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SUMMARY
2024 PROGRAM REVIEW
HISPANIOLA INITIATIVE
THE DOMINICAN REPUBLIC AND HAITI
FEBRUARY 21, 2025
THE CARTER CENTER
ATLANTA, GA

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And to many others, our sincere gratitude.

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ACRONYMS

ASCP	*Agents de Santé Communautaire Polyvalent* (Polyvalent Community Health Workers)
CDC	U.S. Centers for Disease Control and Prevention
CE	Community Engagement
CECOVEZ	*Centro de Prevención y Control de Enfermedades Transmitidas por Vectores y Zoonosis* (Center for Prevention and Control of Vector-Borne and Zoonotic Diseases)
CFA	Circulating Filarial Antigen
CHAI	Clinton Health Access Initiative
CHC	Community Health Council
CHW	Community Health Workers
CI	Confidence interval
CIP	Community Integration Program
COVID-19	2019 novel Coronavirus Disease
DA	Diethylcarbamazine, Albendazole
DAS	*Direcciones de Áreas de Salud* (Health Area Directorates)
DEC	Diethylcarbamazine
DIEPI	Directorate of Epidemiology
DPS	*Direcciones Provinciales de Salud* (Provincial Health Directorate)
FFI	Freedom From Infection
FTS	Filariasis Test Strip
HELP	Human Engagement Learning Platform (at Emory)
HSC	*Hôpital Sainte Croix* (Sainte Croix Hospital)
HS-RDT	Highly sensitive rapid diagnostic test
IDA	Ivermectin, Diethylcarbamazine and Albendazole
IDCP	Institute of Dermatology and Skin Surgery
IRS	Indoor Residual Spraying
ITFDE	International Task Force for Disease Eradication
IU	Implementation Unit
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
Mf	Microfilariae
MMDP	Morbidity Management and Disability Prevention
MSP	*Ministerio de Salud Pública* (Ministry of Public Health, Dominican
MSPP	*Ministère de la Santé Publique et de la Population* (Ministry of Public Health and Population, Haiti)
N/A	Not applicable
NPELF	National Program to Eliminate Lymphatic Filariasis (Haiti)
PAHO	Pan American Health Organization
PCR	Polymerase Chain Reaction

PELF	Program to Eliminate Lymphatic Filariasis (Dominican Republic)
Pfree	Probability of Freedom
PNCM	*Programme National de Contrôle de la Malaria* (National Malaria Control Program, Haiti)
PTS	Post-Treatment Surveillance
RDA	Reactive Drug Administration
RDT	Rapid Diagnostic Test
RPRG	Regional Program Review Group
SC	Spot Check Site
SS	Sentinel Site
SSe	Sensitivity of Surveillance System Estimate
TAS	Transmission Assessment Survey
TDA	Targeted Drug Administration
USF	University of South Florida
WHO	World Health Organization

EXECUTIVE SUMMARY

The eleventh annual Carter Center Hispaniola Initiative Program Review meeting occurred February 21, 2025, in the Cecil B. Day Chapel at The Carter Center in Atlanta, Georgia in hybrid format with the opportunity for in-person or virtual participation. The purpose of the meeting was to review progress and challenges in the elimination of malaria and lymphatic filariasis (LF) in Haiti and the Dominican Republic in 2024 and to make recommendations for activities in 2025.

Attending the meeting were representatives of the ministries of health of Haiti and the Dominican Republic, Carter Center staff, partners, and donors, including representatives from Emory University, the World Health Organization (WHO), the Pan American Health Organization (PAHO), Clinton Health Access Initiative (CHAI), University of Glasgow, and the University of South Florida (USF).

The Carter Center's Hispaniola Initiative works with the ministries of health in Haiti and the Dominican Republic to eliminate malaria and LF from the countries' shared island, Hispaniola. It is the only island in the Caribbean that has not yet eliminated malaria. It also encompasses one of the three remaining LF-endemic countries in the Western Hemisphere, after Brazil was validated in 2024 by WHO as having successfully eliminated LF as a public health problem[1]. In 2006, the International Task Force for Disease Eradication (ITFDE) concluded that elimination of malaria and LF from Hispaniola was "technically feasible, medically desirable, and would be economically beneficial" to both countries and that “such an initiative would require close cooperation and coordination between the governments” of the two countries.[2] The Carter Center launched an 18-month pilot project in 2008 to foster binational cooperation by establishing a cross-border initiative in the Ouanaminthe-Dajabón border region and facilitating the creation of binational plans and budgets for malaria and LF elimination by 2020. In the years that followed, The Carter Center supported regular binational meetings to promote coordination between the Haitian and Dominican ministries of health. In 2014, The Carter Center expanded its support for malaria and LF elimination in Hispaniola, including: i) continued support for binational cooperation, ii) technical assistance to re-orient the programs from control to elimination, and iii) updating the funding needs to achieve elimination goals and help the countries to secure the necessary financial support.

The meeting was chaired by Dr. Gregory Noland, Director of The Carter Center’s River Blindness, Lymphatic Filariasis, Schistosomiasis, and Malaria programs. The meeting opened with welcoming remarks from The Carter Center’s Vice President of Health Programs, Dr. Kashef Ijaz. Dr. Noland provided an introductory presentation for the

[1] World Health Organization. (2024) “Brazil eliminates lymphatic filariasis as a public health problem.” https://www.who.int/news/item/01-10-2024-brazil-eliminates-lymphatic-filariasis-as-a-public-health-problem

[2] Meeting of the International Task Force for Disease Eradication – 12 May 2006. (2007). *Wkly Epidemiol Rec*., 82(4), 25-30.

meeting and paid tribute to former U.S. President and Carter Center co-founder, James “Jimmy” Earl Carter, Jr., who passed away on December 29, 2024.

Notable achievements during 2024 include the Dominican Republic passing the third transmission assessment survey (TAS) in the East region and subsequently meeting the epidemiological criteria for eliminating LF as a public health problem. The Dominican Ministry of Public Health (MSP) also completed a nationwide LF remapping survey. The survey included integrated testing for malaria and collection of self-reported LF morbidity data, which will inform national morbidity management and disability prevention (MMDP) programming. MSP laboratory technicians were trained to conduct polymerase chain reaction (PCR) testing for malaria at the Carter Center-supported molecular surveillance laboratory at the Center for Prevention and Control of Vector-Borne and Zoonotic Diseases (CECOVEZ). MSP also joined the regional initiative for integrated serosurveillance of communicable diseases in the Americas in partnership with PAHO and the U.S. Centers for Disease Control and Prevention (CDC). The Haitian Ministry of Public Health and Population (MSPP) also achieved significant progress against LF during 2024 with 30 districts successfully passing community-based TAS-3 in Grand’Anse and Sud departments, despite continuing challenges with insecurity in the capital, Port-au-Prince.

In 2024, a total of 39,837 cases of malaria were reported in Hispaniola — 38,591 (96.9%) in Haiti and 1,246 (3.1%) in the Dominican Republic — driven by outbreaks in each country. This represents a 171% increase in cases versus 2023 (14,708 cases) but a 54.0% decrease in cases since 2010 when 86,629 cases were reported island-wide following the major earthquake in January of that year. Twenty malaria deaths were reported in 2024 — 17 in Haiti and 3 in the Dominican Republic — compared to 8 deaths (all in Haiti) in 2023.

General Recommendations for 2025: Haiti and the Dominican Republic

1. Contribute data to develop an island-wide malaria surveillance dashboard.
2. Develop a binational partnership for integrated serological testing.
3. Continue to provide each other with malaria tests and treatment, when needed, to maximize resources.
4. Conduct quarterly binational meetings between the national programs to share successes, challenges, and progress to work towards the shared goal of malaria elimination on the island.
5. Conduct bi-monthly meetings with municipalities in the border region to have a broader understanding of malaria prevalence and patterns, and interrupt malaria transmission in and around the area.
6. Develop joint communication materials translated into Spanish, French, and Haitian Creole with both Ministries' logos to strengthen binational collaboration and express binational commitment to malaria elimination on Hispaniola.
7. Pilot LF post-validation surveillance (PVS) strategies in areas that have passed TAS-3.
8. Integrate the essential package of LF MMDP care into national health services.
9. Begin planning for revised LF survey methodologies in alignment with forthcoming WHO revised guidelines.
10. Collate historical data and draft LF elimination dossiers to document progress for Haiti, and to submit to WHO / PAHO for the Dominican Republic.

TABLES AND FIGURES

Table 1. Results from Transmission Assessment Survey (TAS-3) conducted in East Focus, Dominican Republic, December 2023–February 2024

Provinces	Lymphatic Filariasis							Malaria	
	# Self-reported lymphedema	# Self-reported hydrocele	Target Sample Size / # with valid FTS results	Sex (% female) & Age [range, years]	# CFA+ by FTS (%) [97.5% CI]*	Critical cut-off value # (#†)	TAS-3 Result	# Tested with valid results, RDT	# *Pf/Pv*+ by RDT (%) [97.5% CI]*
El Seibo; Hato Mayor; La Altagracia; La Romana; San Pedro de Macorís	6-7 year olds								
	N/A	N/A	909/927	50% [6-7]	0 (0) [0-0.4]	11 (3)	Pass	940	0 (0) [0-0.4]
	15 years or older								
	4‡	0	909/805	85% [15-93]	0 (0) [0-0.5]	N/A	N/A	814	0 (0) [0-0.5]

*one-sided 97.5% confidence interval (CI).
†Critical cut-off values from the updated 2025 WHO *Monitoring and Epidemiological Assessment of Mass Drug Administration in the Global Programme to Eliminate Lymphatic Filariasis: A Manual for National Elimination Programmes*, 2nd edition.
‡Four (4) persons from 3 households self-reported lymphedema, all in San Pedro de Macorís province.

