimination programme in each country;
to enhance knowledge and skills of the LF programme managers or focal points on planning and implementation of TAS;

> to develop a plan of action for implementing TAS in countries.

In order to receive maximum benefit from the workshop, the participants were provided with templates for incorporating relevant data to carry out exercises so as to enable them to prepare a country workplan for TAS, ultimately.

### 3. The Curriculum

This capacity-building workshop was based on 11 modules (Annex 2). Learners’ guides of these modules were made available to the participants and facilitators. The faculty or resource persons included experts in respective fields from WHO-SEARO, CDC Atlanta and VCRC, Pondicherry (Annex 3). The programme schedule was prepared based on the time required for completing the interactive and group exercise sessions of each module (Annex 4). The following were the learning objectives of these modules:

1. understand the methodologies on monitoring, epidemiological assessment and evaluation of MDA programme;

2. understand the principle, criteria and fundamental elements of the TAS;

3. develop a workplan for implementing a TAS in an evaluation unit (EU);

4. improve knowledge on how to compile a dossier for submission for verification of LF elimination.

Country-group exercises were given for each module except the first two. These exercises governed step-by-step procedures to perform TAS, based on the country situation. The results of each exercise were carried forward and at the end, each country developed a workplan for carrying out TAS in an Evaluation Unit. Under the module “field activities’ mock exercises were carried out to demonstrate the procedure to conduct TAS in a school.
While dealing with diagnostic tools, practical demonstrations were given of the *Wuchereria bancrofti* antigen test using ICT cards and the *Brugia* antibody test using Brugia Rapid test kits were given. Participants representing areas that are endemic for *W. bancrofti* and *Brugia malayi/B. timori* were benefited with the demonstration of these point-of-care diagnostics.

At the end of the training, an opportunity was given to participants to put into practice all that they had learnt during the sessions and prepare a detailed TAS protocol. Based on the terms of reference (Annex 5), one participant from each country presented the results in the plenary session, discussed and evaluated by the experts.

4. **The Training Materials**

The contents of the modules, developed by WHO were used without any change. Revisions were proposed based on the interaction and feedback from the participants so that modules could be adopted by countries of the SEA Region. On completion of each learning module, all the relevant information including reading materials were given to the participants.

5. **Teaching Methodology**

The workshop was conducted throughout as a participatory, interactive, problem-solving approach to learning. Lectures were kept minimal. Principally the course was run as a series of small (country) group discussions and exercises. A review of the sessions conducted on the previous day was conducted on the following morning so as to reinforce the learning. Post-session discussions were also held with the facilitators to plan effective conduct of following sessions.

Three schools were selected to demonstrate ICT survey. The participants and observers were divided into three teams to visit the assigned school. On return, one member from each team summarized their observations. Based on the observations a selection of students from the attendance register was recommended and a list of DOs and DONTs were
prepared. Suggestions to overcome the operational constraints were also made.

6. **Primary Discussion Points**

Throughout the workshop, participants and facilitators discussed general and country-specific topics, including assessment of treatment coverage with the upper limit of 2 million population in an evaluation unit, and the importance of training and planning. The facilitators emphasized the importance of conducting a TAS only when confident that the pre-TAS requirements have been met and there is a high likelihood of meeting the TAS criteria. Specific recommendations were made by technical advisers during the workshop.

- If previous treatment coverage is not available for all years in a given IU, it is recommended to conduct a coverage survey for at least the most recent year’s MDA to assess coverage.
- If the programme managers find the reported MDA coverage is not acceptable, it may be recommended to an independent body to assess the MDA coverage through a coverage survey. Additional spot check sites may also be considered to assess Mf prevalence if needed.
- Mf (or Ag) prevalence should be assessed at both sentinel and spot check sites independently; the average should never be taken.
- Mf prevalence can be used for sentinel and spot-check site surveys, but only ICT cards and Brugia Rapid diagnostic tests are recommended for TAS.
- In a school-based survey, the field teams should not exclude students that are older or younger than 6-7 years of age if they are enrolled in the selected classes.
- The informed consent information should include that not every child will be selected during the survey. However, everyone will benefit from the results of the survey.
Programme managers should consider procuring at least 5% excess of diagnostic tests (e.g. ICT cards) from the sample size.

