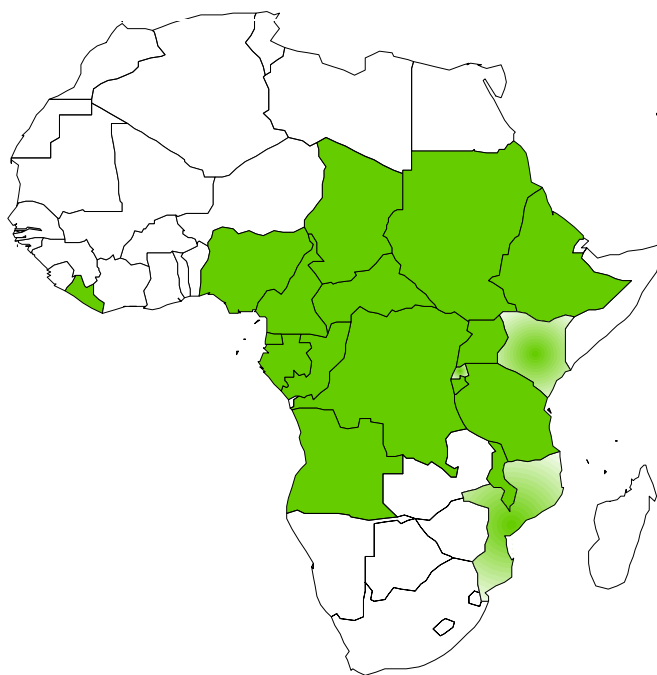

AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)



REPORT OF THE TWENTY-NINTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC) OUAGADOUGOU, 14-19 SEPTEMBER 2009

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ABBREVIATIONS/ACRONYMS

AAF	Administrative & Finance Assistants
ABR	Annual Biting Rate
AfDB	African Development Bank
APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
ATP	Annual Transmission Potential
CBO	Community-Based Organisation
CDD	Community-Directed Distributor
CDI	Community-Directed Intervention
CDTI	Community-Directed Treatment with Ivermectin
CEMV	Centre d'Entomologie Medicale et Veterinaire
CHI	Community Health Implementers
CMFL	Community Microfilarial Load
CSM	Community Self Monitoring
DBL	Danish Bilharzia Laboratory
GPELF	Global Programme for Elimination of Lymphatic Filariasis
HKI	Helen Keller International
DEC	Diethylcarbamazine
DMO	District Medical Officer
DRC	Democratic Republic of Congo
EMEA	European Medicines Evaluation Agency
ECOWAS	Economic Community of West Africa States
FLHF	Front Line Health Facility
FCT	Federal Capital Territory
HR	Human Resource
HSAM	Health Education Sensitization Advocacy Mobilization
HQ	Headquarters
HW	Health worker
ICTC	International Coalition for Trachoma Control
IEC	Information, Education, Communication
INSP	Institut National de Santé Publique de Cote d'Ivoire.
IPM	Independent Participatory Monitoring
IRSP	Institut Regional de Santé Publique
JAF	Joint Action Forum
LF	Lymphatic Filariasis
LGA	Local Government Area
LOCT	LGA Onchocerciasis Control Team
LTS	Lohmann Therapy Systems
MCD	Médecins Chefs de District
MDP	Mectizan® Donation Program
MF	Microfilaria
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
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
PNLO	Programme Nationale de Lutte Contre l'Onchocercose
PHC	Primary Health Care
RAPLOA	Rapid assessment procedure of <i>Loa loa</i>
REA	Rapid Epidemiological Assessment
SAE	Severe Adverse Events
SCI	Special Country Initiative
SHM	Stake Holder Meeting
SSI	Sight Savers International
SWAP	Sector-Wide Approach (health)
SWOT	Strengths Weaknesses Opportunities and Threats
TBR	Threshold Biting Rate
TCC	Technical Consultative Committee (of APOC)
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)
WV	World Vision

OPENING: AGENDA ITEM 1

1. The Technical Consultative Committee (TCC) of the African Programme for Onchocerciasis Control (APOC) held its twenty-ninth session from 14 to 19 September 2009 at the APOC Headquarters in Ouagadougou, Burkina Faso, under the chairmanship of Prof. A. Abiose. The chair warmly welcomed participants to Ouagadougou and informed them that the Director, Dr Uche Amazigo, was authorized to be absent from the meeting because of unforeseen circumstances. She acknowledged the presence of Dr Traore, representing the World Health Organization's representative to Burkina, Dr Djamila Cabral; Dr O. Pannenburg, Mr A. Azimipour and Dr A. Tembon, representatives of the World Bank, Dr J.H.F. Remme; Dr Doulaye; Professor E. Braide, Mr M. Hendji, Dr S. Wanji as well as Dr A. Kuesel, who would participate by 'video link'. She also recognized the presence of TCC experts, adding that their collective knowledge would be brought to bear on discussions concerning APOC's strategic direction, the review of technical reports and recommendations.
2. Dr Yameogo, APOC Coordinator, conveyed the apologies of the Director, for her inability to attend the meeting. Additionally, he conveyed to TCC members the Director's greetings and wishes for successful deliberations. He also noted the unavoidable absence of two other TCC Members, Dr Mary Amuyunzu Nyamongo and Dr André Yebakima.
3. The APOC Coordinator welcomed Dr Bernard Philippon, from the Organisation pour la Prévention de la Cécité (OPC), as the third representative to TCC from the NGDO Coordination Group for Onchocerciasis Control and Prof Evariste Mutabaruka, Acting Director of MDSC, both of whom were participating in TCC for the first time. He also introduced the following new staff members of APOC: Mr T. Siwombe, Dr H. Afework, and Ms Z. Akiwumi, noting that the process of filling other positions is ongoing and should be completed in 2010. Finally, he introduced the new collaborator for the NGDO group and Administrative Assistant of APOC at the WHO/HQ, Ms Juliet Ochienghs.
4. Drawing the attention of Members to the presence of two missions from the AfDB and World Bank, Dr Yameogo informed TCC that the AfDB was conducting an evaluation of the APOC programme following the signing of an agreement between AfDB and APOC, while the World Bank was assisting in preparations for JAF15. In her message to the meeting, the Director called upon the expertise of TCC to define transmission zones and ensure that projects cover 100% of these zones. She was positive that TCC would provide these answers. Dr Yameogo explained that the transfer to other locations of some coordinators has affected project performance, causing a few partners to lose confidence in some of the programme's projects. Noting that the confusion caused to some partners on integration of NTDs has impeded progress with implementation of some CDTI Projects, he reiterated the importance of improving project performance so as to motivate partners. In his closing remarks, Dr Yameogo thanked the TCC members immensely, especially for their indispensable work during country visits in post-conflict areas. He wished all participants a happy stay in Ouagadougou.
5. On behalf of MDSC, Professor Mutabaruka expressed his appreciation for the invitation extended to him to participate in the meeting. He indicated his willingness to collaborate in Onchocerciasis control, emphasizing the past achievements of APOC and the prospects of continuing towards elimination. He pointed out that the priority of MDSC is surveillance, focusing on Onchocerciasis but expanding the scope to some other diseases over a 10 year period.
6. Finally, on behalf of Dr Djamila K. Cabral, WHO representative to Burkina Faso, Dr Traoré apologized for the absence of Dr Cabral who was away on a field visit with the Minister of Health to Burkina Faso main hospital affected by recent floods in the country. Dr Traore declared the meeting open.

