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REPORT ON INDIA'S PROGRESS TOWARDS ELIMINATING LYMPHATIC FILARIASIS

ICMR-VECTOR CONTROL RESEARCH
IN COLLABORATION WITH
WOMEN'S COLLECTIVE FORUM
2025

Gates Foundation

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Foreword

Report on Eliminating Lymphatic Filariasis

India's fight against Lymphatic Filariasis (LF) is deeply intertwined with the nation's aspiration to build a healthier, more equitable future. As a disease that strikes hardest at the poorest and most marginalised communities, LF compels a response that is not only technically sound but also rooted in dignity, inclusion, and community agency. This report, developed following regional workshops supported by the Women's Collective Forum, offers a nuanced and grounded view of the challenges, progress, and strategic priorities emerging from states across the country.

The deliberations documented here bring into sharp focus several critical concerns: never-treated populations that continue to sustain transmission, migration and urbanisation patterns that create new pockets of vulnerability, shortages and operational gaps in diagnostics, and the uneven availability and quality of MMDP services. Equally illuminating are the insights on community participation, the central role of women as caregivers and frontline health workers, and the powerful influence of social norms, beliefs, and local leadership on acceptance of MDA and morbidity care.

We are committed to advancing approaches that place communities at the heart of public health programmes. The findings of this report reaffirm that sustainable LF elimination demands continuous surveillance, meticulous microplanning, intersectoral partnerships, and culturally resonant communication strategies that build trust rather than simply transmit information. When communities are informed, respected, and engaged as equal partners, coverage and compliance follow.

I extend my heartfelt congratulations to ICMR–VCRC, state health departments, CII, our development partners, and civil society and NGO stakeholders whose contributions have shaped these dialogues. Their efforts have enriched our collective understanding and will support more targeted, context-sensitive policy and programmatic action. As India moves with determination toward the 2027 LF elimination goal, this report serves as an important guide to coordinated, evidence-led decision-making so that progress is not just measured in numbers but felt in every household and community.

Mrs Smriti Z. Irani

Founder & Chairperson
The Alliance for Global Good: Gender Equity & Equality
Advisor – Women's Collective Forum

Foreword

Lymphatic filariasis (LF) remains a long-standing public health challenge in India and imposes substantial socio-economic burden on affected individuals and their families. The country implemented the WHO recommended LF elimination strategy consisting of two components: Mass Drug Administration (MDA) of antifilarial drugs and Morbidity Management and Disability Prevention (MMDP) for over the past two decades. While notable progress has been achieved, significant gaps remain in achieving treatment coverage in many districts, implementing morbidity management services, and building robust surveillance mechanisms and this has placed significant strain on the public health infrastructure. Reaching the 2027 elimination target will require sustained collaboration, innovation, and a deep understanding of the diverse contexts faced by the beneficiaries, health providers and policy makers.

ICMR-Vector Control Research Centre (ICMR-VCRC), Puducherry, a WHO Collaborating Centre for research and training in lymphatic filariasis, has carried out many operational research studies in collaboration with the national and state programmes and been providing technical guidance for eliminating LF, whenever required. In this context, the ICMR–VCRC, in collaboration with Women's Collective Forum, Delhi, conducted regional workshops in Varanasi, Surat and Chennai to understand the diverse challenges faced by the programme in achieving the last mile efforts.

This report summarises the key proceedings and outcomes of these workshops which brought together technical experts, researchers, development partners, civil society organisations, and representatives from national and state-level health systems and highlights their insights towards assessment of progress, emerging challenges, and strategic opportunities for accelerating the LF elimination in the country.

The discussions emphasised the need to strengthen core programmatic components - MDA, MMDP, vector control, social mobilisation, surveillance, and operational site specific innovations. Significant attention was drawn to challenges in reaching migrants and never-treated populations, addressing transmission risks in rapidly urbanising settings, and the need for reliable diagnostic supplies and post MDA surveillance capacity. The consultations also highlighted opportunities to expand MMDP services through public–private partnerships, enhance the quality of life of the diseased individuals, streamline disability certification for patients, improve data quality, and enhance intersectoral coordination.

As we move closer to the national elimination target of 2027, the recommendations presented in this report offer a practical roadmap for refining region-specific strategies and supporting evidence-informed decision-making. I commend all participants and partners for their commitment to strengthening India's LF elimination response. With sustained focus and coordinated efforts, India is well-positioned and committed to achieve the LF elimination goals.

Dr. Manju Rahi

Director

ICMR–Vector Control Research Centre, Puducherry

Foreword

Report on Eliminating Lymphatic Filariasis

India's efforts to eliminate Lymphatic Filariasis (LF) represent one of the country's most critical public health commitments, mirroring the nation's broader resolve to strengthen immunization and vector-borne disease control. As a nation carrying the highest LF burden globally, our progress has significant implications not only for India's health security but also for global elimination goals. This report, developed through regional workshops akin to the multi-zone expert consultations on immunization convened by the Women's Collective Forum and IIT Kharagpur, provides an in-depth, evidence-based account of operational realities shaping disease elimination trajectories.

The findings presented here underscore the need for sustained, coordinated, and region-specific strategies. Persistent gaps in Mass Drug Administration (MDA), challenges in identifying never-treated populations, migration-driven risks in post-MDA districts, diagnostic kit shortages, and variability in Morbidity Management and Disability Prevention (MMDP) service delivery highlight complexities that states continue to navigate much like equity gaps and policy disconnects in immunization systems. At the same time, the workshops captured strong examples of innovation from digital supervisory tools and microplanning models to community-led MMDP initiatives and targeted migrant-outreach strategies, echoing eVIN, U-WIN, and cross-sectoral partnerships in immunization.

The CII Centre for Health recognises that eliminating LF requires strengthened convergence across government, scientific institutions, civil society, and industry. Private sector engagement through CSR outreach, digital systems, supply chain support, and capacity building can complement national efforts and accelerate progress toward India's 2027 target.

I acknowledge the contributions of ICMR-VCRC, the Women's Collective Forum, state programme teams, development partners, and frontline workers who have collectively informed this report. Their insights, grounded in community realities, will support more grounded decision-making and guide sustained action ahead. India possesses both the capability and commitment to eliminate LF. The path forward is clear, and this report serves as an important resource in achieving that national goal.

Dr Randeep Guleria

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We also acknowledge the support extended by the Regional Offices of Health and Family Welfare (ROHFW)- Patna, Bhubaneswar, Bengaluru, and Thiruvananthapuram; the State Programme Officers of NCVBDC; and District Vector Borne Disease Control Officers (DVBCOs) for their valuable assistance in organizing the workshops. We are grateful to the representatives from WHO and the Gates Foundation for their guidance and contributions, which greatly enriched the workshop discussions.

On behalf of ICMR-Vector Control Research Centre, Puducherry, the organizing team gratefully acknowledges the financial support provided by the WCF for the successful conduct of the three regional workshops on LF elimination. We also extend our sincere appreciation to Ms Richa Sharma, Chief Communication Officer, WCF, for her logistical support throughout the implementation of the workshops.

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Abbreviations

ALB	Albendazole
ASHA	Accredited Social Health Activist
CFA	Circulating Filarial Antigen
DEC	Diethylcarbamazine
DMO	District Malaria Officer
EPC	Essential Package of Care
FTS	Filariasis Test Strip
ICMR	Indian Council of Medical Research
IDA	Ivermectin, Diethylcarbamazine and Albendazole (triple-drug therapy)
IEC	Information, Education and Communication
IIS	IDA Impact Survey
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
Mf	Microfilaria
MMDP	Morbidity Management and Disability Prevention
NCVBDC	National Centre for Vector Borne Diseases Control
NT	Never-Treated
NCVBDC	National Centre for Vector Borne Disease Control
PVTG	Particularly Vulnerable Tribal Groups
QFAT	Quick Filariasis Antigen Test
ROHFW	Regional Office of Health and Family Welfare
SHG	Self-Help Group
TAS	Transmission Assessment Survey
VCRC	Vector Control Research Centre
WCF	Women's Collective Forum
WHO	World Health Organization

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Executive Summary

The ICMR-Vector Control Research Centre (VCRC), Puducherry, in collaboration with the Women's Collective Forum (WCF), Delhi, organized a series of three regional workshops titled "Lymphatic Filariasis Elimination: Challenges and Priorities in India" to support and complement national efforts in the elimination of Neglected Tropical Diseases in India. The objective was to bring together key stakeholders from across the country to review achievements, progress, share best practices, discuss operational and surveillance challenges, and align regional strategies with the national goal of eliminating LF by 2027, in accordance with the WHO Roadmap 2030. Nearly 100 participants from 11 LF-endemic states (Uttar Pradesh, Bihar, Jharkhand, Odisha, Maharashtra, Gujarat, Kerala, Karnataka, Tamil Nadu, Puducherry, and Andhra Pradesh) participated across three workshops held in Varanasi (June 9, 2025), Surat (June 12, 2025), and Chennai (August 11, 2025). The participants included Regional Directors from Regional Offices of Health and Family Welfare (ROHFW), State Programme Officers from the National Centre for Vector Borne Diseases Control (NCVBDC), district-level officials, WHO representatives, development partners, NGO representatives, and academic institutions, reflecting a comprehensive multi-sectoral engagement in India's LF elimination efforts.

The regional workshops emphasised that achieving LF elimination in India necessitates targeted attention to never-treated populations, migrant communities, and urban vulnerabilities, alongside the strengthening of Mass Drug Administration (MDA) and Morbidity Management and Disability Prevention (MMDP) services. Policy-level interventions must shift from a uniform, blanket approach to risk-based, micro-planned strategies that prioritise high-burden and underserved populations. Strengthened surveillance systems, robust intersectoral convergence, and meaningful community participation will remain critical to achieving the national LF elimination target. Six critical thematic areas emerged from collective deliberations across the three workshops: (1) Strengthening MDA Coverage and Quality, (2) Addressing the Never-Treated Population in MDA, (3) Morbidity Management and Disability Prevention (MMDP), (4) Migration, Urbanisation and Transmission Risks, (5) Surveillance, Diagnostics and Data Systems, and (6) Partnerships, Communication and Community Engagements. Each theme encompasses specific policy recommendations aimed at operationalising India's 2027 LF elimination commitment.

Key Thematic Priorities and Policy Directions for Strengthening LF Elimination in India

Theme 1: Strengthening MDA Coverage and Quality

Key Highlights:

- **MDA Coverage Reporting:** Significant gaps exist between programme-reported MDA coverage and WHO-monitored estimates across districts, raising concerns about data reliability and performance assessment.
- **Urban and Peri-urban Coverage Deficits:** Lower drug consumption rates are observed in urban and peri-urban areas, particularly among the urban peripherals, resettlement areas, slum population, migrant settlements, hostels, and industrial zones, indicating operational blind spots.
- **Operational Fatigue:** Repeated rounds of MDA without adequate recognition have led to reduced motivation among frontline workers and community in some districts.
- **Training and supervision:** Variability in the training and supervision of drug administrators undermines the quality of MDA implementation.
- **Exclusion of Migrant and High-Risk Populations:** Mobile and high-risk groups are frequently missed during MDA rounds due to seasonal migration and inappropriate timing.