Figure 1. Lymphatic filariasis elimination program status, by district, the Dominican Republic, December 2024

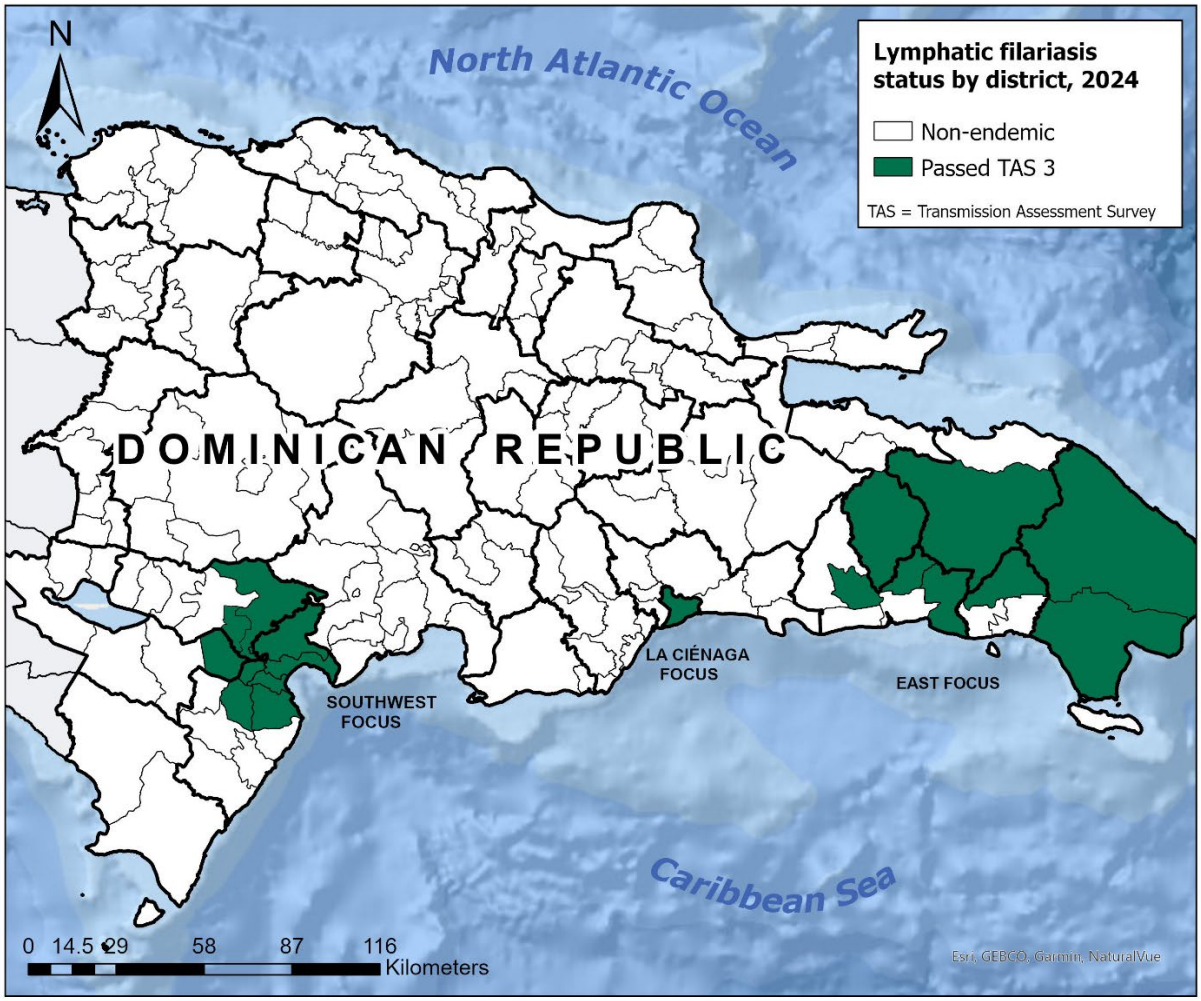


Figure 2. Lymphatic filariasis elimination program status over time, by district, the Dominican Republic

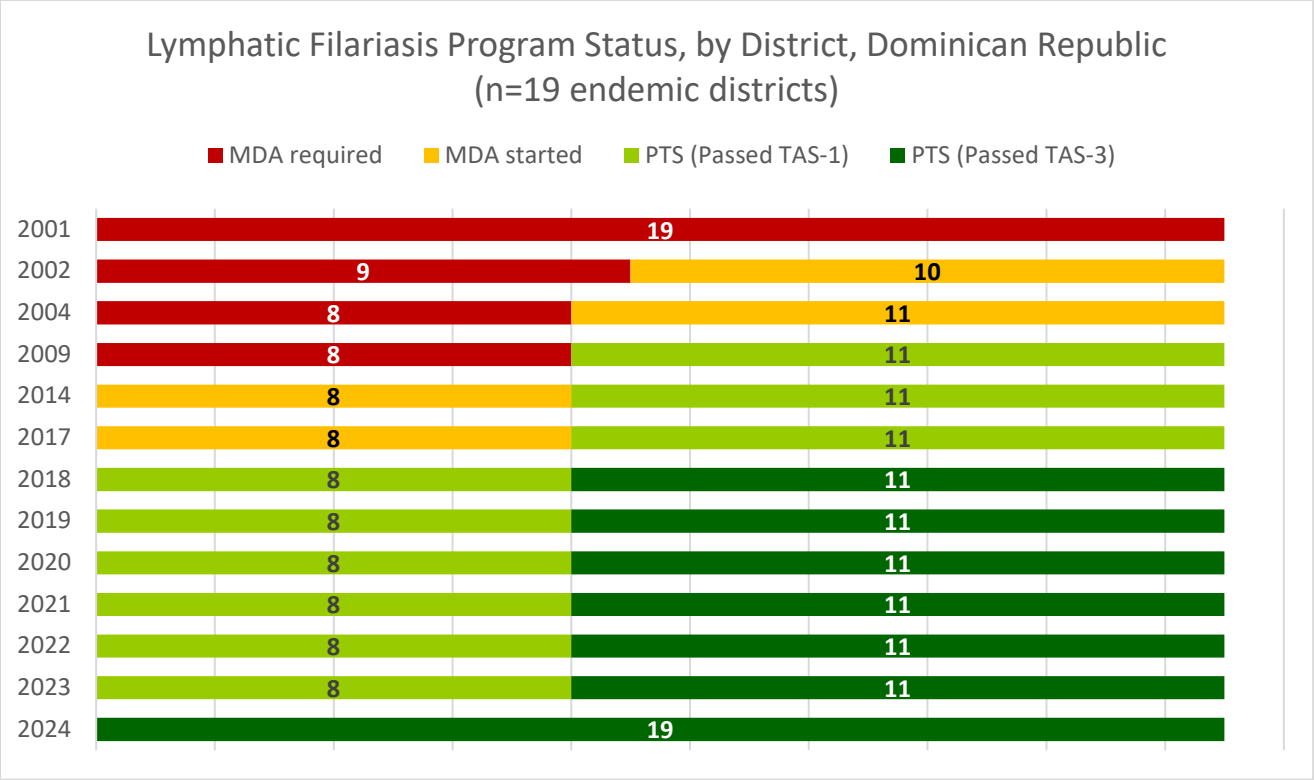


Table 2. Characteristics of individuals who tested positive for CFA by FTS during nationwide integrated remapping survey, Dominican Republic, 2022–2024

DPS or DAS	Age, Sex	Residency: Born in barrio (Year moved to barrio)	Bednet use (last night)	Self-reported LF morbidity (lymphedema or hydrocele)	Mf status
DAS II Santo Domingo	68 Male	No (1992)	No	No	Negative
DAS V Distrito Nacional	51 Female	No (2014)	No	No	Negative
DAS VI Distrito Nacional	29 Female	No (2017)	No	No	Refused night blood sample collection
DPS Bahoruco	56 Female	No (1980)	No	No	Negative
DPS Bahoruco	34 Male	No (2022)	No	Refused	Negative
DPS Bahoruco	29 Female	Yes	Yes	No	Negative
DPS Barahona	47 Male	Yes	No	No	Negative
DPS Barahona	33 Female	Yes	No	No	Negative
DPS Barahona	34 Female	Yes	No	Yes	Negative
DPS Barahona	32 Male	Yes	No	No	Negative
DPS Barahona	38 Female	Yes	No	No	Negative
DPS Independencia	23 Female	Yes	No	No	Negative
DPS La Romana	21 Female	No (2017)	Yes	No	Negative
DPS Maria Trinidad Sanchez	53 Male	Yes	Yes	No	Negative
DPS Maria Trinidad Sanchez	37 Male	Yes	No	No	Negative
DPS Pedernales	40 Male	Yes	No	No	Negative
DPS Pedernales	43 Male	No (2004)	No	No	Negative
DPS Pedernales	60 Female	Yes	No	No	Negative
DPS Valverde	29 Female	No - Haiti (2018)	No	No	Negative

Table 3. Distribution of severity of LF-associated lymphedema evaluated during follow-up among individuals who self-reported morbidities during nationwide integrated remapping survey, Dominican Republic, 2024

Lymphedema stage	I	II	III	IV	V	VI	VII	Unreported	Total
n (%)	5 (14.3)	6 (17.1)	4 (11.4)	1 (2.9)	5 (14.3)	3 (8.6)	7 (20)	4 (11.4)	35 (100)
									

Source: Lymphatic filariasis - managing morbidity and preventing disability: an aide-mémoire for national programme managers, second edition. Geneva: World Health Organization; 2021.