7. The Chair requested participants to introduce themselves. (The list of participants is attached as *Annex 1*).

ADOPTION OF THE AGENDA: AGENDA ITEM 2

8. The agenda provided as *Annexe 2* was considered and adopted with the following amendments:

- (i) The country visit reviews were allotted twenty minutes each,
- (ii) The country visit reports preceded technical reports,
- (iii) Agenda Item No. 13 to change project name from 'Centre 2' to 'Littoral 1,
- (iv) Ogun State 7th year technical report was among the presentations reviewed online.

INFORMATION:

CSA: MATTERS ARISING FROM THE 124TH AND 125TH CSA SESSIONS: AGENDA ITEM 3

9. Dr Yameogo reported on the 124th CSA meeting that was held from 23-24 April 2009 in Atlanta, USA. The critical issues that were discussed included:

- (i) The recruitment of a gender expert as mentioned by the Canadian delegation at the last JAF session in Kampala;
- (ii) The capacity of APOC to provide technical expertise to Yemen in the areas of CDTI strategy and vector control;
- (iii) A paper on the achievements of the feasibility of the interruption of Onchocerciasis transmission in Mali and Senegal should be published in the PloS NTD online journal (now published);
- (iv) The social and global health impact of Onchocerciasis control programme should be considered and assessed by the research team; Strategies to increase donors' interest in Onchocerciasis control activities during this difficult financial environment: CSA requested the World Bank to use the findings of the recent study on the feasibility of elimination of Onchocerciasis in Africa with the current tools;
- (v) Strengthening support to Angola by obtaining support from national authorities and local partners, taking into consideration the language factor;
- (vi) WHO Legal to include in the amended MOU the aligned list of Programme, according to Merck & Co., Inc., the donors of Ivermectin;
- (vii) APOC Management up-date on the issue of interpreters for Spanish and Portuguese in preparation for the 15th session of JAF in Tunis to be hosted by the African Development Bank;
- (viii) The proposal of the nomination of Dr Bernard Philippon as the third representative of the NGDO Coordination Group to APOC/TCC membership; and
- (ix) The APOC Management to finalize the supplementary Addendum, which would be reviewed by CSA 125th session.

10. The CSA 125th session was held on 7 July 2009 as a videoconference through the Offices of the World Bank in Washington and London, the African Development Bank (AfDB) in Tunis, WHO in Geneva and Brazzaville and WHO/APOC in Ouagadougou. It highlighted the following issues:

- (i) The pending issue of how APOC management should proceed to finalise the supplementary Addendum and submit it to TCC;
- (ii) Following requests by some NTD partners to make presentations to JAF, the Committee acknowledged the benefits of this partnership for NTDs. However, APOC management was asked to assess such requests on a case by case basis;
- (iii) A joint APOC/NGDO mission to Nigeria to assist the National Onchocerciasis Control Programme (NOCP) team to collect important data and undertake advocacy activities to officials at the Federal and State Ministries of Health;
- (iv) As a step towards strengthening its epidemiological capacity, APOC informed CSA of the recruitment of an epidemiologist;
- (v) The CSA 126th session will be held from 12-14 October 2009 in Paris, France.

NGDO: MATTERS ARISING FROM THE 34TH SESSION: AGENDA ITEM 4

11. The 34th session of the NGDO Coordination group for onchocerciasis Control, in conjunction with the Lymphatic Filariasis NGDO network and the International Coalition for Trachoma Control (ICTC), took place from 8-10 September 2009 in Accra, Ghana. The main objective of the meeting was to form a coalition among the three networks, and this was achieved. The rationale for the meeting was to remain dynamic and to respond to the changing programmatic, technical and funding landscape.

12. The NGDO NTD network comprises members of the onchocerciasis NGDO group, Lymphatic Filariasis NGDO network, and the ICTC, who are automatically members of the NTD network. In addition, there was an agreement on the formation of an executive group having a chair and vice-chair as well as the Chair and vice-chairs of the three networks. The Chair and Vice-chair are to be made responsible for holding additional meetings, whenever deemed appropriate, in support of the network. Further discussion on the objectives of the network focused on the expansion and effectiveness of advocacy for neglected tropical disease control by giving NGDOs a united voice at national and international levels; facilitating the formation of partnerships among the group's members and supporting the development and maintenance of national task forces of NTD endemic countries.

TCC: FOLLOW UP OF THE KEY RECOMMENDATIONS OF THE TWENTY-EIGHTH SESSION: AGENDA ITEM 5

13. Actions indicated below have been initiated or completed by APOC Management as a follow-up to TCC 28 recommendations (a complete list is attached as *Annex 3*):

- (i) APOC management made funds available to NOCP/Uganda and is following up with the country for the implementation of the mapping activity;
- (ii) The proposed annual awards should not be restricted to National Coordinators, but should be extended to health workers at the district and community level including CDDs;
- (iii) APOC pointed out that the process of translating relevant documents and manuals into Portuguese has been achieved; namely the manual on participatory monitoring and template for the Annual Technical Report;

- (iv) Most of the recommendations on Ethiopia have been implemented *e.g.* the 5th year evaluations of sustainability; funds have been released promptly and made available for the purchase of vehicles in 2010, and sustainability plans will allow APOC to proceed with replacement of capital equipment;
- (v) For DRC, APOC has approved the equipment replacement for 2010, however, APOC was yet to receive information on the outcome of an operational research project submitted to TCC in 2004.
- (vi) In the case of Nigeria, APOC management has stated that the capital equipment will be updated in 2010.

STRATEGIC AND TECHNICAL ISSUES

MEETING ON A CURRICULUM AND TRAINING MODULE ON THE COMMUNITY DIRECTED INTERVENTION (CDI) STRATEGY FOR FACULTIES OF MEDICINE AND HEALTH SCIENCES: AGENDA ITEM 6

Curriculum and training module

14. APOC initiated the development of a curriculum for medical and nursing schools as a means of propagating the CDI strategy in Africa and contributing to the production of future generations of health personnel trained and empowered to use the CDI strategy in health care delivery. Six experts met in Ouagadougou in 2007 to develop the draft document. The draft curriculum and training module were presented at a meeting of experts from 14 ECOWAS countries, held in Bobo Dioulasso later in the year. This meeting was aimed at harmonizing the programmes of different institutions in the sub-region. A review and repackaging of the curriculum was completed in 2008 and in a high-level review meeting of vice chancellors, Deans and senior academics convened in Abuja from June 9-11, 2009. The curriculum and training module were finalized with valuable inputs from participating universities. All 18 universities, from 11 countries across Africa, adopted the curriculum and training module and agreed on pretesting and its inclusion in their different university systems.

