### Key Features for Mapping and Monitoring NTD Programs (Draft: 6/2010)

**WHO M&E Working Group (NTDs)**

**Monitoring of Disease-Specific Indicators Sub-Group**

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

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* 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.