Table 4. Mass treatments for lymphatic filariasis, Haiti, 2024

Department	Commune	Partner	Drug	Month	Total Population (N)	Population treated (n)	Treatment coverage (%)
Nord	Cap-Haitien	RTI	DA	June	253,646	203,888	80.4
Nord	Acul-du-Nord (urban)	RTI	DA	May	18,650	20,866	111.9
Nord	Acul-du-Nord (peri-urban)	RTI	IDA	August	7,355	5,001	68.0
Nord	Limonade	CDC/IMA	IDA	July	62,319	42,379	68.0
Nord	Dondon (urban)	RTI	IDA	August	10,000	9,098	91.0

Table 5. LF Pre-transmission assessment survey (Pre-TAS) results, by evaluation unit, Haiti, 2024

Evaluation Unit (EU)	Site	No. of people tested	No. FTS+	% FTS+
Quartier Morin	Centreville (SS)	308	26	8.5
	Cadush (SC)	301	38	12.6
Milot	Lory (SS)	303	8	2.6
	Desplante (SC)	314	11	3.5
Plaine du Nord (rural)	Robillard (SC)	302	3	1.0
	La Revoir (SC)	313	11	3.5
Plaine du Nord (urban)	Centreville (SS)	302	19	6.3
	Morne Rouge (SC)	313	2	0.6

Table 6. Summary of LF transmission assessment survey (TAS) results, by evaluation unit, Haiti, 2024

TAS	Dept.	No. of Ius	Implementation Units (IUs)	Partner	Survey Date	Survey Type	Target Sample Size	Critical cut-off value # (#*)	No. people tested	No. FTS+	TAS Result
TAS-1	Nord	1	Acul-du-Nord (rural)	RTI	Apr 2024	School	506	6 (1)	421†	2	Fail
TAS-1	Nord-Ouest	1	Port-de-Paix (rural)	RTI	May 2024	School	1,228	14 (4)	741†	10	Fail
TAS-2	Nord	1	Limbe	RTI	Apr 2024	School	1,356	16 (4)	1,293†	13	Fail
TAS-3	Sud	1	Camp Perrin	The Carter Center	Aug 2024	Community	1,228	14 (4)	1,251	0	Pass
TAS-3	Sud	17	Aquin, Arniquet, Cavaillon, Chantal, Chardonnières, Côteaux, Ile-a-Vache, Les Anglais, Les Cayes, Maniche, Port-à-Piment, Port-Salut, Roche-a-Bateau, Saint Jean du Sud, Saint Louis du Sud, Tiburon, Torbeck	The Carter Center	Aug 2024	Community	1,556	18 (6)	1,587	1	Pass
TAS-3	Grand' Anse	12	Abricots, Anse d'Hainault, Beaumont, Bonbon, Chambellan Corail, Dame Marie, Jérémie, Les Irois, Moron, Pestel, Roseaux	The Carter Center	Aug 2024	Community	1,556	18 (6)	1,640	0	Pass
	TOTAL	**33**							**6,933**	**26**	

*Numbers in brackets reflect the critical cut-off values from the updated 2025 WHO *Monitoring and Epidemiological Assessment of Mass Drug Administration in the Global Programme to Eliminate Lymphatic Filariasis: A Manual for National Elimination Programmes*, 2nd edition.
†Target sample size not met.

Figure 3. Lymphatic filariasis elimination program status over time, by district, Haiti

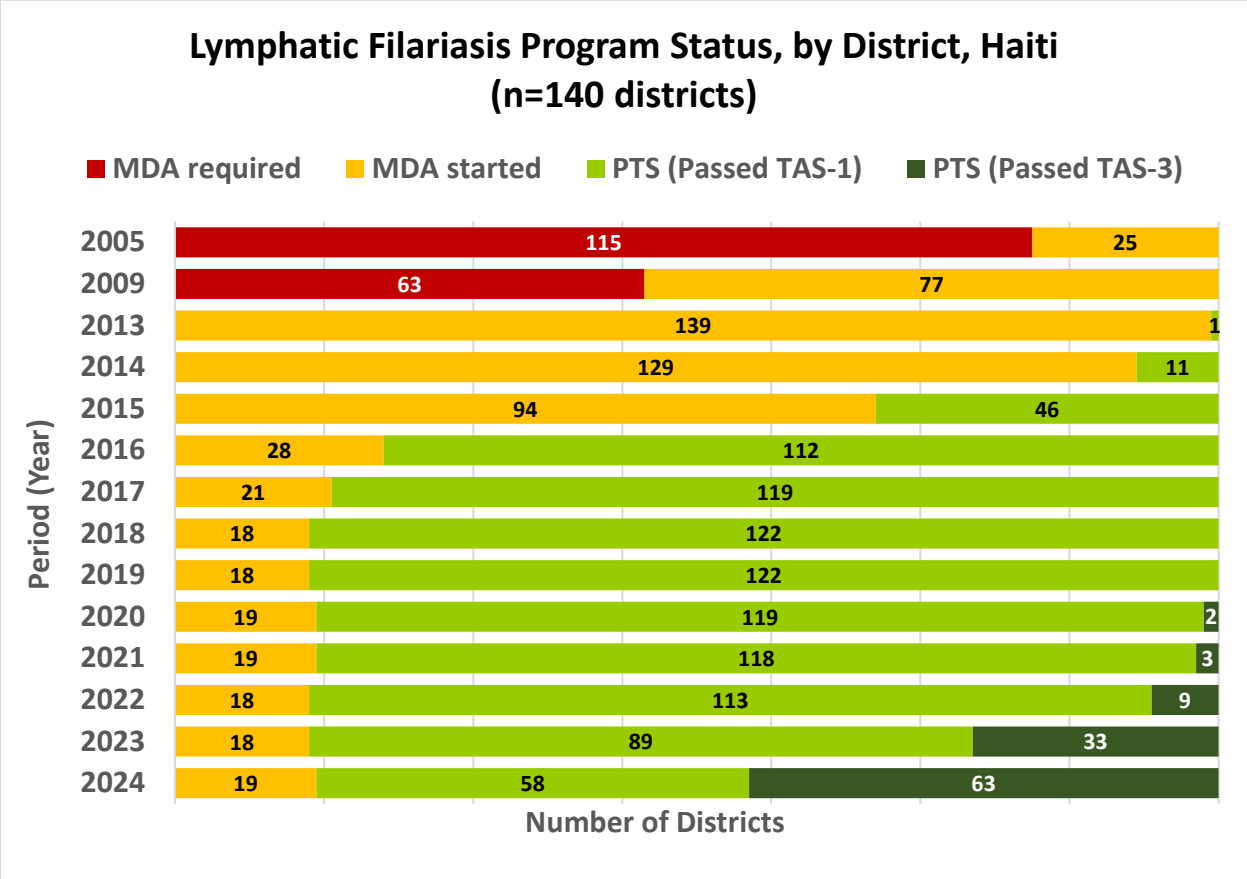


Figure 4. Lymphatic filariasis elimination program status, by district, Haiti, 2024

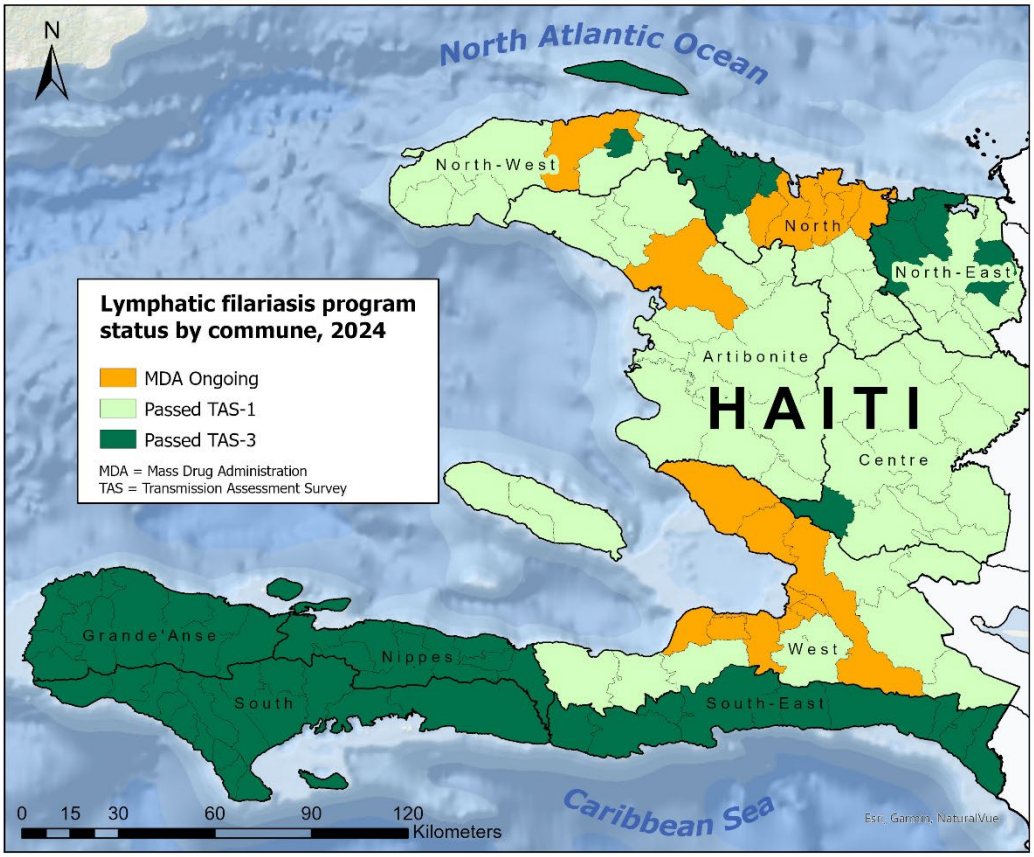


Figure 5. Malaria PCR testing status by province and individual-level results through December 2024 from the 2022–2024 integrated LF Remapping Survey, Dominican Republic