7. **Evaluation Instruments**

The instruments used to evaluate the training were a pre-test given on the first day upon entry into the course before the distribution of any training materials and a post-test given after completing the training. Types of question included filling in the blanks, pictorial problems and true or false, and all had 20 questions. The same questions were used in the post-test also. Evaluation was also done during the country presentations.

8. **Results of the Evaluation of Participants’ Performance**

The participants pre-test knowledge score was 13.1/27 and post-test score was 24/27 which indicated that the workshop was quite productive. The participants also agreed to develop respective plans of action for the proposed districts for TAS and submit to WHO-SEARO by the end of October 2012.

The pre-test was designed to assess participants’ knowledge of fundamental elements of monitoring and evaluation of LF elimination programme with a primary focus on TAS planning and implementation. The 20 test questions covered all essential topics that would be emphasized during the training course. The same questions were administered at the end of the course to assess the knowledge the participants had gained during the workshop.

Answering all 20 questions correctly resulted in a maximum score of 27. The mean score received for the pre-test was 13.1 with scores ranging from 4 to 21. The mean score received for the post-test was 24.2 with scores ranging from 12 to 27. As evidenced by the mean post-test scores, participants demonstrated a significant increase in knowledge of fundamental TAS elements.
9. **Evaluation of the Course by the Participants**

Evaluation forms were given to all the participants to evaluate the training at the end of the day. This evaluation included the quality of the facilitations. The questionnaire used for the evaluation of the course by the participants and the results in terms of a satisfaction index for each statement is given in Annex 8, along with the comments or suggestions made by each participant whose identity was given as a number as the questionnaire was completed without the names of the participants. The questionnaire was divided into 11 sections.

The overall satisfaction index (SI) was 84.0% (Annex 9) with a mean score of 4.2 on a scale of one to five. The SI ranged between 76.7% and 89.2%. The maximum SI of 89.2% in gaining the confidence was assigned to the criteria to define and select an EU. Aspects which showed below 80% SI but above 75% included the need of lead times for obtaining ethical clearance and informed consent prior to TAS, the methodology for following up positive cases during a TAS and how to develop a budget plan for a TAS in an EU. Usually statements with a satisfaction index greater than 60% are considered as being of no concern when developing subsequent courses. All aspects on the quality of facilitators scored above 85% SI with a few suggestions on the improvement of facilitation. Most of the participants felt that four days are sufficient for the training.

10. **Conclusions and Recommendations**

The training course was highly successful in achieving the objectives of the workshop. The course was completed as per the time schedule. The support provided by WHO-SEARO was adequate to strengthen the infrastructure in conducting the training course more successfully. The participants expressed their confidence in planning TAS in their respective countries.

The following recommendations emerged based on the feedback from the participants themselves and post-session discussions with the facilitators.
Recommendations to WHO:

- To share finalized training modules and the facilitators’ guide with the LF-endemic Member States to adapt to their country situation.
- To assist the Member States to develop a plan of action on TAS and develop in-country training teams.
- To establish a mechanism for submitting national TAS plans and reports to WHO-RPRG.
- To develop a format of dossier for verification of interruption of transmission to facilitate countries.
- To develop a standardized reporting format for reporting TAS outcome.
- To develop a strategy to review and verify non-endemic (Mf rate <1%) in IUs where MDA was never implemented and no cases have been found in the past decade.
- To issue guidelines to deal with small pockets where Ag/Ab prevalence is high while conducting TAS.
- To issue guidelines to treat positive cases found during TAS.
- To develop guidelines to implement post-MDA surveillance and surveillance in non-endemic districts.
- To develop guidelines for recording non-response during TAS (absentee, refusal, test not functioning properly, etc.).
- To develop guidelines on how to assess STH prevalence during TAS as an integrated approach.

Recommendations for future training

General

- Talking points should be included for each module.
- Training should be emphasized at every level in all the modules.
Training materials and facilitators should emphasize discussing country-specific decisions with the RPRG, such as defining EU.

Consider whether field teams should practice sampling and data collection in the field prior to actual data collection.