Policy Recommendations:

- **Strengthen Supervisory Systems with Digital Innovations:** Deploy real-time monitoring tools and digital supervision platforms (e.g., Sukritya app model in Bihar) to improve accountability and operational oversight during MDA campaigns.
- **Standardise Refresher Training Protocols:** Mandate structured and uniform refresher training for drug administrators before every MDA round to ensure quality and procedural consistency.
- **Adopt Targeted Microplanning Strategies:** Implement tailored microplanning approaches for hard-to-reach populations, institutional settings, youths, migrant clusters, and urban slums to enhance coverage equity.
- **Institutionalise Mid-Campaign Reviews:** Formalise structured mid-campaign review mechanisms to enable rapid course correction and adaptive decision-making.
- **Enhance Financing and Multi-sector Engagement:** Increase dedicated budget allocations and encourage private sector participation to strengthen IEC and social mobilisation activities during MDA campaigns.

Theme 2: Addressing the Never-Treated (NT) Population in MDA

Key Highlights:

- **Hidden Reservoirs:** Never-treated individuals act as hidden reservoirs sustaining LF transmission despite high reported MDA coverage in many districts, with significant intra-district variation observed (NT rates as high as 39% in some villages despite low state averages).
- **Absence of NT Identification Systems:** Lack of reliable registers makes identification of NTs difficult in many districts, and field-based identification mechanisms remain essential for effective targeting.
- **Barriers to Participation:** Major reasons for non-participation include fear of side effects, lack of awareness, migration, absence during MDA visits, and mistrust of government medicines.
- **Data Quality Concerns:** Recall bias affects accurate reporting of tablet consumption, undermining the reliability of coverage assessments.

Policy Recommendations:

- **Institutionalise NT Profiling and Tracking:** Introduce block-level profiling of never-treated populations within routine MDA microplanning and establish NT tracking as a formal programme indicator within NVBDCP reporting systems.
- **Develop Standardised Tools and Guidelines:** Create standard NT identification tools and guidelines for uniform implementation across all states.
- **Strengthen Community-Level Communication:** Enhance interpersonal communication through peer demonstration strategies, including public tablet consumption by **community leaders** and use of locally familiar language to improve acceptance.
- **Develop Behavioral Change Protocols for Chronic Refusers:** Introduce targeted counselling models involving community leaders and faith-based influencers.
- **Build Capacity for Refusal Conversion:** Introduce capacity-building modules for drug administrators, specifically focused on NT-targeted microplanning and refusal conversion strategies.
- **Incentivise Frontline Workers:** Provide performance-based incentives for ASHAs and community volunteers involved in **MDA in high refusal/ hard-to-reach areas/communities**

Theme 3: Morbidity Management and Disability Prevention (MMDP)

Key Highlights:

- **Treatment Gaps:** Substantial numbers of lymphedema and hydrocele patients remain untreated or improperly graded, limiting effective case management.
- **Quality Assurance Deficits:** Inconsistent grading protocols and a lack of disability certification across programme areas.
- **Psychosocial Distress and Stigma:** LF patients experience social exclusion, mental health distress, and reduced quality of life, which are not adequately addressed.

Policy Recommendations:

- **Scale Up Service Delivery Infrastructure:** Expand MMDP services at PHC and CHC levels with dedicated funding and surgical capacity targets for hydrocele management.
- **Introduce Digital Patient Tracking Systems:** Establish unique patient IDs and registries for lymphedema and hydrocele cases to ensure continuity of care.
- **Standardise Clinical Protocols:** Implement uniform patient grading protocols with mandatory refresher training for healthcare providers.
- **Strengthen Psychosocial Support Services:** Integrate counselling, patient self-help groups, and peer support models into MMDP services.
- **Link MMDP with Social Protection Schemes:** Facilitate direct linkage with disability pensions, transport subsidies, and livelihood schemes.
- **Strengthen Public-Private Partnerships:** Expand hydrocele surgery capacity through formal partnerships with private healthcare providers.
- **Improve Supply Chain Management:** Strengthen procurement and distribution systems for MMDP kits to ensure uninterrupted service availability.

Theme 4: Migration, Urbanisation and Transmission Risks

Key Highlights:

- **Risk of resurgence from Mobile Populations:** Migrants from endemic regions pose **significant** risks to post-MDA districts. Additionally, informal housing and transient populations escape surveillance, remaining outside formal health systems and MDA frameworks.
- **Urban Transmission Pockets:** Rapid urbanisation creates informal settlements with poor infrastructure, limited health access, and weak follow-up systems, generating invisible pockets of transmission, especially in post-MDA districts and urban expansion zones.

- **Low Awareness and Weak Tracking:** Low risk perception and higher non-compliance among urban populations, combined with weak tracking of mobile populations, undermine prevention efforts.

Policy Recommendations:

- **Establish Migrant Registration and Surveillance Systems:** Create registration mechanisms linked to municipal bodies and large employers, and deploy dedicated mobile surveillance teams for migrant-dense clusters to enable systematic tracking and continuous monitoring.
- **Mandate Screening and Workplace-Based MDA Models**: Partner with industries, construction companies, and labour contractors for mandatory screening and ensure MDA coverage for migrant communities through targeted delivery mechanisms or booth-based approach.
- **Develop Urban-Specific Action Plans:** Design tailored LF control strategies addressing slums, construction sites, and informal settlements with dedicated operational frameworks and context-specific IEC strategies.
- **Strengthen Intersectoral Coordination:** Establish formal coordination frameworks between labour, municipal, housing authorities, and health departments, and integrate LF control with urban health missions and WASH initiatives.
- **Ensure robust Post-MDA Surveillance:** Maintain active surveillance systems even in post-MDA phases to detect and respond to reintroduction/**resurgence** risks.

Theme 5: Surveillance, Diagnostics and Data Systems

Key Highlights:

- **Diagnostic Supply Constraints:** Shortage of FTS/QFAT kits delays TAS and IDA impact surveys, affecting programme monitoring and evaluation.
- **Limited Laboratory Capacity:** Inadequate access to molecular and antigen testing infrastructure in some regions restricts diagnostic capabilities and surveillance effectiveness.
- **Limited Digital Capacity:** Lack of digitalization of family registers and MDA/MMDP records which are mostly incomplete

Policy Recommendations:

- **Ensure Uninterrupted Diagnostic Supply:** Avoid delays and ensure timely availability of diagnostic kits at all operational levels.
- **Strengthen Digital Surveillance Infrastructure:** Deployment of a digital information system on LF to maintain digital surveillance dashboards with village-level granularity for real-time data visibility and decision-making.

- **Integrate Advanced Surveillance Methods:** Incorporate molecular xenomonitoring into routine surveillance protocols in high-risk districts for enhanced transmission detection.

Theme 6: Partnerships, Communication and Community Engagement

Key Highlights:

- **Variable Partnership and Coordination:** NGOs play critical roles in social mobilisation and refusal tracking. But intersectoral coordination varies significantly among states.
- **Awareness and Trust Barriers:** Low awareness remains a key barrier to drug consumption, with persistent local beliefs and stigma in high-burden areas, though visible leadership engagement demonstrably improves community trust.

Policy Recommendations:

- **Formalise Multi-Sectoral Partnerships:** Establish structured PPP mechanisms with clear accountability measures, support NGO-led initiatives through dedicated funding, and strengthen cross-sectoral convergence with education, labour, housing, and WASH sectors.
- **Incentivise Private Sector Engagement:** Create incentive structures to encourage private sector involvement in IEC, outreach, and service delivery.
- **Scale Up Culturally Sensitive Communication:** Design and implement context-specific IEC campaigns, leverage local influencers and community leaders in advocacy, and develop customised state-specific communication strategies.
- **Institutionalise Refusal-Conversion Mechanisms:** Establish structured workshops and counselling protocols for addressing refusals and converting hesitant populations

01 Introduction

1.1 Background and Context

Lymphatic filariasis (LF) is a disabling neglected tropical disease caused by parasitic worms- Wuchereria bancrofti, and Brugia malayi and spread through the bites of infected mosquitoes. It remains a major public health challenge in many parts of the world, especially in Asian and African regions.[1] Since the launch of the Global Programme to Eliminate Lymphatic Filariasis (GPELF) in 2000, endemic countries, including India have received substantial support to implement elimination strategies. India initiated its national LF elimination programme in 2004, adopting GPELF-recommended approaches such as interrupting transmission through mass drug administration (MDA) in endemic districts and care for affected individuals through morbidity management and disability prevention (MMDP) (Figure 1).

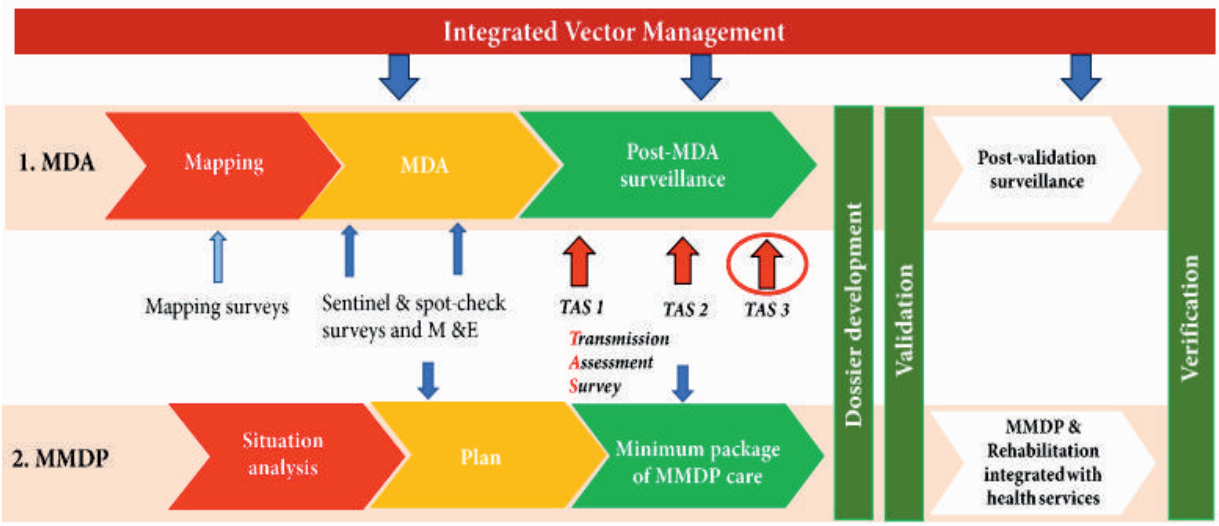


Figure 1: Key programmatic activities for LF elimination (Source: NCVBDC, 2024)

Despite significant progress, India continues to carry the world's highest LF burden, with an estimated 404 million people at risk across 348 endemic districts in 20 states.2,3 As of 2025, the country had recorded approximately 620,000 cases of lymphedema and 120,000 cases of hydrocele. Challenges such as suboptimal MDA coverage and higher infection rates in several districts, even after two decades of programme intervention, highlight critical gaps that must be addressed to advance towards elimination.5,6 India has set an ambitious goal of eliminating LF as a public health problem by 2027, three years ahead of the global target.