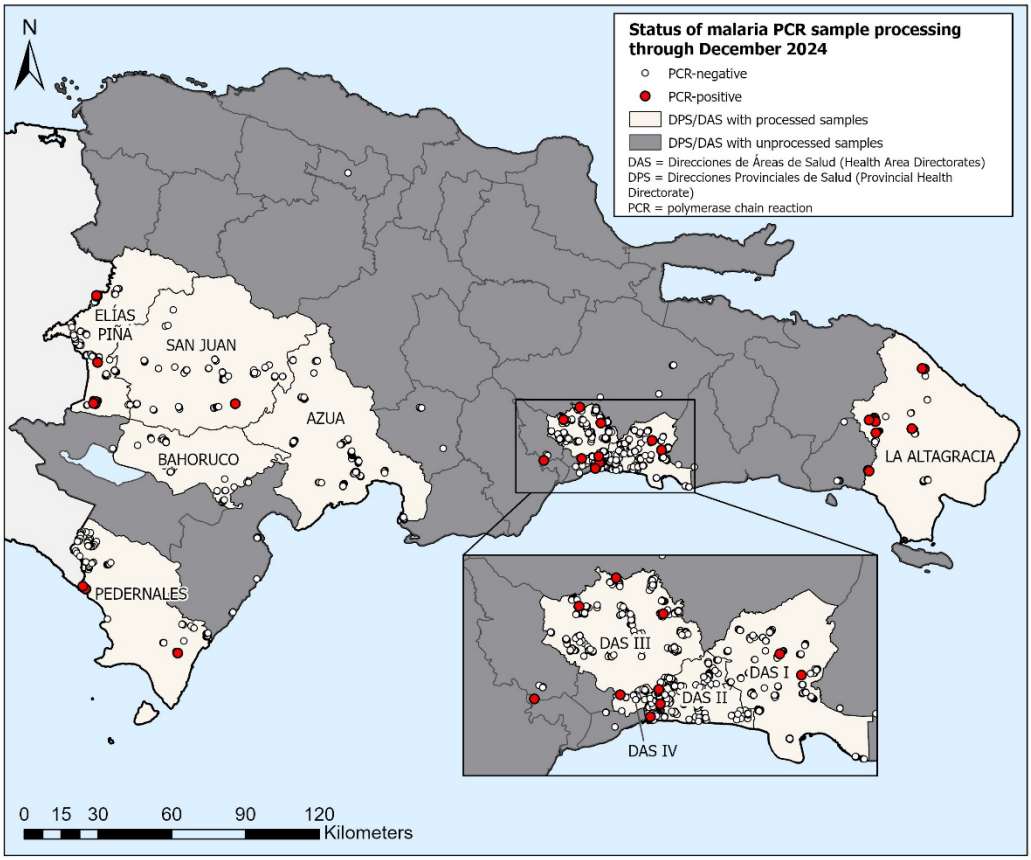


Figure 6. Number of Confirmed Malaria Cases in Haiti and the Dominican Republic, by year (2007–2024)

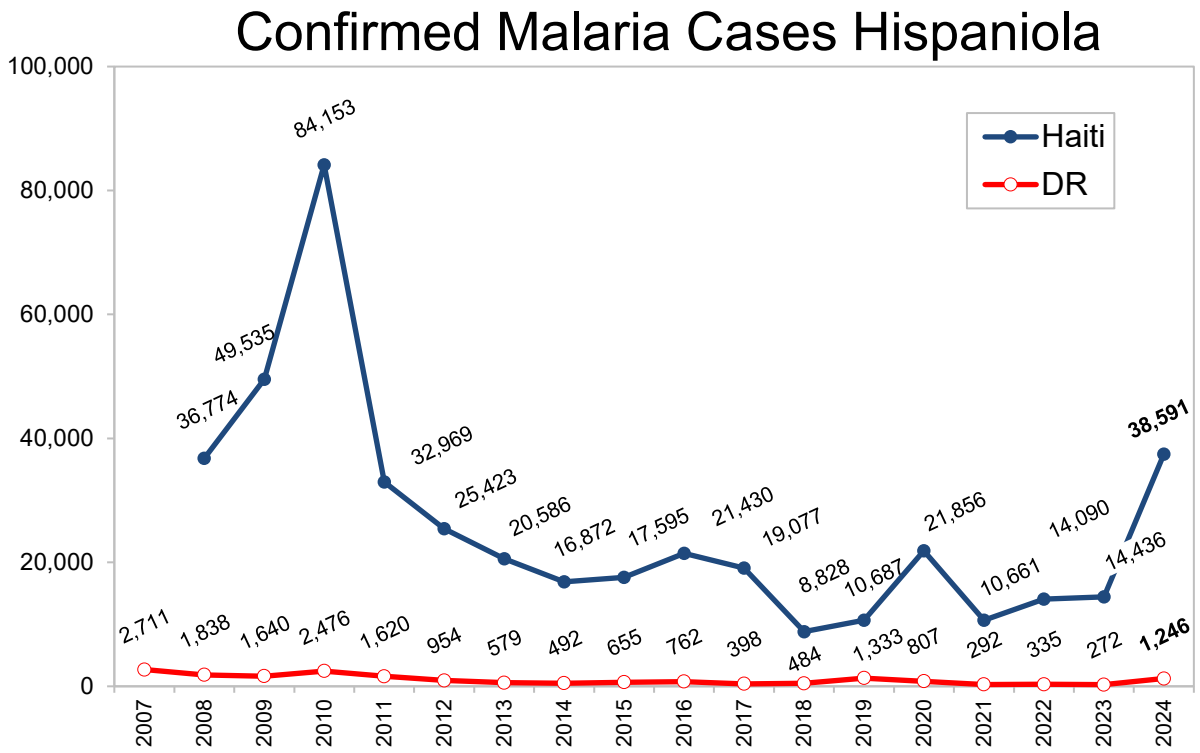


Figure 7. Annual malaria incidence (cases per 1000 persons), by district, Haiti, 2024

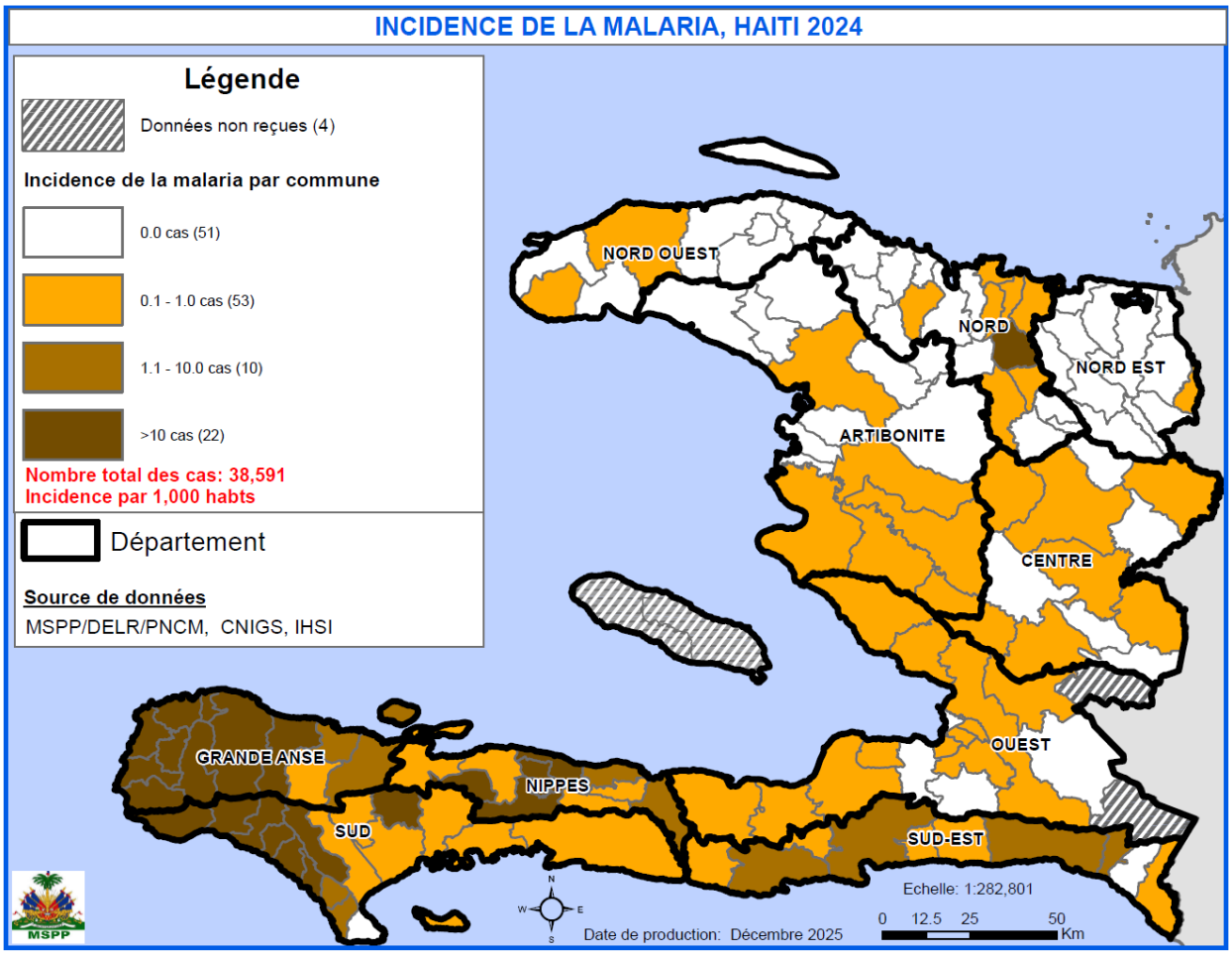
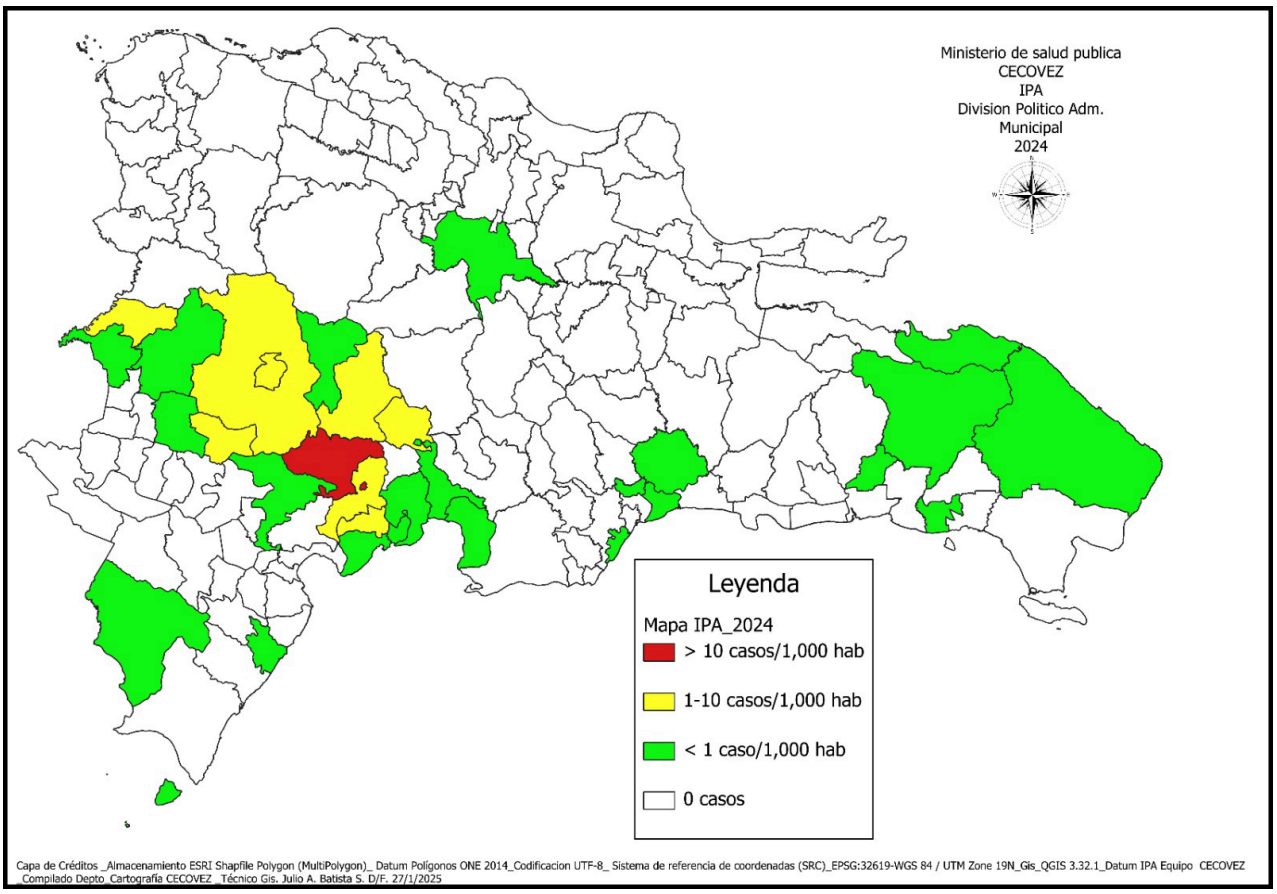