15. The implementation plans for pre-testing are to be submitted by universities before the end of February 2010. So far, plans of action and budgets have been received from the Institut Regional de Santé Publique (IRSP), Benin and the University of Medical Sciences & Technology, Khartoum, Sudan. Implementation of activities for these two universities will be starting in 2009 and APOC management has approved these plans.

16. Following the presentation on curriculum and training module some observations were made:

- a) TCC congratulated APOC on the initiative, noting the positive response from the universities and encouraged a step down to institutions training the mid-level manpower like schools of nursing and health technology;*
- b) TCC encouraged training of trainers on CDTI as well as writing a book on CDI.*

COUNTRY VISITS BY TCC MEMBERS: AGENDA ITEM 7

Malawi

17. The TCC Chair, Prof Abiose, briefed the session on her visit with Dr Mary Amuyunzu-Nyamongo to Malawi from 2-10 August, 2009. The visit included briefing MOH, SSI, WR-WHO, field visits to Thyolo District (Thyolo Mwanza CDTI project) and Phalombe District (Extension project), an exit plan development workshop in Blantyre and debriefing partners in Lilongwe. The timing of the visit was ideal as SWAp 1 was in the process of being reviewed.

18. Findings included a good programme in decentralized and integrated health systems, data management problems, delay of MDA due to co-implementation with LF and delay of arrival of albendazole, human capacity issues at national and district levels, CDD numbers and non-implementation of CSM. Programme implementers were debriefed on the findings during the exit plan development workshop.

19. The team's recommendations include the following: that APOC – Release capital equipment and support training in data management at all levels. At the MOH – Include onchocerciasis in new SWAp, retrain district officers on CSM and encourage its implementation. The Districts should advocate for higher fund allocations to CDI activities in the district budgets. The WR was requested to assist with streamlining the procurement of albendazole and do high level advocacy to ensure that NTDs are part of the new SWAp.

Tanzania

20. Dr Kisito Ogoussan informed TCC of his visit to Tanzania from May 25-29, 2009 with Dr Mary Amuyunzu-Nyamongo. The visit aimed at providing assistance to the CDTI projects in Tanzania on census taking, community participation and its sustainability, current status and need for IEC materials, NTD coordinator issues related to co-implementation, the collation and transmission of data from CDTI projects related to 2008 activities to APOC.

21. There were key *recommendations on onchocerciasis control specific* to the Tanzania programme. TCC members challenged the programme team to link up with researchers from local universities and research institutions to conduct operational research, to endeavour to maintain therapeutic coverage of 80% or above, ensure that integration does not negatively affect the performance of the onchocerciasis project, emphasised the need for the council health team to increase the budgetary allocation for onchocerciasis activities through intensive advocacy and lastly, to increase CDD: population ratio to 1:100 persons. However, they noted that APOC has not provided funds for additional training of CDDs.

22. The TCC team also listed the following recommendations to APOC based on the mission. *Most significantly, capital equipment for Kilosa district:* The project brought to their attention the urgent need for APOC to replace equipment for the CDTI project; Zonal officers need computers for data processing – they are currently entering the data manually which is tedious. APOC should re-examine the submitted plan and budget for GPS needs, in order to provide feedback to the programme accordingly, have the country programme re-submit the plan and budgets, increase findings for additional CDD training to increase the CDD/population ratio, encourage communication with the Tanzanian programme for sending in operational research protocols and also to recognize and commend the Tanga CDTI project coordinator for doing well.

23. With regard to the key outcomes of integration of NTD co-implementation, the NTD diseases to be co-implemented are: Lymphatic Filariasis (LF), Schistosomiasis, trachoma and Soil Transmitted Helminths (STH); and assessing partnership arrangements with other health programmes. Integration is a national policy and guidelines are already developed for its implementation. There is a secretariat and steering

committee in place. There is a near-complete NTD strategy that is awaiting ratification. Health management teams have been sensitized on integration. Five regions have been selected for the initial activities: Ruvuma, Tanga, Morogoro, Iringa and Mbeya. They comprise 34 communities with an estimated population of 10 million people.

24. From the key outcomes, the TCC team recommended:

To the country:

- (i) Strengthen the secretariat through mentorship and training of the NTD coordinator;
- (ii) Proper planning to ensure that and other supplies/materials are in place in time to allow a harmonized drug distribution at the community level;
- (iii) Rationalize the distribution of health staff at the lower levels;
- (iv) Advocacy for donors to be flexible in their requirements;
- (v) Invest in the selection of competent CDDs, training, supervision and monitoring of the data collection and compilation processes through a comprehensive M&E framework.

For WHO

- (i) Continue support to the MOH and the NTD secretariat;
- (ii) Contribute towards the completion and dissemination of the NTD strategic plan;
- (iii) Support the data management and validation through the provision of technical and financial support;
- (iv) Rally donor support towards integration;
- (v) NTD Officer of WHO to be fully engaged and provide guidance in the NTD discussions and debate at the national level. However, the NTD officer is supported by the Trachoma Initiative for 2 years only.

25. On APOC's commitment to integration, the following critical issues were identified:

- (i) What happens if other donors fail to contribute to co-implemented activities? It is critical for APOC to monitor the trends and make adjustments accordingly. In addition, APOC should pro-actively rally other donors to support integration;
- (ii) Put mechanisms in place to minimize delays to the onchocerciasis control programme such as possible delays in the transmission of data at the facility, zone, district, regional and national levels;
- (iii) Invest in data collection and collation in a bid to improve the quality of data;
- (iv) Support the documentation of the integration process and evidence of effectiveness of integration in Tanzania.

Ethiopia

26. A team comprising Prof E. Braide, Mrs F. Olamiju, and Dr H. Afework conducted the visit from 10-20 August, 2009. The mandate was to conduct orientation training of newly assigned Ministry of Health staff after the new reform; conduct advocacy visit to high authorities of the Ministry of Health, and provide technical assistance as needed by the NOTF and this was fully met.

27. The training workshop, which was declared open by Dr Kesetebirhan Adamasu, Director General, Health Promotion and Disease Prevention, drew participants from all levels of CDTI structure and partners, and covered topics on APOC's philosophy and all aspects of CDTI implementation. Advocacy visits were paid to Mr Taye Tolera, Deputy Regional Head of the Oromiya Health Bureau, Dr Fatoumata Nafo-Traore, WHO Representative to Ethiopia, Mr Teshome Gebre, Country representative, the Carter Center and Mr Getachew Abera the country programme coordinator of Light for the World. All partners promised to consistently support CDTI and contribute towards sustainability of the programme in Ethiopia. Dr

Afework and Dr Gebre provided technical assistance to NOTF Ethiopia in preparation for the proposal to conduct Rapid Epidemiological Assessment (REA) and geographical coverage and village identification.