1.2 Rationale for Regional Workshops

The regional workshop series was conceived as a strategic response to the need for collaborative, multi-stakeholder dialogue to identify and address region-specific implementation challenges while sharing best practices across states. Often, the experiences and solutions developed and tested in one region remain standalone and are not effectively shared with other areas facing similar challenges, leading to missed opportunities for helpful ideas and lessons. States in the north, such as Uttar Pradesh, Bihar and Jharkhand, struggle with high LF endemicity, operationally challenging geography and health system and heavy out-migration for employment that complicate elimination efforts, such as achieving MDA coverage thresholds, mapping patients and hotspots and surveillance. In central Maharashtra and Gujarat, challenges related to rapid urbanisation, informal settlements, and a large flow of migrants from endemic states. Southern states such as Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, and the Union Territory of Puducherry, now largely in post-MDA phase, need to maintain strong surveillance and prevent resurgence risk due to increasing population mobility.

The workshops created an opportunity to engage in evidence-based deliberation, where state progress presentations were complemented by expert technical inputs, and group discussions on key programmatic challenges. Participants highlighted gaps between programme reported and validated MDA coverage, operational fatigue among front-line health workers, and low drug uptake in urban settings. Reaching people who have never taken the drugs and migrants was emerged as a top priority in discussions. They recommended increased investment in microplanning, community engagement, awareness activities, capacity building of drug distributors and the adoption of digital supervision tools for MDA. They also pointed out barriers in patient identification, case grading, hydrocele surgery access and disability certifications. Participants recommended strengthening vector surveillance and ensuring uninterrupted diagnostics as a core requirement for progress. Overall, the consultations affirmed that India's 2027 LF elimination goal remains within reach, but only if strategies are tailored to the unique risks and challenges of each region.

1.3 Workshop Locations, Dates, and Geographic Scope

Three regional workshops were conducted across different geographic regions of India. The first workshop, held in Varanasi, Uttar Pradesh, brought together the stakeholders from the northern states. The second, held in Surat, Gujarat, engaged representatives from western and eastern states. The final workshop, in Chennai, Tamil Nadu, involved participants from the southern states. This geographic distribution ensured representative participation from India's most LF-endemic regions, capturing the complete spectrum of epidemiological stages—from high-burden endemic states (Odisha, Bihar, Jharkhand, Uttar Pradesh) still conducting intensive MDA, to states and UTs that have advanced to post-MDA surveillance phases (Tamil Nadu, Kerala, Puducherry) and are preparing for subnational elimination validation.

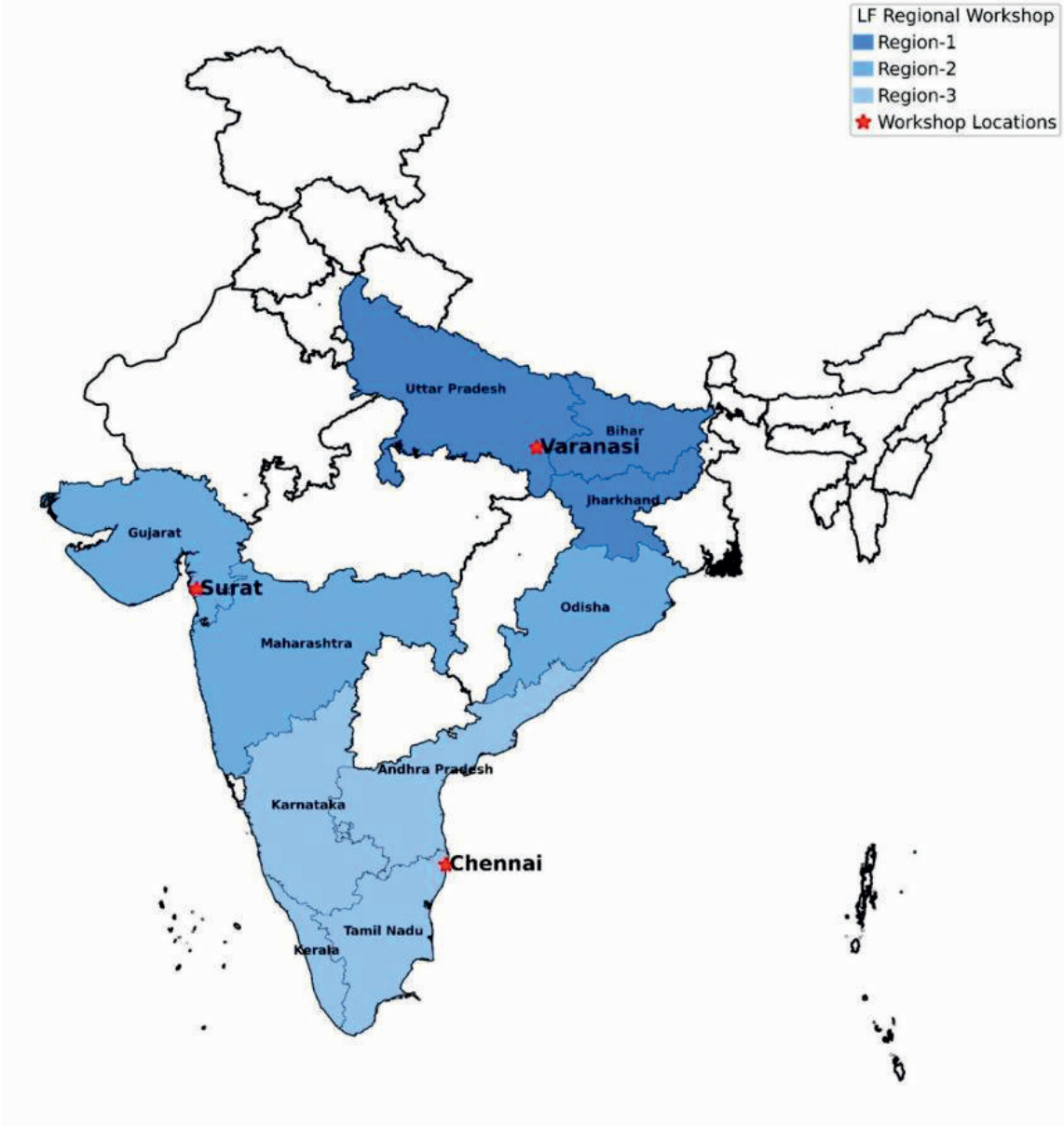


Figure 1: States represented in the workshop and workshop locations

1.4 Participant Profile and Stakeholder Representation

The workshops were attended by nearly 100 participants from 12 states, comprising a diverse range of stakeholders representing multiple sectors and levels of the health system.

Government Representatives/Programme Managers:

- Regional-level officials: Regional Directors from Regional Offices of Health and Family Welfare (ROHFW) from multiple states, who provide senior technical and administrative oversight to state health programmes
- State-level officers: State Programme Officers from the National Centre for Vector Borne Diseases Control (NCVBDC), State Entomologists, State Filaria Consultants, and State health administrators

- District-level managers: District Vector Borne Disease Control Officers (DVBCOs), Assistant District Malaria Officers (ADMOs), and Medical Officers.
- Municipal Corporation officials: Representatives from urban health systems, notably from Surat Municipal Corporation, engaged in urban LF elimination efforts.

National and International Development Partners:

- WHO representatives: National Professional Officers (NPOs) and Regional Coordinators for Neglected Tropical Diseases at both national and regional levels who are involved in LF programme monitoring and impact evaluations.
- Gates Foundation Representatives: Programme Officers supporting LF research and elimination initiatives in India.
- Research and Academic Institutions:
- ICMR-VCRC scientists and staff: Scientists from various divisions (Biostatistics, Epidemiology and Operational Research, Vector Biology) who are involved in LF-related research and programme.
- University faculty: Faculty and research scholars from institutions such as Banaras Hindu University (BHU) doing operational research on vector-borne diseases.

Non-Governmental Organisations (NGOs):

- NGO representatives: Senior officials from organisations like Project Concern International (PCI), Hans Foundation, Lepra Foundation, and PATH, who are actively engaged in community mobilisation, refusal tracking, and patient care.

This diverse stakeholder composition ensured that workshop discussions incorporated multiple perspectives, programmatic, technical, implementation, research, and community-level, thereby facilitating an inclusive deliberation on LF elimination strategies.

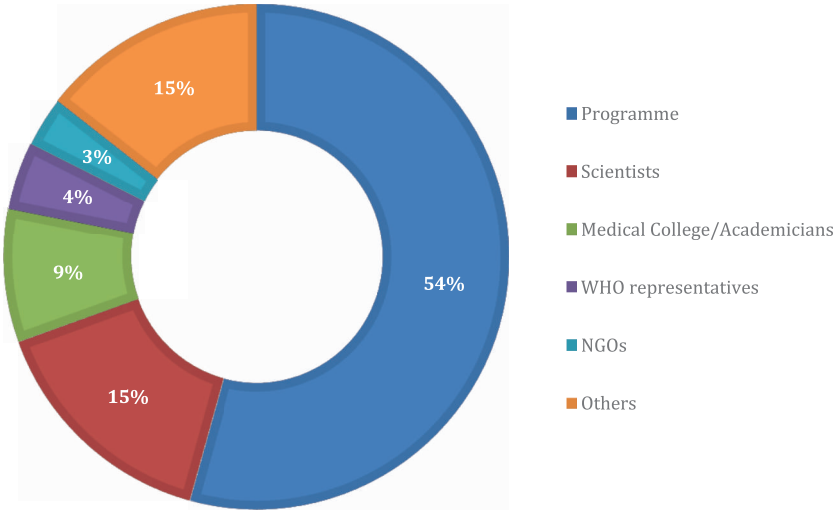


Figure 1: Type of participants

02

Workshop Proceedings

REGIONAL WORKSHOP, VARANASI

Overview

The regional workshop for the northern region was held on 9th June 2025 at the New Hotel Broadway, Varanasi, U.P. It brought together regional directors, state programme officers, district malaria\filaria officers from Uttar Pradesh, Bihar, and Jharkhand, along with representatives from WHO, Gates Foundation, NGOs, medical colleges and scientists and staff from ICMR-VCRC. The meeting commenced with a welcome address by Dr. Srividya A, Scientist F, ICMR-VCRC. Following the welcome address, participants introduced themselves, after which Dr. Manju Rahi, Director, ICMR-VCRC, addressed the gathering.

Opening Address- Dr Manju Rahi, Director, ICMR-VCRC, Puducherry

Dr. Manju Rahi, Director, ICMR-VCRC, officially opened the workshop by outlining its key objectives — to review the current LF status across states, reflect on achievements and challenges, and define the actions needed to achieve elimination by 2027. She emphasised that eliminating LF from the country is of critical importance, particularly as India bears the highest LF burden globally. She reminded participants that success in this endeavour will contribute significantly to global elimination targets and improve the quality of life for millions at risk.

Dr. Rahi explained that even after reaching the current LF elimination threshold (microfilaria rate < 1%), the work must not stop. She encouraged states to aim for further reductions- to 0.5%, 0.25%, and lower - noting that these incremental gains are essential to ensuring the disease does not resurge. Highlighting significant gaps in the programme in some states, she urged state teams to set clear targets and timelines. She stressed the need to strengthen both key pillars - Mass Drug Administration (MDA) and Morbidity Management and Disability Prevention (MMDP) - and to ensure that all eligible lymphedema patients receive disability certification. Dr. Rahi also briefed about the upcoming study on never-treated population in MDA, explaining who the 'never treated individuals' are and the possible reasons for their refusal to consume tablets during MDA rounds could make them the human reservoirs supporting LF transmission. She highlighted the importance of identifying and treating this population to achieve LF elimination.