Figure 8. Annual malaria incidence (cases per 1000 persons), by district, the Dominican Republic, 2024



LYMPHATIC FILARIASIS

LF Elimination Progress in the Dominican Republic - Dr. Jose Manuel Puello (MSP)

In 1998, the Dominican MSP created the Program to Eliminate Lymphatic Filariasis (PELF) with the goal of eliminating LF as a public health problem by 2020. Baseline mapping conducted from 1999–2003 and completed in 2007 (after a pause due to global test kit shortages and performance issues) revealed that transmission was limited to 19 (12%) of 155 municipalities (districts), classified as LF-endemic and in need of mass drug administration (MDA), clustered into three geographic foci (**Figure 1**): Southwest (comprising 10 districts), East (8 districts)—two vast agricultural regions—and La Ciénaga (1 district), a small urban focus in the National District of Santo Domingo (distinct from La Ciénaga of Santo Domingo West, a recent malaria transmission focus). After a series of MDA campaigns with diethylcarbamazine (DEC) and albendazole, LF antigen prevalence was reduced to less than 2% in all foci by 2018, and MDA had stopped (**Figure 2**). Post-treatment surveillance (PTS) surveys conducted in the Southwest (2009, 2012, 2018, and 2020), in La Ciénaga (2011, 2014, 2018, and 2021), and in the East (2018 and 2021) indicated that transmission remained below hypothesized sustainable levels. PELF's revised goal is to eliminate LF as a public health problem by 2025.

A TAS-3 in the East focus that started in late 2023 was completed in early 2024. Samples with valid results from 927 children ages 6–7 years old and 805 samples from household members ages 15 years or older were collected for LF circulating filarial antigen (CFA) testing by filarial test strip (FTS). None (0%) of the samples were FTS positive (**Table 1**), indicating that MSP has met the WHO epidemiological criteria for having eliminated LF as a public health problem.

As reported in detail during last year's meeting, fieldwork for a nationwide integrated LF remapping survey also was completed in early 2024. Of the 16,115 survey participants with a valid FTS result, 19 were positive for CFA, but none of the 18 who were reached for follow-up night blood testing had circulating microfilaria (Mf) detected by microscopy (**Table 2**). The survey also assessed malaria infection status (refer to malaria section of this report) and LF morbidity information. Among 16,127 adult survey participants, 177 self-reported morbidity: 169 (1%) lymphedema and 20 (0.3%) of 6,275 adult males hydrocele (inclusive of 12 who reported both). Among these 177 individuals, 113 (63.8%) were located and consented to be examined (107 [63.3%] of 169 and 9 [45.0%] of 20 who self-reported lymphedema and hydrocele, respectively). Twenty (18.7%) presented findings compatible with lymphedema due to LF, and 3 (33.3%) had already received hydrocele-correcting surgery. Teams were referred to 15 additional suspected cases of lymphedema who were also examined. In total, 35 persons (ages 33–97 years, 77% female) were confirmed to be living with lymphedema due to LF in 13 provinces, 12 (34.3%) of whom reported having never received specialized care. Twenty-eight (80%) reported experiencing acute attacks (median annual frequency = 4). The distribution of severity according to WHO stages of lymphedema was: I (14.3%), II (17.1%), III (11.4%), IV (2.9%), V (14.3%), VI (8.6%), VII (20%), unreported (11.4%) (**Table 3**).

With this information, coordination efforts commenced to integrate MMDP care into primary health care in areas with known LF patients in alignment with WHO MMDP guidelines. MSP began formalizing an agreement with the Institute of Dermatology and Skin Surgery (IDCP), which will enable morbidity care services at the regional IDCP locations. Additionally, the development of a smartphone application was initiated to connect individuals living with chronic LF morbidities to MMDP services.

LF Elimination Progress in Haiti – Dr. Marc-Aurèle Telfort (MSPP)

The Haitian National Program to Eliminate Lymphatic Filariasis (NPELF) coordinates LF elimination activities for MSPP. Baseline mapping in 2001 identified infections in 88% of the country's districts (*communes*), however, MSPP elected to implement MDA nationwide. Among the 140 communes currently recognized by NPELF, 122 (87%) had met WHO criteria to stop MDA by the end of 2023, leaving 18 still in need of MDA. Despite ongoing political instability and insecurity in metro Port-au-Prince, MSPP conducted MDA campaigns in four communes of Nord department in 2024, with Acul-du-Nord split into urban and peri-urban sub-areas. A total of 281,232 people were treated, with reported epidemiological coverage of 80% in Cap-Haitien and 112% in Acul-du-Nord (urban) using DEC and albendazole, and reported coverage of 68% in Acul-du-Nord (peri-urban), 68% in Limonade and 91% in Dondon (urban) using triple-drug ivermectin, DEC, and albendazole (IDA) (**Table 4**).

In 2024, pre-transmission assessment surveys (pre-TAS) were conducted in sentinel sites (SS) and spot-check sites (SC) in four evaluation units (EU) which had previously failed pre-TAS (Quartier Morin, Milot) or TAS (Plaine du Nord - rural, and Plaine du Nord - urban). None of the EUs met the WHO threshold of CFA less than 2% in both SS and SC, meaning that all four EUs failed the 2024 pre-TAS, with site-specific CFA prevalence ranging from 1–13% (**Table 5**). MSPP plans for continued MDA in these areas.

Stop-MDA TAS-1 surveys were conducted in two EUs that passed pre-TAS in 2023: Acul-du-Nord (rural) in North department and Port-de-Paix (rural) in Nord-Ouest department. Neither EU reached the target sample size using school-based sampling. Two (2) individuals with CFA were detected in Acul-du-Nord (rural) and 10 in Port-de-Paix (rural). In light of ongoing MDA or failed TAS in nearby areas, the WHO regional program review group (RPRG) recommended using the more stringent threshold (CFA prevalence <1%) of the new WHO monitoring and evaluation guidelines (unpublished at the time of the surveys) to evaluate the results. When compared to the new critical cut-offs of 1 and 4, respectively, for the corresponding target sample sizes, the number of CFA-positive individuals in each EU exceed the threshold, meaning that the areas should continue MDA (**Table 6**).

Among the 122 districts nationwide that had previously met criteria to stop MDA, PTS surveys were conducted in 31 communes, organized into four EUs in 2024 (**Table 6)**. A school-based TAS-2 was conducted in Limbe in April 2024. Of 1,293 samples collected (less than the target of 1356), 13 (1.0%) were positive. This is greater than the cut-off value of 4 from the updated WHO monitoring and evaluation guidelines, meaning that Limbe failed TAS-2 and is recommended to resume MDA. TAS-3 (all community-based) were conducted in 30 communes across Sud and Grand'Anse departments with sufficient sample sizes achieved in each EU. No FTS positives were detected in 12 communes of Grand'Anse (1,640 tested) or in Camp Perrin commune of Sud department (1,251 tested), and only 1 positive (0.06%) among 1,587 tested across 17 other communes of Sud. All TAS-3 results were below the respective critical cutoffs, meaning these areas met WHO epidemiological criteria for LF elimination as a public health problem. By the end of 2024, 19 districts remain in need of MDA, while 121 districts were actively in PTS after passing

TAS-1, of which 63 had also passed TAS-3 (**Figure 3, Figure 4**). Mobile data collection was used for Carter Center-assisted surveys where dashboards were developed and remotely monitored by staff at headquarters with daily communications and follow-up with field teams.

In 2024, specialized LF care and services continued to be provided at Hôpital La Providence des Gonaïves in Gonaïves, Artibonite department and Hôpital Sainte Croix (HSC) in Léogâne, Ouest department. The two facilities reported a total of 367 LF clinical care visits, with 19 being new case visits and the participation of 1,747 LF patients in psychosocial activities during 2024. Additionally, the Carter Center assisted with the development of a smartphone application that intends to link persons living with chronic LF morbidities (lymphedema and hydrocele) with MSPP to evaluate their conditions and connect them with LF care providers.

WHO Lymphatic Filariasis Monitoring and Evaluation Guidelines - Dr. Jonathan King (World Health Organization)

The Global Programme to Eliminate Lymphatic Filariasis (GPELF), launched by the World Health Organization (WHO) in 2000, had two strategic aims: to interrupt transmission of lymphatic filariasis (LF) through mass drug administration (MDA) and to alleviate the suffering of people affected by the disease. Through collective efforts of national governments, WHO, and partners to implement the strategy, 21 countries have documented elimination of LF as a public health problem; more than 9.7 billion cumulative treatments have been delivered. MDA has been implemented in 71 of the 72 countries considered to be endemic for the disease.