28. The following recommendations were made by the mission team after consultations with training participants and partners:

- (i) APOC should fund replication of the just-concluded training for all health workers at lower levels;
- (ii) Projects should resubmit Annual Technical Reports for East Wollega and West Wollega, addressing recommendations by TCC 27 and 28;
- (iii) All Projects should submit sustainability plans to APOC;
- (iv) APOC should fund the implementation of REA in areas that need refinement and geographical coverage and village identification;
- (v) NOTF should resolve in-country funds utilization and liquidation problems;
- (vi) NOTF should invite persons handling APOC funds to subsequent CDTI training and meetings.

Burundi

29. The country visit to Burundi was carried out by Drs Mamadou Mariko and Kisito Ogoussan from 27 July to 2nd August 2009. The highlights of the mission were ongoing sensitization and mobilization of communities, except in Bururi; the realization that CDDs are still willing to distribute Mectizan at the community (colline) level for 2 weeks to 1 month; in some communities, CDDs receive incentives of 100 FBW per household and the supervision seemed to be well executed.

30. The outstanding key problems and challenges identified, included CDD incentives, cessation of project financing after five years of APOC funding, fear of losing CDTI specialists following the pooling of NTDs under the Ministerial department umbrella. The following recommendations were made by the TCC team: CDDs incentive issue is for communities to decide, with the support of political/administrative authorities; Government should continue to increase its contribution; APOC will continue to fund projects until 2012; after this period, government should continue to fund projects and the NOCP must endeavour to draw up sustainability plans for the two remaining projects

Congo

31. The Congo mission was conducted by Professors Louis-Albert Tchuem Tchuente and Mamadou Souncale Traoré from 23 August to 1 September 2009. The mission included visits to CDTI Projects, meeting with the WHO country representative, the authorities of the Ministry of Health/Provinces/Health Centres, communities, community drug distributors and leaders, conducting advocacy towards the authorities at all levels, aimed at improved release of funds for onchocerciasis control, providing technical support to the NOTF, Congo for implementation of CDTI projects through field visits and helping APOC countries to reinforce mechanisms to strengthen CDTI projects and health systems at all levels.

32. The TCC team's recommendations included the following: *To the NOCP:* Regarding the national annual counterpart budget: to draw up annual plans of action and budget and understand government fund disbursement procedures. On the issue of IEC, to promote sensitisation and mobilisation, reproduce guides for CDDs, produce IEC materials and diversify information sources of communities by using different media. Emphasis should be placed on the community approach by urging communities to "own" the CDD selection process, encourage decision-making by communities on a CDD incentive package, promote increased participation of women in CDTI activities and encourage the use of the CDTI strategy for integrating other health interventions.

33. *To departmental authorities-* The TCC team recommended that communities should be encouraged to give incentives to CDDs, to promote experience sharing in CDTI implementation among health districts and also to promote increased participation of women in CDTI activities;

34. *To the Ministry of Health-* The team recommended to the MoH to provide adequate funds for NOCP activities, to facilitate budget allocation/disbursement procedures, to strengthen coordination and integration of onchocerciasis control and NTD control activities and also to mobilise partners for NTD control (representatives of Ministries concerned: Health, Finance, Rural Development, WHO, NGOs and other partners).

35. *To APOC Management -* APOC management were reminded to assist the NOTF/Congo to finalise and implement APOC's devolution and exit plans.

Côte D'Ivoire

36. Professor Soungalo Traoré and Dr André Yebakima carried out a mission to Cote d'Ivoire from 15-21 March 2009. The objectives of the mission were; i) to provide support to PNLCé; ii) to conduct advocacy towards the national authorities and iii) To make recommendations to efficiently re-launch CDTI. The whole of Côte d'Ivoire and all its river basins are affected by onchocerciasis. The country has undergone vector-control with OCP and subsequently CDTI. Unfortunately, socio-political conflicts caused disruption of these activities.

37. There are 20 health regions and 83 health Districts, of which 53 are affected by onchocerciasis (Southern extension zone: 39; Forest zone: 13; Intermediate: 1.). The CDTI implementation which had been organised was interrupted from September 2002 to November 2008, and was then officially re-launched in July 2008. TCC members held working sessions with the staff of PNLCé and various other meetings as follows: Ministry of Health and Public Hygiene: Director General of Health, and other senior Ministry officials, Director of training and Research; Ministry of Economy and Finance: Director of budget; staff of CEMV and of the INSP; representatives of WHO and HKI; and debriefing with the Minister of Health in the presence of the WHO representative.

38. During the field visits, TCC members were accompanied by the Director – Coordinator (Dr Kouakou-Ilunga) and deputy Coordinator (Dr Brika Gbayoro), to the Abengourou Health Departmental Headquarters. Apart from the Departmental level (Abengourou, Akoupé), the team also visited two Health Centres (Anianssoué, Bana-Comoé) and two communities (N'grakou, Bana-Comoé).

39. Resulting from the various meetings and discussions the following recommendations were made: *to the PNLCé:* Train all those involved in CDTI, particularly the focal persons and CDDs; intensify efforts to recruit female CDDs; follow-up epidemiological evaluations; initiate entomological evaluations; seek private financing (agro-industrial businesses and others, clubs, services.....) to support the various activities; initiate operational research in collaboration with INSP, CEMV, the Management of Training and Research of MSP and all other relevant partners. The management of PNLCé should assist in identifying research themes and organise meetings with these institutions. In addition, initiate and create an NOTF to manage the project; put in place and make available IEC support, submit an Annual Technical Report of activities to the management of APOC; the first report would be examined by TCC29 in September 2009; collate the baseline demographic and health information that is essential for good implementation and to monitor progress of CDTI: number of villages, population at risk, details of health facilities, health workers mobilised in CDTI; assign one or two people from the Ministry of Finance to field activities; undertake a review of onchocerciasis; reinforce partnerships with NGOs and develop co-implementation with other programmes.

40. *To the Ministry of Health and Public Hygiene PNLCé* - to reinforce advocacy by participating in international meetings on onchocerciasis, notably JAF meetings;, maintain and increase financial participation of the State; seek, together with the Ministry of Finance, a mechanism for dealing with the budget line “field activities”; create National Onchocerciasis Task Force (NOTF) with a National Coordinator; reinforce the institutional capacity of the PNLCé; reinforce the logistic capability of the PNLCé by purchasing additional vehicles.

41. *To the WHO Resident representative* - the necessity to sustain various forms of support already provided to CDTI implementation and also support in the procedure for ordering Mectizan.