Concluding her address, Dr. Rahi encouraged participants to use the workshop as a platform to exchange ideas, share success stories & practical solutions, and reinvigorate their commitment to LF elimination. "I hope that this workshop will give us renewed energy to tackle LF in some of the high-burden states of the country," she said, reinforcing the shared responsibility of all stakeholders in achieving the 2027 target.

Presentation 1: Aligning Regional Efforts with WHO Roadmap 2030 Needs and Priorities

Dr. Tanuj Sharma, State Coordinator–NTD, WHO, Uttar Pradesh

Dr Sharma presented an overview of the WHO Neglected Tropical Diseases (NTD) Roadmap 2030 in the context of LF elimination. He explained its three core pillars: 1) accelerating programmatic action; 2) intensifying cross-cutting approaches, and 3) changing operating models and culture, which collectively support global elimination targets. Linking the roadmap to India's efforts, he outlined the National Programme strategies, including sustained high-coverage MDA, integration with other health initiatives, robust surveillance, and strengthening MMDP services for lymphedema and hydrocele patients. He also briefly discussed the strategies implemented by the National Programme to eliminate LF. He emphasised that coordinated efforts among governments, partners, and communities are essential to achieve India's 2027 LF elimination goal and contribute to the global 2030 vision.

Presentation 2: Role of Never-Treated Population in LF Transmission

Dr. Dinesh Raja J., Scientist C, ICMR-VCRC

Dr Dinesh presented an upcoming study on the role of the never-treated population in LF transmission. The study aims to assess LF infection status among individuals who have never participated in MDA rounds across selected districts in India and to explore reasons for non-participation in order to inform targeted strategies. The findings are expected to devise appropriate strategies for improving coverage in endemic areas. Several key suggestions emerged to strengthen the identification and engagement of the never-treated population:

- **Block-level profiling:** prepare a block-level matrix including block name, population, average MDA coverage (past three years), mf rate (past three years), and the estimated number of never-treated individuals.
- **Direct field identification:** Since registers listing never-treated individuals are unavailable in many places, plan for identification to be carried out directly by survey teams during fieldwork, supported by local Self-Help Group leaders, ASHAs, Anganwadi workers, and community mobilizers.

- **Reducing recall bias:** show actual samples of the MDA tablets to community members and use locally familiar phrases (e.g., “Kide ki dawai khaye kya?”) instead of formal medicine names.
- **Boosting community acceptance:** Encourage ASHAs to consume the tablets in front of the community, especially in high-refusal areas, and distribute IEC materials through ASHAs accompanying survey teams to improve awareness.
- **Leveraging local knowledge:** Rely on local informants for accurate information on tablet consumption, particularly in remote districts such as Sonbhadra.
- **Verifying actual coverage:** Compare PHC drug supply and consumption records with blood survey results to estimate actual coverage, using dosage-based calculations.

Presentation 3: Progress and Challenges of LF Elimination in the State of Jharkhand

Dr. Ravi Shankar Singh, Senior Regional Director, ROHFW, Patna

Dr. Singh presented the progress and challenges in LF elimination in Jharkhand. He

outlined the LF-endemic status of all districts in the state, noting that nine districts are implementing the IDA drug regimen, five districts have completed TAS, and three are in the post-TAS phase. Coverage data from the February and August 2024 MDA rounds indicated an average WHO-reported coverage of 70.7% for the state. Jharkhand has reported over 50,000 lymphedema cases and more than 40,000 hydrocele cases, with regular MMDP activities and around 3,900 patients receiving disability certificates. He highlighted best practices, including mapping high-priority villages for focused interventions, ensuring drug compliance among migratory populations, strengthening intersectoral coordination with 24 departments, and fostering strong partnerships with WHO, the Piramal Foundation, and GHS. Initiatives such as distributing drug-consumption slips through SHGs and conducting special drives to reach Particularly Vulnerable Tribal Groups (PVTGs) were also shared. Key challenges identified in rural areas included limited supervisory involvement, migrant populations, and high refusal rates, while urban challenges involved awareness gaps and low consumption in housing societies and workplaces. He also highlighted gaps in hydrocele surgeries. Dr. Singh concluded with a success story from Pakur village, illustrating effective local action against LF.

Presentation 4 : Progress and Challenges of LF Elimination in Uttar Pradesh

Dr. Tanuj Sharma, State Coordinator NTD, WHO, Uttar Pradesh

Dr. Sharma presented an overview of the LF elimination status in the state, outlining key milestones and timelines of activities undertaken. He reported that 51 districts and 782 blocks in Uttar Pradesh remain endemic for LF, with over one lakh lymphoedema cases and nearly 10,000 hydrocele cases, noting a significant gap in hydrocele surgeries. Post-MDA achievements were highlighted, including the improvement in WHO-reported coverage from 24% in 2017 to 73% in 2025, and a substantial reduction in missed areas from 2,250 in December 2017 to just 19 in February 2025. He also provided an update on the Transmission Assessment Survey (TAS) status across the state, and discussed the implementation of MMDP services, including the identification and management of lymphoedema and hydrocele cases. Key challenges include the limited availability of filarial antigen testing kits such as QFAT/FTS, delays in implementing IDA treatment in certain districts, and insufficient funds for NBS surveys and pre-TAS activities. Dr. Sharma emphasised the need for additional budgetary support for IEC activities to strengthen programme impact.

Presentation 5: Progress and Challenges of LF Elimination in the State of Bihar

Dr. Ravi Shankar Singh, Senior Regional Director, ROHFW, Patna

Dr. Singh noted that Bihar, being a larger state than Jharkhand, faces more complex operational challenges and currently conducts a single MDA round annually. He provided an overview of LF programme activities, district-wise MDA coverage from the February 2025 round, and highlighted the identification of high-priority blocks. The state has mapped 199 high-priority blocks based on NBS scoring, including 44 with microfilaria rates above 5% or coverage below 45%. In the latest MDA round, programme-reported coverage was 84%, while WHO-monitored coverage stood at 67%. Bihar has reported over 1.5 lakh lymphedema cases and more than 20,000 hydrocele cases, with targeted efforts underway to conduct 12,000 hydrocele surgeries by October 2025. The programme implements three-day booth activities followed by 14 days of house-to-house microplanning for MDA, supported by two-member teams to ensure quality. Local celebrities, community leaders, and influential stakeholders were engaged in advocacy. Special campaigns targeted officers, prisons, CRPF camps, military residential areas, hostels, brick kilns, and nomadic groups. Daily coverage is monitored through the Sukritya mobile

application. Key challenges remain, such as the need for enhanced drug administrator training, coverage gaps in certain urban areas, and limited intersectoral convergence. Additionally, the large number of lymphedema cases makes it difficult for medical officers to grade all patients, and inconsistencies in grading between officers further complicate case management.

Presentation 6: Role Of the Private Sector and NGOs in LF Elimination

Dr. Rajshree Das, Senior Director (NTD Programs), PCI-India

Dr Rajashree spoke on the important role of the private sector and NGOs, with a particular focus on reaching the never-treated population during MDA rounds. She also outlined the Social Mobilisation Assessment conducted post-MDA at both district and block levels, which examined drug consumption behaviour and MDA awareness among households. She emphasised that every household must understand the importance of both the disease and the drugs, regardless of whether they receive a visit from an ASHA. Using the IDA rollout in Simdega as an example, she noted low drug consumption among males and highlighted that data collected since July 2021, covering around 35,000 people across 116 districts in six states, revealed significant variation at the granular level. In Jharkhand, for instance, while the state's never-treated (NT) rate was only 4%, certain villages and blocks recorded rates as high as 39%. She identified key reasons for being NTs, includes absence of drug administrator visits, non-receipt of drugs, lack of awareness, fear of side effects, and mistrust of government medicines. Since 2024, as the WHO began leading NT data collection, PCI shifted its focus toward studying refusal patterns among individuals. She concluded by highlighting never-treated individuals within the refusal group, noting that a survey among college students revealed a persistently high NT, despite overall improvements in drug consumption.

Presentation 7: Herbal Solutions for Lymphatic Filariasis: Laboratory Evidence

Dr. Anchal Singh, Associate Professor, Banaras Hindu University

Dr. Singh shared insights from over 12 years of research on lymphatic filariasis conducted in her laboratory. The team explored diverse knowledge sources, including traditional literature, homoeopathy, and Ayurveda, to identify herbs with potential anti-filarial properties. Through this work, they identified two plants- Centratherum anthelminticum and Ocimum sanctum, which demonstrated significant efficacy in killing adult worms. Dr. Singh also outlined the processes for herbal extraction, the research methodology employed, and the key findings that support the potential of these plants in LF management.

Presentation 8: Partnership of the Gates Foundation for LF Elimination in India

Dr. Vishal Dogra, Program Officer, Gates Foundation

Dr. Dogra, highlighted the Foundation's longstanding support for LF research and elimination activities in India. He emphasised that the Foundation has contributed to advancing operational research, developing innovative strategies for MDA, and strengthening monitoring and evaluation frameworks. It has also supported capacity building and collaborative initiatives with national and state health authorities to accelerate progress toward LF elimination.

Presentation 9: Overcoming Field Challenges in LF Elimination: Experience from Sonbhadra District, Uttar Pradesh

Dr. Dharmendra, District Vector-Borne Disease Officer (DVBDCO), Sonbhadra,

Dr. Dharmendra, District Malaria Officer, Sonbhadra, shared ground-level challenges in implementing LF-related activities in the district. He highlighted that linguistic diversity across different blocks creates communication barriers. The absence of mobile network coverage, poor road connectivity, and limited access to remote villages significantly hampers field operations. He also noted that drug refusals persist due to local beliefs, fear of side effects, and widespread alcohol use. Dr. Dharmendra emphasized that these challenges must be addressed during the planning and execution of field activities for the NT study by ICMR-VCRC in the district.

REGIONAL WORKSHOP, SURAT

Overview

The regional workshop for the eastern and western regions was held on 12th June 2025 at the conference hall of the Sardar Vallabhai Patel National Institute of Technology, Surat, Gujarat. It brought together regional directors, state programme officer and district officials from Gujarat, Odisha and Maharashtra, along with representatives from Surat Municipal Corporation, WHO and Gates Foundation, and scientists and staff from ICMR-VCRC. The meeting commenced with a welcome address by Dr. Anju Viswan, Scientist C, ICMR-VCRC. Following the welcome address, participants introduced themselves, after which Dr. Muhammed Jabir MM, Scientist C, ICMR-VCRC, provided an overview of the workshop

Presentation 1: Aligning Regional Efforts with WHO Roadmap 2030: Needs and Priorities

Dr. Kamalakar Arjun Lashkare, National Professional Officer, WHO, New Delhi

Dr. Lashkare spoke about aligning India's LF elimination efforts with the WHO Roadmap 2030. While acknowledging that full elimination by 2027 may be challenging, he stressed that the immediate focus should be on stopping MDA. Sharing state-wise updates, he highlighted Gujarat's strong progress, with most districts having cleared TAS 3 and no current WHO presence due to its success, though continued surveillance remains essential. In contrast, he emphasised that states like Madhya Pradesh face low MDA coverage, weak preparatory work, poor community awareness, and inadequate supervision, calling for remapping in some districts and better training for drug administrators. In Maharashtra, he noted that despite good overall coverage, has specific problem areas such as Nanded, Gadchiroli, and Chandrapur, where poor-quality tablets, improper survey methods, and weak monitoring hinder progress. He appreciated that the state of Odisha is performing well in MDA but is awaiting FTS kits to complete TAS 1. MDA implementation in urban areas remains a challenge, and Brugia malayi cases require specific diagnostic kits. Dr. Lashkare also outlined key action points, recommending the use of triple-drug treatment in newly identified endemic areas, addressing delays in TAS and IDA Impact surveys caused by shortages of testing kits like FTS and QFAT, ensuring the timely issuance of disability certificates, and expanding MMDP services through PHCs. He further suggested integrating **AYUSH** and traditional medicine for lymphedema management and strengthening collaboration with WASH initiatives to support LF elimination.