Monitoring and evaluation have been essential in generating evidence for programme decisions, such as when to start and stop MDA. In 2011, WHO published the *Monitoring and epidemiological assessment of mass drug administration*: *a manual for national lymphatic filariasis elimination programmes*, which introduced TAS to standardize the strategy for deciding to stop MDA and to conduct post-MDA surveillance.

Since 2011, countries have expanded MDA and implementation of TAS, and new MDA regimens have been recommended by WHO and used in countries. Additional challenges arise as countries progress towards elimination of LF as a public health problem and begin post-validation surveillance. To address these challenges, an updated framework for monitoring and evaluation has been developed to improve programme decision-making and strengthen surveillance to sustain progress in elimination of LF. This second edition, anticipated for publication during 2025, is based on the GPELF approach to reflect changing epidemiology, lessons learnt during extension of the programme, and knowledge generated in operational research.

The 2025 revision of the 2011 guidance includes the following changes:

- A new mapping protocol, confirmatory mapping, adapted from the TAS, is recommended as a practical tool for determining when MDA is required in areas of uncertain endemicity.
- Epidemiological monitoring surveys (EMS) have replaced pre-TAS and focus on the assessment of infection in the adult population using either <2% CFA or <1% microfilariae (Mf) as the threshold to progress to a stop MDA survey.
- A survey to measure impact of the new IDA triple therapy regimen is included, the IDA impact survey (IIS), using <1% Mf as the threshold in most settings to stop treatment.
- TAS has been strengthened, lowering the threshold to <1% CFA (and subsequently the number of children allowed to test CFA positive to “pass” below the threshold) to more confidently document that new infections are below target levels which transmission is assumed to be unsustainable.
- Follow-up actions are included to respond to people found infected during surveys.
- Platforms for post-validation surveillance are recommended, including a combination of health facility screening, standardized surveys, molecular xenomonitoring, and surveys targeted to high-risk areas or high-risk groups.

Technical details and tools for implementing the guidance are provided in the manual's annexes. The diversity of the epidemiology of LF and the unique program situations encountered may not correspond to all the categories or scenarios presented in the new manual, and consultation with WHO continues to be recommended in such cases.

Recommendations for 2025: Haiti - LF

1. Convene regular (at least annual) partner meetings to coordinate activities.
2. Resume LF MDA with enhanced community sensitization in 10 (those outside of metro Port-au-Prince) of the 19 remaining endemic districts, as security situation permits.
3. Conduct LF TAS, including scheduled surveys and those delayed due to insecurity, as the security situation permits.
4. Continue to scale up LF MMDP activities by organizing workshops to train clinical staff and establishing a designated referral center for LF care in the North and Northwest departments.
5. Identify sites to establish LF care clinics in each department.
6. Publish results from the 2021 Carter Center-assisted integrated malaria-LF MDA coverage and prevalence surveys in Léogâne and Gressier.
7. Publish results from the 2024 Carter Center-assisted integrated malaria-LF TAS in Grand'Anse and Sud departments.

Recommendations for 2025: Dominican Republic - LF

1. Publish results of TAS-3 and other PTS surveys.
2. Strengthen MMDP by integrating MMDP into primary care services and organizing workshops to train clinical staff at the primary care level.
3. Finalize and submit for WHO/PAHO validation the dossier claiming LF elimination as a public health problem by September 2025.
4. Publish results of the nationwide integrated LF remapping survey conducted from 2022–2024.
5. Develop a post-validation surveillance strategy to help inform criteria to attain WHO verification of LF elimination of transmission.
6. Resume and consider expanding Hope Clubs with an enhanced focus on sustainability.

LABORATORY SESSION

Regional Initiative on Integrated Serosurveillance – Dr. Ana Morice (PAHO consultant)

Integrated serosurveillance is an innovative approach that can accelerate efforts to identify populations with immunization gaps or waning immunity to vaccine-preventable diseases and monitor populations' exposure to communicable diseases. In 2016, a partnership between the Pan American Health Organization (PAHO), the U.S. Centers for Disease Control and Prevention (CDC) and selected countries of the Americas was formed to launch a regional initiative using multiplex bead assay (MBA) to measure antibodies for multiple pathogens simultaneously in a single blood sample. An interprogrammatic country team is required to respond to key programmatic questions, considering epidemiological scenarios to select the diseases to be surveyed considering overlapping risks, epidemiological data and interventions in specific groups of population and geographical areas. In addition to transferring and strengthening laboratory capacities it is crucial to ensure appropriate skills in survey design, statistical methods, data analysis, and interpretation to generate valid, reliable, and generalizable results to support actionable programmatic decisions.

Molecular Lab Progress in the Dominican Republic – Dr. Indhira Guillen (MSP)

The Serosurveillance and Molecular Biology Laboratory at the Center for Prevention and Control of Vector-Borne and Zoonotic Diseases (*Centro de Prevención y Control de Enfermedades Transmitidas por Vectores y Zoonosis* [CECOVEZ]) in the Dominican Republic plays a critical role in strengthening disease surveillance, diagnosis, and monitoring. As part of a broader health system-strengthening initiative, the laboratory enhances the country's capacity to detect and control communicable diseases, particularly malaria. Traditional diagnostic methods like rapid diagnostic tests (RDTs) and microscopy have limitations, particularly in detecting low levels of *Plasmodium* parasites in asymptomatic individuals. To address this, the laboratory has introduced polymerase chain reaction (PCR) testing, a more sensitive diagnostic method versus conventional tests. Through December 2024, the laboratory reported extracting DNA from 4,417 samples collected during the nationwide integrated LF remapping survey, of which 2,534 had completed PCR testing. Among these, *Plasmodium falciparum (Pf)* infections were detected by PCR from 50 (2.0%) samples that were negative by RDT, suggesting possible pockets of asymptomatic infections (**Figure 5**). This approach aids MSP to guide decision-making for targeting elimination efforts.

Beyond malaria, CECOVEZ plans to integrate the laboratory with the regional initiative for integrated serosurveillance using MBA. The initiative will build local capacity through targeted training programs for bioanalysts, ensuring that laboratory personnel are equipped with the necessary skills to conduct advanced surveillance methods, data analysis, and interpretation. Further steps include updating surveillance protocols in collaboration with national health authorities, establishing routine sample collection procedures, and exploring additional methods to improve understanding of disease epidemiology.

Recommendations for 2025: Laboratory

1. Determine the relevance of incorporating malaria molecular surveillance into each country's national strategic plan for malaria.
2. Establish capacity to conduct MBAs for integrated serosurveillance in the Dominican Republic.
3. Collaborate with the Dominican Directorate of Epidemiology (DIEPI) to update the manual for malaria surveillance to incorporate molecular surveillance and to develop a protocol for routine sample collection.

MALARIA

Malaria Elimination Progress in Haiti – Dr. Marc-Aurèle Telfort (MSPP)

The Haitian National Malaria Control Program (*Program National de Contrôle de la Malaria* [PNCM]) coordinates malaria elimination activities for MSPP. The goal of the Revised National Strategic Plan for the Elimination of Malaria in Haiti (2020–2025) is the elimination of malaria by 2025, measured by zero cases of autochthonous malaria transmission and zero malaria deaths by 2025. In 2024, there were 38,591 cases of malaria (**Figure 6**) and 17 malaria deaths reported in Haiti. This represents a 167.3% increase in cases, compared to 14,436 reported in 2023 and a 112.5% increase in reported malaria deaths versus 2023 (8). The increase in cases occurred with a 28.0% increase in the number tested: from 180,881 in 2023 as compared to 231,506 in 2024. Still, 2024 represents an over 2-fold decrease in malaria cases since 2010, when 84,153 cases were reported following the major earthquake in January of that year. Over 98.7% of 2024 malaria cases were reported from four departments: Grand'Anse (54.3%), Sud (33.8%), Nippes (8.5%), and Sud-Est (2.1%) (**Figure 7**). Overall, in 2024, the geographic distribution of cases across the country became more polarized. While progress continued in several areas - with 30 districts reporting zero cases over the past three years and demonstrating strong surveillance, along with four additional non-reporting communes likely having zero cases (totaling 34) - other areas continued to experience persistent transmission. The four non-reporting communes for 2024 were Anse à Galets, Cornillon, Fonds Verrettes, and Pointe à Raquette. Anse à Galets and Pointe à Raquette, located on La Gonâve Island, were difficult to access, while Cornillon and Fonds Verrettes were affected by gang activity. Meanwhile, the number of districts reporting more than 50 cases in one or more of the past three years increased to 39, compared to 35 in 2023.

In 2024, 94 Carter Center-supported community health councils (CHCs) continued to provide malaria sensitization and environmental activities, such as sanitation and elimination of mosquito breeding sites, in communes with high malaria transmission in Grand'Anse (59) and Sud (35) departments. MSPP provided training to 83 journalists in 6 departments (Artibonite, Centre, Nord, Nord-Est, Nord-Ouest, and Ouest) on malaria elimination efforts. MSPP also provided training to 485 healthcare network providers and nearly 250 professionals from the private medical sub-sector in malaria management. MSPP trained 2,000 Polyvalent Community Health Workers (ASCPs) to conduct RDT-testing for suspected cases, treat positive, uncomplicated malaria cases, and refer complicated cases to local health facilities. Additionally, 20,306 long-lasting insecticidal nets were distributed during mass campaigns with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Malaria Elimination in the Dominican Republic – Dr. Massiel Encarnación Segura (MSP)

The Dominican MSP reported a total of 1,246 cases of malaria with 3 deaths in 2024 (**Figure 6**). This represents a 358.1% increase from the 272 cases and an increase from the 0 deaths reported in 2023. Over half (635; 51.0%) of all cases reported in 2024 were detected by active surveillance conducted by community health workers and 611 (49.0%) by passive surveillance. There were 1,215 autochthonous cases detected (all *P. falciparum*) and 31 imported cases (30 *P. falciparum* and 1 *P. vivax*). Although the absolute number of imported cases increased from 18 to 31 from 2023 to 2024, the proportion of imported cases relative to nationwide totals decreased from 6.6% to 2.5%, respectively. Areas of origin include Haiti (27), Angola (1), Democratic Republic of Congo (1), Equatorial Guinea (1), and Guyana (1). Geographically, 93.5% of confirmed cases were reported in Azua (54.4%) and San Juan (39.1%)—the same two major foci of transmission in 2023. An outbreak of 24 autochthonous cases was also reported in Elias Piña province in 2024. Cases were reported in 30 (19.4%) of 155 municipalities (districts), up from 16 (10.3%) municipalities in 2023. Incidence of <1 case per 1000 persons was reported in 21 districts, <1–10 cases per 1000 persons in 8 districts, and >10 cases per 1000 persons in one district (Las Yayas de Viajama in Azua, which had an incidence of 16 per 1000 persons in 2024) (**Figure 8**).