**Module 5**

- Demonstrate how to use Table A.5.1. to select study sample before demonstrating Survey Sample Builder 2.0 (SSB) so that participants can associate SSB and Table A.5.1.
- Include more details about the sampling fraction and sampling interval.

**Module 6**

- Show examples of the EU where average student size in a school is relatively large (thus reach the required number of students before reaching 30 schools) and where average student size in a school is small (thus need to visit more than 30 schools to find the required number of students).
- Explain the rationale behind the recommended sampling methodology:
  - Why ranking clusters by geographical distance than alphabetical orders?
  - Why at least 30 clusters are required?
- Emphasize that when you surveyed more than the number of students calculated by SSB in the actual surveys, you need to re-define the critical cut-off value from the Table A.5.1. using the actual number of students surveyed.
- Emphasize that 15% non-response rate is default and can be changed, and it includes not only those who were absent on the day of surveys but also those who refused to participate in the surveys.
- Add more clarification about differences between using lists in a school versus a community.
Recommendations to the national LF programmes

- To develop a national Plan of Action on TAS to WHO-SEARO for further necessary actions
- To adapt WHO-developed final training modules and the facilitators’ guide to country situation.
Annex 1

List of participants

**Bangladesh**

Dr Israt Hafiz  
Technical Consultant  
Filaria Elimination Program  
Disease Control Unit  
Directorate General of Health Services  
Dhaka, Bangladesh  

Dr Tashin Begum  
Deputy Civil Surgeon  
Pabna, Dhaka, Bangladesh  

Dr Rouseli Haq  
Deputy Programme Manager  
Filaria Elimination Programme  
Directorate General of Health Services  
Mohakhali, Dhaka

**India**

Dr N.S. Dharmshaktu  
DDG (NSD)  
New Delhi  

Dr P.K. Srivastava  
Joint Director  
Directorate of National Vector Borne Disease Control Programme  
Delhi-110054  

Dr M.M. Pradhan  
Deputy Director Malaria  
National Vector Borne Diseases Control Programme  
Bhubaneswar-751001, Orissa  

Dr Champa Naik  
State Programme Officer for VBDC  
Directorate of Medical Health Campus  
Hyderabad-500095  
Andhra Pradesh

**Indonesia**

Dr Eksi Wijayanti  
Subdivision of Filaria and Helminthiasis Control  
Directorate of Vector Borne Disease Control  
Ministry of Health  

Drh. Rita Marleta Dewi, M.Kes  
Head, Sub-division of Non human Biomedic,  
Board of Health Research and Development  
Ministry of Health  

Dr Irene, MKM  
Head, Division of Diseases and Disaster Control  
Provincial Health Office West Sumatra Province  
West Sumatra  

Ms Chairiyah Anwar, SKM, M.Kes  
Head, Sub-division of Standardization  
Division of Filaria and Helminthiasis  
Directorate General of Disease Control and Environmental Health, Ministry of Health  

Dr Gertrudis Tandy, MKS  
Staff  
Sub-directorate of Filaria and Helminthiasis  
Directorate General of Disease Control and Environmental Health, Ministry of Health  

Dr Dominicus Husada  
Institute of Tropical Disease, Airlangga University, Mulyorejo, Surabaya 60115  

**Maldives**

Ms Neesha Nasir  
Assistant Public Health Programme Officer,  
Centre for Community Health and Disease Control  
Male
Report of the regional capacity-building workshop on Transmission Assessment Survey

Myanmar
Dr San Kyawt Khine (Ms)
Team Leader
Vector Borne Diseases Control
Sittwe, Rakhine State
Dr Ni Ni Aye (Ms)
Deputy Director (Dengue/Filariasis)
Department of Health
Naypyitaw, Yangon

Nepal
Mr Tulasi Ram Adhikari
Health Assistant
Epidemiology & Disease Control Division
Directorate of Health Services
Kathmandu
Dr Bikash Lamichhane
Officiating Director
Far Western Regional Health Director,
Dipayal

Sri Lanka
Dr K. C. Nagodawithana
Medical Officer
Anti Filariasis Campaign
Colombo-5