Presentation 2: Lymphatic Filariasis and Other Vector Borne Diseases in Surat: Current Status, Gaps and Control Measures

Dr. Keshav Vaishnav, Former InsecticideOfficer at Surat Municipal Corporation

Dr Vaishnav shared that Surat has historically been one of the most LF-endemic regions, dating back to the time of Bombay State. Early MDA efforts in the 1950s faced significant challenges due to limited drug supply and high rates of adverse reactions, eventually leading to the withdrawal of the program in 1960. The revised MDA program, reintroduced in 2004 with improved dosage and better coverage, has resulted in a substantial decline in infection rates. A well-equipped laboratory now functions at the headquarters, supported by adequate insect collectors, filaria inspectors, and health workers. Each year, over 30,000 female mosquitoes are dissected to monitor larval stages (L1 to L3), generating vital data on infection and infectivity rates in the community. Routine surveillance activities, including night blood surveys between 9:00–10:00 PM, follow a systematic sampling method by preparing household lists for selected mohallas or streets and randomly selecting 6–10 per cent for slide collection. In 2024 alone, more than 50,000 slides were examined. He highlighted the major challenge posed by Surat's rapid urban expansion, which grew from 112 sq. km in 2006 to 476 sq. km in 2020, incorporating newly merged areas with unknown LF status. Informal settlements, often lacking basic infrastructure, have emerged alongside this growth, and migrant populations from highly endemic states such as Odisha, Uttar Pradesh, and Bihar have significantly contributed to the LF burden. These groups, especially transient and undocumented populations, are often 19 missed by treatment programs, creating pockets of potential transmission even in a post-MDA phase. Stigma associated with visible symptoms such as elephantiasis further discourages health-seeking behavior. Dr. Vaishnav stressed that in such a context, continuous monitoring, strong laboratory support, targeted strategies for migrant communities, and active community participation are critical to sustaining LF elimination gains.

Presentation 3: LF situation in post-MDA districts and role of migrants in transmission

Dr. A. Srividya, Scientist F at ICMR-VCRC

Dr Srividya presented an upcoming project by VCRC with the support of the Gates Foundation. The primary aim is to assess whether migration from LF-endemic districts contributes to the spread of LF in districts that have already cleared Transmission Assessment Survey (TAS-3) and are in the post-treatment phase. The study also aims to evaluate the potential role of migrants in LF transmission in MDA-naïve areas, where MDA has never been implemented. She underscored that while these post-MDA districts are officially considered to have interrupted transmission, the continued influx of migrants from endemic regions could reintroduce the infection, posing a risk to the hard-earned elimination gains.

Outlining the study plan, she explained that surveys would be conducted in both post-MDA and MDA-naïve districts, with Surat district representing a post-MDA area and Chhota Udaipur representing an MDA-naïve area. The surveys will include blood surveys and molecular xenomonitoring, with clearly defined sample sizes, testing protocols, and thresholds for determining LF transmission status. Sociological surveys will also be conducted to understand the health needs of the migrant population and the possible ways to bring them under the MDA umbrella. To facilitate implementation, Dr. Srividya requested support from the state representatives in identifying blocks with large migrant populations, as these are likely to be hotspots for potential reintroduction of LF.

Presentation 4: Progress and Challenges of LF Elimination in the State of Odisha

Dr. Suchithra Sasmal, Senior Regional Director, RoHFW, Bhubaneswar

Dr Sasmal presented the LF elimination status of Odisha, noting that all 30 districts in the state are endemic and collectively contribute significantly to the national LF burden. She highlighted that around 44 million people- 94% of the state's population are at risk, making Odisha the state with the third-highest disease burden in the country, accounting for 13% (82,136) of all reported lymphedema cases and 17% (14,340) of hydrocele cases nationwide. MDA activities in Odisha began in 2004, and to date, 10 districts have successfully stopped MDA after achieving microfilaria (MF) rates below 1%. The state has shown progress in reducing MF rates over time, demonstrating the effectiveness of sustained

MDA rounds. Dr. Sasmal also underscored the state's morbidity situation, which remains high, and outlined ongoing measures such as MMDP kit distribution and hydrocelectomy surgeries. She shared several best practices, including a structured 180-day MDA preparatory phase, timely implementation aligned with national guidelines, and the involvement of Self-Help Groups in community engagement. The use of daily online real-time coverage reporting with an automated dashboard has enabled immediate analysis down to the village level. She also pointed to the active participation of NSS volunteers, schools, and youth groups in social mobilization efforts, alongside initiatives like refusal conversion workshops, daily monitoring, and mid-campaign reviews to improve outcomes. However, she also drew attention to challenges, including high endemicity across multiple districts, a favourable environment for vector breeding, the presence of both Wuchereria bancrofti and Brugia malayi, population coverage gaps- particularly in peri-urban areas, shortages of diagnostic kits for surveillance, and the added complexity of addressing two different parasite species in the elimination program.

Presentation 5: Progress, Best Practices, and Challenges in LF Elimination in Maharashtra

Dr. Anagha, Medical Officer at ROHFW Pune

Dr. Anagha provided an update on Maharashtra's LF elimination progress. She noted that while several districts have completed TAS 3 and discontinued MDA, others continue MDA using either triple-drug or double-drug regimens, depending on district status. The state continues to report morbidity cases, particularly lymphedema and hydrocele, in specific regions. Routine surveillance is maintained through control units, night clinics, and survey laboratories, with the Regional Health Office providing technical training, supervision, and monitoring support. Mapping has also been completed in non-endemic areas. Sharing her observations from a recent MDA round, she pointed out challenges such as community refusals. She highlighted Maharashtra's best practices, including the use of IEC materials in regional languages, strong field-level commitment, and effective coordination between central and state authorities. However, she also acknowledged challenges, such as DEC quality concerns, funding delays, and the need for more granular block-level data to better assess programme performance.

Presentation 6: LF elimination in Urban Settings: Challenges

Dr. Dhwani Patel, Deputy Medical Officer, Surat Municipal Corporation

Dr. Dhwani spoke about the key challenges of LF control in urban settings, especially in Surat, underscoring how rapid urbanisation has strained public health infrastructure and workforce capacity. The issue of migrant populations was highlighted, with many residing in densely populated slums. She noted that migrants often return to their native places and resettle in different locations, making follow-up and tracking difficult. She mentioned that although TAS 1, TAS 2, TAS 3 have been cleared and MDA have been stopped in the district, the teams are still actively monitoring the situation. They continue to distribute IEC materials in the morning and conduct night blood surveys. She gave an overview of the mosquito surveys conducted and mentioned that the number of positive Culex mosquitoes is gradually decreasing, which is a good sign. However, she pointed out that challenges remain such as low awareness about LF, frequent movement of people, and limited access to health services in newly developed urban areas. She concluded by emphasising the need for improved urban planning, stronger community outreach, and better training for health workers to effectively manage LF and other vector-borne diseases in urban and peri-urban areas.

Group Discussion: Approaches for Tracking and Identifying Migrant Populations: Discussion

Moderator: Dr. Keshav Vaishnav, Former Insecticide Officer, Surat Municipal Corporation

The session focused on strategies for identifying and tracking migrant populations in specific areas, an issue of particular importance in post-MDA districts where the movement of people from endemic regions could reintroduce transmission risks. Participants were divided into three teams, each discussing practical approaches for effective monitoring and follow-up.

The first team suggested that shop owners, factory managers, and house owners should inform the municipality about incoming migrant workers or tenants from other states, providing essential details such as name, age, phone number, and place of origin. They proposed issuing mandatory registration cards for all migrants, which would track their employment location and serve as a prerequisite for accessing health and other benefits.

The second team recommended that large companies, including factories and construction sites, collect detailed information from migrant workers upon joining, covering personal, health, family, and intended duration-of-stay details. For smaller or informal occupations such as rickshaw drivers and restaurant staff, they suggested conducting house-to-house surveys or using mobile apps for efficient data collection and management. They stressed the importance of structured follow-up for migrants testing positive for diseases at intervals of one month, six months, and two years, while also highlighting the challenge of follow-up when migrants relocate-calling for a stronger tracking system. They noted that migrants from the same state often cluster in specific localities, offering an opportunity for targeted interventions.

The third team proposed marking migrant houses during surveys, following the approach used in polio campaigns, to identify covered households and streamline follow-up visits. They also emphasized the need for clear state government guidelines requiring factories, shops, and other workplaces to provide complete migrant worker details immediately upon hiring, enabling health teams to track and follow up more effectively.

Presentation 7: Partnership of the Gates Foundation for LF Elimination in India

Dr. Vishal Dogra, Programme Officer (LF), Gates Foundation

Dr. Vishal Dogra, Programme Officer at the Gates Foundation, provided an overview of how LF-related work was initiated at the Foundation and highlighted key ongoing projects, including collaborative studies with VCRC. He also outlined the Foundation's future priorities, with a particular focus on supporting molecular xenomonitoring. Emphasising the importance of social mobilisation and community-based research, he noted that Gujarat, having already achieved the LF elimination threshold, could be considered as one of the intervention states. He expressed keen interest in exploring future collaborations and extending support to the state.


सरदार वल्लभभाई पटेल भवन
SARDAR VALLABHBHAI PATEL BHAVAN

REGIONAL WORKSHOP, CHENNAI

Overview

The regional workshop for the southern region was held in hybrid mode on 11th August 2025 at the ICMR–National Institute of Epidemiology, Chennai. It brought together regional directors, state programme officers and district officials from Kerala, Tamil Nadu, Puducherry, Andhra Pradesh, and Karnataka, along with representatives from WHO, NGOs, and scientists and staff from ICMR-VCRC. The meeting commenced with a welcome address by Dr. M.M. Muhammed Jabir, Scientist C, ICMR-VCRC, who underscored the importance of the workshop and briefly revisited the outcomes of previous regional workshops. Following the welcome address, participants introduced themselves, after which Dr. Manju Rahi, Director, ICMR-VCRC, addressed the gathering

Director's Address

Dr. Manju Rahi, Director of ICMR-VCRC

Dr. Rahi officially inaugurated the workshop by outlining the core objectives and setting the tone for the discussions ahead. She congratulated the efforts taken particularly by the southern states of India, in being the role models and torch bearers of improved health. She focused on the need to focus on measurable and objective targets to achieve complete elimination of lymphatic filariasis. She underscored the critical need to strengthen MMDP activities in the southern states, noting that many districts in the region are either in the post-MDA phase or states are in the process of preparing dossiers for subnational elimination. Drawing attention to a pressing concern, she highlighted that the movement of migrants from LF-endemic to non-endemic states poses a significant risk of reintroducing the disease, potentially undermining the hard-earned gains of elimination programs. Dr. Rahi stressed that proactive strategies must be adopted to monitor and manage this challenge. In her concluding remarks, she urged participants to view the workshop as an opportunity to exchange innovative ideas, share practical field-based solutions, and renew their collective commitment to sustaining LF elimination from the country.

