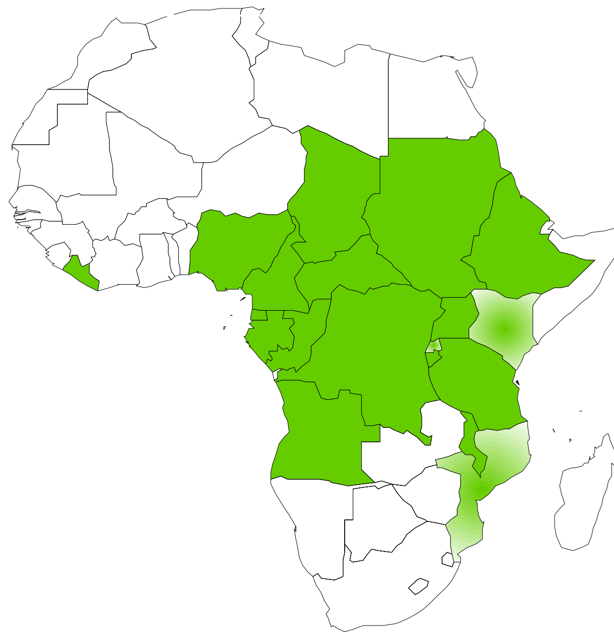
World Health Organization

APOC

AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)



REPORT OF THE TWENTY-SEVENTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC)

OUAGADOUGOU, 15-20 SEPTEMBER 2008

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ABBREVIATIONS

APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
CBO	Community-Based Organisation
CDD	Community-Directed Ivermectin Distributor
CDI	Community-Directed Intervention
CDTI	Community-Directed Treatment with Ivermectin
CSA	Committee of Sponsoring Agencies
CSM	Community Self-Monitoring
DEC	Diethylcarbamazine
DMO	District Medical Officer
DOTs	Directly Observed Treatment Short-course (for TB)
DPC	Disease Prevention and Control Officer
DRC	Democratic Republic of Congo
FAO	Food and Agriculture Organization
GAELF	Global Alliance for the Elimination of Lymphatic Filariasis
FLHF	Frontline Health Facility
GSM	Global Management System
HKI	Helen Keller International
HSAM	Health Education Sensitization Advocacy Mobilization
HQ	Headquarters
HEW	Health Extension Workers
HW	Health worker
IEC	Information, Education, Communication
JAF	Joint Action Forum
LF	Lymphatic Filariasis
LGA	Local Government Area
LOCT	LGA Onchocerciasis Control Team
MDP	Mectizan® Donation Program
MDSC	Multi-disease Surveillance Centre
MoH	Ministry of Health
NGDO	Non-Governmental Development Organization
NOCP	National Onchocerciasis Control Programme
NOTF	National Onchocerciasis Task-Force
NTD	Neglected Tropical Diseases
PAB	Plan of Action and Budget
PHC	Primary Health Care
SHM	Stake Holders Meeting
SSI	Sight Savers International
TCC	Technical Consultative Committee (of APOC)
TDR	WHO-based Special Programme for Research &Training in Tropical Diseases
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
UTG	Ultimate Treatment Goal
VAS	Vitamin A Supplementation
WHO AFRO	Regional Office of the WHO Africa Region
WHO/NTD	Neglected Tropical Diseases - department within WHO cluster of communicable diseases (WHO/NTD)
WR	WHO Country Representative

Agenda item 1: OPENING SESSION

1. The twenty-seventh session of the Technical Consultative Committee (TCC) of the African Programme for Onchocerciasis Control (APOC) was held from 15 to 20 September 2008 at the APOC Headquarters in Ouagadougou, Burkina Faso, under the chairmanship of Professor Adenike Abiose.

2. APOC Director Dr Amazigo, welcomed participants, especially Prof Homeida, Dr Hans Remme, and Dr Conombo Gislaine, the representative of WR Burkina Faso, and also recognized the presence of Drs Balbina de Sousa TV Felix, Harry Opata and Florent Ekwanzala, respectively, Disease Prevention and Control Officers (DPCs) of Angola, Ghana and DRC. She also welcomed Mr Doulaye Sacko of the West African Health Organization (WAHO) and Mr Abdulai Daribi of WHO/NTD Geneva. The director briefed the meeting on programme activities since the last TCC session, noting that APOC became the first WHO programme to join the Global Management System (GSM) in the African region in July 2008. The introduction of GSM has created some unforeseen teething problems, resulting in the non-accomplishment of some tasks recommended by TCC26. The APOC director however, expressed confidence that the challenges would be overcome. She emphasized the importance of the Addendum to the Plan of Action and Budget PAB 2008-2015 on the TCC 27 agenda, noting that APOC was seeking the Committee's guidance on the Addendum. DPCs had been invited to the TCC session following the Regional Director's approval of the request for WHO Country Representatives to attend TCC sessions with their DPCs. The APOC director wished the participants successful and fruitful deliberations.

3**.** Professor Kader M. Konde, Director ai MDSC also welcomed participants and, so did the Representative of WR Burkina Faso, Dr Gislaine, who said it was a pleasure for her to participate in the TCC session.

4. TCC Chair Prof Abiose welcomed participants, especially Mrs F. Olamiju and Dr Ngorok who were attending TCC for the first time as Observers. She also congratulated Dr Remme on his retirement from TDR, Geneva, while underscoring his commitment to onchocerciasis control. Prof Abiose expressed the hope that the participation of DPCs would enrich deliberations of the TCC session, given their in-country field experiences. She welcomed Dr Elizabeth Elhassan who would be making a presentation on the first in-country review of annual technical reports from Nigeria. Cameroon and Uganda have initiated steps for similar reviews, while Malawi, which is making efforts at ownership of the control programme, is also expected to do the same. The Chair noted the difficulties being encountered by APOC management on the introduction of GSM, and expressed her optimism that the Programme would overcome the initial difficulties.

Agenda Item 2: Adoption of the Agenda

5. The Agenda was adopted with the following amendments: Report on CDD incentives was included under other matters. One topic on Agenda Item 19.17, which was repeated twice, was deleted and Agenda Item 8 was modified to remove the phrase "determining the end-point." Agenda Item 4 was corrected to read …conclusions and recommendations of NGDO 32nd meeting, instead of 34th meeting. (the adopted agenda is attached as Annex 2)

6. In response to TCC26 recommendation that the NOTF/Uganda be invited to TCC27 session to explain the progress on onchocerciasis elimination activities, APOC management explained that the administrative process was initiated and invitation letters were sent out but the invitees could not make it to this session. It is expected that NOTF Uganda would attend the next TCC meeting.

7. To facilitate the work of TCC sessions and ensure much more organised deliberation, the meeting resolved that agenda items should be modified in such a way that subsequent meetings should start with the review of young projects first, followed by the summary of projects of 7 years and above and then review of operational research proposals.

Agenda Item 3: CSA: Matters arising from 120th and 121st sessions

8. APOC Director, Dr Uche Amazigo gave a historical background to the formation of the Committee of Sponsoring Agencies (CSA). She informed TCC that CSA was originally called the Steering Committee from 1972, comprising the FAO, WHO, UNDP and the World Bank, which ran the OCP and invited other donors. Later, the Steering Committee was renamed CSA, which now oversees the activities of APOC and reports back to the Joint Action Forum (JAF), the governing board. At the closure of OCP in 2002, and since APOC is not concerned with the issue of settlement of freed zones, FAO stopped participating in the Phase II control programme. WHO has remained the executing agency of APOC, the World Bank, which recently renewed its funding commitment, the fiscal agent, while the UNDP is one of the key sponsors of the Programme. The CSA meets three to four times in a year. To reduce cost, the CSA recently held its first session by video conference.

9. **The 120th session of CSA** was held at APOC headquarters. Among key issues discussed were the Addendum to PAB 2008-2015, closure of SIZ, NGDO Group activities, membership of TCC, constitution of a Technical group between TCC and the Global Alliance for the Elimination of Lymphatic Filariasis (GAELF) to advise APOC on co-implementation, and the recruitment of technical adviser for Angola. Other issues were the development of tools for NTD mapping, ways to bring UNICEF to join CSA, planned publication by APOC on the follow-up to the situation in Ghana, and the approval of final evaluation of SIZ.

10. **The 121st session of CSA,** by video conference, discussed MDSC's continued involvement in onchocerciasis control and gave approval for APOC Trust Fund to be made available to support MDSC to build national capacity on disease surveillance. The paper work on the APOC/MDSC collaboration has been prepared awaiting the release of funds. The session also urged CSA chair to follow up on the participation of Director NTD/Geneva in CSA meetings. The CSA increased from US$10,000 to US$20,000, the budget ceiling for each approved Operational Research proposal, with the provision that a special case could be made, where necessary, for a review of the upper limit of the funding. CSA is also to revisit the Addendum to PAB 2008-2015.

Agenda Item 4: NGDO: matters arising from 32nd session: recommendations.

11. Dr Tony Ukety, the Responsible Officer for the NGDO Coordination Group for Onchocerciasis Control reported on the main conclusions and recommendations of the 32nd session of the Group. The session, which coincided with the 3rd Joint Meeting of the NGDO Group for Onchocerciasis Control, the LF NGDO Network and the International Coalition for Trachoma Control was held 9-11 September 2008 in Chester, UK. (Detailed conclusions and recommendations of the NGDO meeting is attached as Annexe 3).

12. TCC noted the great interest in NTDs at the international level and the development of new partnerships. Participants welcomed the growing NGDO support to CDTI activities in countries such as Côte d'Ivoire and Uganda by SSI and MAP International. TCC members observed that the expansion of the NGDO Group meant more challenges. The benefits of the expansion should be maximized without diluting the focus on onchocerciasis control. The involvement of WAHO is expected to facilitate collaboration at country level in West Africa. TCC reiterated that countries should be in the driving seat of implementing health interventions, building on the lessons learnt from the onchocerciasis control programme. In view of the expansion of the NGDO Group, the emerging challenges, and the need to maximize benefits from the expansion for effective coordination of NTD interventions:

13. *TCC recommended that the tripartite group - LF, Trachoma and Oncho - should form Task forces at the country level similar to oncho NOTFs, to facilitate the financing, management and coordination, integration and co-implementation of NTD activities.*

Agenda item 5: Follow-up of key recommendations of 26th session of TCC

14. APOC Programme Coordinator, Dr Laurent Yaméogo briefed the Committee on the implementation of TCC26 recommendations. He explained that although plans were made for the implementation of the recommendations, this year's activities were affected by the launching of the WHO Global Management System (GSM). On the field visits by TCC members to build national capacity and improve programmes' performance, participants were informed that TCC Chair undertook a visit to Ethiopia while Dr Ogoussan visited the Central African Republic. He also participated in a workshop in DRC on SAEs. Dr Yébakima's visit to Cameroon was postponed because of the decision to suspend all other WHO missions to the country while preparing for the Regional Committee meeting. (The status of implementation of the recommendations presented is attached as Annexe 4).

Agenda Item 6: NOTFs: matters arising from the 5th annual meeting

15. The 5th annual meeting of the National Onchocerciasis Task Forces was held in Addis Ababa (Ethiopia) from 1st to 5th July 2008. The meeting, opened by the WR of Ethiopia, was attended by 10 countries (Cameroon, Central African Republic, Chad, Democratic Republic of Congo, Ethiopia, Liberia, Malawi, Nigeria, Uganda and Tanzania),as well as the Coordinator of the Oncho NGDO coalition and APOC Management. The main objective of the meeting was to review data on government financial contributions to onchocerciasis control, co-implementation and to prepare countries' presentation to JAF14. The meeting agreed on the format for developing a PAB to be used by all countries for submission to APOC for 2009 onwards. Countries were briefed on APOC's joining of the WHO GSM. Because of administrative bottlenecks, it was agreed that subsequent NOTFs annual meetings should be held at APOC HQ. The decisions and recommendations of the NOTF session are attached as Annex 5.

Agenda Item 7: SIZ: Final external evaluation of the SIZ

16. Dr Yameogo briefed TCC members on the external evaluation of SIZ activities carried out between 2003 and 2007 under the general oversight of APOC management, to bring the entomo-epidemiological parameters in the areas concerned to a level that could be easily managed by the countries. After five years of operation, a final external evaluation of the SIZ was undertaken in 2008. The main lessons learnt and best practices included the need for continued support for epidemiological and entomological surveillance and statistical analysis to be provided to all ex-OCP and APOC countries. Mechanisms for this should be considered and developed to ensure sustainability. The target of 80-85% therapeutic coverage is achievable, even in areas of shifting populations and high endemicity. It was noted with great interest that population records generated for the purposes of CDTI are being used by other programmes to help plan their activities, showing that CDTI is indeed contributing to strengthening the base for other programmes, particularly in remote areas. The process of bringing programme managers together at annual review meetings, and sending them to other countries to learn best practices, is also beneficial for professionalism of in-country staff and capacity building in national programmes.

17. Responding to TCC members' question on when the OCP final evaluation would take place, APOC Management explained that the evaluation would be decided by donors.

18. The meeting noted WAHO's support to oncho control in former OCP countries as expressed in recommendations at its meeting last year:

(i) WAHO should collaborate with APOC and MDSC for cross-border surveillance in ex-OCP countries;

(ii) WAHO should collaborate with APOC to conduct studies to identify areas in the ex-OCP countries where ivermectin treatment can be discontinued without the risk of recrudescence of transmission.

19. As a result of the historical differences in goals of ex-OCP and APOC, the targets of performance by the two programmes also varied in terms of therapeutic coverage of 80% against 65% respectively. With the current results of APOC mature projects reaching over 80% therapeutic coverage rates and with the possibility that elimination of onchocerciasis might be possible in Africa, TCC reaffirms that the goal of projects should be to reach the UTG.

STRATEGIC AND TECHNICAL ISSUES

Agenda Item 8: Addendum to PAB 2008-2015

20. The APOC Director briefed TCC on the rationale for the Addendum to the PAB 2008-2015, as recommended by CSA. The Addendum as a modest addition to the PAB 2008-2015, seeks to address unforeseen challenges that were not captured in the original document. The Addendum addresses three of the six objectives of the PAB 2008-20015, as follows:

(i) *To establish sustainable onchocerciasis control programmes in all countries where they are needed, with special reference to post-conflict countries;*

(ii) *To implement onchocerciasis control activities in conjunction with other health interventions (co-implementation)*;

(iii) *To determine when and where ivermectin treatment can be stopped.*

21. With the control programme in a critical stage and to avoid jeopardising the gains of over three decades, it is imperative to remain steadfast and sustain donor support as APOC gradually decentralizes and devolves its functions to countries and partners. APOC management requests the TCC to look critically at the document so as to secure uninterrupted support to the control programme. The cost implication for the Addendum is US$25 million. The breakdown is US$6,050,000 for activities under objective 1; US$6,100.000 for objective 2; and US$12,041,160 for objective 3. As part of activities under objective 3, Dr Remme cited the potential benefits of the ongoing elimination study in Mali and Senegal and the findings of the Working Group on the future of onchocerciasis control in Africa. He reminded TCC of the third recommendation of the Working Group on the future of APOC to "develop evidence to determine when and where ivermectin treatment can be stopped, and provide guidance to countries on how to prepare for and evaluate cessation of treatment". The evidence for achieving this objective resulted from the ongoing study on the feasibility of onchocerciasis elimination with ivermectin in Mali and Senegal. This is a four-year study (2005 - 2009) designed to assess the impact of 16 years of ivermectin treatment on infection and transmission in several villages around the Gambia, Faleme and Bakoye river basins. Preliminary epidemiological and entomological results showed that there was no recrudescence of infection two years after stopping treatment and no recrudescence in transmission one and half years after stopping treatment around rivers Gambia and Bakoye. However, the situation is not uniform in the Faleme river basin where more infection and transmission are being observed in the Southern part of the focus.