Thailand
Dr Suwich Thammapalo
Director
Office of Disease Prevention and Control 12,
Songkla
Department of Diseases Control
Ministry of Public Health
Bangkok
Miss Sunsanee Rojanapanus
Public Health Technical Officer
Bureau of vector Borne Diseases
Department of Disease Control
Ministry of Public Health
Bangkok

Mr Theerayot Kobasa
Public Health Technical Officer Bureau of
Vector Borne Diseases
Department of Disease Control
Ministry of Public Health
Bangkok

Timor-Leste
Mr Jose Liu Fernandes
National Unit NTD’s Programme Manager
Ministry of Health
Dili

Resource Persons - Special Invitees
Dr Kimberly Y. Won
CDC Atlanta,
United States
Dr Michael Deming
CDC Atlanta,
United States
Ms Kathryn Lee Zoerhoff
RTI, Washington DC,
United States
Dr Louise Kelly-Hope
CNTD, Liverpool
School of Tropical Medicine,
United Kingdom

Temporary Advisers to WHO-SEARO
Prof R.C. Mahajan
Dept of Parasitology
Postgraduate Institute of Medical
Education & Research
Chandigarh - 160 012, India
Dr P. Jambulingam
Director
Vector Control Research Centre (VCRC)
Puducherry - 605 006, India
Dr K. Krishnamoorthy
Deputy Director (Sr. Grade)
Vector Control Research Centre
Pondicherry - 605 006, India
Dr Sandhya Dilhani Samarasekera  
Consultant, Community Physician  
Ministry of Health  
Anti Filariasis Campaign  
Public Health Complex  
Colombo-05, Sri Lanka

Observers

Dr J. Bhattacharjee  
Consultant (Lymphatic Filariasis)  
National Vector Borne Diseases Control Programme (NVBDCP)  
Delhi, India

Dr T. Kalimuthu  
Assistant Director (Malaria & Filaria)  
NVBDCP Unit  
Directorate of Medical Services  
Govt. of Pondicherry  
Pondicherry, India

WHO Country Office Focal Points

Dr Sampath Krishnan  
India

Dr A.B. Joshi  
Indonesia

Mr Faisal Mohammad  
Maldives

Dr Mya Spai Ngon  
Myanmar

Dr Nihal Singh  
Nepal

Dr N. Janakan  
Sri Lanka

Mr Cipriano Pinto  
Timor-Leste

WHO-Secretariat

Dr Aya Yajima  
Technical Officer (PCT)  
NTD, WHO-HQ  
Geneva, Switzerland

Dr A.P. Dash  
Regional Adviser (Vector Borne and Neglected Tropical Diseases Control)  
WHO-SEARO, New Delhi, India

Dr C.R. Revankar  
NTD Officer, VBN Unit  
WHO/SEARO, New Delhi, India

Mr Brijesh Kumar  
Administrative, Secretary, VBN Unit  
WHO/SEARO, New Delhi, India
Annex 2

Training Modules

Module 1 - Lymphatic Filariasis (LF) Background
Module 2 - Monitoring and evaluation
Module 3 - Evaluation unit
Module 4 - Diagnostic tools
Module 5 - Survey design
Module 6 - Survey implementation
Module 7 - Preparing for a TAS - Logistics
Module 8 - Field activities
Module 9 - Budget
Module 10 - After a TAS
Module 11 - Verification of elimination
Annex 3

Faculty members of the workshop

Dr Aya Yajima, Technical Officer (PCT), NTD, WHO-HQ, Geneva, Switzerland

Dr A.P. Dash, Vector-borne and Neglected Tropical Disease Control, WHO-SEARO, New Delhi, India

Ms Kathryn Lee Zoerhoff, RTI, Washington DC, USA

Dr Kimberly Y. Won, CDC Atlanta, USA

Dr K. Krishnamoorthy, Deputy Director (Senior Grade), Vector Control Research Centre, Puducherry, India

Dr Michael Deming, CDC Atlanta, USA

Dr C.R. Revankar, WHO-SEARO, New Delhi, India

Prof. R.C. Mahajan, Department of Parasitology, Postgraduate Institute of Medical Education and Research, Chandigarh

Dr P. Jambulingam, Director, Vector Control Research Centre, Puducherry, India
Annex 4