Presentation 1: LF Surveillance Strategies for Post-MDA Situation

Dr. Srividya A, Scientist F, ICMR-VCRC, Puducherry

Dr. Srividya A, Scientist F, ICMR-VCRC, Puducherry, presented the major findings of her recently completed study in Thanjavur district, Tamil Nadu, which aimed to assess the status of filarial infection in both humans and vectors after 14 years of stopping MDA. The primary objective was to develop a robust and operationally feasible sampling strategy for post-MDA surveillance. She explained that the study involved screening over 2,000 children aged 5–15 years and conducting adult surveys among more than 7,000 community members. In addition, xenomonitoring was carried out to assess vector infection levels. The results revealed 11 CFA-positive cases (8 males and 3

females), with no infection detected among children (5–15 years) across all parameters. Both CFA and Mf prevalences were found to be well below the LF elimination thresholds, indicating sustained interruption of transmission. She also noted that DBS samples collected from children are currently being processed using the Wb123 assay, and mosquito samples are being tested through PCR assays, with analysis ongoing. The data from this study based on simulation with various sampling designs is expected to devise a most feasible surveillance strategy with most suitable indicator and target population for post MDA surveillance.

Presentation 2: Strengthening of LF-related Morbidity Management and Disability Prevention (MMDP)

Prof. Suma Krishnasastry, ICMR Emeritus Scientist and Former Director of the WHO Collaborating Centre, Government T. D. Medical College, Alappuzha

Prof. Suma delivered a session on strengthening MMDP. She emphasized the importance of MMDP interventions for alleviating the suffering of patients and meeting LF elimination validation requirements. She outlined the WHO Essential Package of Care (EPC) for LF patients, which includes the treatment of acute attacks, lymphedema management, hydrocele surgery, and treatment for LF infection. She stressed the promotion of hygiene, skin and wound care, and regular exercise to reduce patient suffering. Prof. Krishnasastry presented evidence showing the positive impact of the EPC, such as reducing the incidence of acute attacks, decreasing the prevalence and severity of entry lesions, and slowing disease progression. She also underscored the need for psychosocial support for patients. However, she highlighted several persistent challenges, including health system workforce shortages, comorbidities among patients, knowledge gaps, shortages of essential supplies, inadequate patient tracking, and ongoing stigma

and social exclusion.

Presentation 3: Gender perspectives in MMDP care

Dr. Arya Rahul, Scientist C, ICMR-VCRC

Dr Arya presented gender perspectives in MMDP care based on her study among lymphedema patients in Puducherry. She noted that only 46.4% of participants regularly practiced home-based limb care and highlighted the challenges women face due to gender stereotyping, limited control over resources, and restricted decision-making power. Women often experience economic dependence, reliance on others for travel and related expenses, and barriers arising from body image concerns and cultural practices. Workplace discrimination further compounds these difficulties. Despite these challenges, she observed greater resilience among women living with LF. Dr. Rahul recommended implementing gender-sensitive MMDP interventions with tailored outreach for women, integrating mental health services into LF care frameworks, especially for patients without caregivers. She also suggested training health workers to address cultural and gender-related dimensions of care, promoting family-level caregiving support and launching community campaigns to combat stigma and transform social norms.

Presentation 4: Progress, Best Practices, and Challenges in LF Elimination in Tamil Nadu

Dr. M. Senthil Kumar, State Programme Officer (NCVBDC), Tamil Nadu

Dr. Kumar presented the progress, best practices, and challenges in LF elimination in the state. He highlighted that out of 38 districts in Tamil Nadu, 26 were endemic for LF, with the last round of MDA conducted in 2014. Since then, all endemic districts have completed Transmission Assessment Surveys (TAS) and were under post-MDA surveillance from 2014 to 2022. Confirmatory mapping surveys showed microfilaria rates of less than 1% in all districts, and the final round of MDA achieved 97.3% coverage using DEC+ALB. The state implemented several innovative interventions, including the deployment of 30,400 Filaria Preventive Assistants (FPAs) sourced from volunteers, NGOs, self-help groups, ICDS, social welfare, and education departments, with each drug distributor covering 250 people. Strong sensitization campaigns were carried out using multiple IEC strategies, and a unique registration number (URN) system was introduced for all lymphedema cases. Special financial assistance of Rs. 1,000 per month is provided to all Grade IV cases, benefiting more than 8,000 patients.

Physiomedico treatment centres have been established to provide various therapies, with live demonstrations and training sessions organized for patients. Currently, Tamil Nadu has 20,182 lymphedema cases and 61 hydrocele cases, all of which have been surgically managed.

A major challenge identified was the influx of migratory populations from other states into post-MDA districts. The 2024 survey screened over 90,000 migrants and found 246 microfilaria-positive cases, underscoring the potential risk of reintroduction of transmission in areas that have already achieved elimination targets. Dr. Senthil Kumar stressed the importance of addressing migration-related risks through targeted surveillance and treatment strategies to safeguard the state's LF elimination gains. The state has now prepared and submitted its dossier for LF elimination.

Presentation 5: LF Elimination in Kerala: Progress and Challenges

Dr. Reetha K.P., State Programme Officer (NCVBDC), Kerala

Dr. Reetha presented the progress and challenges in LF elimination in the state. She reported that 11 out of 14 districts in Kerala are endemic, with TAS-3 surveillance completed in 8 of these districts, while the remaining are preparing for TAS-1. She noted that Brugia malayi remains a concern in Alappuzha district, where there is a shortage of WHO-provided testing kits. The implementation of MMDP cards and the status of migrant positivity were also discussed. Currently, 83 MMDP clinics are functional across the state, providing support to patients. Extensive IEC activities are being carried out in all endemic districts through intersectoral coordination with other departments. The recent CES conducted during the MDA reported coverage of 77.4%. Dr. Reetha highlighted the urgent need to initiate TAS-1 in two of the districts. She emphasised that the delay in completing TAS is primarily due to the unavailability of WHO-supplied FTS kits, which need to be urgently provided. The state also plans to conduct confirmation mapping in districts where TAS-3 has been completed

Presentation 6: LF Elimination in Puducherry: Progress and Challenges

Dr. R. Vasantha Kumari, State Programme Officer, Puducherry

Dr. Kumari spoke on the status of LF in the Union Territory, highlighting that TAS 3 was completed in all districts in 2019. Currently in the post-MDA surveillance phase, the state is focusing on entomological data collection, vector control through the use of mosquito larvicidal oil, screening of migrant populations, and intensification of MMDP activities. She noted that a major challenge in the UT

is the reluctance of migrants to undergo blood smear examinations and their low willingness to opt for hydrocele surgeries. Additionally, some patients fail to visit MMDP clinics despite the services being available, posing a barrier to effective morbidity management and disability prevention efforts.

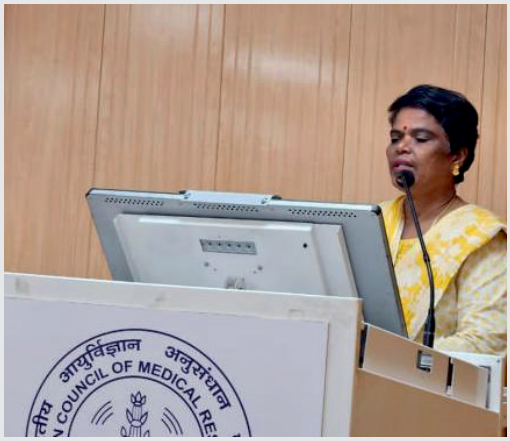
Presentation 7: Progress, Best Practices, and Challenges in LF Elimination in Karnataka

Dr. Mahmood Shariff, State Programme Officer, Karnataka

Dr. Shariff presented the progress of LF elimination in the state during the workshop, which he attended online. He reported that Karnataka has achieved an MDA coverage of 85%. He highlighted that over 80% of the LF cases concentrated in the districts of Yadgir, Kalaburagi, and Bidar. The state has mapped 153 high-endemic and high-risk villages in these districts for interventions. A key challenge, according to Dr. Shariff, is the higher drug refusal among sections of the population, particularly the elderly, to consume the medicines. He highlighted that more than 60% of refusals were shown among the elderly. The state has recorded 278 Mf cases, and the never-treated population and the out-migrant population continue to pose a serious threat to sustaining elimination gains. Dr Shariff stressed that the programme should ensure the adequate availability of RDT kits.

Presentation 8: LF Elimination in Andhra Pradesh: Progress and Challenges

Dr. Wilson P., District Malaria Officer, Kakinada, Andhra Pradesh



Dr. Wilson shared the state's progress in LF elimination. He reported that 10 districts in Andhra Pradesh are endemic for LF, with more than 40,000 recorded lymphedema cases. A three-month action plan has been introduced to accelerate interventions, alongside the implementation of TAS in districts considered as Evaluation Units. The responsibility for leading the LF elimination mission has been assigned to district malaria officers. Dr. Wilson also highlighted the state government's pension scheme for patients with bilateral lymphedema, which provides Rs 6000/- , much-needed financial support. MMDP activities are actively ongoing, and NBS is also being implemented to strengthen surveillance and sustain progress toward elimination.

Presentation 9: Aligning Regional Efforts with WHO Roadmap 2030: Needs and Priorities

Dr. Samadhan Debaje, WHO Coordinator for NTD in the South Region

Dr. Debaje, highlighted the positive impact of integrating various ministries into national programmes aimed at reducing the LF burden. He stressed the importance of addressing localised endemicity and identified key gaps in elimination efforts, particularly in states such as Odisha. He discussed challenges, including the shortage of expert surgeons for hydrocele surgeries, the need for a consistent supply of high-quality drugs, and the timely initiation of triple drug therapy in appropriate areas. Dr. Debaje noted that the absence of dedicated coordinators and limited resources hinders the full implementation of WHO guidelines in the southern states. He assured that these issues would be communicated to the relevant ministries to ensure smoother operations. Additionally, he committed to facilitating the timely supply of kits wherever required and reaffirmed WHO's full support for achieving LF elimination in India.

Presentation 10: Partnership for LF elimination: Role of the private sector and NGOs

Ms. Radhika Mamidi, State Coordinator for Andhra Pradesh and Telangana at the Lepra Foundation

Ms. Radhika highlighted the significant role of private and non-governmental organizations in LF elimination. She described how Lepra's interventions have transformed the lives of LF patients through its LF–Leprosy integrated management approach. She emphasized the urgent need to identify suitable donors for CSR activities and outlined Lepra's capacity to support home-based care. Key initiatives include promoting livelihoods for LF patients by providing seed capital as loans and facilitating partnerships for LF surgeries. She also pointed out critical challenges, such as the lack of prioritization of MMDP at the PHC level, limited attention to LF residual morbidity, delays in the distribution of MMDP kits to the Mandal level, and difficulties in sourcing specialised footwear for patients from local markets.