42. *To the Management of APOC* - to reinforce technical and financial support to PNLCé in various areas: Epidemiological and entomological evaluation, training (CDTI, technicians entomologists and epidemiologists), logistics, equipment (computer and laboratory).

COUNTRY EXIT PLANS: PRESENTATIONS. AGENDA ITEM 8

Exit plan development for APOC countries

43. The overall goal of APOC’s phasing-out and exit strategy is to have established, by 2015, a country-led system capable of eliminating onchocerciasis as a public health problem in all African countries endemic for onchocerciasis, both those within the geographical area covered by APOC’s mandate and those in the ex-OCP area that are causing concern. Various suggestions were tabled, among which included: JAF directed that country-led APOC exit plans should be developed and submitted. APOC has requested countries to submit exit plans but only Cameroon, Uganda and Tanzania responded within the time frame and Dr Philippon and Professor Abiose were commissioned to repackage/update these three plans and assist other countries to develop their plans.

44. The process consisted of development of a template, followed by consultation with countries and country visits or electronic communication. Following consultations and consensus building among partners, a planning development workshop is held and the plan produced by the NOTF, approved by the national government and submitted to APOC. The current status of exit plan development is as follows:

COUNTRIES		STATUS
1. Central African Republic	African	Submitted
2. Chad		Expected
3. Cameroun		Submitted
4. Congo		Submitted
5. Ethiopia		Submitted
6. Malawi		Final stages
7. Nigeria		Submitted
8. Tanzania		Previously approved but update awaited
9. Uganda		Previously approved but update requested by TCC 28 to include two previously insecure districts where REMO can now be conducted and CDTI started.

45. The next step would be the submission of these plans to JAF through the TCC. Copies of the plans for Ethiopia, Nigeria, Cameroun, and Congo were circulated to TCC members during the meeting. The exit plans for other countries will eventually be developed.

TASK FORCE ON THE REVIEW OF THE TECHNICAL REPORT ON NIGERIA AND CAMEROON: AGENDA ITEM 9

NIGERIA

46. The chair of Nigerian Technical Review Committee (TRC), Prof Eka Braide, informed TCC that the 3rd meeting of the Committee was held in Abuja from 20 to 24 July, 2009. The meeting reviewed 21 Technical reports of projects 7 years and above, 12 operational research proposals, and a report from NOTF on the extent of implementation of recommendations of TRC2. A presentation was also made on Challenges of Technical Reporting by the Kaduna State CDTI Coordinator. A summary of the outcome of review of all 21 Technical reports and details of the review of 2 rejected reports (Kwara and Osun), were given. TCC was informed that of the 12 operational research proposals reviewed, 3 were approved for submission to APOC for funding while 9 required further input and refocusing.

47. Generally, projects were found to be doing well in advocacy, sensitization, mobilization, and coverage but poorly in responding to TRC/TCC recommendations, planning of CDTI activities, community involvement, capacity building, supervision, monitoring and evaluation, operational research, sustainability evaluation and submission of sustainability plans. TRC3 resolved not to accept technical reports from projects that had not conclusively addressed all recommendations in the previous reports and not to review any technical report not endorsed and circulated at least 2 weeks before the meeting.

48. In reaction to the recommendations by TCC28, TRC Nigeria had commenced work on comparing projects 7 years and above and a format for this assessment will be presented to TCC after TRC4 which will be held in Calabar in February 2010. Recommendations made during TRC3 include the following:

- (i) NOCP should request Zonal Coordinators (ZOs) to review project reports (using TCC/TRC format) and present the reviews at annual review meetings. To facilitate this, ZOs should be invited to subsequent TRC meeting as observers;
- (ii) NOCP should carry out special interventions in Benue, FCT and Osun projects for appraisal and technical assistance;
- (iii) NOCP should monitor implementation of sustainability plans in all projects;
- (iv) The projects should consider utilizing National Youth Corps members for CDTI implementation at State and LGA levels;
- (v) NOTF should facilitate up-scaling of CSM and SHM by all projects;
- (vi) All projects should train adequate numbers of CDDs and health workers;
- (vii) NOTF should investigate Mectizan wastage in projects.

49. *TCC accepted the report and approved the recommendations of TRC3*

CAMEROON:

50. The TRC Cameroon was created in June 2009 and is composed of 8 members. Its main objectives are to review the technical reports and research proposals for CDTI in Cameroon, keep the Ministry of Health and the management of APOC aware of the progress of each CDTI project, and also eventually to examine the technical reports of other programmes.

51. The first session examined four CDTI technical reports:

- (i) North CDTI project, year 6,
- (ii) Centre III CDTI project, year 9,
- (iii) South West I CDTI project, year 10,
- (iv) Centre II CDTI project, year 6.

52. *The four reports were accepted by TCC 29.*
53. Following the presentations by the TRC:
- a) *TCC congratulated Cameroon on convening their first TRC and encouraged them to address the full mandate of the committee and review the proposed timing of their meetings to ensure timely reporting to TCC;*
 - b) *TCC also encouraged APOC to speed up the setting up of similar committees in other countries with mature projects such as Tanzania and Uganda.*

**FEASIBILITY OF ELIMINATION OF ONCHOCERCIASIS TRANSMISSION IN AFRICA:
AGENDA ITEM 10**

Key points from the informal consultation meeting on elimination of onchocerciasis transmission and update on the epidemiological evaluation in APOC countries.

54. Dr Hans Remme presented to TCC members an up-date on onchocerciasis elimination with ivermectin in Africa following the informal consultation on elimination of onchocerciasis transmission which took place in Ouagadougou, Burkina Faso from 25-27 February 2009. In his presentation, Dr Remme outlined several action points for moving forward to elimination as follows:

- (i) Generate more empirical evidence on feasibility of elimination under different circumstances;
- (ii) Develop/improve guidelines by:
 - Programmatic changes to achieve elimination,
 - Refine/test guidelines for deciding when to stop,
 - Surveillance after elimination;
- (iii) Refine target areas for treatment and delineate transmission zones;
- (iv) Define accomplishments in project areas:
 - Epidemiological situation in each project,
 - Assess feasibility of elimination,
 - Where feasible, define strategy/plans;
- (v) Research on better tools:
 - Tools to kill/sterilize adult worms,
 - Diagnostic tools for assessing viable adult worms;
- (vi) Linking with LF programmes;
- (vii) Regular up-date/review mechanism.

55. The presentation also reflected on the criteria for selection of first evaluation sites as follows:

- (i) At least 10 years of ivermectin treatment:
 - Complete geographical coverage;
 - Therapeutic coverage > 70%;
 - Treatment coverage data available.
- (ii) Relatively 'isolated' areas:
 - At least 20 km from other endemic areas where treatment started later

- (iii) High level of pre-treatment endemicity level:
 - Nodule prevalence > 40%;
 - Where parasitological data are available:
 - (i) Prevalence of mf > 65% or
 - (ii) CMFL > 40 mf/s
- (iv) Status to date:
 - Elimination confirmed:
 - 3 foci in Senegal and Mali/1 focus in Guinea Bissau
 - Elimination probably achieved:
 - 2 foci in Nigeria (Kaduna)/ 2 foci in Chad
 - Close to elimination:
 - 2 foci in Nigeria (Boki, Akampka)
 - Still some way to go (but possibly on track)
 - 1 foci in Nigeria (Taraba)
- (v) Summary:
 - 10 out of 11 foci studied are close to, or have already achieved elimination.