22. TCC members sought clarification on whether operational research had confirmed that CDTI works in post-conflict countries. APOC management informed the meeting that an independent science writer had in a Lancet report confirmed that the CDTI strategy works in post-conflict countries, as shown by documentations from field visits to Uganda and DRC. A UNICEF Consultant’s report on DRC which supports onchocerciasis control strategy for Vitamin A supplementation also commends the CDTI strategy as a powerful health intervention tool in post-conflict area.

23. APOC Management also explained the rationale for the US$1 million earmarked for activities in non-oncho areas in the Addendum as critical investment to safeguard the gains of the control programmes. The role of the MDSC in support of onchocerciasis control is also clearly spelt out in the PAB 2008-2015.

24. During discussions, DPC/Angola informed TCC that her country was replacing the use of electricity generators with solar panels in the immunization services as a cost-cutting measure. To get Ministries of health to contribute >25% of budget to CDTI activities she also suggested that it might be useful to provide evidence to show the economic impact of the control programme. Angola has human resource problems, but would be willing to support CDTI activities if the need is specified. APOC management explained that the human resource need was particularly critical at the lower - district and sub-district levels. There is also the need to push for greater participation of women in CDTI activities within the context of mainstreaming of minorities, not just women, but also youth, in the control programme.

25. *TCC recommended that the budget on moxidectin and transmission trials should be reflected in the Addendum to the PAB 2008-2015. Contributions by APOC and ex-OCP countries should also be acknowledged in the Addendum, while the impact of environmental degradation should be taken into account in the assessment of CDTI gains. TCC further noted that the Patch test could be used operationally to evaluate effectiveness of ivermectin treatment and the refinement of REMO made a priority. There is also the need for a few references on publications to be added to strengthen the Addendum.*

Agenda Item 9: Monitoring of drug efficacy in large scale treatment programmes for onchocerciasis control.

26. Dr Janis Lazdins informed TCC that TDR was evaluating a research strategy and proposals to further characterize the parasite genetic changes associated with ivermectin use and the development of a tool for detection of ivermectin resistance. This research will require capacity building, technology transfer and establishment of an African research centre(s) for bio-banking and characterization of parasitological material obtained from surveillance activities. Based on the surveillance strategy, TCC is to provide feedback for a suitable location of the centre(s). TDR will solicit letters of intent from African centres accordingly. TCC recommended that funding for molecular research should be on a small scale mainly to help investigators to leverage funds from other sources.

27. Following Dr Ladzins' presentation, TCC members pointed out that they required advance documentation before regular TCC sessions to enable them to offer sound opinions on technical issues such as the Macrofil research. The TCC then set up a small working group on Tools for Ivermectin efficacy surveillance.

28. The working group in its report submitted to the TCC, noted that Dr Lazdins had solicited TCC opinion for setting up an "African Centre for bio-banking and research" for the surveillance of the efficacy of ivermectin in Africa. The original paper made several suggestions, including starting work in Northern countries (Canada and/or Australia) on samples collected in Africa, pending the transfer of technology. Convinced that the technical competence already exists in Africa, TCC chose the option of mobilizing three regional laboratories with public entity status in addition to the MDSC, which would play the "Centre of Reference" role at continental level. These regional laboratories will form a network operating in close scientific collaboration with Northern teams.

29. One of the basic conditions will be the commitment of countries to financially support the labs or Centres of the respective countries. Onchocerciasis control, will, of course be the initial priority, but each regional lab will have to address other diseases. In practical terms, APOC Management, with the assistance of Dr Lazdins, will identify a number of laboratories in Africa, develop a memorandum of understanding, with specifications addressed to Ministries of Health of countries concerned. Following responses to these requests, APOC Management will organise a meeting of the Laboratories, with teams from the North and Dr Lazdins participating. The meeting will, among other things, help to determine the capacity of each laboratory and practical start-up modalities.

30. *TCC recommended that APOC management take all necessary steps to initiate this process.*

Agenda Item 11: Update on Moxidectin.

31. In up-dating TCC members on Moxidectin trial, Dr Lazdins explained that recruitment of all cohorts for the Phase 2 study in Hohoe OCRC, Ghana had been concluded. Based on safety information Phase 3 will be initiated in 4 sites: Rethy, (Ituri Nord district), Butembo (Nord- Kivu Province) in DRC; Bolahun, (North-West County) in Liberia and Hohoe, (Upper Volta Region), in Ghana. Progress on site preparation was reported. The key points were:

(i) Patient recruitment in Rethy and Bolahun will be limited by the launch of CDTI. TCC indicated that there is some possibility for flexibility;

(ii) The need to exclude moxidectin recruited subjects from CDTI. APOC will facilitate this process;

(iii) Access of ivermectin to treat moxidectin screening failures. TCC recommended APOC to facilitate access to ivermectin.

(iv) Preparation of a pediatric study is being initiated. TDR asked TCC for a recommendation on the lower age limit given that the age limit in the pediatric trial will determine the age limit for moxidectin use by control programmes.

32. *TCC recommended an age limit of 4 years for use of moxidectin in onchocerciasis control.*

33. Dr Ladzins also reported progress on the Albendazole effect on Loa loa study in Cameroon. One of the cohorts shows consistent significant diminution of microfilaria in blood. On the question whether Albendazole could reduce Loa loa microfilaremia, TCC was informed that there was proof of principle that the drug could bring down microfilaria load.

34. *TCC recommended that follow-up should continue for 22 and 26 months. TCC also requested that ongoing product research and development activities conducted and sponsored by other groups should be reported to it, while APOC and TDR should propose how to operationalize this request.*

Agenda Item 16: Review of the new format of DEC Patch Test and its operational value for epidemiological evaluation

35. Drs Janis Lazdins and Hans Remme informed TCC that DEC Patch had been developed by LTS Lohmann Therapic System, Germany. Safety and efficacy have been established by Dr K. Awadzi, OCRC Hohoe, Ghana and its effectiveness demonstrated in field studies in endemic areas in Senegal by Dr L. Diawara and Mali by Dr M. Traoré. Now, the product needs to be transitioned into large-scale for epidemiological surveillance in low prevalence areas. The available technical, clinical and field information will be revisited by a TCC sub-committee. TCC noted that the DEC Patch was easier to promote than skin snip in view of HIV/AIDS pandemic. On the procedures for obtaining country approval for the trials, DPCs of Angola, Ghana and DRC, said that their countries did not foresee any problem if the request for patch test came from WHO. The process should go through WHO Country Offices. TCC then set up a sub-committee to look in-depth at available documentations to enable the TCC to offer sound advice to APOC taking into account safety implications. The appropriate national health authorities will then be approached to obtain their approval for large-scale use in surveillance activities.

36. *The sub-committee set up by TCC on the DEC Patch test study, which is chaired by Professor M.S. Traoré, with Profs Homeida and Abiose* as members, *recommended that all relevant documentations should be made available to all TCC Members and the DPCs that attended TCC27. The sub-committee should work by email exchange and circulate a report to TCC Members for adoption by the end of October 2008. TCC Chair will report the recommendations to JAF14.*

Agenda Item 10: Update on operational research – CDI study

37. Dr Remme updated TCC members on the multi-country multi-site CDI study. Interest by WHO/AFRO was highlighted and he also reported that copies of the preliminary results had been distributed, including during the April 2008 PHC conference in Ouagadougou. The need for continued advocacy was stressed and the publication of a French version of the CDI study results and follow-up research should be considered.

Agenda Item 12: Reports on Country visits by TCC members

ETHIOPIA

38. TCC Chair Prof Abiose briefed the session on her visit to Ethiopia June 14-29, 2008. Initial discussions were held with the WHO Country Office, Director of Public Health, the Ministry of Health, NGDO partners and zonal officer in East Wollega. A field visit to East Wollega was undertaken and a one-day workshop conducted for East Wollega, West Wollega, Kellem Wollega and Shoa CDTI Coordinators.

39. Findings included difficulties with reporting, financial returns, translation of IEC material into local languages, inadequate financial support by government, frequency of staff changes and administrative restructuring and division of districts. Debriefing was undertaken in country and a report submitted to APOC management. TCC commended the report and requested copies to enable other visits follow a similar format. APOC management indicated commitment to act on recommendation directed at APOC

40. The two objectives of the mission were to:

1. ***To provide guidance on the implementation of CDTI projects within the context of TCC decision that members adopt APOC countries for mentorship.***

2. ***To assist Ethiopia in preparing its country APOC exit plan***

41. *Recommendations under objective 1 to projects, included adoption of January to December cycle, staff training, monitoring and supervision. There were also recommendations to zonal health authorities on government commitment and ownership, and to NOTF/MoH, for the designation of an oncho national coordinator. Recommendations to APOC related to REMO, sustainability evaluation and Plans, and provision of manuals for CSM.*

42. *On objective 2, the chair informed TCC that a draft Ethiopia exit plan has been drawn up in consultation with MoH and NGDOs. The draft has been submitted to MoH for the budget component, but the process was stalled due to the departure of national coordinator from MoH.*

CAR

43. Dr Kisito Ogoussan informed TCC that his visit to CAR in May 2008 was to provide technical assistance to the national NOTF, especially on drug management. Ten of 16 districts in the post-conflict country are onchocerciasis endemic. CDTI project was re-launched in 2007. Following APOC director's visit, the programme hired a technical adviser and CBM is also providing support. Some of the findings included non-adherence to CDTI strategy and low coverage as a result of insecurity. But the project team appears motivated and a sustainability plan has been drafted. Recommendations to project, MoH, APOC and CBM, included the need for intensified advocacy, more sensitisation and mobilization supervision, integration of oncho into the Primary Health System, need for government financial contribution to CDTI and continued technical/financial assistance by APOC and NDGO partners.

44. Dr Ogoussan also visited DRC for a workshop on SAE following the study on red eye as an early diagnostic sign of neurologic SAE for better management.

45. *TCC recommended that stakeholders should intensify support to the struggling CDTI programme in CAR.*

Agenda Item 13: Task Force on the review of Technical reports Nigeria

46. Dr Elhassan made a presentation on the Technical Review Committee or Task force (TRC) of Nigeria, which met in Calabar, Cross River State from 21-23 July 2008. The TRC reviewed a total of 19 Technical Reports from 19 CDTI projects. Most of the projects were in their 8th year. Presentations were made on the format for the TCC Review of Technical Reports and samples of reports of review of Technical Reports from Ethiopia and Cameroon were used as guide. Of the 19 technical reports reviewed, 17 were accepted and two were rejected. The challenges encountered during the review included late receipt of technical reports by the reviewers, lack of the list of capital equipment donated and distributed to projects and the non-availability of copies of the previous year's reports for reference purposes. APOC financed the TRC meeting and the recommendations by the review committee are listed under review of country technical reports below.

47. *TCC congratulated the Nigerian task force for the results of the review and recommended that* other *countries set up national technical review committees in order to reduce the work load on TCC and APOC management. This will also enhance sustainability and ownership of programmes. The national committees should also look into other health interventions and assist with review of operational research proposals and sustainability plans for CDTI projects. This process should be cascaded, with serving or ex-TCC members assisting countries to kick start the Technical Review. TCC recommended that reports reviewed in-country in February should go to the March TCC sessions whilst reports reviewed in July should go to the September TCC sessions.*

Agenda Item 14: Review of Operational research proposals

General overview

48. APOC management informed TCC that 117 research proposals had been reviewed between 2000 and 2007 and these were classified into 6 main subject areas. Notification to APOC of publication status was incomplete. Final reports of research projects were submitted to APOC on completion of research projects prior to disbursal of the final portion of approved funds.

49. *TCC recommended that the list of operational research projects and their status should be completed and presented to the next TCC meeting. APOC should create a desk to follow through research proposals and their implementation and publication and ensure that findings are disseminated for the benefit of onchocerciasis and other control programmes. The existing mechanism for in-country review of operational research proposals should be strengthened prior to the exit of APOC. A mechanism should be put in place to gradually shift responsibility to NOTF of some countries on the process of reviewing research proposals in conjunction with APOC management and TCC.*

Review of new research proposals submitted to TCC27

50. The proposals presented to TCC included two from Uganda and two from Cameroon with a total budget of US $ 50,645.

51. **Proposals**:

(i) Strategies for sustained high preventive chemotherapy coverage: the role of schools and churches in dissemination of health education messages on the importance of long-term treatment with ivermectin in Uganda (US $ 20,550);
(ii) The impact of compliance with ivermectin treatment on onchocercal skin disease in Nebbi district, Northern Uganda (US $ 9,200);

(iii) Factors affecting persistent non-participation of communities in CDTI in Mbam-et-Kim & Mbam-et-Inoubou in Cameroon Centre Province (US $ 11,260);

(iv) Implications of involvement of women in CDTI in the districts of Mokolo, Koza & Roua in Cameroon far North Province (US $9,635).

CAMEROON

Title*: *Participation of women in community-directed treatment with ivermectin activities (CDTI) in the health districts of Mokolo, Koza and Roua (Extreme North Province, Cameroon.

52. The reviewers noted that this study could provide additional information on the low participation of women in CDTI activities. To make the study profitable, the investigators should:

(i) Concentrate on the first specific objective;
(ii) Take into account the percentage of communities that have no women CDDs;
(iii) Select, preferably, two communities without female CDDs and a community with female CDDs, i.e. three communities per health district;
(iv) Specify the sample size;
(v) Ensure strict and rigorous management of tools;
(vi) Communicate the right message (accurate translation) to the persons being investigated, particularly at the community level;
(vii) Review numbering of paragraphs of the document;

53. *TCC recommends that APOC should finance this operational research.*

***Title*: *Study on factors underlying the persistent non participation of communities in CDTI in Mbam-et-Kim and Mbam-et-Inoubou (Centre Province) of Cameroon*.**

54. The reviewers noted that:

(i) The timeliness of such a project cannot be over-emphasised, given the issue being addressed;
(ii) The subject is well introduced, but the bibliography references are not up-to-date;
(iii) There is lack of specific data on CDTI coverage and non-participation of communicates in the study area;
(iv) The order of presentation needs to be re-arranged (for instance objectives must be presented before results);
(v) The duration of study also needs to be specified;
(vi) Budget must not include honorarium of researchers, only their per diem is covered.

55. *TCC recommended that the proposal should be re-drafted, taking into account the observations by the reviewers.*

UGANDA

***Title*: *Strategies for sustained high Ivermectin treatment coverage: the role of schools and churches in dissemination of health education messages on the importance of long – term treatment with Ivermectin in Uganda. (*Re-submission)**

56. TCC commented that this is an interesting and innovative study that could contribute to improved health education of communities and ultimately sustained compliance with annual treatment. TCC26 had raised several issues that needed to be reviewed for funding consideration.

57. The proposal addresses some of the issues but in the process raised new questions that need to be considered. The following recommendations are suggested to improve the proposal:

- (i) The team should consider an additional objective of *"strengthening the delivery of health education using sustainable community structures;"*
- (ii) Provide additional information on study sites including number of communities, households, children to be interviewed per household, FGDs, coverage data per district (control and intervention), etc;
- (iii) Provide additional information on the methodology i.e. age range of the target classes in the schools and how the teachers and religious leaders will be selected and trained;
- (iv) Provide information on how the health education messages will be delivered by the teachers and the religious leaders;
- (v) Provide information on data processing and management;
- (vi) The team should review the study instruments;
- (vii) FGDs: provide information on participants and review the guide to focus more on the study objectives;
- (viii) Questionnaires: should focus on the objectives of the study i.e. if children have shared the information with other people, how community members got information from, how the information influenced the community uptake of treatment;
- (ix) The researchers should collaborate with the relevant government departments namely health education in MoH and ministry of education who have experience in these areas.