Presentation 11: Lessons from Global LF Elimination Successes: Implications for India's 2027 Target

Dr Muhammed Jabir MM, Scientist C, ICMR-VCRC

The concluding session was led by Dr. Jabir, who shared insights on the strategies adopted by countries that have successfully eliminated LF in the last decade, drawing from his recent publication. He discussed the major challenges India faces in its LF elimination efforts, including coverage gaps in Mass Drug Administration (MDA), deficiencies in Morbidity Management and Disability Prevention (MMDP) services, and inadequate surveillance in urban areas. He

highlighted the high level of mistrust toward MDA drugs in certain urban communities and the reluctance of gated communities to allow entry, which hinders outreach. Dr. Jabir placed particular emphasis on the growing concern of migration from endemic to post-MDA districts and the persistent presence of never-treated groups, both of which pose significant risks for LF reintroduction and transmission. He also pointed out the limited availability of antigen testing kits and the need to strengthen diagnostic capacity. Drawing from global experiences, he stressed the importance of integrated disease management, tailored drug distribution strategies, targeted outreach to migrants and never-treated populations, robust social mobilisation, strengthened vector control, and the strategic use of digital technologies.

03

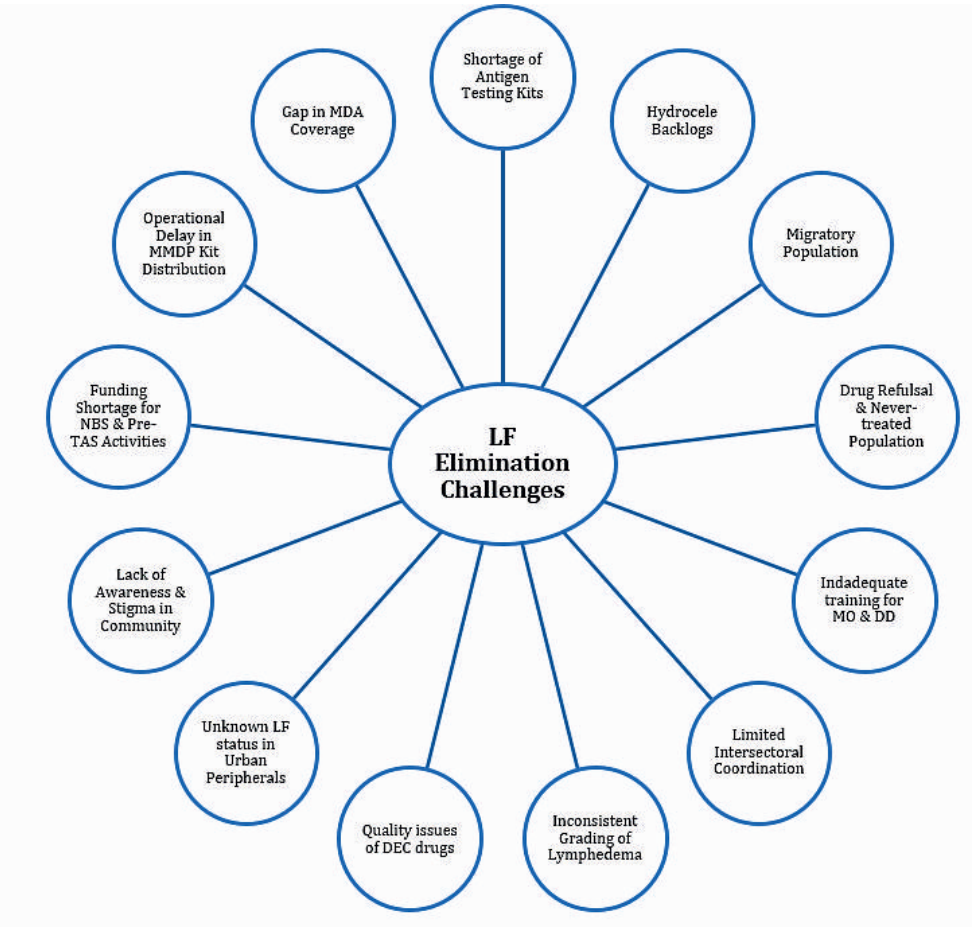
Challenges and Best Practices: State-wise Analysis

State	Best Practices	Challenges	Recommendation
Uttar Pradesh	• Cluster meetings before MDA - involved frontline workers, block-level staff, and local leaders to plan coverage. • Use of digital dashboard for MDA coverage survey and reporting	• Shortage of antigen testing kits (QFAT/FTS) for surveillance. • Delays in implementing the IDA regimen in certain districts. • Insufficient funds for NBS surveys and pre-TAS activities. • Budget constraints for IEC and community mobilisation. • Hydrocele surgery backlog	• Timely procurement/distribution of FTS kits • Accelerate IDA rollout in pending districts • Dedicated budget for NBS • Periodic hydrocele surgeries •
Jharkhand	• Disability certificate for grade IV lymphedema patients • Special migrant outreach — drug distribution teams coordinated with local industries and brick kiln owners to cover migrant workers. • Integrated coordination with 24 departments. • Partnership with WHO and NGOs like Piramal and GHS • Distribution of drug consumption slips through SHGs •	• Limited supervisory involvement for MDA in rural areas • Large out migration • High refusal rates in some villages. • Coverage gaps in urban areas • Gaps in hydrocele surgery	• Strengthen supervisory visits during MDA • Migrant tracking and follow-up system • Targeted refusal-conversion efforts • Urban MDA planning • Expand the hydrocele surgical capacity
Bihar	• Mapping of high priority blocks based on NBS scoring • Dedicated hydrocele surgery camps • Advocacy campaign	• Higher lymphedema and hydrocele case load • Inadequate training of drug distributors • Coverage gaps, especially in urban areas	• Enhance drug administrator training • Improve intersectoral coordination

	using celebrities and local influencers ● Special camps for prisoners, CRPF settlements, hostels and brik klins ● Use of the Sukruthy mobile app for MDA administration	● Limited intersectoral coordination ● Inconsistent grading of lymphedema patients by medical officers ●	● Standard grading protocols and training for medical officers ● Strong IEC and BCC activities for coverage improvement
Odisha	● Structured 180-day MDA preparatory phase for MDA to ensure readiness. ● Daily online real-time coverage reporting with an automated dashboard down to village level. ● Involvement of Self-Help Groups, NSS volunteers, schools, and youth groups in social mobilization. ● Refusal conversion workshops to improve compliance	● Very high endemicity — 94% of the population at risk. ● Presence of both Wuchereria bancrofti and Brugia malayi, requiring different diagnostic approaches. ● Gaps in coverage- remote and inaccessible areas ● Shortages of FTS kits (Brugia malayi) ● Favorable environmental conditions for vector breeding across districts. ● Large morbidity burden (lymphedema and hydrocele) . ●	● Strengthen outreach to remote areas with mobile units. ● Scale up vector control in high-risk areas. ● Fast-track FTS kit procurement. Expand morbidity management and hydrocele surgeries. ●
Gujarat	● Robust surveillance through control units, night clinics and laboratories ● Strong IEC in regional languages ● Intersectoral coordination ● Hotspot targeting	● Higher drug refusals in some districts ● Poor quality DEC tablets ● Funding delays ● Lack of granular data for accurate performance assessment	● Intensive IEC and BCC in higher refusal areas ● Address drug quality issues ● Streamline funding for the programme

Maharashtra	• Strong entomological surveillance and systematic NBS • Well-equipped laboratory supports • Targeted migrant outreach strategies • Strong IEC	• Rapid urban expansion and unknown LF status • High influx of migrants from endemic states • Stigma surrounding lymphedema and poor health-seeking behaviour among patients • Low awareness of LF in newly developed peri-urban areas •	• Structured programme and surveillance in new urban/peri-urban areas. • Localised MDA for migrants in large clusters • Sensitisation campaigns for stigma-reduction campaigns •
Maharashtra	• Strong entomological surveillance and systematic NBS • Well-equipped laboratory supports • Targeted migrant outreach strategies • Strong IEC	• Rapid urban expansion and unknown LF status • High influx of migrants from endemic states • Stigma surrounding lymphedema and poor health-seeking behaviour among patients • Low awareness of LF in newly developed peri-urban areas •	• Structured programme and surveillance in new urban/peri-urban areas. • Localised MDA for migrants in large clusters • Sensitisation campaigns for stigma-reduction campaigns •
Kerala	• Strong MMDP services through 83 functional MMDP clinics across the state • Intensive IEC activities through intersectoral coordination • MMDP cards for patient tracking	• Concern of Brugia malayi in Alappuzha district • Shortage of FTS kits, especially for Brugia malayi • Low coverage in certain pockets •	• Ensure FTS supply especially for Brugia malayi • Targeted coverage drives in low-coverage pockets. • •
Puducherry	• Mapping of all 153 high-risk villages • Sensitisation programmes	• High drug refusal, especially among the elderly • Out migration and coverage gaps • Never-treated population • Shortage of RDT •	• Tailored IEC for elderly population and communities in high-risk villages • Track and treat migrant workers going out for work • Adequate RDT supply. • Identify and treat never-treated groups.

Maharashtra	● Mapping of all 153 high-risk villages ● Sensitisation programmes	● High drug refusal, especially among the elderly ● Out migration and coverage gaps ● Never-treated population ● Shortage of RDT	● Tailored IEC for elderly population and communities in high-risk villages ● Track and treat migrant workers going out for work ● Adequate RDT supply. ● Identify and treat never-treated groups.
Andhra Pradesh	● Pension scheme for bilateral lymphedema patients (Rs.6000 per month) ● Strong MMDP activities with interdepartmental coordination	● High burden of lymphedema cases ● Lack of strong surveillance to prevent reintroduction ● Operational delays in MMDP kit supply	● Timely procurement and maintaining a buffer stock of MMDP kits. ● Strong surveillance system ● Increase frequency of patient reviews and rehabilitation support.