56. **Following the presentation, some observations were made:**

- a) *TCC expressed satisfaction with the progress made with the studies on the feasibility of elimination of onchocerciasis since the last meeting;*
- b) *TCC encouraged further analysis of the extensive REMO data to try and determine the onchocerciasis transmission zones in Africa. The preservation of mf samples from subjects was encouraged for future genetic analysis in the context of developing molecular markers for ivermectin resistance.*

Model prediction of elimination: strategies, assessment and critical factors.

57. Dr Duerr introduced the theoretical background of threshold concepts with respect to elimination strategies for onchocerciasis, in particular referring to the concept of breakpoints. Breakpoints are thresholds referring to the intensity, density or prevalence of parasites. In contrast to vector control, for which only one threshold is relevant (the threshold biting rate, TBR), breakpoints depend on the annual biting rate (ABR). Breakpoints decrease with the ABR, implying that efforts to eliminate the infection must increase if there are more flies elevating the annual transmission potential (ATP). In other words: even if there is only one infected person in the whole population, it makes a difference whether only ten or a thousand flies fed on him/her, spreading then the infection over the remaining population. Current modelling studies calibrated for savannah onchocerciasis / *S. damnosum* suggest that breakpoints for the elimination of onchocerciasis are very low if the ABR is in the order of thousands, and they quickly approach values which are practically zero if the ABR is in the order of ten thousands.

58. These findings would challenge the prospects of success through community-directed treatment with ivermectin (CDTI) which means 'parasite control' relying on breakpoints (in contrast to 'vector control' relying on the TBR). As the model does not consider an effect of ivermectin on adult *O. volvulus*. The results presented here would be over-pessimistic if ivermectin substantially affects the viability of adult worms. However, it is noted that the model in its current form did not include the fact that ivermectin can have an effect on viability of adult worms. If such an effect exists, the results of the model would probably be more optimistic. As there are no other experiences in predicting breakpoints, the current results should be verified by independent approaches or studies.

59. Apart from quantitative uncertainties in the model based prediction of breakpoints, the following conclusions hold in general:

- (i) Breakpoints decrease with the ABR, implying that CDTI which has achieved elimination in a region with low ABR can fail in regions with higher ABR. Thus, measures quantifying vector abundance are still useful and important;
- (ii) Sustained CDTI increases the TBR, making vector control measures more likely to succeed compared to OCP times without CDTI. Partial (and even minor) vector control may lead into elimination if CDTI alone can only approach, but not under run, a breakpoint. Because of the TBR shift, it is not necessary to kill all flies;
- (iii) As an elimination schedule depends on the most long-living stage within the parasite's life- cycle, breakpoints for onchocerciasis should refer to the adult worm stage. Although breakpoints can be calculated also for other parasite stages (*e.g.* MF or L3), elimination would require that these parasite measures had to under run the breakpoints over the whole life expectancy of the adult worms;
- (iv) For the latter reasons, diagnostics for adult worms should be re-considered;
- (v) If the vector-parasite-host relationship is regulated involving limitation processes, CDTI does not proportionally reduce the rate of re-infection. A remaining low level re-infection can extremely compromise an elimination strategy because adult worms live for years and thus, could delay elimination.

60. **The following observations and conclusions were made by TCC:**

- a) *TCC members noted that the concept of the study could have some financial implications and programmatic changes to the ongoing control programme. It was suggested that further investigations be conducted to clarify all these implications (financial, diagnostic and M&E tools, programmatic changes);*
- b) *In the discussion, the need to confront the prediction with OCP data and consider the effect of ivermectin on adult worms was highlighted, especially in view of the difference between the negative predictions but positive findings in the field in the elimination and epidemiological studies;*
- c) *TCC thanked Dr Duerr for his presentation, which described a model with calibrated data and deterministic properties, and requested follow-up information on subsequent developments, given the interest generated by the presentation.*

Vector migration and vector/ parasite complexes, human and migration issues

61. Dr Boakye illustrated the magnitude of seasonal migrations of species of the *Simulium damnosum s.l.* complex, especially the savanna and forest ones, using large amounts of data collected in the OCP area; those different fly species may constitute vector-parasite complexes with the various strains of *Onchocerca volvulus* which develop in them; such complexes differ in their compatibility and result intensity and pattern of infection of fly population. Migrant flies are physiologically old and can fly over distances up to hundreds of km and may carry and import high rates of infective parasite larvae. Ecological changes (man-made or natural ones: deforestation, climatic warming) may result in permanent changes in the distribution of vector-parasites complex populations.

62. Blackfly vector migration is therefore of utmost importance for the delineation of onchocerciasis foci, as well as for the understanding of patterns and intensity of transmission. Although vector species composition is rather well known in the former OCP area, fly species distribution and movements are not

so well documented in most of the APOC countries. The situation in Cameroon can compare with that of West Africa. Further East, the vector populations are generally of a more focal nature; this is especially true for *S. neavei* which is absent from West Africa, but also for *S. damnosum* cytospecies, which are much more diverse in numbers, behaviour and relation to *O. volvulus*. Isolated foci are known which have allowed vector elimination or enable it to take place in certain foci (e.g. Bioko, Itwara, Mount Elgon, Mpamba Nkusi, Abu Hamed).

63. There is a need to collect more distribution data in APOC countries to understand if re-infection/re-population might occur in infection-free/vector-free areas. Transmission data on the various species or cytospecies are also needed. They would make it possible to contribute significantly to the follow-up and surveillance of control/elimination in all areas of onchocerciasis control in Africa (APOC and ex-OCP), considering that high vector densities may be of importance in situations of microfilariae populations drastically lowered by control.

64. Human migration is a growing phenomenon in terms of populations' concerned and geographical extension, due to economic, climatic, sociological and other factors. They have to be considered in the context of an initial residual distribution of the onchocerciasis infection and disease, treatment of target populations, re-infestation of onchocerciasis-freed zones, and known vector movements and migrations. Studies by social science specialists have to be initiated in all areas onchocerciasis control programmes, especially in the APOC area.

