Key Features for Mapping and Monitoring NTD Programs (Draft: 6/2010)
WHO M&E Working Group (NTDs)
Monitoring of Disease-Specific Indicators Sub-Group

	Onchocerciasis	**Lymphatic filariasis**	**Schistosomiasis**	**STH**	**Trachoma**
Administrative level	Village	District	Community	District or Community	District or community
Mapping	Prevalence of infection	Prevalence of infection	Prevalence of infection	Prevalence of infection	Prevalence of TF and TT
Tested population	Adults (≥ 15 years) Population at risk aged ≥ 1	Adults or school children (5-14 years)	School children (5 to 14 years)	School children (5 to 14 years)	Children (1-9 years old)
Procedure	Nodule prevalence	Blood test (microfilaremia or ICT	Stool exam (*mansoni*) (Urine-*haematobium*)	Stool exam – Kato-Katz	Eye exam (TF/TI/TT)
Threshold for starting MDA	≥40% prevalence	≥1% prevalence of infection	≥10% prevalence[#]	≥20% prevalence	≥10%TF among 1-9 year old children
Monitoring program impact	Not done routinely	Mf in sentinel sites	Recommended, but not done routinely	Recommended, but not done routinely	Not done routinely
Disease-specific health impact	Blindness, itching, skin disease	Lymphangiectasia, lymphangitis, lymphedema, elephantiasis, hydrocele	Anemia, fibrosis; growth deficits	Anemia, growth deficits	TF/TI, trichiasis
Indications for changing MDA frequency*	N/A	Not yet defined	Not yet defined	Not yet defined	N/A
Criteria for stopping MDA	Absence of antibody (Ov16) Absence of parasite DNA in blackflies	<1% prevalence of infection in 6-7 year old children	<10% prevalence in children[#] Not defined for elimination	<20% prevalence in children	<5% TF among 1-9 year old children
Suitability of diagnostic tools for stopping MDA and post-MDA surveillance	Tests not adapted for field use	Lack of antibody test for sub-Saharan Africa	Lack of a test that is both highly sensitive as well as specific	Lack of acceptable alternative for stool exam	Lack of antigen or antibody test

* Annual treatment is assumed for donated drugs, although accelerated interruption of transmission may be possible by increasing the frequency of MDA. Effectiveness of less frequent treatment regimens needs to be evaluated for schistosomiasis.

[#] Frequency of treatment is defined by infection prevalence; where prevalence < 10%, children should be treated upon entering and prior to exiting primary school.

Highlighted cells represent areas where additional efforts are needed, either through operational research or development and dissemination of guidelines.