LF Elimination Challenges
Shortage of Antigen Testing Kits
Hydrocele Backlogs
Migratory Population
Drug Refulsal & Never-treated Population
Indadequate training for MO & DD
Limited Intersectoral Coordination
Inconsistent Grading of Lymphedema
Quality issues of DEC drugs
Unknown LF status in Urban Peripherals
Lack of Awareness & Stigma in Community
Funding Shortage for NBS & Pre-TAS Activities
Operational Delay in MMDP Kit Distribution
Gap in MDA Coverage


Best Practices
Pension & Disability Certificates for Lymphedema Patients
Digital Dashboard/Mobile App for MDA
NGO partnership
Drug Consumption Slips
Targeted Hydrocelectomy
Use of Celebrities for Advovacy
Targeted outreach among prisoners, military settlement, hostels, etc
Involvement of NSS, SHGs, Youth Clubs for Community Sensitisation
Hotspot Mapping
Deployment of Filaria Preventive Assistants (FPAs)
Uniques Registration and MMDP Cards for Patients

Towards LF Elimination in India

Recommendations and Benefits

Recommendations	Advantages/benefits
MDA	
• Strengthen supervisory visits during MDA • Deploy digital supervision and real-time monitoring tools • Targeted refusal-conversion strategies • Targeted microplanning for urban slums, migrant clusters, hostels, and industrial zones • Improve accuracy of coverage reporting • Localized MDA for migrants in destination areas • Targeted drives in low-coverage pockets • Better reach to remote/hard-to-reach areas. • Enhance drug administrator training • Accelerate IDA rollout in newly identified districts	• Improvising MDA implementation using real-time monitoring • Improve treatment coverage and compliance • Accessibility to preventive chemotherapy • Better drug administrator performance
MMDP	
• Better patient identification and care outcomes • Standardised grading protocols for lymphoedema • Training of medical officers on grading and MMDP • Private partnership to reduce hydrocele backlog • Strengthen counselling to increase surgery acceptance • Improve the supply chains of MMDP kits • Lymphoedema patient follow-up and tracking system • Strengthen disability certification and social protection schemes for advanced patients • Liaison with private sector and NGOs to deliver psychosocial support	• Better care for patients and prevent disease progression/disability • Reduces hydrocele backlogs and increases acceptance and uptake of surgical services • Improves the patient's psychosocial well-being

Addressing the never-treated and migrants

• Institutionalize NT profiling and tracking • Introduce SBCC for chronic refusers • Build capacity for refusal conversion • Track and treat migrant workers going out for work • Surveillance of migrants in post-MDA districts • Implement localized MDA for migrants with industrial partners	• Helps reach higher coverage and eliminates hidden reservoirs sustaining transmission • Prevents resurgence in post-MDA districts and maintains LF-free status

Surveillance and Diagnostics

• Timely procurement and distribution of FTS/QFAT kits • Intensified surveillance in high-risk migrant settlements • Structured surveillance for new urban/peri-urban areas • Strengthen xenomonitoring in post-MDA areas • Scale up vector control in high-risk areas	• Facilitates earlier detection of emerging transmission hotspots for timely response • Improves programme evaluation • Enhances detection of infection in vectors and strengthens early response

Community engagement

• Intensive campaigns in high-refusal areas, among the elderly, slums, etc. • Scale up culturally sensitive IEC/BCC using local influencers • Involve trusted NGOs and SHGs • Sensitisation to reduce stigma among patients	• Builds community trust and increases participation in MDA and MMDP services • Reduces stigma and promotes timely care-seeking

Programme Management

• Availability of funds for conducting NBS and TAS/IIS activities • Improve intersectoral coordination • Address drug quality concerns	• Improves efficiency of programme operations through better coordination and planning • Ensures drug quality and safety

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APPENDIX
List of delegates

State Representatives

1. Dr Ravishankar Singh, Regional Director, RoFHW (GOI), Patna
2. Dr. Suchitra Sasmal – SRD, ROHFW, Bhubaneswar
3. Dr. Smita Rawat – Sr. Regional Director, ROHFW, Bangalore
4. Dr. Haritha – Regional Director, ROHFW, Kerala
5. Dr. M. Senthil Kumar – State Programme Officer, Tamil Nadu
6. Dr. Reetha K.P. – State Programme Officer, Kerala
7. Dr. R. Vasantha Kumari – State Programme Officer, Puducherry
8. Dr. Mahmood Shariff – State Programme Officer, Karnataka
9. Dr. Sudesh Kumar, State Entomologist, Uttar Pradesh
10. Dr. Anuj Singh Rawat, State Consultant LF, Bihar
11. Dr. Ashish Kumar, Filaria Consultant, ROHFW Office, Lucknow
12. Dr. Bharani Kumar, Chief Entomologist, DPH, Tamil Nadu
13. Mr. P. Vinoth, Entomologist, Puducherry
14. Mr. T. Ezhilarasu, Senior Entomologist, DPH, Tamil Nadu
15. Mrs. Sherly Varadhan, DPH, Tamil Nadu
16. Dr. P. Aishwarya, Medical Officer, ROHFW, Chennai
17. Dr. Anagha B. F. – Medical Officer, ROHFW, Pune
18. Mr. Senthil Kumar, ROHFW, Bangalore
19. Mr. Danny, ROHFW, Bangalore
20. Ms. Usha, ROHFW, Bangalore
21. Ms. Vivaxa Keedia – RDD Entomologist
22. Dr. Keshav Vaishnav, Insecticide office, Fr. Surat Municipal Corporation (SMC)
23. Dr. Anil B. Patel, Chief District Health Officer, Surat
24. Mr. Clemence L D'Souza, A.I.O, SMC, Surat
25. Dr. Kai, AIO, SZA
26. Dr. Dhwani Patel, DMOH, SMC
27. Dr. Manivarma, DVBDCO, Kanchipuram
28. Dr. Baijnath Prasad, DVBDCO, Arwal District, Bihar

29. Dr. Dharmendra N Srivastava, DVBDCO, Sonbhadra district, UP
30. Sharat Chandra Pandey, DVBDCO, Varanasi district, UP
31. Dr. Ganesh Chaudhari, DVBDCO, Chotteudaipur district, Gujarat
32. Dr. Wilson P., DVBDCO, Kakinada, Andhra Pradesh
33. Prashant V. Sailor, DVBDCO, Surat district, Gujarat
34. Krupa J. Patel, ADMO, Surat
35. Ms. Trupti K. Faldu – DVBDC, Surat
36. Mrs. Ekta Shankhla – DVBDC, Chhota Udaipur
37. Mrs.Urvi Hariyani, VBD Consultant, Surat
38. Mr. Kumar Shubham, VBD Consultant, Sonbhadra
39. Dr. Amit Singh, Biologist, District Health Office, Varanasi
40. Mr. Manoj Kumar Choudhary, VBD Consultant, Arwal District, Bihar

WHO representatives

1. Dr. Kamalakar Arjun Lashkare – National Professional Officer, WHO India
2. Dr. Tanuj Sharma – State Coordinator, NTD, WHO, U.P.
3. Dr. Manjeet Singh Choudhary – Zonal Coordinator, NTD, WHO, U.P
4. Dr. Samadhan P.D. – WHO Coordinator (NTD), South Region.
5. Dr. Vishal Dogra – Program Officer, Gates Foundation

Non-governmental Organizations

1. Dr. Rajshree Das – Senior Director, PCI
2. Arun Kumar – District Coordinator, PATH, Varanasi
3. Ms. Radhika Mamidi – State Coordinator (AP & Telangana), Lepra Foundation
4. Hans Foundation, Varanasi

Academia and research institutions

1. Prof. Suma Krishnasastry – ICMR Emeritus Scientist; Former Director, WHO Collaborating Centre; Former Principal, Govt. T.D. Medical College, Alappuzha
2. Dr. O. P. Singh – Assistant Professor, BHU
3. Dr. Anchal Singh – Assistant Professor, BHU
4. Dr. Abhisheik Jaiswal – Assistant Professor, BHU
5. Mr. Sunil Kumar – PhD Researcher, BHU
6. Ms. Shivani Sharma – Research Scholar, BHU
7. Mr. Animesh Tripathi – Research Scholar, BHU
8. Ms. Tripti Singh – Research Scholar, BHU

ICMR-NIMR

1. Dr. Sachin Sharma – Senior Consultant

ICMR-VCRC

1. Dr. Manju Rahi – Director
2. Dr. Vijesh Sreedhar K – Scientist F
3. Dr. A. Srividya – Scientist F
4. Dr. Dinesh Raja J – Scientist C
5. Dr. Muhammed Jabir M.M. – Scientist C
6. Dr. Anju Viswan T – Scientist C
7. Dr. Arya Rahul – Scientist C
8. Ms.M. Kishanthini – Technical Assistant
9. Ms.Malavika – Technical Assistant
10. Mr.Ashiq Rasool R.Z. – Technician
11. Mr.Shakti – Technician
12. Mr Krishna Prabha– Project technical staff

Frontline workers

1. Mr. Jitendra D. Patel, AIO, EZ-B, SMC, Surat
2. Mrs. Smita P. Patel, AIO, SMC, Surat
3. Mr. M. B. Suthar, AIO, SMC
4. Mr. Naresh Vasavu, AIO, SMC, Surat
5. Mr. Girish S. Kalal, AIO, SMC, Surat
6. Mr. Saurabh Bhuvia, AIO, SZA
7. Mr. J. B. Pawar, AIO, SZA
8. Mrs. Priti R. Patel, AIO
9. Mr. R. S. Mandlekar, Assistant IO, SMC, Surat
10. Mr. B. G. Patil, Assistant IO, SMC, Surat
11. Mr. J. P. Vagadia, Additional IO, SMC, Surat
12. Mr. J. R. Parmar, AIO, SMC, Surat

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The ICMR- Vector Control Research Centre (VCRC), established in 1975 at Puducherry, is a premier institute under the Indian Council of Medical Research (ICMR), Government of India. It is recognized as a WHO Collaborating Centre for research and training in Lymphatic Filariasis (LF) and Integrated Vector Management.

VCRC's mission is to develop effective strategies for the prevention, control, and elimination of vector-borne diseases (VBDs) through research, surveillance, and capacity building. The institute conducts basic, applied, and operational research on diseases such as LF, malaria, dengue, chikungunya, Japanese encephalitis, scrub typhus, and leishmaniasis. Over the years, VCRC has supported the National Centre for Vector Borne Disease Control (NCVBDC) in shaping policies for VBD control and elimination and in providing robust monitoring and evaluation tools for programmatic decision-making.

The institute has made significant contributions towards accelerating LF elimination, including the development of sampling strategies for molecular xeno-monitoring for post-MDA surveillance, mapping and remapping of endemic areas and M&E protocol for accelerated Mass Drug Administration (MDA) with IDA (Ivermectin, Diethylcarbamazine and Albendazole). The institute is also advancing innovative vector control tools, has established GLP-certified laboratories, and has developed several vector control products and technologies. In addition, VCRC is a national leader in entomology training and offers a postgraduate course in Public Health Entomology.

About The Women's Collective Forum (WCF)

The Women's Collective Forum (WCF) is a pan-sectoral platform focused on equity-led systems transformation through scalable, institutionally grounded models.

Its enterprise initiative, SPARK – The 100K Collective, addresses the "missing middle" of women-led businesses—enterprises that are already established but remain excluded from formal finance, markets, digital systems, and regulatory frameworks. Through bootcamps in 300 locations, SPARK will work with 100,000 women entrepreneurs to strengthen their capacity to engage with capital, platforms, and institutions, ensuring that systems become navigable for those already building.

Beyond enterprise, WCF collaborates with leading health, technology, and management institutions to advance maternal health protocols, disease elimination, and the integration of new health technologies. In law and governance, WCF supports implementation of India's evolving criminal law frameworks with a focus on survivor-centricity and institutional accountability.

WCF also convenes cross-sectoral dialogues to highlight India's leadership in frugal innovation and systems change, engaging with global leaders and national platforms to translate research into policy and practice.

Across all these areas, WCF's model is consistent: build partnerships that connect evidence to institutions, and design approaches that can scale to strengthen systems for equity.

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REPORT ON
INDIA'S PROGRESS TOWARDS ELIMINATING LYMPHATIC FILARIASIS

ICMR-VECTOR CONTROL RESEARCH
IN COLLABORATION WITH
WOMEN'S COLLECTIVE FORUM
2025