65. The following conclusions and recommendations were made by TCC:

- a) *TCC expressed its appreciation of the presentation noting that its members shared the viewpoint of the presenter. TCC notes the need to have better knowledge of the distribution of species of Simulium;*
- b) *TCC again stressed the need for improved knowledge and investigation on the 'identity, distribution, abundance and movements' in the context of 'shrinking the Oncho map' and surveillance in transmission free areas.*

MACROFIL AND RESEARCH: AGENDA ITEM 11

66. Dr A. Kuesel of WHO/TDR provided the TCC members with an update of Macrofil research, focusing her discussion on the following:

(i) Moxidectin development:

- Phase 2 studies in Ghana on safety and efficacy follow up for subjects is continuing. Final data are expected in 1-2 Q2010;
- Phase 3 study started in Liberia in April 2009 and 77 subjects have been recruited to date. Its start in DRC is still pending approval of Protocol Amendment 1 by the MoH. The delay in study start in Liberia and in particular DRC may result in the reduction of study subjects (initially 1500 individuals). This is unlikely to impact conclusions on the relative efficacy of moxidectin and ivermectin, but will reduce the amount of safety data available before moxidectin administration in the community studies;
- The protocol of the Paediatric study to be conducted at the Onchocerciasis Chemotherapy Research Centre is being finalized based on feedback from the European Medicines Evaluation Agency (EMEA) and the TDR PDT;

- Next Step (a): Community studies, to obtain data on the effect of moxidectin on disease transmission and to compare the effect of moxidectin with the effect of ivermectin. Site selection needs to start in the next few weeks;
- Next step (b): Preparation for submission to EMEA for 'Scientific Opinion' as prerequisite for submission for registration in endemic countries.

(ii) *'IVM response marker'*

- Laboratories in Ghana, Cameroun, MDSC, Australia and Canada are finalizing a joint research plan;
- Given the other projects financed by TDR and APOC contributions under the MACROFIL agreement, additional funds need to be raised to finance this project.

(iii) *Study on the effect of bimonthly doses of albendazole on Loa loa microfilaremia,*

- Final data analysis resulted in the conclusion that neither treatment regimen is suitable as a pre-CDTI treatment in *Loa loa* co-endemic areas.

(iv) *Study on the clinical and pathological changes caused by B. malayi in children and effect of albendazole treatment*

- Planned follow up for 3 years has been completed and final data are expected in September 2009. Data to date show that lymphatic pathology is reversible with albendazole, which has given the GPELF an important tool for advocacy. Extension of the follow up period (without budget implications) is planned by the investigator.

(v) *Evaluation of molecules as potential new drug candidates:*

- Potential candidate molecules are emodepside (Bayer) and monepantel (Novartis).

(vi) *DEC patch availability for APOC elimination studies*

- The delivery to APOC of the DEC patch batch manufactured by Lohmann Therapy Systems (LTS) is pending finalization of the 'Risk Coverage Letter'. The issue requiring resolution is product liability insurance coverage. The legal agreement for further DEC patch batches is also under negotiation. It will include numerous obligations of WHO and recipient countries.

67. ***The specific questions to APOC and TCC were:***

- (i) *Is there enough information on vector distribution to determine the entomo-epidemiological zones in the APOC area to support vector species being included in site selection?*
- (ii) *Can a map of available information on vector distribution be generated and be overlaid with the CDTI priority area and Loa loa map?*
- (iii) *Can a table of CDTI project ages and maps of CDTI project areas in the different countries be provided?*
- (iv) *Is there a potential synergy for infrastructure and personnel capacity building between preparation of community study sites and sites for APOC ivermectin response monitoring/surveillance?*
- (v) *Is there a possibility to obtain the data from the 'ivermectin comparison year' as part of the APOC ivermectin response monitoring/surveillance?*
- (vi) *Should consideration be given to include utilization of the DEC patch in the ivermectin comparison year to provide the data requested by Rotterdam for people with 'low level mf counts'?*
- (vii) *What is the AE reporting / pharmacovigilance system in place in CDTI programmes?*

68. The following observations and recommendations were made by TCC:

- a) *TCC still expressed concern over the delay in the implementation of the moxidectin studies with the increase of budget and reduction of study subjects;*
- b) *APOC should provide funds to fill the gap of funding needed for IMV marker and moxidectin projects;*
- c) *APOC should meet up with TDR to deal with the questions posed by TDR related to the moxidectin project.*
- d) *APOC will look for available data on vector distribution and collaborate with the experts to fill the gaps as might be necessary*
- e) *The desirability of performing experiments on the Loa-monkey model regarding side-effects was noted; however the expense of this was recognised as a constraint.*

Update on Loa loa mapping in APOC countries:

69. Rapid assessment procedure of *Loa loa* (RAPLOA) has been conducted in 7 APOC participating countries. A total of 3429 villages were surveyed in Angola (261 villages), Cameroon (600), Congo (43), DRC (2166), Equatorial Guinea (87), Nigeria (113) and Sudan (159). The mapping of Loiasis was undertaken in areas where community-directed treatment with ivermectin is indicated. Progress has been made in analysis of RAPLOA field data to delineate areas at high risk of the occurrence of serious adverse events (SAEs) following completion of a geostatistical analysis programme of *Loa loa* prevalence data by Lancaster University under the leadership of Prof Peter Diggle. The high risk map of *Loa loa* in all countries surveyed will be submitted to TCC during its 30th session in March 2010. The APOC Programme will complete RAPLOA surveys in DRC and Southern Sudan and will extend the mapping of *Loa loa* to all APOC participating countries where available historical epidemiological prevalence data on loiasis and where the *Loa loa* high risk map developed by the Liverpool School of Public Health (Madeleine Thomson) indicate the need for carrying out field data collection of *Loa loa* prevalence.

70. The following observations and recommendations were made by TCC:

- a) *TCC discussed whether or not these surveys have to be implemented right now in those areas for which information on the level of endemicity for lymphatic filariasis is scanty? Indeed, it might be more cost-effective to conduct such surveys only in those areas where ivermectin mass treatment would be useful. TCC therefore recommends that any epidemiological survey on LF should be coupled with RAPLOA, and that any decision regarding the launching of a RAPLOA survey should be taken in the light of available epidemiological information about LF endemicity;*
- b) *TCC recommends that RAPLOA and REMO maps be made available to the concerned countries and the scientific community. TCC noted that guidelines exist for treatment in areas of co-endemicity for LF, and reiterates the need for its use;*
- c) *TCC recommends the submission of Loa loa high risk maps to its 30th session in March 2010;*
- d) *TCC also recommends the completion of RAPLOA surveys in the entire programme area where needed.*

REVIEW OF OPERATIONAL RESEARCH: AGENDA ITEM 12

71. Since the March TCC28 meeting the one project that was accepted from Dr Henriette Nkwidjan was funded, (*Participation of women in CDTI implementation in Cameroon*) but no interim report has yet been received on progress as implementation of the project started in August 2009.