Agenda

- Registration
- Opening session
- Objectives of the Workshop:
  - To update the progress of the national LF elimination programme in each country
  - To enhance knowledge and skills of the LF programme managers or focal points on planning and implementation of TAS
  - To develop a plan of action (PoA) for implementing TAS in countries.
- Curriculum:
  - Current status of lymphatic filariasis elimination
  - Country updates on Progress in LF elimination
  - Discussion on manual on TAS
  - Sampling techniques for transmission assessment survey
  - Hands on exercises
  - Field demonstration of TAS
  - Discussion of Plan of Action (POA)
- Closing
## Annex 5

### Guidelines for the country exercise

<table>
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<th>Country</th>
<th>Total districts</th>
<th>Endemic districts/ IUs</th>
<th>IUs – ongoing MDA</th>
<th>EU proposed for TAS</th>
<th>School/ community based TAS</th>
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<td>8</td>
<td>School</td>
<td>13 962</td>
<td>11 Months</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>13</td>
<td>13</td>
<td>0</td>
<td></td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 6

Evaluation by participants of the Training Course

This training workshop is one of our first global efforts to develop the standardized modules and tools to facilitate training and implementation of Transmission Assessment Survey (TAS). We would like to build on our experience of learning together. Your feedback, suggestions and criticisms will be more than welcome. Please spare 5 minutes to make your contribution in improving the TAS modules and tools!

Please add your answers or comments in writing.

Instructions: Use the following code to indicate to what extent you gained confidence in the topics you learnt today on a scale of 1 to 5.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>1</td>
</tr>
<tr>
<td>Not well</td>
<td>2</td>
</tr>
<tr>
<td>Neutral</td>
<td>3</td>
</tr>
<tr>
<td>Well</td>
<td>4</td>
</tr>
<tr>
<td>Very well</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: The difference between 1 and 2 or between 4 and 5 is a matter of degree only.

Example: 1.

If you want to express your complete disagreement with the statement, put an X in the box “1” as above:

Please take adequate time for the completion of this questionnaire.
To what extent did you gain confidence in the following topics you learnt today?

<table>
<thead>
<tr>
<th>Module</th>
<th>Topic</th>
<th>Confidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The rationale of stopping MDA in relation to prevalence</td>
<td>87.2 %</td>
</tr>
<tr>
<td>1.2</td>
<td>The key differences between the original M&amp;E guidelines and the new guidelines for stopping MDA</td>
<td>86.4 %</td>
</tr>
<tr>
<td>1.3</td>
<td>The overall programme steps from mapping to verification I was given sufficient information on the aims and methods of the course before and upon my arrival.</td>
<td>83.2 %</td>
</tr>
<tr>
<td>1.4</td>
<td>How can we improve this module or support you?</td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Providing copies of materials, new modules acceptable, clarify mapping, include teaching methodology, provide modules before the start of the workshop</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>How to calculate the three coverage indicators used in monitoring LF MDA</td>
<td>81.7 %</td>
</tr>
<tr>
<td>2.2</td>
<td>The different purposes of sentinel site and spot check site surveys in M&amp;E of National Programme on Elimination of Lymphatic Filariasis National Programme on Elimination of Lymphatic Filariasis</td>
<td>86.7 %</td>
</tr>
</tbody>
</table>
2.3 The pre-requirements that need to be met in order to start planning TAS.

2.4 How can we improve this module or support you? Provide more details, examples of calculation.

3 Module 3: Evaluation Unit

3.1 The criteria to define and select an EU

3.2 How can we improve this module or support you? More presentations.

4 Module 4: Diagnostic tools

4.1 The difference in target indicators and pros and cons of various diagnostic tools available for TAS

4.2 How to use ICT cards and interpret the results

4.3 How to use Brugia Rapid and interpret the results.

4.4 How can we improve this module or support you? Provide more details, examples of calculation.

5 Module 5: Survey design

5.1 The rationale for selecting children aged 6-7 years as a target population for TAS
5.2 How to choose survey designs and calculate sample size

5.3 How to use critical cut-off threshold for making programmatic decisions.

5.4 How can we improve this module or support you?
Good enough

6 Module 6: Survey implementation

6.1 How to use SSB to select the sampling strategy and sample size

6.2 The method of randomized site selection using a numbered list of all primary schools or Evaluation areas (EAs) in advance of TAS.

