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samples (100 µL) were collected by certified laboratory scientists from all assenting children to determine the presence of circulating filarial antigen using the BinaxNOW Filariasis immunochromatographic test (ICT) (Alere Inc., Scarborough, ME). Results were read at 10 minutes, recorded on paper forms, and communicated to each child confidentially. ICT-positive children were offered albendazole–ivermectin according to FMOH guidelines. Participation in the surveys was voluntary. Individual oral assent was obtained from se-

(4/537 = 0.7%) and Mikang (5/249 = 2.0%) in EU-2 had more than two positive samples, with focal clustering (more than one positive per school) observed in only one school in Riyom and Mikang. Antigenemia was significantly more prevalent among males (20/3,710 = 0.54%) than females (5/3,421 = 0.15%; $\chi^2 = 7.87$, = 0.005).

These results indicate that LF transmission in these EUs was below sustainable levels and that stopping MDA was warranted according to WHO guidelines. A final round of 3.5 million albendazole–ivermectin MDA was provided in September 2012 in the 21 LGAs. In total, they received a median of 10 years (range = 8–12 years) of MDA. Although the Global Program to Eliminate LF assumes that 4–6 years of MDA at effective coverage is sufficient to interrupt transmission,[1] the Plateau–Nasarawa experience is consistent with models predicting 10 or more years of albendazole–ivermectin MDA are required in areas with baseline prevalence > 15%.[7] Reported treatment coverage, however, was not verified in all LGAs by coverage surveys, and actual consumption of medicines may have differed from reported coverage. Besides MDA, long-lasting insecticidal nets helped reduce LF transmission in this area.[8] Continued efforts to further increase net ownership and use in Nigeria through universal net coverage should help prevent LF recrudescence following the halt of MDA in Plateau and Nasarawa.

WHO guidelines recommend approximately 5 years of posttreatment surveillance (PTS) following MDA stoppage.[1] Ongoing transmission in neighboring states and potential residual foci identified here highlight the importance of PTS to detect importation or recrudescence. A major challenge for interpreting PTS data, however, is the continued distribution of ivermectin for onchocerciasis in 12 of the 30 LGAs of Plateau and Nasarawa.[9] Though not recommended as an MDA strategy for LF elimination, ivermectin monotherapy exerts microfilaricidal activity against *W.* ***ft*** ,[10] and continued ivermectin MDA for onchocerciasis may sufficiently suppress microfilaremia among remaining infected persons to prevent recrudescence. This raises the question of whether repeated TAS in areas with ongoing ivermectin MDA for onchocerciasis can be considered as true PTS for LF. If elimination of LF transmission becomes the goal (as opposed to elimination as a public health problem), then delayed PTS until the halt of ivermectin MDA would appear to be necessary, in line with WHO guidelines for onchocerciasis elimination.[11]

This study has several limitations: 1) follow-up mf testing was not conducted for antigen-positive individuals. However, as antigen levels persist following mf clearance, the true transmission potential among the sample population is likely lower than antigen prevalence estimates. 2) Five selected schools were not visited due to ethnic conflicts. Such events occur periodically in central Nigeria, meaning that affected areas may not have received MDA and that pockets of transmission may persist. Such areas should be specifically monitored during PTS. 3) The sampling of primary school children may underestimate community-wide LF burden as prevalence is lower in children compared with other age groups.

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