58. *TCC recommended that the proposal be revised and resubmitted to it. The reviewers are willing to render support to the research team.*

***Old title*: The Impact of compliance with ivermectin treatment on onchocerciasis in Nebbi District, Northern Uganda. The revised proposal examines the impact of compliance on onchodermatitis only.**

59. TCC 26 had noted that the study was interesting but too extensive to be carried out as presented and recommended refinement of the study and that it be carried out in two phases.

1. The operational research aspect should examine the impact of compliance on onchodermatitis. The present protocol should be refined to address this specific aspect, taking account of the methodology issues raised and ensuring inclusion of a dermatologist and social scientist as co-investigators. The budget should be revised downwards accordingly and justified. The revised proposal was to be sent to the reviewers.

2. Nebbi District should be included in the larger APOC study on evaluation/surveillance and monitoring of efficacy of ivermectin, using standardized methodology which will be developed before the end of 2008; and be one of the sites where nodulectomy will be carried out. The effect of compliance on microfilaria carrier rate and adult worm fecundity and longevity could be investigated in this context. The Carter Centre should be requested to provide baseline data which will facilitate this.

***New title*: Impact of compliance on onchocercal skin disease in Nebbi District, Northern Uganda**

TCC 27 comments:

60. *Proposal now revised and focuses on impact of compliance with annual ivermectin treatment on onchocercal skin disease. A dermatologist is now involved in the study.*

61. Information has been provided on geographic coverage with ivermectin treatment. The budget has been revised downwards to US$ 9,200.

62. *TCC accepted the revised research proposal with the following amendments:*

- *(i) The classification of skin disease should be standardized as per Murdoch et al methodology used for APOC impact assessment. A manual should be obtained from APOC;*
- *(ii) It is more efficient to carry out community mobilisation and sensitization at the same time as CDD registers are examined to identify different categories of compliers. This would save time and money;*
- *(iii) The individuals should be examined within the community rather than ask them to report at health facilities elsewhere. This would reduce number of refusals and absentees;*
- *(iv) The compliance information to be blind from clinical data to avoid bias;*
- *(v) Researcher to give some clarity on data entry and analysis.*

Agenda Item: 15 Update on Integration of oncho control into health systems and co-implementation of neglected tropical diseases (NTDs) control with some components of malaria

63. Dr Grace Fobi informed TCC that APOC management organised two international meetings on integration and co-implementation for Anglophone, Francophone and Lusophone APOC and ex-OCP countries. The international follow-up meeting which took place in Addis Ababa, Ethiopia in June 2008 was attended by 6 of the 10 Anglophone countries that participated in the first meeting held in Brazzaville, Congo in February 2007. The participating countries - Nigeria, Ghana, Sierra Leone, Tanzania, Uganda and Ethiopia showed evidence of having implemented in one way or another the recommendations of the Brazzaville meeting. Following those recommendations, the majority of countries had put in place management structures for co- implementation, developed strategic plans of action, while some are co-implementing interventions with some flexibility in the use of donor funds. However, there are still challenges with regards to country leadership, development of policy, mapping of diseases, resource allocation, and availability of commodities, community empowerment, inter-country collaboration and political commitment The meeting also noted that the multi-country study on Community-directed interventions (CDI) in Uganda, Cameroon and Nigeria had provided strong evidence for integrated delivery of ivermectin, vitamin A supplementation, home-based management of malaria and long lasting insecticide treated bed nets. The Final communiqué which contains the conclusions and recommendations of the meeting is attached as Annexe 5.

64. *TCC expressed its satisfaction with progress made and recommended that countries intensify efforts on integration and co-implementation using CDI as a powerful tool for the delivery of multiple health interventions.*

MANAGEMENT OF APOC TRUST FUND

Agenda Item 17: Financial management of APOC funded Projects

65. An overview of projects being implemented in 2008 was presented to TCC. A total of US $ 5,878,000 was budgeted for funding 117 projects and other activities in 2008 of which US $ 6,039,158 had been released for 111 national projects. By 13 September 2008, 85% of the APOC global budget (US $ 15,500,000) had been disbursed to support 111 projects, and for technical assistance and other

activities. A standard format for submission of 2009 Plan of Action and Budget (PAB) developed during the July 2008 NOTFs meeting in Addis Ababa was introduced. Issues related to the implementation of the GSM system from July 2008, such as the release of funds and financial transactions are being addressed.

Agenda Item 18: Financial, Administrative & technical review of APOC operations in Nigeria, DRC and Ethiopia

66. Three teams comprising APOC, WHO Country Office and NOCP administrative and finance staff visited 17 projects in Ethiopia, DRC and Ethiopia between May and June 2008. The purpose was to address accounting irregularities and provide training and assistance for improved financial management.

67. The recommendations of the mission were:

(i) NOCP to inform APOC management when a project accountant is reassigned, to ensure the training of the new accountant;
(ii) Training sessions on APOC financial procedures to be organised for project accountants;
(iii) New accountant to be nominated urgently for Bauchi project;
(iv) Zonal officers to be recruited and trained for APOC activities in each zone;
(v) APOC management and DPC/DRC to follow up on the reimbursement of 2007 funds kept by the NOTF Secretariat;
(vi) DPC/DRC to investigate the reasons for the difficulties in getting the funds released to Butembo-beni CDTI project

68. *Following discussions on the situation in DRC, TCC urged the DPC/DRC to assist in recovering the money seized by the national coordinator for Goma-Rutshuru and Butenbo-Beni projects. If the NOTF secretariat still refuses to disburse the amount it should be deducted by the WHO country office.*

REVIEWS

Agenda Item 19: APOC Management review of 1st – 9th year financial reports and subsequent year budgets

69. A total of 111 out of 117 proposals for Letters of Agreement (LoAs) expected in 2008 were received. LoAs for the 111 projects were prepared, signed and returned and funds were released. Nine hundred and two (57%) of the 1586 financial returns expected for 2007-8 were received, of which 385 (43%) were reviewed at country level. APOC HQ had analysed 517 returns by the end of August 2008.

70. Field missions were conducted by APOC in collaboration with WHO country office administrative and financial staff to collect overdue financial returns, and training of some project accountants was undertaken.

Agenda item 20: Review of Country Annual Technical Reports

ETHIOPIA

Agenda Item 20.1: East Wellega CDTI 3rd year

71. The report is poorly written. Some key tables are missing (23-35), while some of the tables in the report have wrong information. The team is using the wrong UTG and therefore it needs to recalculate the treatment coverage.

72. *TCC rejected the report with the following recommendations:*

Report-related

(i) Include TCC25/26 recommendations and respond to them;
(ii) Recalculate the UTG and the treatment coverage;
(iii) Review all the tables and ensure consistency in the data;
(iv) Review the report to ensure that all the sections are addressed – the reviewers were unable to assess some sections of the report due to lack of information, e.g. community self-monitoring, monitoring and evaluation, operations research, etc;
(v) Correct information on report period

Project-related

(i) Establish mechanisms for addressing poor record-keeping and reporting by CDDs;
(ii) Streamline census up-dating;
(iii) Evolve mechanisms to increase the participation of health workers to address the absence of health providers during summer.

Agenda Item: 20.2: West Wellega CDTI project 3rd technical report

73. Very poorly written report of a fairly well-run project fully integrated into the health systems of the country.

74. *TCC rejected the report. It should be re-submitted to next TCC and NOTF to provide in-country support to rewrite as baseline. TCC made the following recommendations for a revised report:*

(i) Indicate period covered by report
(ii) Provide information on partnership
(iii) Provide response to previous TCC recommendations
(iv) Provide adequate background information including the administrative changes and impact on project
(v) Reconcile data in tables 2, 4, 11
(vi) Complete tables 5, 12, 13, 14
(vii) Provide information on integration and the national health extension package workers, who are participating in CDTI.

75. A third year sustainability evaluation is due and should be carried out. This would provide opportunity for more support to project. After this a decision should be taken on division or otherwise of project into Kellem Wollega and West Wollega and how resources will be shared.

Agenda Item 20.3: Gambella CDI project 3rd year

76. This is a revised report following comments by TCC26. The report shows a therapeutic coverage of 83% with a geographic coverage of 100% which should be commended. However, the report has gaps that should be addressed. Although the team was asked to review the report by TCC26, some of the identified gaps have not been filled.

77. *TCC accepted the report with the following recommendations:*

Report-related

(i) Complete Table 13 on financial contributions and ensure consistency with figures in Table 14 (US$ 27.089 released US$23,681.52 spent);
(ii) Provide more detailed information on advocacy and sensitization/mobilization paying attention to the outcomes.

Project-related

(i) Design strategies to address the Dimma sites: refugees' refusal of treatment, low numbers of health providers engaged in the project, low numbers of female CDDs and 15,473 drugs expired are major issues that should be critically looked at;
(ii) Establish mechanisms to increase the proportion of community supervisors because the current levels are quite low (17%);
(iii) Establish mechanisms of improving reporting, documentation and supervision of health workers;
(iv) Identify areas for OR – this could include investigating innovative mechanisms of increasing female participation; factors influencing the programme activities in Dimma, etc;
(v) Ethiopia/Sudan border issue to be taken into account;
(vi) The team should plan to conduct a mid-term sustainability evaluation;
(vii) APOC should release funds in a timely manner to facilitate programme activities.

DRC

Agenda Item 20.4: Status of CDTI projects in DRC

78. APOC management briefed TCC on the performance of CDTI projects in DRC, showing that APOC Trust fund released to projects in the country in 2007 stood at (US$1,919,098), and (US$1,339,533) in 2008. DRC is oncho and Loa loa co-endemic and of the 21 projects in the country, 17 running for less than 4 years are located in difficult terrain. The problem of NOTF secretariat project and the issue of blocked APOC funds generated much discussion. TCC constituted a sub-committee to advice it on the status of CDTI projects in DRC.

General Observations on CDTI projects in DRC

79. The DRC is one of the countries where the APOC programme has been in existence for several years. For 2007, APOC's financial input amounted to US$1 900 000. As was the case during TCC24, the status of CDTI projects in this country gave rise to lengthy discussions during TCC27. The discussions were enriched by the very informative interventions of DPC/DRC, who participated in the session. Apart from questions pertaining to the general situation of the country (communication difficulties, insecurity in some region, delay in imprest returns to APOC, the recurrent problems reported by most of the project coordinators had to do with lack of support to CDDs by communities, and delay in disbursement of funds by APOC and NGDO partners. APOC Management explained the procedures in force, stressing also on the responsibility of the local actors in this unfortunate situation.

80. It came to light that some delayed transfers on the field were attributable to the national coordinator. Lateness in forwarding reports by the countries, and the failure to provide all financial returns could also cause delays in disbursement.

81. The review of reports by TCC members brought to light a number of issues of concern:

(i) Treatment indicators (geographic and therapeutic coverage) are low or average overall;
(ii) Lapses and irregularities attributable to national management team as well as the quality of some field actors and their working conditions;
(iii) Sustainability plans are seldom drawn up;
(iv) Health zones currently not covered due to their oncho-loa loa co-endemicity situation;
(v) High number of SAE cases;
(vi) Large quantity of lost Mectizan tablets;
(vii) High rate of absenteeism;
(viii) Disparity in the technical reports;
(ix) Lack of seriousness in writing some reports (several incorrect and unverified data; contradictory information in report etc.);
(x) Loss/absence of treatment data;

(xi) Lack of records;
(xii) Dearth of information on the use of previous drug stocks in most of the projects;
(xiii) Low participation of women in CDTI activities.

82. Regarding APOC technical support, TCC was informed about the posting of an additional technical adviser to DRC to scale up assistance to the country. A second adviser is to be posted to the interior of the country.

83. ***Seriously concerned by the poor performance of DRC projects, TCC made the following recommendations:***

1 – To the political and administrative authorities of DRC:
- (i) Increase and sustain the financial contribution of the government of DRC to onchocerciasis control activities;
- (ii) Continue efforts at effective integration of CDTI into the national health system;
- (iii) Involve provincial health inspectors in CDTI activities.

2 – To NOTF:
- (i) National coordination should assist field teams;
- (ii) Develop and submit operational research on projects to APOC or other institutions;
- (iii) Establish contact with local universities;
- (iv) Return outstanding money to APOC.

3 – To Project Coordinators:
- (i) Recognise the importance of reporting and improve the quality of reports;
- (ii) Crosscheck and properly analyse data;
- (iii) Improve record-keeping;
- (iv) Intensify supervision activities (namely, supervision of CDDs), as well as Advocacy and mobilisation of partners;
- (v) Increase the participation of women in CDTI activities;
- (vi) All projects to include map and project locations in their reports;
- (vii) Examine the issue of SAEs in order to mitigate their negative impact on community participation in CDTI activities.

4 – To NGDOs:
- (i) Continue efforts in providing material, technical and financial assistance;
- (ii) Assure quality of report endorsed by various partners.

84. TCC noted with satisfaction the contribution of NGDOs, first-line partners in CDTI implementation and follow-up.

5 – To WHO Country office and APOC Management:
- (i) Continue efforts at scaling up the efficiency of all CDTI projects in DRC;
- (ii) Support DRC authorities in training medical officers on CDTI philosophy;
- (iii) Involve doctor/epidemiologists of WHO provincial offices in CDTI implementation and follow-up;
- (iv) Technical allowance to coordinators should be tied to performance in project management.

85. *In addition, TCC highly recommends that APOC Management post two additional Technical Advisors to DRC. This arrangement will improve geographical spread of 3 technical advisors and address the poor project performance acknowledged by all.*

86. *TCC very much appreciates the presence and input by the DPC/DRC at the session, which will positively impact CDTI activities in the field.*

87. *TCC recommends that APOC Management invite a top official of the Ministry of Health of DRC to the next TCC session, which will address issues concerning projects in the country. The participation of this official will be an opportunity to pool efforts for improved project performance.*

Agenda Item 20.5: Katanga-South CDTI Project 1st year technical report (Re-submission)

88. This is a re-submitted report rejected by TCC23.
89. TCC noted all the effort made to address the recommendations and observations that motivated the rejection of the previous report.

90. Main comments:

(i) The executive summary is better presented,
(ii) The report provides key information and the tables are explanatory.

91. *TCC accepted the report and encouraged the project team to persevere in its efforts to improve future reports and consolidate the project.*

Agenda Item 20.6: Katanga-South CDTI 2nd year

92. TCC noted that the TCC25 recommendations had been addressed.

Report-related remarks
(i) Report relatively easy to read;
(ii) Nevertheless there are a few inconsistencies; (i) Geographical coverage is 66% on page10 and 67% on page 25 (ii) General information on partners on page 12 should be more detailed iii) Update census in table 3 (iv) figures in table 5, (v) no information on mobilisation of policy-makers, implications on communities; (vi) verify figures in tables 13 and 14.

Project-related remarks
(i) The mean therapeutic coverage in the 5 health zones treated is 73.2%, indicating good coverage, but it is only 42% in the total project zone;
(ii) The geographical coverage is 100% in 4 health zones and 97% in 1 health zone. It is 66% in the total project zone;
(iii) The increase in the number of female CDDs by 50% is good for improved project performance;
(iv) Inadequate budget is a threat to the project;
(v) Advocacy to Government to increase salaries and incentives should help reduce attrition of health workers.