6.3 How to develop a TAS protocol for your country.

6.4 How can we improve this module or support you?
Good enough support on survey and technical assistance

7 Module 7: Preparing for a TAS - Logistics

7.1 The need of lead times for obtaining ethical clearance and informed consent prior to TAS

7.2 The procedure to obtain ethical clearance and informed consent for TAS
7.3 All the information needed for school-based and community-based surveys prior to TAS. 84.2 %

7.4 How to develop a supply list and estimating the time needed for supply procurement for my country 86.1 %

7.5 All the activities required for a TAS and constructing a timeline of all the activities 82.5 %

7.6 How can we improve this module or support you? Good enough, develop common format for logistics, include health checkup for children

8 Module 8: Field activities 85.0 %

8.1 How to compose teams needed to complete a TAS and allocate tasks for field team members 82.5 %

8.2 The daily work flow for school/village-based surveys 77.4 %

8.3 The methodology for following up positive cases found during a TAS. 84.2 %

8.4 How can we improve this module or support you? Positive case treatment, decentralized TAS workshop
9 Module 9: Budget

9.1 How to develop a budget plan for a TAS in an EU

9.2 How can we improve this module or support you?
Budget for data recording and maintaining, more exercise, breakup at different levels, more clarity required

10 Module 10: After the TAS

10.1 The activities necessary after passing or failing a TAS

10.2 How to develop a plan for post-MDA surveillance, assuming that the target EU has passed a TAS

10.3 How can we improve this module or support you?
Copies of the presentation, on line data management, collection of data and documentation for dossier, share experience from countries, grade for passing verification

11 Module 11: Verification of LF elimination

11.1 The information that needs to be collected for the dossier for verifying interruption of transmission

11.2 The process from TAS to verification of LF elimination

11.3 How can we improve this module or support you?
Educate the community and leaders at village level, need experts to prepare dossier, getting the entire background, no data management, no data available, organizing, relevant documents, losing history, sharing information verification
I. How was the quality of facilitators?

Satisfaction index (%)

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Days 1 and 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Facilitators knew the subject matter very well.</td>
<td>87.3</td>
<td>88.4</td>
</tr>
<tr>
<td>3.2 Facilitators gave clear explanation of the topics.</td>
<td>88.2</td>
<td>85.3</td>
</tr>
<tr>
<td>3.3 The speed of the lectures was appropriate.</td>
<td>86.7</td>
<td>86.7</td>
</tr>
<tr>
<td>3.4 Facilitators were welcoming to questions and responded to them appropriately.</td>
<td>88.6</td>
<td>87.8</td>
</tr>
<tr>
<td>3.5 How can improve our facilitation?</td>
<td>Facilitators are doing very well</td>
<td>OK with this field level demonstration, well facilitated but module 10 and 11 not clear, sharing experiences, share research findings, test kits to be provided</td>
</tr>
</tbody>
</table>
Annex 7

Satisfaction Index (%) – day 1 & 2

Satisfaction Index (%) – day 3

Participants’ assessment
Lymphatic filariasis (LF) is one of the leading causes of permanent disabilities causing socioeconomic problems. Since the launch of the global programme to eliminate LF in the South-East Asia Region in 2000, by 2011 the nine endemic countries had made significant progress. Since more and more implementation units (IUs) in the SEA Region are completing minimum required mass drug administration (MDA) rounds with a declining microfilarial rate to below 1%, it is essential to plan Transmission Assessment Surveys (TAS) in LF elimination programme as per the WHO manual for national elimination programmes 2011.

WHO-SEARO organized a capacity-building workshop at the Vector Control Research Centre (VCRC), Pondicherry, India (WHO Collaborating Centre) to enhance the knowledge and skills of the LF programme managers on planning and implementation of TAS. The workshop had 11 modules. The pre- and post-test questionnaires were designed to assess how far knowledge and skills of the participants improved after completing training. The participant’s pre-test knowledge score was 13.1 of the 27 scores and post-test score was 24 of the 27 scores which indicated that the workshop was productive. The participants agreed to develop a country plan of action where TAS is to be implemented and submit these to WHO-SEARO.