From mid-January through mid-April 2024, MSP piloted a reactive drug administration (RDA) campaign in Azua and San Juan. The RDA strategy involved preventive treatment of individuals living in or near households of confirmed malaria cases using chloroquine and primaquine – the first-line regimen in the country for uncomplicated Pf. At week 3 of the pilot, only persons living in households of confirmed index cases were contacted for treatment. Among 331 confirmed malaria cases during the pilot period, 197 index cases from 182 homes were identified with RDA initiated. A total of 964 persons were contacted, of whom 829 (86.0%) started treatment, and among those who started, 580 (70.0%) finished treatment. In Azua, where more resources and personnel were concentrated, increased testing and treatment were associated with a subsequent decline in malaria cases. In contrast, San Juan did not receive the same level of support, which limited the impact. Overall, the pilot RDA did not significantly decrease the malaria burden in the country.

From October to December 2024, the MSP also conducted indoor residual spraying (IRS) in the Azua and San Juan foci. In Azua, 321 (96%) of 333 targeted homes were completely sprayed, and in San Juan, 5,008 (83%) of 6,000 targeted homes were completely or partially sprayed. Partial spraying was defined as houses where residents only allowed certain areas of the house to be treated. In addition, CECOVEZ evaluated the resistance to insecticides in *Anopheles albimanus* populations in the provinces of San Juan and Azua. In total, 2,728 *An. albimanus* mosquitoes were evaluated, 1,427 in San Juan and 1,301 in Azua. Tests showed results compatible with low-intensity resistance to the pyrethroid insecticides deltamethrin (12.5 µg/bot) and alphacypermethrin (12.5 µg/bot) in San Juan, and susceptibility to pyrethroid insecticide permethrin (21.5 µg/bot), organophosphate insecticides fenitrothion (50 µg/bot), and malathion (50 µg/bot). In Azua, susceptibility was shown to all five types of insecticide.

MSP strives to integrate malaria testing into LF cross-sectional surveys. The 2023–2024 LF TAS-3 survey in the East region tested 940 children 6–7 years old and 814 household members ages 15 years or older for malaria by RDT. None tested positive for malaria (*P. falciparum* or *P. vivax*) (**Table 1**). Only 1 (<0.01%) confirmed case of malaria was detected among 16,521 participants with valid RDT results during the 2022–2024 nationwide integrated LF remapping survey.

Freedom From Infection – Dr. Luca Nelli (University of Glasgow)

The Freedom From Infection (FFI) framework, a method developed for the context of veterinary epidemiology and adapted to that of human malaria, estimates the sensitivity of the surveillance system (SSe) and the probability of freedom from malaria (Pfree). Initially introduced as a tool with worldwide applications, now in its third year in the Dominican Republic, the FFI model has been specifically adapted to assist the Dominican MSP in transitioning towards malaria elimination.

In 2024, the FFI model was improved by integrating additional interview and routine data collected from visits to 48 health facilities during October–November 2023, plus data at the time of analysis on current fever status and results of rapid diagnostic tests for malaria from 16,521 participants in the ongoing integrated nationwide remapping survey. These data were instrumental in refining focus classifications.

This comprehensive data integration has significantly improved the SSe. Through the application of the FFI model, significant findings have emerged:

- High-performing facilities demonstrated reliable estimates without the need for additional data integration.
- Facilities previously identified with insufficient data have benefited markedly from integrating the remapping survey data, showing significant improvements in their Pfree estimates.
- Most facilities achieved a high Pfree (>0.95) at least once, but sustaining these levels has been challenging, often due to intermittent gaps in surveillance data which may contribute more to uncertainty rather than ongoing transmission.

The application of the FFI model has demonstrated the importance of continuous data integration and quality surveillance systems, underscoring the model's role as a robust tool in the global fight against malaria.

Community Integration Program (CIP) for Malaria – Dr. Jim Lavery (Emory University)

Effective community engagement is vital for malaria elimination, especially in marginalized communities. The Brokered Design approach, developed by Emory University's Human Engagement Learning Platform (HELP) with The Carter Center, was first used in Haiti to address declining participation in lymphatic filariasis treatments[3]. In 2024, this method was adapted in the Dominican Republic to improve health communications in San Juan and Azua provinces through a Rapid Assessment utilizing community conversations. Key insights emphasized the importance of respectful, inclusive communication, collaboration with community partners, and using in-person channels in comfortable settings. These findings are shaping the MSP's malaria risk communications strategy and broader organizational learning. Subsequently, HELP engaged with the national health communications team, MSP, and partners to test messages in communities as a response to the learning from the rapid assessment.

As part of the ongoing malaria elimination efforts, the country piloted the Community Integration Program (CIP) in Azua in February 2024. The CIP pilot engages Haitian migrant communities by training Haitian community health workers to provide health education, conduct rapid diagnostic tests, and support timely malaria diagnosis and treatment. The program is viewed as a success by MSP, stemming from its collaborative design, tailored messaging in Haitian Creole, and involvement of trusted community members. HELP, along with CECOVEZ and its partners, is conducting an in-depth evaluation of the CIP to inform future program designs and explore its transferability to other health interventions. A core component of the CIP evaluation is the Realist Evaluation approach, which seeks to understand not only whether the program worked but how and why it worked in a complex social context. This method investigates the mechanisms that drive outcomes by examining the interactions between the program, the community, and the broader social environment. The evaluation aims to answer key questions about what makes the CIP effective, what contextual factors influence its performance, and how the program might be transferable to other regions. The approach involves gathering data from interviews, documents, and community insights to generate theories about how the intervention produces results. By identifying which elements of the CIP are essential for success and how they operate in different contexts, the evaluation provides actionable insights to improve the program and guide its replication in other malaria elimination efforts.

[3] Wodnik, B. K., et al. (2020). "The roles of stakeholder experience and organizational learning in declining mass drug administration coverage for lymphatic filariasis in Port-au-Prince, Haiti: A case study." *PLoS Neglected Tropical Diseases* **14**(5): e0008318.

Recommendations for 2025: Haiti - Malaria

1. Urge the Haitian MSPP to finalize and publish the Revised National Strategic Plan for Malaria Elimination 2026-2030.
2. Establish routine malaria partners meetings to share progress and work plans to maximize efforts and resources to align with implementing the national strategic plan.
3. Consider contributing data to develop an island-wide malaria surveillance dashboard.
4. Collaborate with other programs at the Haitian MSPP to utilize CHCs for other health activities.
5. Consider the feasibility of applying novel approaches (e.g., use of highly sensitive rapid diagnostic tests [HS-RDT] for reactive case detection) to identify and treat more asymptomatic infections.
6. Consider re-establishing molecular and genomic surveillance to evaluate for antimalarial resistance, parasite connectivity, and parasite diversity to inform treatment policy decisions, malaria patient care, and disease elimination on the island and to strengthen binational collaboration with the Dominican Republic.
7. Consider developing joint communication materials translated into Spanish, French, and Haitian Creole with both Ministries' logos to strengthen binational collaboration and express binational commitment to malaria elimination on Hispaniola.
8. Re-initiate routine binational meetings between the national programs to share successes, challenges, and progress to work towards the shared goal of malaria elimination on Hispaniola.

Recommendations for 2025: Dominican Republic - Malaria

1. Urge the Dominican MSP to finalize and release an updated national strategic plan for malaria.
2. Establish routine malaria partners meetings to share progress and work plans to maximize efforts and resources to align with implementing the national strategic plan.
3. Collaborate with partners to train MSP laboratorians to conduct multiplex serological assays.
4. Maintain malaria testing capacity nationwide, including in residual-active and eliminated foci.
5. Integrate community health worker (CHW) surveillance data into the national surveillance system.
6. Orient surveillance systems and facility-based records to prepare for certification of malaria elimination.
7. Consider contributing data to develop an island-wide malaria surveillance dashboard.
8. Consider aggressive approaches (e.g., expanded community-based testing and treatment, indoor residual spraying [IRS], and possible targeted drug administration [TDA] towards agricultural workers and migrant populations) to halt the geographically shifting series of malaria outbreaks in the Dominican Republic.
9. Consider transitioning to non-pyrethroid insecticides (e.g., Actellic300CS, which has been used in Hispaniola, to which no historic resistance in *An. albimanus* has been detected) in IRS campaigns.

10. Enhance malaria awareness among migrant populations in outbreak-affected areas (San Juan and Azua) to increase acceptance of malaria testing and treatment and promote prevention measures in settings with limited access.
11. Publish results of ethnographic research conducted in malaria outbreak-affected areas of Santo Domingo. Refine community engagement strategies for interrupting malaria transmission based on results.
12. Publish the results of the RDA pilot in Azua and San Juan provinces.
13. Enhance support for binational collaboration to interrupt malaria transmission in and around cross-border areas.
14. Consider the feasibility of applying novel approaches (e.g., use of highly sensitive rapid diagnostic tests [HS-RDT] for reactive case detection) to identify and treat more asymptomatic infections.
15. Consider establishing molecular and genomic surveillance to evaluate for antimalarial resistance, parasite connectivity, and parasite diversity to inform treatment policy decisions, malaria patient care, and disease elimination on the island and to strengthen binational collaboration with Haiti.
16. Consider developing joint communication materials translated into Spanish, French, and Haitian Creole with both Ministries' logos to reinforce the involvement and collaboration of Haitian migrants in the malaria elimination on Hispaniola.
17. Re-initiate routine binational meetings between the national programs to share successes, challenges, and progress to work towards the shared goal of malaria elimination on Hispaniola.