93. *TCC accepted the report with the following recommendations:*

(i) Intensify advocacy to Government ;
(ii) Organise mop-up sessions to reduce number of absentees;
(iii) Present better estimate of project cost;
(iv) Distribute ivermectin during periods chosen by communities.

Agenda Item 20.7: Katanga-North CDTI Project 2nd year

94. TCC noted that 2 recommendations of TCC26 were addressed: strengthening of advocacy, increase in CDD numbers and their training.

Report-related

(i) Good presentation of executive summary and overall description;
(ii) Overall, the report is well written and easy to read;
(iii) Number of health centres and posts is not indicated;
(iv) There is no indication of the material support obtained following advocacy.

Project-related

(i) No reason why Manono zone was not treated;
(ii) No information on the integration process;
(iii) Following the information given by APOC Management, TCC noted that the delay in disbursement was attributable to the National Coordination;
(iv) Monitoring and evaluation were not conducted;
(v) The project had no supervision from the national coordination.

95. *TCC accepted the report with the following recommendations:*

(i) Give further information on outcome of mobilisation efforts;
(ii) Specify what "parcelles" means, with respect to the ratio of CDDs. It is requested that this ratio be expressed in relation to the population (ex. 1 CDD:120 persons);
(iii) Continue advocacy in order to bring down the rate of absenteeism, and raise geographic and therapeutic coverage;
(iv) Take the necessary steps to draw up a sustainability plan;
(v) Continue efforts at integrating and co-implementing with other existing projects in the region.

Agenda Item 20.8: Bandundu CDTI Project 4th year (Re-submission)

96. The report shows that previous recommendations of TCC have been addressed. TCC notes that the project has for the first time reached100% geographic coverage and has a supervisor in each community. TCC also noted the great efforts made by the project to co-implement CDTI with vitamin A and Mebendazole distribution. The report has treatment data for the two interventions and TCC encourages the project to continue in this direction. TCC notes the challenges encountered in the co-implementation effort. In future, details of this co-implementation should be included in the report so that lessons can be learnt.

97. Observations:

(i) The table on advocacy is similar to that in the previous report; More information is needed since this might give the impression that advocacy has no effect;
(ii) Train CDDs in the whole health zone;
(iii) Sustainability plans submitted in 2007 are presented only in a few lines. More information should be included in the next report.

98. *TCC accepted this revised report and recommended that the next report to TCC should take into consideration the following:*

(i) Avoid copy and paste;
(ii) Give details on differences observed between high and low therapeutic coverage in the health zones;
(iii) Give more information in the table on advocacy;
(iv) Undertake sensitization/advocacy to reduce late disbursement of funds and provision of Vitamin A and Mebendazole;
(v) Give details on the sustainability plan
(vi) Undertake CSM in more villages.

Agenda Item 20.9: Kasongo CDTI 1st year

99. The report is generally well written.

100. *TCC accepted the report with the following recommendations:*

Report-related

- (i) The executive summary should be in prose,
- (ii) Complete tables with the relevant information and comment on them,
- (iii) Explain the use of US$21,294 under item "others",
- (iv) Include project months on the top of the report.

Project-related

- (i) The project has to carry out its first treatment;
- (ii) Continue to mobilize and sensitize women group to embrace CDTI;
- (iii) Intensify advocacy with administrative and political leaders for support of the project;
- (iv) Train/recycle health personnel at all levels;
- (v) Sensitize communities and their leaders to select CDDs for training.

Agenda Item 20.10: Kasongo CDTI Project 2nd year

101. Kasongo CDTI project is located in oncho and loa-loa co-endemic area. This is the second year technical report of CDTI implementation corresponding to the first year of ivermectin mass distribution in only 1 out of 8 health zones of the project area, namely Kasongo health zone. A total of 363 out of 1,621 communities and 99,646 out of 929,985 people in the project area were treated, representing a geographical and therapeutic coverage of 22.4 % and 10.7 % respectively. Five SAE cases recorded were well managed and without fatality.

102. *TCC accepted the report and recommended that:*

- (i) Project should avoid including tables in the executive summary,
- (ii) Project should increase geographic and therapeutic coverage figures.

Agenda item 20.11: Mongala CDTI project 2nd year

103. The report contains the necessary information for assessing its performance. However, in the future, those who endorse the report are requested to thoroughly read the report before endorsement.

104. Ivermectin mass distribution was conducted in only 2 out of 8 health zones in the project area. There is the need to improve the geographical coverage. The involvement of women was low, and there were a number of absentees in the Lolo health zone without any explanation.

105. *TCC accepted the report with the following recommendations:*

- (i) Those who endorse the report to effectively read it prior to submission;
- (ii) Improve the geographical coverage of the project;
- (iii) Involve women in the CDTI process;
- (iv) Increase sensitisation and IEC activities to reduce the number of absentees and refusals;
- (v) Address the issues of CDDs incentives by the communities, and the involvement of women in CSM activities.

Agenda Item 20.12: Mongala CDTI Project 3rd year

106. The report is well-written, although certain sections are too elaborate. No reason was given on why the four districts did not benefit from CDTI activities. Treatment indicators are still weak.

107. *TCC accepted the report with the following recommendations:*

(i) Present executive summary in narrative form,
(ii) Clarify the response of communities to sensitisation,
(iii) Explain why districts were not treated,
(iv) Continue sensitisation activities to reduce the rate of refusals and absentees,
(v) Scale up training and advocacy in the other districts,
(vi) Conduct CSM activities,
(vii) Prepare sustainability and evaluation plans.

108. The review of the two reports of the Mongala project shows that, out of the eight health zones, two (Bongandanga and Boso Modanda) had treatment (2006 and 2007), 4 (Pimu, Bosondjo, Lolo, Yamongili) had 1 treatment in 2006, 2 (Bumba and Binga) had 1 treatment in 2007.

109. *TCC recommended that this inconsistency in treatment of zones should be avoided. If it is not possible to treat all areas on a regular basis, it is better to concentrate on some sites that will be treated with efficacy, in line with the CDTI philosophy.*

Agenda Item: 20.13: Bas-Congo CDTI project 3rd year

110. The report is well written and has responded to the TCC 25 recommendation. A high number (83.3%) of qualified health workers engaged in CDTI. No SAEs recorded and a low attrition rate of CDDs. However, for a project in its 4th (3rd of treatment) year, the therapeutic coverage of 48.4% is low (Zeke Banza has 35.8% geographical and 9.7% therapeutic coverage). Unexplained variation in communities and populations involved (Tab. 9 page 28), and high refusal/absenteeism rates. Nothing is said about integration, M&E or sustainability plan. There was also no mention of co-endemicity.

Suggestions for improving the report

(i) Complete table 2 and provide footnotes to explain variations in communities and populations in table 9;
(ii) Provide information on M&E, sustainability plan and integration in the appropriate sections of the report;
(iii) Pay attention to zones with low therapeutic and geographic coverage;
(iv) Provide number of bicycles purchased in table 14 and complete table 12;
(v) Include Mectizan surpluses in table 10 for better drug inventory;
(vi) Complete table of acronyms (ESPM, PDM).

Suggestions for improving project implementation

(i) Take stock of available Mectizan before ordering the next consignment to avoid large quantities of left-overs after distribution;
(ii) Intensify sensitization of the communities and their leaders so as to reduce refusals/absentees;
(iii) Explain use of US$42,328 classified under item “Others”;
(iv) Intensify sensitization on CSM and institute SHM in the villages;
(v) Sensitize women to be more involved in CDTI;
(vi) Carry out monitoring;
(vii) Draw up sustainability plan;
(viii) Provide information on integration in 14 zones.

Agenda Item 20.14: Butembo-Beni CDTI Project 1st year

111. This first year project had little to report citing lack of funding to implement activities.
The report covers the May-December 2007 period, during which only advocacy was carried out to some personalities. Although APOC released funds to this project, and ivermectin was available, project performance did not match the level of funds made available.

112. *TCC accepted the report, given the peculiar situation of the country and urged the project to begin ivermectin treatment without delay.*

Agenda Item 20.15: Equateur-Kiri CDTI Project 3rd year

113. TCC *strongly deplores the foul language addressed to APOC Management in this report (pages 9, 16 and 37). Discourteous language should never be addressed to the management of an institution.*

114. Reviewers' observations:

Report Related

- (i) Last TCC recommendations were not satisfactorily addressed;
- (ii) Essential data are incorporated in the executive summary;
- (iii) Total number of health personnel is still lacking so it is difficult to estimate the proportion of health staff involved in CDTI;
- (iv) The population figures have enormously increased;
- (v) Number of communities with local supervisors could not be determined;
- (vi) Good performance of annual training objectives.

Project-related comments

- (i) The number of health staff involved in CDTI is decreasing compared to the previous year (198 against 255);
- (ii) One of the consequences of advocacy was the establishment of free of charge management of SAEs at the health centres which is a good step;
- (iii) 84 % of the communities have female CDDs;
- (iv) The ratio of CDD/population ranges from 1/280 to 1/190;
- (v) The geographical coverage is around 50 % and the therapeutic coverage is low (26.6 %);
- (vi) The number of refusals and absentees are high, 14,485 and 17,837 respectively;
- (vii) The number of left-over tablets is very high: 1,094,000;
- (viii) CSM was not conducted;
- (ix) Sustainability plan was not mentioned;
- (x) Integration procedures were not explained;
- (xi) Improve rates of therapeutic coverage;
- (xii) Complete tables 1 and 10;
- (xiii) Prepare sustainability plan;
- (xiv) Conduct supervision and more evaluation activities;
- (xv) Take steps to avoid large amount of left-over tablets.

115. *TCC rejected the report. It should be re-submitted and in proper language.*

Agenda Item 20.16: Ituri CDTI project 1st year

116. The report was endorsed. The executive summary is quite concise and reflected the information in the report although it was not written in prose and contains tables. There is no information on the presence or absence of Loa loa in the project area. Treatment was not carried out.

117. *TCC accepted the report with the following recommendations:*

Report-related

- (i) Complete list of acronyms to facilitate reading,
- (ii) Complete all tables with relevant information,
- (iii) Explain activities on which US$10,415 were spent,
- (iv) Include figures on village in the project area.

Project-related

(i) Carry out first Mectizan distribution,
(ii) Mobilize funds for CDTI activities,
(iii) Carry out training at all levels and in all aspects.

Agenda Item 20.17: Lualaba CDTI Project 3rd year

118. The project has achieved good geographic and therapeutic coverage, but the report contains several inaccurate data, particularly figures in the summary and in tables 7 and 10. There was inadequate involvement of women and the large quantity of left-over tablets was not explained.

119. *TCC accepted the report, and recommended that it be sent to APOC Management after correcting summary and tables 7 and 10.*

Agenda Item 20.18: Lubutu CDTI Project 1st year

120. The project did not conduct mass treatment for lack of finance.

121. *TCC accepted the report with the following recommendations:*

(i) Launch drug distribution in 2008;
(ii) Use media for community mobilisation/sensitisation;
(iii) Contact NGDO network for partnership through APOC and Responsible Officer of the NGDO Coordination Group;
(iv) Open line of communication with APOC on fund release.

Agenda Item 20.19: DRC NOTF/HQ 8th year

122**.** The report has addressed TCC25 recommendations and the summary is more detailed than previous ones, although some sections are still not in conformity with the body of the report. Therapeutic coverage increased in 13 out of 15 projects (except Bas Congo, Kasai, Mongala). Rates remain low, though, even in projects of over three years. Weaknesses observed included: discrepancy in some data, 8 deaths, and outcome of advocacy is not reported. Incomplete tables 4 and 12, information on CSM/SHM either incorrect or unavailable, only 2 out of 20 projects carried out CSM. No explanation for other expenditure in table 13 amounting to $US20990 (24% of the budget), results of operational research are not provided on p36, strengths and weaknesses, challenges and opportunities are virtually the same as in 2006, No 2009 Plan of Action.

123. ***TCC accepts the report subject to the NOTF Secretariat's revising it and sending it to reviewers before it goes to APOC.***

NOTF should:

(i) Re-read the document to ensure that all sections have been completed,
(ii) Check and complete the tables in order to harmonize data in the whole document,
(iii) Provide precise and detailed financial situation of each project by correctly filling in table 12,
(iv) Conduct a SWOT analysis in order to highlight key 2007 issues,
(v) Provide the 2009 plan of action prior to financing of the activities.

Agenda Item 20.20: Kasai CDTI project 6th year

124. This is a well written report which touched all aspects of CDTI implementation including add-ons and operational research. The project is commended for reaching 99.7% geographical and 68.3% therapeutic coverage in a vast area of 8,020 villages, with >4.5 million people treated, although these figures are below those expected from a mature project of this nature.

125. *TCC accepted the report with the following recommendations:*

Report-related

(i) State project cost recovery in page 13,
(ii) Explain change in population figures.

Project-related

(i) Shorten treatment duration (presently 5 months),
(ii) Pay advocacy visits to the government authorities and NGDO to obtain equipment for CDTI,
(iii) Improve geographical and therapeutic coverage.

Agenda Item 20.20A: Rutshuru/Goma CDTI project 2nd year

126. The report is endorsed and presented according to the TCC recommended format. Report is written in simple language.

Recommendations to improve the report

(i) Include remarks on the tables presented in the summary;
(ii) Propose solutions to problems identified during supervision;
(iii) The number of health workers in the health zone and number of health workers in the project are the same as in 2006;
(iv) No indication on the quality and quantity of human resource necessary for project implementation;
(v) Explain the drop in the number of communities from 623 in 2006 to 617 in 2007;
(vi) In 2006, the authorities made a verbal commitment to support CDTI; Was there no action in 2007?
(vii) Therapeutic coverage is 45.7%, in 2007 compared to 41% in 2006;
(viii) The number of persons treated dropped from 784 in 2006 to 684 in 2007;
(ix) The male/female CDD ratio is 2:9 as against 4:7 in 2006;
(x) The acceptance of Mectizan by the people, assurance of financing by APOC and CBM and the absence of SAEs should allow for increased geographic and therapeutic coverage rates;
(xi) Carry out sensitisation and mobilisation to further reduce the number of refusals and absentees;
(xii) Train more CDDs to further lighten their workload;
(xiii) Encourage more women to participate in health education meetings, and take active part in CDTI activities, through sensitisation of communities with a view to bridging the inequality gap between the two sexes;
(xiv) Take measures to conduct trainer of trainers in CSM and SHM so as to apply these in the communities;
(xv) Develop data collection tools to quickly replace those which were looted ;
(xvi) Improve the form of the next report, taking into account the remarks made about the report;
(xvii) Draw up a sustainability plan.

127. *TCC accepted the report with the observations and recommendations above.*

Agenda Item 20.21: Sankuru (DRC) CDTI project 4th year

128. This project is commended for the dramatic increase in the number of people treated with Mectizan in 2007 compared to 2006. The project achieved 72% therapeutic coverage and 98% geographic coverage. The project is encouraged to reach 100% geographic coverage in year 5 and to strive for ultimate treatment goal (UTG) of nearly 689,000 people, while paying close attention to training and sensitization in the Loa loa-endemic health Zones.

129. *TCC accepted the report subject to its revision and return to reviewers after addressing the following issues:*

Report-related

(i) Executive Summary should provide more information on programme activities such as mobilization, training, supervision, etc.
(ii) Figures for the UTG, number of people treated in 2007, number of CDDs in 2007 and total population in the meso-/hyper-endemic areas were inconsistent throughout the report;
(iii) The project should review all data in the report and provide correct figures in tables 2, 7,9,10, 13 and 14;
(iv) The outcome of advocacy and sensitization should be included in the report;
(v) Information on SAEs should be provided;
(vi) The project should use up-to-date reporting format.

Project-related

(i) The project should intensify efforts to involve more women in CDTI;
(ii) Many of the equipment items in the project area (vehicle, computers, printers, etc.) are reported to be non-functional. How is the project functioning under these circumstances?
(iii) The project should discuss the release of funds with APOC management so that a solution can be found.

Agenda Item 20:22 Tshopo CDTI Project 4th year

130. Recommendations of TCC26 were addressed in this report, which is well written. The project is in an Oncho-loa loa co-endemic area, with high risks of SAE, hence the exclusion of 4 of the 19 health zones from treatment. The project took off in 2003 but was interrupted for two years (2004 and 2005) following high SAE fatality. Though progress has been made in geographic coverage (from 28% in 2003 to 69% in 2007) and therapeutic coverage (from 13% in 2003 to 37% in 2007), these rates remain low. Women's participation in CDTI activities is also very low; the same goes for the participation of health personnel. Numbers of SAE cases and deaths are high. The project conducted operational research and TCC encourages it to continue with data analysis and to include the results in the next report.

131**.** *TCC accepts report with the following recommendations:*

(i) Review table 13;
(ii) Continue efforts to improve geographic and therapeutic coverage, and also cover the remaining 4 health zones;
(iii) Scale up the participation of health personnel and women in CDTI activities;
(iv) Make efforts to enhance sensitisation and mobilisation to reduce the number of refusals and absentees;
(v) Improve management of SAEs so as to limit mortality;
(vi) Carry out evaluation of sustainability.

Agenda Item 20.23: Tshuapa CDTI Project 3rd year

132. Project is in its 3rd year in an Oncho-loa loa co-endemic area. Activities were carried out in only 2 out of the 12 health zones. Therapeutic and geographic coverage rates were very low - 24% and 13 % respectively in 2 zones.

133. *TCC accepted the report with the recommendations below.*

Report-related recommendations

(i) Adhere to technical reporting format and ensure that report is signed/endorsed;
(ii) Include information on mobilisation and sensitisation in executive summary;
(iii) Include data on health personnel of all the health zones in table 1;
(iv) Complete tables 2 and 9 according to the format recommended in the technical reporting form.

Project-related

(i) Project should be encouraged to extend CDTI to the excluded health zones;
(ii) Calculate and indicate the UTG in the relevant tables - this is an important performance indicator;
(iii) Improve CDD/population ratio to 1:100;
(iv) Encourage the participation of women;
(v) Explain why the project, in its 3rd year, has been slow in covering the 12 health zones;
(vi) Explain why there was no distribution in the Befale health zone in 2007, whereas distribution took place the previous year;
(vii) Explain how the project operates with a number of non-operational equipment;
(viii) Communicate with APOC on release of funds;
(ix) Meso and hyper-endemic areas should be clearly identified;
(x) Confirm that the 2 districts treated were the same treated previously.

Agenda Item 20.24: Ubangi-North CDTI project 3rd year

134. TCC25 recommendations were addressed.

135. *TCC accepted the report with the following recommendations:*

Report-related

(i) The report is well written and easy to read;
(ii) Avoid repetition in page 9;
(iii) Revisit the Mobayi health zone (2006 and 2007) where the number of communities to be treated increased, whereas the total population dropped by about 7,000;
(iv) Harmonize total population (page 11: 664 217) and page 49: 644 217);
(v) Indicate the response of communities to mobilisation/sensitisation sessions, and suggest improvement;
(vi) Give detailed information on SAEs.

Project-related

(i) The project recorded an increase in geographic and therapeutic coverage, but the rates are still low. There is room for improving coverage through sensitisation to dispel rumours about SAEs following ivermectin treatment;
(ii) SAEs are well managed, especially by CDDs, who referred patients to the appropriate health facilities;
(iii) Project should extend treatment to all communities in meso and hyper-endemic areas, while monitoring SAEs and sequelaes;
(iv) Conduct CSM and SHM in villages;
(v) CDTI is being integrated into PHC, but the process is slow; there is need for acceleration;
(vi) Time lapse between census/mobilisation and treatment needs to be reduced;
(vii) Project is nearing its fourth year, so it is encouraged to envision a sustainability plan.

Agenda Item 20.25: Ubangi-South CDTI project 3rd year

136. The project is in its 2nd year of mass Mectizan distribution, though it started three years ago.

137. *TCC accepted the report with the following recommendation:*

(i) Avoid putting tables in the executive summary;
(ii) Indicate the cost of treatment per individual treated in the executive summary;
(iii) Give clear information on integration of Vitamin A, de-worming and ITN activities in project area;
(iv) Carry out intensive advocacy to authorities for increased disbursement of funds by the Ministry of Health.

Agenda Item 20.26: Uele CDTI project 5th year

138**.** TCC24 recommendations were addressed in this report, which is well-written with precise information and details. Geographic coverage was 100% and therapeutic coverage was stable at 75%. A sustainability plan was drawn up. However, treatment data are inconsistent, especially in the unstable areas. Community participation in CDTI activities was inadequate.
139. *TCC accepted the report with the recommendations below. The report should be sent to APOC after corrections to table 10 and page 27.*

Report-related
(i) Review calculation in Table 10 and clarify data on treatment. It was mentioned in the report on page 28 that data was available only for 2498 communities, following the loss of data for 37 villages. Yet, data in table 10 relate to 2535 communities;
(ii) Justify expenditure made from funds provided by the Ministry of Health in Tables 16 and 17.

Project-related
(i) Increase the number of health personnel involved in CDTI, and community participation in CDTI supervision;
(ii) Intensify sensitisation and mobilisation to reduce the number of refusals and absentees;
(iii) Encourage participation of more women in CDTI activities;
(iv) Stop de-worming children under one year old.

TANZANIA

Agenda Item: 20.27: Kilosa CDTI 6th year

140. Reviewers of this 6th year project noted that:

(i) Therapeutic coverage of 75.5% and 100% Geographical coverage are encouraging;
(ii) Male/female CDD ratio is 1:1;
(iii) Sustainability is threatened by:
- Problems of release of funds by the district,
- Frequent transfer of health workers,
- Heavy work load on CDDs (1 CDD per 219 people.

141. *TCC accepted the report with the following recommendations:*

(i) Improve CDD/population ratio;
(ii) Encourage district councils to release funds for CDTI activities;
(iii) Train all health workers in district in CDTI to overcome the challenge of trained health workers to non-CDTI areas. APOC is willing to finance this activity if the project prepares the budget;
(iv) Reduce the numbers of absentees and refusals;
(v) Document coverage in urban areas

Agenda Item: 20.28: Morogoro CDTI 3rd year re-submission

142. The project has provided a concise and well-written report describing a year of successfully implemented CDTI. The project is commended for reaching 100% geographical coverage, including in new communities that were added to the project area after completion of REMO. Therapeutic coverage has been 75% for the last two years. The project is encouraged to make efforts to reach the UTG in the next treatment cycle.

143. *TCC accepted the report with the following recommendations.*

Report-related

- (i) In future reports, the project should provide information on the outcomes of advocacy;
- (ii) On supervision (Section 2.9), many of the responses were the same as those given in Year 2 report. Is the situation the same?
- (iii) The type of community support for CDTI was not explained in Section 3.3;
- (iv) Many of the strengths, weaknesses, challenges, and opportunities provided in this report were the same as in Year 2 report. Is the situation the same?

Project-related

- (i) The project is commended for having strategies for reaching women and minorities and is encouraged to develop additional strategies for reducing absentees and refusals;
- (ii) The project trained only 50% of the health centre staff planned for Year 3. Can the project explain why the ATO was not reached? When will the remaining health centre staff be trained?
- (iii) The number of refusals in 2007 was exactly the same as in the Year 2 report. Are the figures the same?
- (iv) The project should begin to plan for cessation of APOC funding for the provision of equipment and equipment maintenance.

CAR

Agenda Item 20.29: Central African Republic (CAR) CDTI Project 6th year

144. The project is implemented in a post-conflict context. In spite of the loss of all documentation, project staff still show the willingness to re-launch activities with success.

145. *TCC recommends that the report be resubmitted to reviewers with the following recommendations:*

- (i) Send report to NGDO partner for endorsement;
- (ii) Validate census data for reliability;
- (iii) Involve communities in the CDD and supervisor selection process;
- (iv) Improve the participation of women as CDDs and supervisors, and raise percentage;
- (v) Include religious and traditional authorities as target in future advocacy efforts, and ensure increase in fund disbursement of the Health Ministry;
- (vi) Address reasons for refusals, absenteeism and problems identified during supervision, in order to raise therapeutic coverage;
- (vii) Establish a plan of action with a view to achieving a 100% geographic coverage in 2009 and not in 2011;
- (viii) Use the UTG of 0.84 instead of 0.8;
- (ix) Increase the number of supervisors from communities receiving treatment;
- (x) Always set success indicators, such as ATO prior to implementing activities (vital for assessing performance) and make mention of them in technical report;
- (xi) Improve CDD/population ratio to 1:100;
- (xii) Pay particular attention to tables;
- (xiii) Review drug inventory;
- (xiv) Correct tables (Tables 2, 3, 5, 6 (indicate ATO and 11);
- (xv) Have CBM endorse report before submitting it to reviewers.

NIGERIA

146. As noted under **Agenda Item 14** above, the national Task force (TRC) on the review of in-country annual technical reports of Nigeria reviewed 19 projects, most of which were in their 8th year and above.

147. The TRC rejected two of the reports and accepted 17, with the following recommendations:

Kebbi CDTI Project

148. Reviewers' comments:

Report-related
- (i) Coordinators should go through the checklist and address all recommendations.

Project-related
- (i) Institute effective leadership of project,
- (ii) Improve quality of implementation,
- (iii) Increase number of female CDDs,
- (iv) Increase CDD/Population ratio,
- (v) Ensure effective sensitization to attract incentives and forestall attrition,
- (vi) Conduct Training on management of SAEs,
- (vii) Increase number of health staff involved in CDTI,
- (viii) Guard against huge losses of tablets,
- (ix) Repair broken down vehicles and procure a new vehicle,
- (x) Conduct monitoring and evaluation,
- (xi) Prepare, and commence implementation of sustainability plan.

149. *TCC rejected the report and recommended that it be re-submitted to TRC*

Kaduna CDTI Project

150. Reviewers' comments:

Report-related
- (i) A lot of ground covered but not reflected in Summary,
- (ii) Include Mectizan request and procurement.

Project-related
- (i) Improve on funding by Government at all levels,
- (ii) Update census,
- (iii) Prevent huge loss of tablets in future,
- (iv) Conduct CSM and SHM

151. *TCC accepted the report and endorsed the recommendations.*

Kano CDTI Project

152. Reviewers' comments:

Report-related
- (i) Train state officer charged with the responsibility of writing report on the use of excel software programme in doing the computation. Many of the errors detected were from quantitative aspects of the report;
- (ii) Indicate cost of treatment per person;
- (iii) Show the percentage of attrition i.e. number of CDDs that dropped out, divided by total number of CDDs in that year.

Project-related

(i) Conduct operational research on the use of the hamlet (‘zuriya’ in Hausa) system among the Hausa;
(ii) Introduce the zuriya system in the recruitment and training of CDDs. The hamlet system is a system in which each lineage (hamlet) selects its own CDD from among its own people. Since the CDD is serving his/her people the issue of incentive would not arise again;
(iii) Married women who have completed primary school should be recruited as CDDs based on the zuriya system;
(iv) CDDs’ to update census. The old census figures are being used and this gives high UTG;
(v) Avoid long duration of treatment;
(vi) Treatment should be carried out during the dry season (preferably March to May). This means training should be done before March;
(vii) Use available funds (there is enough funding from partners) for training of CDDs;
(viii) Resolve some of the weaknesses listed in Section 5 of the report.

153. *TCC accepted the report along with the reviewers’ recommendations*

Jigawa CDTI Project

154. The report was well-written.

Project-related recommendations

(i) Improve number of health staff in project area involved in CDTI,
(ii) Shorten duration of distribution and supervision,
(iii) Improve CDD population ratio to 1:100,
(iv) Devolve ordering and delivery of Mectizan tablets to the state for sustainability,
(v) NOTF should support the state in intensifying advocacy to policy-makers at all levels,
(vi) Intensify human resource development in CDTI in the project area,
(vii) APOC should provide project with special initiative funds.

155. *TCC accepted the report with the recommendations above.*

Osun CDTI Project

156. Reviewers’ comments:

Report-related

(i) In future accurate population figures should be used,
(ii) Errors detected in table 13 should be corrected,
(iii) Calculate and present the cost of treatment per person,
(iv) Provide information on attrition rate.

157. In future, TCC recommendations should be stated with their implementation clearly indicated.

Project-related

(i) Conduct operational research on the use of the hamlet system among the Yoruba;
(ii) Introduce the use of hamlet lineage system in selection of CDDs;
(iii) Improve on female/male CDD ratio in Ife Central, Isokan, Iwo, Obokun, and Orolu districts/LGAs.

158. *TCC accepted the report along with the reviewers’ recommendations*

Plateau CDTI Project

159. Reviewers' recommendations:

(i) State Government should provide counterpart funding,
(ii) Train more health staff for CDTI project area,
(iii) Train more female CDDs for the area,
(iv) Conduct CSM and SHM training in all CDTI communities,
(v) Endeavour to maintain current good treatment coverage,
(vi) State should take over request and procurement of Mectizan,
(vii) Track absentees to reduce high number of absentees,
(viii) Conduct monitoring and evaluation.

160. *TCC accepted the report with the recommendations.*

Anambra CDTI Project

161. Reviewers' recommendations:

(i) Conduct operational research to address gaps in project implementation,
(ii) Select and train more CDDs,
(iii) Intensify advocacy visits to policy makers for release of counterpart funds,
(iv) Need to calculate cost per treatment.

162. *TCC accepted the report with the recommendations*

Oyo CDTI project

163. Reviewers' recommendations:

Report-related

(i) Provide ratio of male: female CDDs per population,
(ii) Provide cost per treatment,
(iii) Implement recommendations from TCC,
(iv) Explain timing of activities,
(v) Justify use of funds when CDTI is carried out with other activities,
(vi) Provide number of CDDs by gender,
(vii) Finalize sustainability plan,
(viii) Sort out mix-up in number of health staff trained.

Project-related

(i) Train more CDDs,
(ii) Increase number of female CDDs,
(iii) Increase number of health staff involved in CDTI.

164. *TCC accepted the report along with reviewers' recommendations*

Ondo CDTI Project

165. The project has performed well and the report is well-written.

Recommendations for improvement

(i) Conduct operational research,
(ii) Ensure that CSM and SHM are carried out,
(iii) Calculate cost per treatment,
(iv) Produce and use IEC materials to aid sensitization.

166. *TCC accepted the report with the recommendations*

Niger CDTI Project

167. Reviewers' comments:

Report-related recommendations

(i) Ensure brevity in reporting.

Project-related

(i) Ensure integration of CDTI activities into PHC (planning, training, HSAM, drug delivery, M&E);
(ii) Ensure timely commencement of CDTI activities;
(iii) Improve number of health staff in project area involved in CDTI;
(iv) Ensure mobilization and training in Kontagora, Mushegu, Lapai, Mokwa, Rafi, Lavun and Shiroro LGAs and intensify health education and mobilization in other LGAs;
(v) Increase CDD population ratio to 1:100;
(vi) Improve distribution and management of Mectizan® tablets;
(vii) Improve monitoring and supervision;
(viii) Improve low geographic coverage in Rijau, Lapai (51%), Mokwa, Wushishi (73%), Borgu (62%), Lavun, Bosso (71%) and Gurara LGAs;
(ix) Improve therapeutic coverage in Lapai (42%), Wushishsi (55%), Borgu (51%), Munya (69%) and Bosso (49%) LGAs;
(x) Ensure treatment of all endemic communities in Mushegu LGA;
(xi) Address cross-border issues with Benin Republic. It is insufficient to carry out monitoring and supervision without ensuring implementation of recommendations;
(xii) Partners should adequately support core CDTI activities;
(xiii) NOTF should carry out high-powered advocacy visit to State and LGAs;
(xiv) NOTF should use the state administrative health zones to revamp CDTI implementation;
(xv) APOC should support high-level advocacy workshop for policy makers for state and LGAs and provide logistic support commensurate to endemicity, enormity and magnitude of need in this eighth year project.