ANNEX 1. Milestones: Hispaniola Initiative

2024: In the Dominican Republic, the East Focus completed and passed TAS-3, meaning the country met the epidemiological criteria for eliminating LF as a public health problem. In Haiti, 30 districts across Grand'Anse and Sud departments also passed TAS-3.

2023: The Carter Center and the Dominican MSP commenced TAS-3 in the East Focus and inaugurated a molecular lab at CECOVEZ. Despite ongoing security challenges, the Carter Center and the Haitian MSPP conducted three LF TAS-3 in Haiti, established four more malaria CHCs in Sud department, Haiti, and capacitated Hôpital La Providence in Gonaïves, Artibonite department, as the nation's second LF MMDP service facility. The Dominican Republic received a Malaria Champion of the Americas award from PAHO.

2022: The Carter Center and the Dominican MSP commenced an integrated LF remapping survey. Despite ongoing security challenges, the Carter Center and MSPP conducted LF TAS in three districts in Haiti. The Carter Center established 19 more malaria CHCs in Sud department, Haiti.

2021: The Dominican Republic reported the lowest number of malaria cases in the country (290) since 1975 (when there were 159). PTS surveys for LF were completed in the East and La Ciénaga foci of the Dominican Republic that indicated LF transmission remained interrupted in both foci. The country launched the first-ever support group for LF patients. The Carter Center and MSPP conducted surveys to measure post-LF MDA coverage and LF and malaria prevalence in Leogane and Gressier districts, Haiti. Haitian president Jovenel Moïse was assassinated on July 7th exacerbating instability in the country. Progress reports on efforts to eliminate malaria and lymphatic filariasis from Hispaniola were presented to ITFDE.

2020: The COVID-19 pandemic disrupted public programs globally. The Carter Center supported two rounds of MDA for LF in Léogâne and Gressier, Haiti—one in February–March (delayed from 2019) and one in December. The Carter Center established an additional 12 CHCs in Haiti and supported CE for a second Malaria Zero MDA campaign. PTS surveys for LF were completed in the Southwest focus of the Dominican Republic; results indicated LF transmission remained interrupted.

2019: The Carter Center established 36 more CHCs in Grand'Anse, Haiti.

2018: The East focus passed TAS-1, meaning all formerly LF-endemic areas of the Dominican Republic qualify to stop MDA. In partnership with Malaria Zero, The Carter Center established 23 CHCs in Haiti and supported CE for a pilot IRS-MDA campaign in select areas of Grand'Anse, Haiti.

2017: The Dominican Republic and Haiti won a Malaria Champions of the Americas Award recognizing their outstanding work in interrupting malaria transmission and developing local systems to access malaria diagnosis and treatment.

2016: The Carter Center conducted a survey for malaria and LF in agricultural areas across the Dominican Republic to investigate the burden of these diseases in isolated communities historically suspected of being reservoirs for disease transmission.

2015: The Carter Center, the ministries of health in Haiti and the Dominican Republic, and other partners formed a consortium, known as the Malaria Zero alliance, with funding from the Bill & Melinda Gates Foundation, to accelerate malaria elimination on Hispaniola. The Carter Center led CE to promote and deliver community-based interventions for malaria elimination as part of Malaria Zero activities, The Carter Center staff helped develop curriculum and served as instructors for malaria elimination training for MSPP staff, and drafted plans for Malaria Zero implementation.

2014: The Hispaniola Initiative expanded institutional support for malaria and LF elimination in Hispaniola. In Haiti, The Carter Center participated in meetings to update Haiti's National Strategic Plan for malaria. In the Dominican Republic, The Carter Center provided financial support for LF MDA launching in the East and technical assistance for an LF TAS in the La Ciénaga area of Santo Domingo. The Carter Center also commissioned an economic study to provide an updated cost of eliminating malaria and LF in Hispaniola. Progress reports on efforts to eliminate malaria and LF in Hispaniola were presented to ITFDE.

2013: The Carter Center sponsored additional meetings to continue binational coordination of malaria and LF elimination activities.

2012: The Carter Center sponsored four binational meetings to update malaria and LF elimination plans. In November, ITFDE reviewed progress on malaria and LF elimination in Hispaniola.

2011: President Carter participated in the first launching of MDA for LF in metropolitan Port-au-Prince, Haiti.

2010: In January, Haiti experienced a massive earthquake, causing significant loss of life and physical destruction.

2009: Haiti and the Dominican Republic produced a binational plan to eliminate malaria in Hispaniola by 2020. Haiti also produced a national plan to eliminate LF by 2020. In October, President Carter met with heads of state of both countries to mobilize support for these plans.

2008: The Carter Center helped the ministries of health establish a cross-border pilot project to target malaria in Ouanaminthe, Haiti (pop. 92,000), and Dajabón, Dominican Republic (pop. 27,000). The project included purchase and distribution of insecticide-

treated bed nets; provision of laboratory supplies, motorbikes, and other equipment; training for health staff; and protocol standardization for malaria diagnosis and treatment.

2006: ITFDE concluded that implementation of an integrated comprehensive program to eliminate both malaria and LF on the island of Hispaniola is technically feasible and medically desirable and would be economically beneficial to both the Dominican Republic and Haiti.

ANNEX 2. Carter Center-Authored Hispaniola Publications

2024 publications shown in bold.

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ANNEX 3. List of Program Review Participants

(v) - virtual participant

The Carter Center
Alex Addison
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Gregory Noland
Hannah Lawinger
Helen Law (v)
Hunter Keys (v)
Jenna Coalson
Jenny Dorris White (v)
Juan Mena
Karen Hamre
Karmen Unterwegner
Kashef Ijaz
Lauri Bernard
Laurie Baxley (v)
Lindsay Rakers
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Madelle Hatch
Maura Toole (v)
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Monica Johnson
Nicole Kruse (v)
Paola Mejia (v)
Philip Adolwa (v)
Samhita Kumar (v)
Sara Wom (v)
Sara Baxter (v)
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Shandal Sullivan
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Ursula Hamilton (v)
Ursula Kajani (v)
Valery Beiriger Valdez (v)
Victoria Krauss
Yasir Deafalla (v)
Yohannes Dawd

Anesvad Foundation
Ana Löwenberg (v)

Clinton Health Access Initiative (CHAI)
Nichole Michelen Strofer

Crosscut
Coite Manuel

Emory University
Deborah McFarland (v)
Karla Estudillo Fuentes
James Lavery

Gates Foundation
Katey Owen (v)

Global Institute for Disease Elimination (GLIDE)
Simon Bland (v)

Helmsley Charitable Trust
Melissa Crutchfield (v)

Hôpital Sainte Croix
Martha Désir (v)

Independent
Eric Rogier (v)
Frank Richards
Larry Slutsker

Ministry of Public Health - Dominican Republic
Vice Minister Eladio Pérez
Indhira Guillén
Jose Luis Cruz Raposo
Jose Manuel Puello
Keyla Ureña
Massiel Encarnación Segura

Ministry of Public Health and Population - Haiti
Darlie Antoine
Farah-Nelhy Momprevil
Vice Minister Gabriel Thimothé
Jean Frantz Lemoine (v)
Lorence Jean
Marc-Aurèle Telfort

Noor Dubai Foundation
Manal Taryam (v)

PAHO
Ana Morice (v)
Keith Carter (v)
Romeo Montoya (v)
Ronaldo Scholte (v)

PATH
Abdel Direny (v)

RTI International
Mike French (v)

Sightsavers
Thomas Millar (v)

UNICEF
Ezra Jerome (v)
Ida-Marie Ameda (v)

University of Florida
Madsen Valery Beau de Rochars

University of Glasgow
Luca Nelli

University of Ottawa
Alison Krentel (v)

University of South Florida
Gillian Stresman

University of Queensland
Beatris Martin (v)
Colleen Lau (v)

World Health Organization
Jonathan King

ANNEX 4. 2024 Hispaniola Initiative Program Review Agenda

Start	End	Title	Speaker
		Opening Session	*Dr. Gregory Noland (chair)*
9:00 AM	9:10 AM	Welcome and Introductions	Dr. Gregory Noland
9:10 AM	9:15 AM	Opening Remarks	Dr. Kashef Ijaz
9:15 AM	9:30 AM	Tribute to President Carter	
9:30 AM	9:45 AM	Hispaniola Initiative Overview	Dr. Gregory Noland
		Lymphatic Filariasis Session	
9:45 AM	10:20 AM	LF Progress in the Dominican Republic	Dr. Jose Manuel Puello
10:20 AM	10:35 AM	*Discussion*	
10:35 AM	11:10 AM	LF Progress in Haiti	Dr. Marc-Aurèle Telfort
11:10 AM	11:25 AM	*Discussion*	
11:25 AM	**11:55 AM**	**Photo and Coffee Break**	
11:55 AM	12:00 PM	East Focus TAS-3 in the Dominican Republic	
12:00 PM	12:15 PM	Update: WHO Lymphatic Filariasis M&E Guidelines	Dr. Jonathan King
12:15 PM	12:20 PM	*Discussion*	
		Laboratory Session	
12:20 PM	12:35 PM	Regional Initiative on Integrated Serosurveillance	Dr. Ana Morice
12:35 PM	12:50 PM	Molecular Lab Progress in the Dominican Republic	Dr. Indhira Guillen
12:50 PM	1:00 PM	*Discussion*	
1:00 PM	**2:00 PM**	**Lunch**	
		Malaria Session	
2:00 PM	2:35 PM	Malaria Elimination Progress in Haiti	Dr. Marc-Aurèle Telfort
2:35 PM	2:50 PM	*Discussion*	
2:50 PM	3:25 PM	Malaria Elimination Progress in the Dominican Republic	Dr. Massiel Encarnación Segura
3:25 PM	3:40 PM	*Discussion*	
3:40 PM	**4:00 PM**	**Coffee Break**	
4:00 PM	4:15 PM	Freedom From Infection	Dr. Luca Nelli
4:15 PM	4:25 PM	*Discussion*	
4:25 PM	4:40 PM	Community Integration Program for Malaria	Dr. Jim Lavery
4:40 PM	4:50 PM	*Discussion*	
4:50 PM	5:00 PM	Summary and Closure	Dr. Gregory Noland
5:00 PM	5:00 PM	Session Adjourned	
5:00 PM	7:00 PM	**Reception**	
7:15 PM	7:15 PM	Shuttle departs for hotel	