168. *TCC accepted the report with the recommendations.*

Imo CDTI Project

169. Reviewers' comments:

Report-related recommendations

(i) Use accurate population figures;
(ii) Improve on quality of executive summary…make it concise, consistent and comprehensive;
(iii) Provide cost of treatment per person.

Project-related

(i) Use information from operational research report by Dr. Emukah on the use of the hamlet (umunna) system among the Ibo to improve on selection and training of CDDS; The hamlet system is a system in which each lineage (umunna = Igbo word for patri-lineal hamlet) selects its own CDD from among its own people. Since the CDD is serving his/her people the issue of incentive would not arise. The number of CDDs would increase and reduce the work load ;
(ii) Repair broken-down equipment;
(iii) Maintain the present gender balance in CDD, ensuring that female CDDs do not far exceed male CDDs.

170. *TCC accepted the report along with the reviewers' recommendations.*

Edo CDTI project

171. Reviewers' comments:

Reported-related recommendations

- (i) Correct UTG,
- (ii) Clarify disparity in number of CDDs trained in sections 2.4 and 2.5.

Project-related

- (i) Improve on training of health staff and CDDs,
- (ii) Ensure timely release of funding by State and LGAs for maintenance of motorbikes to support CDTI activities;
- (iii) Ensure adequate health education and mobilization of communities;
- (iv) Update census;
- (v) Improve CDD: population ratio;
- (vi) Check sufficiency of drugs requested and drug inventory;
- (vii) Improve therapeutic coverage in Akoko Edo, Etsako West, Igueben, Ovia Northeast and Owan West LGAs;
- (viii) Identify NGOs and CBOs active in the state within and outside the health sector to support CDTI;
- (ix) Ensure implementation of CSM and SHM in all communities;
- (x) Continue implementation of the recommendations of the sustainability evaluation and internal monitoring;
- (xi) Conduct operational research;
- (xii) Improve on general CDTI implementation.

172. This is an old project that needs to ensure consistent therapeutic and geographic coverage. State and LGA Government partners released $48,670, which should have enabled the project to improve on the recommendations of the previous TCC meeting.

- (i) APOC, NOCP and NGDO should support advocacy visit to state policy-makers.

173. *TCC accepted the report with the recommendations*

Nassarawa CDTI Project

174. The project was well reported and has shown improvement in therapeutic and geographical coverage.

Reviewers' recommendations:

- (i) More CDDs should be trained, and more health staff involved in the project;
- (ii) Efforts should also be intensified on the conduct of CSM and SHM;
- (iii) Sustainability plan should be implemented;
- (iv) Need to calculate cost per treatment;
- (v) Monitoring and Evaluation should be conducted;
- (vi) Generate operations research.

175. *TCC accepted the report with the above recommendations*

Benue CDTI Project

176. A well-written report, reflecting good performance by the project, particularly coverage.

Reviewers' report-related recommendations

- (i) Address recommendations by last TCC,
- (ii) Implement CSM and SHM,
- (iii) Provide census update.

Project-related

(i) Increase number of health staff involved in CDTI,
(ii) Train more CDDs to improve the present ratio of 1:531.86,
(iii) Track attrition of CDDs,
(iv) Conduct CSM and SHM,
(v) Replace broken down equipment,
(vi) Produce sustainability plan,
(vii) Intensify integration.

177. *TCC accepted the report along with the reviewers' recommendations.*

Gombe CDTI Project

178**.** Reviewers' comments:

Report-related recommendation

(i) Provide missing figures - ratios and cost per treatment

Project-related:

(i) Increase number of trained health workers and female CDDs,
(ii) Carry out operational research on Attrition,
(iii) Intensify supervision

179**.** *TCC accepted the report and endorsed the reviewers' recommendations.*

Taraba CDTI Project

180. A good report with a lot of grounds covered.

Report-related recommendations for improvement

(i) Provide cost of treatment per person treated,
(ii) Provide information on attrition rate,
(iii) Effect correction in Tables 4, 7 and 10.

Project-related

(i) Obtain adequate counterpart funding from MoH and State,
(ii) Train more CDTI health staff,
(iii) Recruit and train more female CDDs,
(iv) State should take over request and procurement of Mectizan,
(v) Address refusals and absentees,
(vi) Improve on CDD/population ratio (Currently 1:200).

181. *TCC accepted the report with the recommendations*

Delta CDTI Project

182. Some sections of the report are similar to those of the Edo State CDTI report.

Recommendations to improve the report

(i) NGDO partner to endorse report,
(ii) State Coordinator to write the state technical report.

Project-related

(i) Project to facilitate introduction of CSM and SHM as recommended by TCC23;
(ii) Train more CDDs to increase the CDD/population ratio as recommended by TCC21;
(iii) Check census population of Ika South and Oshimili North LGAs and coverage in shimili South LGA;
(iv) NGDO partner to devolve ordering and delivery of Mectizan® tablets to state MoH;
(v) Provide information on government equipment;
(vi) Source for funds for activities outstanding since TCC 21, 23 and TCC25 such as CDD training, census update and introduction of CSM and SHM;
(vii) APOC should provide state with special initiative funds

183. *TCC accepted the report with the recommendations.*

Yobe CDTI Project

184. Report was written in a hurry with very scanty and error-filled executive summary.

Report-related recommendations

(i) Make executive summary more comprehensive.

Project-related

(i) Improve the therapeutic coverage in Busari, Gujba, Karasuwa and Potiskum LGAs. This is a project that has received good funding from government over the years. Despite the level of funding, the therapeutic coverage is low in these areas;
(ii) Update census in Gulani and Fika LGAs;
(iii) NGDO partner to devolve ordering and delivery of Mectizan®;
(iv) Improve CDD/population ratio;
(v) Improve female participation;
(vi) Repair six non functional LGA motor cycles;
(vii) Provide figure for cost per treatment;
(viii) Implement all TCC recommendations.

185. *TCC accepted the report with the recommendations.*

Abia CDTI Project

186. Report was apparently written in a hurry with very scanty and error-filled executive summary.

Reported-related recommendations for improvement

(i) Report should be signed by the relevant stakeholders,
(ii) Revise the Executive summary,
(iii) Implement recommendations from last TCC,
(iv) Select more CDDs,
(v) Reinforce add-on interventions in order to raise communities' interest in CDTI.
(vi) Provide information on treatment cost and CDD attrition.

Project-related

(i) Add on more interventions to CDTI,
(ii) Train more CDDs,
(iii) Conduct census,
(iv) Train for CSM and SHM,
(v) Produce sustainability plan,
(vi) Intensify integration with other projects,
(vii) Intensify advocacy for improved funding by Government at all levels.

187. *TCC rejected the report and recommends that it be re-submitted to TRC.*

SUMMARY OF TECHNICAL REPORTS 7TH, 8TH, 9TH,^ AND 10TH YEAR

188. **Electronic review of CDTI projects 7th year and above**

CAMEROON

North Province CDTI project 9th year

189. The project has provided a well-written report describing its 9th year of CDTI implementation. The TCC commends the project for reaching 100% geographical coverage. Therapeutic coverage has been between 75% and 79% for the past several years and project is encouraged to make efforts to reach the UTG in the next treatment cycle and beyond.
190. *TCC accepted the report with the following recommendations:*

Report-related

(i) Outcomes of advocacy were not reflected in the report. They should be reported in the future;
(ii) The project is encouraged to provide detailed progress information in its Year 10 report.

Project-related

(i) The project is strongly encouraged to move forward with the plans for advocacy mentioned in this report. Advocacy should be carried out with political and administrative leaders to secure support (financial and otherwise) for the implementation of CDTI. Communities should be mobilized to embrace CDTI, and to provide support to CDDs;
(ii) CDD training should emphasize the importance of social mobilization in CDTI and training should be carried out prior to drug distribution. The project should monitor the impact of such training on coverage, refusals, and absentees;
(iii) Family/clan strategy should be used for the selection of CDDs;
(iv) While the overall therapeutic coverage was 75% in the 9th year, the district of Rey-Bouba had coverage of less than 65%. The situation should be investigated and solutions proposed for improvement. Monitoring of district-level coverage should be a routine part of project activities;
(v) Project is encouraged to find solutions to recurring problems, some of which could be addressed through supervision, training, and social mobilization.

CHAD

Chad CDTI Project 8th year

191. This 8th year report describes a mature CDTI project that has maintained 100% geographic coverage since 2000. In the reporting year (2007), the project nearly reached its ultimate treatment goal (UTG), with therapeutic coverage at 82%. The project is commended for these accomplishments and is encouraged to improve as it moves into the post-APOC period.

192. *TCC accepted the report with the following recommendations:*

Report-related

(i) The roles of only some partners in CDTI were provided. Future reports should explain the role of each partner;
(ii) No census was conducted during the reporting year by the project according to the information under Table 2; although the timeline of activities (Table 3) mentions a period of census update for each health district. This needs to be clarified;
(iii) The programme does not indicate plans for replacing equipment in the post-APOC period. How will equipment be obtained?

Project-related

(i) Project to work towards threshold CDD/population ratio of 1:100;
(ii) While the report talked about no refusals and only 877 absentees, there is still a difference of nearly 38,000 people (about 3% of the UTG) between the UTG (1,427,631) and the number of people treated in 2007 (1,389,921). The project should reconcile population figures to determine the number of people that missed treatment and address the issue;
(iii) There are 249,357 tablets (4,310,000 - 4,060,643 = 249,357) remaining rather than the 4,841 reported. The project should verify the figures in Table 10;
(iv) No budget/expenditure reported for NGO partners. Is the support from these organizations only in kind?
(v) For a project in its 8th year, APOC is still providing significant funding; the project should be aggressively looking for alternative sources of funds for CDTI for the post-APOC period.

MALAWI

Extension Districts 8th year

193**.** This is a well-written report, with details on the five zones. The project should be commended for attaining 100% geographic and 82.7% therapeutic coverage. Advocacy and sensitization activities are fairly high level and should be encouraged. The programme has a CDD/population ratio of 1:103.

194. *TCC accepted the report with the following recommendations:*

Report-related

(i) Project to explain the drop in health staff and female CDDs between 2006 and 2007;
(ii) What happened to community supervisors in Blantyre and Phalombe which had supervisors in 2006 but none in 2007?
(iii) Explain the lack of community self-monitoring - Complete Table 13 – information on cost per treatment is provided but unclear;
(iv) Complete Table 13 and fill in other gaps.

Project-related

(i) ATO should be increased especially for CDDs, which currently stands at 60.5%. Many of the CDDs are untrained;
(ii) Facilitate CSM;
(iii) Design mechanisms to stem CDD attrition.

Thyolo/Mwanza District 11th year

195**.** A very well-written report of a very mature and smooth running project integrated into the country's health systems and financially supported by it.

196. APOC Management to confirm whether TCC23 and TCC25 recommendations have been addressed.

197**.** *TCC accepted the report with the following suggestions for improvement:*

(i) CSM training should be carried out;
(ii) The residual tablets are too many and suggest difficulty with calculating requirements;
(iii) This should be addressed in the training and the remaining tablets must not be allowed to expire;
(iv) Address census issues;
(v) NOTF Malawi and APOC management to facilitate in-country review of technical reports by Technical Review Committee.

TANZANIA

Ruvuma CDTI project 8th year

198. The project reported good Geographic and Therapeutic coverage.

Recommendations:

(i) Frequent transfer of trained personnel to non-CDTI areas should be addressed by training all health staff in the endemic area;
(ii) Record-keeping, especially where there are untrained health workers, should be improved;
(iii) Project to improve the current CDD/population ratio of 1:221;
(iv) Ensure good record-keeping in all communities and districts.

199. *TCC accepted the report with the above recommendations.*

UGANDA

Phase 1 CDTI project 11th year

200. This is a well-written report and the project is doing well. The team should be commended for continuing to maintain 100% geographic coverage and therapeutic coverage of 79% and 80% in round 1 and 2 distributions, respectively. Integrated implementation of activities in the five zones is commended. It is, however, important for the project performance to be closely monitored given the semi-annual treatment in 4 out of the 5 zones.

201**.** *TCC accepted the report with the following recommendations.*

Report-related

(i) The executive summary should be limited to one page,
(ii) Information in the summary should be consistent with the body of document,
(iii) Provide information on absentees and refusals in Table 7,
(iv) Table 13 should be completed,
(v) Provide information on refusals and absentees.

Project-related

(i) Project should implement CSM;
(ii) Develop an Operational Research around the semi-annual treatment and also on the reported reluctance shown by the youth to continue with medication in the long-term.

Phase II CDTI project 10th year

202**.** A well-written report on a mature project in its 10th year. The CDD/population ratio at 1:37 is commendable.

203. *TCC accepted the report with the following observations:*

(i) More information on the implementation of the integrated NTD project should be provided to highlight the challenges of co-implementation;
(ii) The denominators on which the therapeutic coverage of both rounds of treatment were based did not add up to the total population;
(iii) Therapeutic coverage is lower in the biannual treatment area, is there a specific reason for this, or has the increased mobilization for biannual treatment boosted the coverage in those areas?
(iv) Correct table 5 on training of health workers;
(v) Project should provide the number of refusals and absentees in the report.

Phase III CDTI project 9th year

204**.** This is a 9th year technical report on 2007 activities. The 5th year report was to TCC22 in 2006 and it provided responses to TCC17 of September 2003 recommendations. It is not clear if reports for the 7th and 8th year were submitted. The 6th year rejected Technical Report has not been re-submitted. There is an improvement in the number of health staff involved in CDTI but CSM and SHM have still not been implemented. Coverage in Koboko district was still a low 51%.

205. *TCC accepted the report with the recommendations below:*

Report-related comments

(i) Improve future executive summaries,
(ii) Provide information on technical reports for 7th and 8th years,
(iii) Tables 13 and 14 should not include staff salaries,
(iv) Submit the 6th year rejected Technical Report.

Project-related

(i) Ensure training and implementation of CSM and SHM,
(ii) Address low coverage in Koboko district,
(iii) Explain disparity in refusals and absentees,
(iv) Clarify the number of left-over tablets,
(v) Explain disparity in funds available to project in table 13 and expenditure in Table 14.

Phase IV CDTI project 9th year

206. A well-written and detailed report. But there is no explanation on expired drugs in Kibale which was mentioned in the last report. There should be more government funding and less dependence on donor support. CSM and SHM are still lacking in this mature project.

207**.** *TCC accepted the report and encouraged project to strive for better performance.*

DRC

Kasai CDTI project 7th year

208. The report is very detailed, but contains several errors, especially figures in the executive summary and tables 1, 2, 7 and 10. The project has, however, recorded good coverage over several years, though some communities have geographic coverage of less than 25% without any explanation.

209. *TCC accepted the report, subject to corrections by the project as indicated above.*

Agenda Item 21: Other Matters

Incentive to community implementers of control programme activities

210. A presentation by Dr Katabarwa on data from Cameroon, Ethiopia, Nigeria, and Uganda shows that CDDs can achieve and sustain a desired coverage without demand for incentives by programme implementers as precondition for their service to the communities. However, this is best achieved through the kinship system. Kinship refers to a central social structure that defines human relationships on: how they interact; the things they do and say in their dealings with one another; the ideas about their relationship; their conceptions of one another; and the understandings, strategies and expectations that guide their behaviour. Kinship refers intuitively to "blood relationships". Communities tend to be comprised of kinship groups occupying specific geographic areas.

211. Rewarding services provided is not a condition for provision of services, but a "joyful" obligation and security to all kinsmen. Also, beneficial behaviours are passed on, and sustained within

the kinship, and individuals who are likely not to comply find themselves boxed in by sanctions pre-determined by the social legal systems, otherwise they risk being criticised or even ex-communicated. Such community-adopted behaviours may become norms and values of the culture. Therefore:

(i) Kinships are vital units for health education and training promotion;
(ii) Desired behaviours are likely to be passed on as accepted norms and values to young and future generations;
(iii) The more people are trained and involved within the kinship structure, the faster the pace for entrenchment of desired norms and values for disease prevention and control;
(iv) Kinships compete in almost everything, including programme performance (Coverage of health education and treatment). This ensures sustainability of desired performance in all kinships.

212. Organising CDTI and indeed other health activities within the kinship units or zones helps to improve and maintain involvement and ownership of the programme, coverage of health education and treatment without demand for incentives by community-directed implementers. With an example of a village from Plateau, in Nigeria, it was possible to demonstrate how real life in the community, existence of kinship structures, and how, if utilized can minimize or even eliminate demand by CDDs for incentives as a condition for provision of services. It also ensures equity and trust of community-directed implementers by all community members. The same system could also significantly enhance women's involvement in CDTI.

213. *TCC recognised the important role of kinship in communities but stressed that the incentive issue is multi-dimensional and possible solutions may be location-specific. The demand for internal incentives may be solved by the kinship system, but external monetary incentives pose other challenges among various health and community projects. TCC recommended that further studies be carried out on the subject.*

Summary on onchocerciasis control in Ghana

214. Pre-control prevalence of onchocerciasis in Ghana was very high (hyper-endemic situation in most villages evaluated) before the beginning of OCP programme in 1974. Larviciding started in 1975 while ivermectin treatment was introduced operationally in 1988. The forest area in Ghana was never treated with larvicides. Geographic and therapeutic coverage of CDTI were on the decrease and below the threshold of 100% and 65% respectively before the closure of OCP in 2002. Therefore, although prevalence of onchocerciasis infection in villages evaluated between 2000 and 2002 showed a significant decrease in many villages, they were still at an unacceptable level in Kulpawn/Mole and Black Volta river basins.

215. To assess the reasons for this unsatisfactory epidemiological situation, OCP had undertaken a number of studies including population movements and the "impact of forest degradation on onchocerciasis in Southern Ghana". The findings were that savannah was progressing into the forest area, thus increasing the population of savannah flies from a maximum of 11% in dry season in 1980 to around 26% in the 1990s. These changes in the composition of fly population, coupled with the human population movements had led to an increase in the onchocerciasis prevalence, which doubled in some cases between 1986 and 1995. Because of these unsatisfactory epidemiological results, OCP recommended that Ivermectin treatment should continue twice a year after 2002 in the two river basins mentioned above. This recommendation was not implemented and even with the yearly treatments, the 100% geographical and 65% therapeutic coverage were not achieved. As a result of this unsatisfactory treatment coverage and the continued population movements, the latest epidemiological evaluations show an increase in onchocerciasis prevalence in most of the villages surveyed, a situation that could lead to the spread of the disease to neighbouring countries. It was therefore concluded that there was a strong need for support to the country to i) complete mapping of the disease; ii) put in place the CDTI strategy; iii) ensure good management of data.

216. Discussions centred on recurrent issues related to adequate implementation of onchocerciasis control activities in Ghana over the years, the impact of LF control in overlapping areas of onchocerciasis and LF. Also discussed was the status of the study proposed by the working group after the publication of the article of Osei et al. One of the concerns of TCC was the implementation of the recommendations of the Working group by the Ghana team, making sure that there is good therapeutic and geographic coverage in the two problem areas. It was confirmed that the Ghana government had been informed and action from them is still being awaited.

217. The Disease Prevention and Control officer (DPC) from WHO/Ghana enlightened the group on changes that have occurred in Ghana in the restructuring of the control programme, which has moved from the research unit to the public health unit of MoH, hence setting the stage for implementation of programme which, however, still needs strong support. He then suggested as a next step, a strong round-table discussion involving all partners, with the country taking the lead in convening this round- table. APOC has offered to co-fund such a meeting with the Ministry of health and the WHO country office.

218. *TCC took cognisance of the Ghana situation, noting that final evaluation of the SIZ had been done, and that the release of the report was being awaited. It recognised the importance of continued support to this country. TCC highlighted the importance of expediting the study proposed by the working group; and recommended that a round table conference involving all partners should be organised as soon as possible to address the situation identified above. The government of Ghana is requested to address the issues related to the importance of expediting implementation of TCC26 recommendations on the study in the country and also to improve coverage.*

Summary on implementation of CDTI in Angola

219. Angola has an area of 1.2 million sq km, with an estimated population of 13.7 million. The country's REMO map was prepared after eight REMO exercises conducted between 2002 and 2008. According to this map, the population at high risk is estimated at 1.329.268 persons distributed across 50 health districts. Six (6) CDTI projects have been elaborated and approved since 2003: Lunda Sul, Lunda Norte, Moxico 1, Huila, Kuando Kubango and Bengo. CDTI was launched in Angola in 2004 with the project in Lunda, which, at that time, brought together the current projects of Lunda Sul and Lunda Norte. The only project that is yet to start activities is Bengo, due to the need to refine RAPLOA results, and sufficiently train health workers in SAE management. Four (4) RAPLOA exercises have revealed, since 2003, that some districts in the Bengo, Cuanza Norte and Uige provinces have villages whose Loa loa prevalence are above or equal to 40%.

220. Since 2003, APOC, through Letters of Agreement, has approved a total amount of US$ 1,272,311, for oncho control activities in Angola, of which over US$ 559.840 has been made available to projects for CDTI field activities. The CDTI project of Lunda Sul, which has already conducted 3 annual ivermectin distributions, has recorded geographic coverage which has progressed up to 91%, but went up to 67% in 2007. The CDTI projects of Lunda Norte, Huila, Kuando Kubango and Moxico 1, which were at their first distribution rounds, recorded therapeutic coverage above 30%. These five projects treated 414,965 persons in 2007 in 1489 communities, with a geographic and therapeutic coverage of 94% and 51% respectively.

221. APOC Management sent to the country a technical mission made up of two CDTI experts to assist in implementing CDTI projects. This mission, among other things, facilitated the training of 164 health workers and organised the entry of dispersed CDTI data for 1113 communities. A rapid analysis of community-based data reveals that 55% of communities achieved the threshold therapeutic coverage of 65%. Since 2002, APOC Management has also given technical and financial assistance to the NOTF of Angola for onchocerciasis control. The assistance was for following the activities - mapping of onchocerciasis and Loa loa, drawing up CDTI project proposals, training of trainers on the APOC philosophy and CDTI strategy, training of project managers on WHO/APOC administrative/financial procedures and training on SAE management.

222. DPC/Angola highlighted the need to maximize existing opportunities to improve the CDTI performance within the context of revitalisation of PHC service and also to integrate NTD control approach under the coordination of the national directorate of public health.

223. *TCC recommended that all stakeholders, especially the WHO control office should continue to support the CDTI projects in Angola*

Agenda Item 22: Date and venue of the twenty-eight session of the TCC

224. It was agreed that TCC28 be held 9-14 March 2009 and TCC29 on 14-19 September 2009.

225. APOC management expressed concern over the dates of the NGDO meeting in Vienna and Accra, respectively in March and September 2009. APOC and NGDO are to plan these meetings to ensure that one of the meetings takes place in Ouagadougou, otherwise allow one week interval between TCC and NGDO sessions to enable APOC to participate.

Agenda Item 23: Adoption of TCC27 report

226. The report was adopted after a careful review by TCC members.

Agenda Item 24: Closure of session

227. TCC Chair thanked all participants, observers, and especially DPCs for their contributions. She also thanked APOC management for providing the background information that enriched the deliberations as well as the MDSC, and the interpreters for their steadfastness.

228**.** APOC Director thanked TCC members for their continued support, sacrifice and contribution to onchocerciasis control in Africa. She said that Dr Danny Haddad who has moved to the Children without Worms, would be greatly missed, but noted that it was another opportunity for APOC to expand partnership. The director also expressed gratitude to outgoing TCC member Dr Katabarwa, who had served on the Committee for almost 6 years, and expressed the hope that the Carter Center would allow him to continue to support onchocerciasis control programme. She also thanked the DPCs, as well as Prof Homeida and the MDSC director. The director expressed the hope that new observers Dr Ngorok and Mrs Olamiju would become full members.

ANNEXES

ANNEX 1: List of participants

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ANNEX 2: Agenda

Rev. 2

TECHNICAL CONSULTATIVE COMMITTEE
Twenty-seventh session
Ouagadougou, 15 – 20 September 2008

PROVISIONAL AGENDA

1. Opening
2. Adoption of the Agenda

Information

3. CSA: matters arising from the 120th and 121st sessions
4. NGDO: matters arising from the 32nd session: recommendations only
5. TCC: follow-up of the key recommendations of the twenty-sixth session
6. NOTFs: matters arising from the 5th meeting
7. SIZ: final external evaluation of the SIZ

Strategic and technical issues

8. Addendum to PAB 2008 -2015 – Determining the endpoint to ivermectin treatment in APOC countries
9. Monitoring of drug efficacy in large-scale treatment programmes for onchocerciasis control
10. Update on operational research – CDI study
11. Update on Moxidectin
12. Country visit by TCC Members (CAR, Ethiopia)
13. Task Force on the review of technical reports: Nigeria
14. Review of operation research proposals
15. Integration of Onchocerciasis Control into the health systems and co-implementation of Neglected Tropical Diseases (NTD) control
16. Review of the new format of DEC Patch Test and its operational value for epidemiological evaluation

Management of APOC Trust Fund

17. Report on the financial management of APOC-funded Projects
18. Technical, administrative and financial review of APOC operations in the countries

Reviews

19. Report on the review by the APOC Management of 1st, 2nd, 3rd, 4th ,5th, 6th and 7th , 8th , 9th , 10th, 11th year progress reports and subsequent year budgets
20. Review of new project proposals and 1st, 2nd, 3rd, 4th ,5th, 6th and 7th , 8th, 9th, 10th, 11th year annual technical reports
21. Other matters
22. Date and place of the twenty-eighth session of the TCC
23. Conclusions and recommendations of TCC27
24. Closure of the session

DIR/COORD/APOC/16.09.2008

WORLD HEALTH ORGANIZATION
SANTE AFRICAN REGION

ORGANISATION MONDIALE DE LA
REGION DE L'AFRIQUE

AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)
PROGRAMME AFRICAIN DE LUTTE CONTRE L'ONCHOCERCOSE
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TECHNICAL CONSULTATIVE COMMITTEE
Twenty-seventh Session (TCC27)
Ouagadougou, 15 to 20 September 2008

PROVISIONAL ANNOTATED AGENDA

Monday 15/09/08

Agenda Item:

1. Opening 09H00-09H30

2. Adoption of the Agenda 09H30-09H40

Information

3. CSA: matters arising from the 120th and 121st sessions (Amazigo) 09H40-10H00

Coffee Break 10H00 - 10H20

4. NGDOs: matters arising from the 32nd meeting (recommendations) (Ukety) 10H20-10H40

5. TCC: follow-up of the key recommendations of the twenty-sixth session.. 10H40-11H05
(Yaméogo)

6. NOTFs: matters arising from the 5th meeting (Noma + Fobi).. 11H05-11H30

7. SIZ: final external evaluation of the SIZ (Yameogo).. 11H30-11H50

Strategic and technical issues

8. Addendum to PAB 2008-2015 .... 11H50-12H20

Lunch Break: 12H20- 14H45

9. Task Force on the review of technical reports: Nigeria (Elhassan).. 15H00-16H00

10. Integration of Onchocerciasis Control into the health systems and co-implementation of Neglected Tropical Diseases (NTD) control: update (Fobi).. 16H00-16H30

Coffee Break: 16H30- 16H50

Management of APOC Trust Fund

11. Report on the financial management of APOC funded projects (Agblewonu) 16H50-17H20

12. Technical, administrative and financial review of APOC operations in Nigeria Ethiopia and DRC (Agblewonu) 17H20-17H50

13. Report on the review by the APOC management of 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th and 9th year financial reports and subsequent year budgets (Keita) 17H50-18H20

Tuesday 16/09/08

14. Review of the new format of DEC Patch Test and its operational value for epidemiological evaluation (Lazdins and Remme) 08H00-08H30

15. Monitoring of drug efficacy in large scale treatment programmes for onchocerciasis control (Lazdins) 08H30-09H00

16. Update on Operational research - CDI study (Remme)........ 09H00-09H30

17. Update on Moxidectin (Lazdins) 09H30-10H10

Coffee Break: 10H10 -10H30

18. Reports on country visits by TCC members (CAR, Ethiopia) 10H30-11H00

19. Introduction to the review exercise: Summary budget of submitted proposals (Agblewonu) 11H00-11H30

Reviews

20. Review of new Project Proposals and 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th and 9th year Annual Technical reports on the implementation of CDTI and Vector Elimination Projects. Recommendations on the 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th and 10th year implementation of the projects

20.1 East Wellega CDTI Project (Ethiopia) 3rd year technical report 11H30-12H00

20.2 West Wellega CDTI Project (Ethiopia 3rd year technical report 12H00-12H30

Lunch Break: 12H30- 14H45

20.3 Gambella CDTI Project (Ethiopia) 3rd year technical report (revised)........ 15H00-15H30

20.4 Status of CDTI projects in DRC including costs (Noma + Ekwazala)........ 15H30-16H00

20.5 Katanga-South CDTI Project (DRC) 1st year technical report (Re-submission) 16H00-16H30

Coffee Break: 16H30- 16H50

20.6 Katanga South CDTI Project (DRC) 2nd year technical report 16H50-17H20

20.7 Katanga North CDTI Project (DRC) 2nd year technical report 17H20-17H50

20.8 Bandundu CDTI Project (DRC) 4th year technical report 17H50-18H20

20.9 Kasongo CDTI Project (DRC) 1st year technical report 18H20-18H50

Wednesday 17/09/08

20.10 Kasongo CDTI Project (DRC) 2nd year technical report.. 08H00-08H30

20.11 Mongala CDTI Project (DRC) 2nd year technical report.. 08H30-09H00

20.12 Mongala CDTI Project (DRC) 3rd year technical report 09H00-09H30

20.13 Bas-Congo CDTI Project (DRC) 3rd year technical report... 09H30-10H00

Coffee Break: 10H00 -10H20

Summary of 6th, 7th, 8th, 9th, and 10th year technical reports 10H20-12H30

Lunch Break: 12H30- 14H45

20.14 Butembo-Beni CDTI Project (DRC) 1st year technical report.. 15H00-15H30

20.15 Equateur-Kiri CDTI Project (DRC) 3rd year technical report 15H30-16H00

20.16 Ituri CDTI Project (DRC) 1st year technical report 16H00-16H30

Coffee Break: 16H30-16H50

20.17 Lualaba CDTI Project (DRC) 3rd year technical report.. 16H50-17H20

20.18 Lubutu CDTI Project (DRC) 1st year technical report.. 17H20-17H50

20.19 NOTF/HQ CDTI Project (DRC) 8th year technical report 17H50-18H20

Thursday 18/09/08

20.20 Ruthuru/Goma CDTI Project (DRC) 2nd year technical report...................................... 08H00-08H30

20.21 Sankuru CDTI Project (DRC) 4th year technical report 08H30-09H00

20.22 Tshopo CDTI Project (DRC) 4th year technical report... 09H00-09H30

20.23 Tshuapa CDTI Project (DRC) 3rd year technical report... 09H30-10H00

Coffee Break: 10H00-10H20

20.24 Ubangi-North CDTI Project (DRC) 3rd year technical report 10H20-10H50

20.25 Ubangi-South CDTI Project (DRC) 3rd year technical report 10H50-11H20

20.26 Uele CDTI Project (DRC) 5th year technical report 11H20-11H50

20.27 Kilosa CDTI (Tanzania) 5th year technical report 11H50-12H20

Lunch Break: 12H20- 14H45

20.28 Morogoro CDTI Project (Tanzania) 3rd year technical report.. 15H00-15H30

Review of Operational Research proposals... 15H30-16H30

- Update on operational research by NOTFs (Noma + Leak)

Coffee Break: 16H30-16H50

21. Other matters 16H50-17H50

    - Incentives to community implementers of control programme activities

22. Date and venue of the twenty-eighth session of the TCC 17H50-18H10

<u>Friday 19/09/08</u>

23. Report (Conclusions and Recommendations of TCC27)

23.1 Preparation of the report (conclusions and recommendations)
(Rapporteurs).. 08H00-10H00

Coffee Break: 10H00-10H15

23.2 Adoption of the report (conclusions and recommendations) of TCC27.......................... 10H15-12H15

24. Closure of the session 12H15-12H45

Rapporteurs : **-** Mr Paul Ejime
- Dr Tony Ukety
- Dr Grace Fobi

<u>Reports reviewed by TCC member online - Summary to be presented by Dr Fobi on Wednesday</u>

1. North Province CDTI Project (Cameroon)
2. CAR CDTI Project (CAR) 6th year technical report
3. Chad CDTI Project (CHAD) 6th year technical report
4. Chiradzulu District CDTI Project (Malawi) 8th year technical report
5. Chikwara District CDTI Project (Malawi) 8th year technical report
6. Blantyre District CDTI Project (Malawi) 8th year technical report
7. Mulanje District CDTI Project (Malawi) 8th year technical report
8. Phalombe District CDTI Project (Malawi)8th year technical report
9. Extension District CDTI Project (Malawi) 8th year technical report
10. Thyolo District CDTI Project (Malawi) 11th year technical report
11. Mwanza District CDTI Project (Malawi) 11th year technical report
12. Thyolo/Mwanza CDTI Project (Malawi) 11th year technical report
13. Kasaï CDTI Project (DRC) 6th year technical report
14. Kasaï CDTI Project (DRC) 7th year technical report
15. Ruvuma CDTI Project (Tanzania) 8th year technical report
16. Phase I CDTI Project (Uganda) 11th year technical report
17. Phase II CDTI Project (Uganda) 10th year technical report
18. Phase III CDTI Project (Uganda) 9th year technical report
19. Phase Iv CDTI Project (Uganda) 9th year technical report

ANNEX 3: Follow up of key recommendations of TCC26

Recommendations	Follow up action
<u>Para.12:</u> • TCC recommended that APOC should continue working and encouraging countries to prepare and submit their APOC exit strategic plans.	*In addition to the three countries (Tanzania, Uganda and Cameroon) that have submitted their APOC exit plans, two countries (Nigeria and Ethiopia) are working on their plans and two others (Congo and Chad) will follow shortly.*
• TCC recommended that health staff should allow communities to continue to take a lead in the selection of CDDs, as a way to guarantee sustainability and to reduce the need for incentives. However, APOC should provide support to ensure that no communities are left out.	*During Addis meeting of coordinators, field visits by APOC management and consultants, this message is conveyed to all, starting with the NOTF staff.*
<u>Para.16:</u> • TCC recommended that the Ministry of Health Ghana should ensure that the study sites are left free from other interventions in order to allow the team to complete the study.	*The message was made available to the Ministry of health staff on many occasions including during a review meeting in Kumasi, Ghana, but unfortunately, some interventions had already started in the area.*
• TCC recognized that there was low coverage in the study area however recommended that APOC should look beyond the coverage issue and continue to explore further the two hypotheses outlined in the study.	*APOC and TDR are operating in the recommended direction. A consultant will support APOC management on this.*
<u>Para.21:</u> • TCC to set up a subcommittee to look further at *the different implications involved in scaling up the integration of LF and onchocerciasis* and going into the non-onchocerciasis endemic parts of LF implementation units.	*Will probably be taken up by TCC27.* *Meanwhile, APOC management is preparing country maps combining Onchocerciasis and LF in preparation to the scaling up.*
• APOC management should explore a closer *collaboration with the executive group of GAELF to look at wider scale integration of LF and onchocerciasis control using CDI.*	*Contacts have been established but very little progress for the moment.*
<u>Para. 23:</u> • TCC recommended that the results of the elimination study be published as soon as possible, as a way of bringing encouragement to partners and countries. TCC also requested to be kept up to date.	*Dr Remme will inform the Committee on this subject.*
• TCC recommends that *distribution of ivermectin continue to be stopped in the R. bakoye and R. gambia basins*. For the R. faleme basin, where a north-south gradient was present, the northern part, where distribution was already halted could continue to stop ivermectin distribution. However for the southern part of the basin, where epidemiological and entomological	*Dr Remme will inform the Committee on this subject.*

levels were still around the thresholds, *more detailed study will be necessary and treatment should only be stopped in a couple of study villages, which will continue to be monitored. An additional study should look at possible cross border issues with Guinea* that might influence results in the southern part of the R. faleme basin. • TCC acknowledged that there is now a *need to conduct a similar study on the feasibility of elimination of onchocerciasis transmission in ex-OCP countries that have had 16 years of treatment and in APOC countries with more than 10 years of treatment*.	 *Will be discussed during presentation on Addendum.*
<u>Para.28</u> • On the issue of setting up national task forces on the review of technical reports and operational research proposals, TCC recommended that APOC management should ensure efficiency and sustainability by providing an oversight of the process. The spirit of partnership must be maintained and the involvement of the NGDO Group should be reinforced. <u>Para.37</u>: • TCC recommended that APOC management and NOTFs should use the experience in small/stable countries to upscale co-implementation in post conflict countries <u>Para.43:</u> • TCC recommended that APOC should re-train accountants to improve their performance of financial returns. <u>Para. 66</u>: • The TCC invites the Management of APOC to find a solution to the problem of vehicle raised by the South province CDTI project in Cameroon for three years. <u>Para.67:</u> • TCC recommended that APOC Management write a letter requesting the Western province CDTI project in Cameroon to give cost value and including evidence of the theft. The letter should be copied to the national coordinator, Chair TCC, MDP and Merck	 *Countries were advised to follow the idea and in Nigeria where the committee is operational, this spirit has been applied. Same to be done in Uganda.* *Will be discussed during the presentation on the Addendum.* *Plan was drawn and activities had started but need to be fully implemented – GSM launching constraints.* *The project has one functional vehicle. The request for another vehicle will be considered after the evaluation of sustainability as for the other projects.* *A letter was sent in March 2008 to the national coordinator to the attention of the project but we are yet to receive a feedback. Director APOC to come in.*
<u>Para. 84</u> • TCC recommended that a team of TCC and APOC visit Malawi to retrain programme staff and district teams of projects in all aspects of CDTI and help the teams to improve sustainability of the projects. In addition, support should be sought from SSI, which has offered to do CDTI activities in Malawi. TCC members were also asked to offer mentorship to the projects.	 *Discussions were going with TCC members and aconsultant was identified but not yet implemented. Will probably be conducted late this year.*

<u>Para 97:</u> • TCC recommended that Tanzania NOTF be informed of the real situation in the Tukuyu focus: being elimination of the original vectors and subsequent re-invasion by the other vectors from outside the focus.	*Discussed with the national coordinator and the technical officer in charge of the project. Nevertheless, an official memo still need to be written.*
<u>Para.99:</u> • TCC recommended that the National Onchocerciasis Coordinator of Uganda and NGDO partners involved in onchocerciasis control and elimination, be invited to TCC27 to present a full report of progress on CDTI activities, elimination and co-implementation. This would provide an opportunity to discuss how the country will in future provide information to TCC on activities in the whole country. <u>Para.104:</u> • TCC recommended that APOC management Clarifies REMO in Yumbe and Koboko districts in Uganda <u>Para.109:</u> • TCC recommended that APOC should continue with the exercise on gender data analysis and present to TCC the final disaggregated data, which will help TCC to make an informed decision about the next steps. To investigate whether the increasing female CDDs has an impact on therapeutic coverage, a field study to be funded by APOC. <u>Para.113:</u> • TCC recommended *independent validation of reports submitted on the special initiative* and that APOC presents the analyzed data from the ten projects before TCC can advise on the funding of the next 17 projects, and if necessary reassess and revise the process. <u>Para.114:</u> • The TCC recommended that MDP takes cognisaire of the internet access difficulties in some countries and provides alternative application method for such. <u>Para.7.(i):</u> • APOC management requested TCC26 to contribute towards the production of a strategy aimed at strengthening the health systems.	*Invited but they were already committed for something else.* *Funds have been released and administrative actions are being taken but the activities are yet to be conducted.* *In the Addendum to the PAB 2008-2015, the gender issue is being addressed to take into account the preoccupation of TCC. APOC management is also waiting for the input of one TCC member who offered to work with us on the subject.* *Planned for a later date.* *Representative of MDP to inform TCC* *To be discussed during TCC27*

ANNEX 4

NGDO: Matters arising from 32nd session: Conclusions and recommendations.

1. The third session of the joint meeting of the NGDO Coordination Group for Onchocerciasis Control, the LF NGDO Network and the International Coalition for Trachoma Control was held on 9 - 11 September 2008 at the Blossoms Hotel in Chester, United Kingdom. It was attended by the representatives of the three groups, private sector, WHO/APOC and WHO/NTD. The meeting was also attended by several observers, including Children Without Worms, Liverpool Associates for Tropical Health, Global Network for Neglected Tropical Disease Control (GNNTDC), West African Health Organization (WAHO), International Agency for the Prevention of Blindness (IAPB), Malaria Consortium Africa, MAP International, Schistosomiasis Control Initiative (SCI), Izumi Foundation and International Foundation of Dermatology.

NTD main issues:

2. Participants noted the impossibility for the joint NGDO technical working group to gather during the last 12 months. Considering the roles played by the NGDOs, especially at the field level, it was recommended to formalize this technical working group to address specific issues related to inter agency collaboration and integration of NTD control efforts. A small group was formed to develop the terms of reference for the NGDO NTD technical working group. This small group will meet in Washington DC on 24 - 25 October 2008.

3. Following drug donations, participants noted the remarkable achievements over the past few years in addressing some health interventions in poor communities and ultimately the emergence of NTD initiative, particularly for onchocerciasis and LF. However, there is a need to take into account other components of disease control interventions in SAFE strategy, LF morbidity management and treatment of Soil-Transmitted Helminthiasis (STH).

4. Participants recognised the need for data collection, management and sharing among different partners for advocacy purposes, particularly for trachoma and STH.

5. Participating NGDOs were urged to provide their respective technical and managerial support within the existing health systems in the endemic countries and to advocate for co-implementation of various specific health interventions according to their specific mandate.

6. WHO/NTD was congratulated for developing tools for integrated implementation, data management and monitoring preventive chemotherapy. Participants look forward to the finalisation of the manuals and future launching of the data matrix. All partners were requested to provide validated and solid data through the national channels to ensure quality of data.

7. Participants congratulated GNNTDC and its partners for advocacy in raising the awareness of NTDs and searching for new funding opportunities.

8. Participants recommended prioritizing funding for the provision of non-donated drugs and capacity-building in the neediest countries.

NGDO Coordination Group for Onchocerciasis Control issues:

9. The chair of the NGDO Coordination Group for Onchocerciasis Control was requested to formally approach the Committee of Sponsoring Agencies (CSA) of APOC to consider co-funding the post of NGDO Group Responsible Officer (GRO) within WHO.

LF NGDO Network specific issues:

10. Participants commended GSK for the extraordinary achievements in global LF elimination programme during the last 10 years in partnership with WHO and other stakeholders and private sector.

ICTC specific issues:

11. Participants acknowledged the role played by ICTC member organizations in addressing the SAFE strategy and recommended that a review and revision of the current survey guidelines be conducted to facilitate access to Zithromax. In addition, it was recommended to focus on the ten top trachoma endemic countries in collaboration with Vision 2020 national plans.

12. Members of ICTC were encouraged to extend their activities in the priority countries.

Other matters

13. Schistosomiasis Control Initiative (SCI) was welcomed as a new member of the NGDO Coordination Group for Control of Onchocerciasis.

14. Ms Joan Fahy from the Liverpool Centre for NTD was elected as the Coordinator of LF NGDO Network. Dr Tony Ukety was requested to closely work with her for a smooth hand-over for all matters regarding LF elimination activities.

15. Mr Simon Bush (SSI) was elected as the new chairman of the NGDO Group for a period of two years. Mrs Franca Olamiju (MITOSATH) accepted the responsibility of Vice-Chairperson.

16. The next joint NGDO meeting (4th) will take place on 8 - 10 September 2009 in Accra, Ghana and will be hosted by SSI. The next meeting of NGDO Group for Onchocerciasis Control will be held on 4 - 5 March 2009 in Vienna, Austria.

ANNEX 5: Conclusions and Recommendations of the 5th annual NOTFs session

(i) The present format for collection of counterpart contributions will not be changed, and NOTFs should share this as well as the format for plans/budget with the projects for systematic data collection.

(ii) NOTF meetings should be held in October in Ouagadougou.

(iii) Countries should maintain consistency in data/information shared with partners and APOC. In future full treatment and training data for a previous year are to be submitted to APOC by the end of July. All countries should close their data registers by end of June.

(iv) By August 2008 countries should submit information, with appropriate background, on co-implementation using the agreed format. Where no data is available a brief summary on status of and plans for co-implementation should be sent.

(v) To facilitate collection of information on co-implementation partners (government and NGDOs) should share information on what they are doing. The Chair of the NOTF should facilitate this process.

(vi) Data/information on co-implementation should be limited to CDTI areas only.

(vii) Countries should use kinship or other relevant structures in order to increase number of CDDs involved in CDTI.

(viii) To improve effective supervision and reduce work load NOTFs should work towards achieving a CDD/pop ratio of 1:100 as quickly as possible; they are also to pursue training and increased involvement of front line health facility workers and community supervisors, within the availability of human resources and structures in the country.

(ix) Recognizing the importance of Community Self-Monitoring (CSM) in CDTI and its low degree of implementation, APOC and other partners are requested to provide funds specifically to institutionalize this activity for at least 2 years. Countries should put in place mechanisms to sustain CSM. APOC should revise the training manual for this activity.

(x) Countries should evaluate the extent of implementation of recommendations made before the next NOTF meeting, and report accordingly. The NOTF meeting will adopt report of the previous meeting and review extent of implementation of the recommendations.

(xi) National Coordinators are to prepare adequately and attend the meeting with complete data from previous years and substantial data for the current year.

(xii) On behalf of the NOTFs and APOC Management, guidance of TCC is requested to facilitate the ownership of the programme operations by participating countries in view of the exit of APOC Programme from countries.