72. The study on Social Benefits and Impact of CDTI that a previous TCC meeting had requested is now in progress but was delayed mainly for administrative reasons. This multi-country study, led by Dr Mary Nyamongo and the African Institute for Health and Development with collaborating scientists from elsewhere, is taking place in Uganda, DRC, Cameroon and Nigeria. So far a planning/standardisation meeting has been held in Nairobi to ensure that researchers have the same basis for the research methodology and will use standardised protocols and tools. They developed questionnaires/tools for conducting the field research in Nairobi and these have been translated into French by APOC in Ouagadougou. Ms Yolande Longang started field work in Cameroon on 16 September and this will continue until 16 October. It is expected that Dr Nyamongo will provide an update on the research at the March 2010 TCC meeting.

73. A proposal has been written for the APOC PAB Supplementary Addendum for strengthening and increasing operational research but this is still under review by APOC management.

74. Contacts have been made with DBL – the former Danish Bilharzia Laboratory concerning the possibility of collaborating with them in order to strengthen operational research. In principle there is agreement from them to provide support to research that would come mainly in the form of training.

NEW PROPOSALS

75. All the proposals reviewed were from Cote d'Ivoire, which submitted five operational research proposals.

76. TCC congratulated the management of PNLCE Côte d'Ivoire for having kept its agreement to send research proposals after the TCC members' visit in March 2009.

77. **Project 1: Terms of reference of a pilot study for large-scale control of blackfly nuisance using a palm oil (*Elaeis guineensis*) based cream in the river basins of Cote d'Ivoire.** TCC was very interested in this project. The large-scale use of repellents could play a significant role in the context of elimination of onchocerciasis in Africa. The reduction of contact between blackflies and the most infected human populations would be able to reinforce the impact of CDTI on the intensity of transmission. Meanwhile, this tool could allow the potential development of resistance to ivermectin to be slowed down. Consequently, TCC recommended funding this project. However, a certain number of weaknesses were apparent and TCC recommended that the following amendments be made before re-submission to reviewers not later than 1 November 2009.

- 1). **Review the title as follows:** «Acceptability and perceptions of the efficacy of a palm oil based cream (*Elaeis guineensis*) on blackfly nuisance: a study in four sites in Cote d'Ivoire.
- 2). **Study sites:** Provide more descriptive baseline data on the sites.
- 3). **Objectives:** Re-do the objectives based on the new title.

4). **Methodology:**

- Describe briefly the method of blackfly capture on humans;
- Provide details on the manufacture of the cream;
- Include in the project, the questionnaires on perceptions of the people on the nuisance and the effectiveness of the repellent;
- Provide more details on how the surveys will be conducted to evaluate the acceptability of the cream by the people;
- Proceed to a quantitative evaluation of the perception of the efficacy of the repellent presence of control capturers in the project area.

5). **Expected results:** Adapt them to the revised objectives

6). **Budget:** Revise the budget based on the new information and taking into account the expenses of a student researcher.

78. **Projects 2 & 3:**

79. TCC noted that the problem being addressed by the two projects was very similar, and only differed in the study sites. It appeared that the project number 2 was better constructed, and that the epidemiological situation in the study area of this project merited particular attention. Consequently, TCC recommended that only Project 2 be financed at this stage.

80. In addition, a number of weaknesses were observed and TCC recommended that the following amendments be made before resubmission to the reviewers no later than 1 November 2009:

Revise the title: see 9

1. **Study site:** Provide background historical epidemiological, entomological, parasitological and socio-demographic and economic data. Give relevant information concerning the choice of these sites and the activities that have been undertaken at them since 1978.
2. **Objective:** Limit the proposal to a single objective: "To evaluate the impact of stopping distribution of ivermectin on the entomological transmission parameters for onchocerciasis"
3. **Methodology:**
 - a. The collection of baseline data (preliminary activities) should not be part of the project and the protocol must be elaborated taking into account these baseline data;
 - b. Link up with MDSC and prepare a budget for this.
4. **Expected Results:** Adapt them to the objectives.
5. **Budget:** Revise in view of the new information and foresee engaging a student for the study.

81. **Project 4 Comparative efficiency of different methods of protection against nuisance from blackflies in the forest and savanna zones of Cote d'Ivoire.**

82. TCC considered that the proposed research project only repeated other studies for which the results have already been published in scientific reviews/journals, and presented in University memoirs. These results being more or less conclusive, TCC judged that it would not be necessary to repeat the study.

83. **Project 5: Adoption of a community-directed ivermectin treatment strategy (CDTI) in post-conflict Côte d'Ivoire.**

84. TCC noted that the research project was of interest and is worthwhile being conducted.

85. **TCC made the following observations:**

- (i) The relevance and justification for the project are well presented;
- (ii) The epidemiological context and the CDI dimension CDI are not adequately taken into account for selecting the study area
- (iii) The literature review is clearly insufficient;
- (iv) The methodology needs to be completed taking into account:
 - Include in the specific objectives, the selection and motivation of CDDs;
 - **Choice of villages:** two villages per zone seem insufficient. Also it would be necessary to include the therapeutic coverage in the selection criteria;
 - **Study population:** Provide more detail;
 - **Research team:** provide their CVs and experience;
 - A Guide for conducting interviews and the questionnaire(s) are to be included in the project proposal;
 - Give details on the procedures and software which will be used to analyse the data.
 - Revise the budget according to the new data.

86. TCC recommended that the project be financed. However, the amendments which have been asked for by TCC must be made and a new version of the research proposal must be submitted to the reviewers not later than 1 November 2009.

87. **The following people reviewed the proposals and resubmission should be made directly to them:**

1. Dr Bernard PHILIPPON: abphilippon@yahoo.fr
2. Dr André YEBAKIMA: yebakima@cg972.fr or yebakimakebara@yahoo.fr
3. Dr Michel BOUSSINESQ: boussinesq@ird.fr or michel.boussinesq@wanadoo.fr
4. Prof. Soungalo TRAORE: pefoungo@yahoo.fr

STUDY ON DOXYCYCLIN IN LITTORAL 1 PROJECT AREA IN CAMEROON: AGENDA ITEM 13

88. Dr Wanji described in detail the background for treatment of onchocerciasis with doxycyclin and gave an overview of existing knowledge before explaining the latest trial in Cameroon using the CDTI approach.

89. The objective was to explore the feasibility of the community directed approach in the treatment of onchocerciasis using Doxycyclin in areas where the endemicity of loiasis is sufficiently high to present a potential risk of severe side effects following ivermectin mass treatment.

90. Study communities were selected based on:

- (i) A rapid epidemiological survey to confirm the endemicity of *L. loa* and *O. volvulus*;
- (ii) Combined RAPLOA and REA were used to assess the prevalence of loiasis and onchocerciasis;
- (iii) Three health areas were selected, from Mbanga health district (Matouke, Kotto and Mombo) and two from Melong health district (Essekou and Mbokambo).

91. The methodology consisted of firstly, introducing the CDI strategy through advocacy meetings on community directed treatment with doxycyclin. The meetings were held with health system personnel at the central, regional, district and front-line health facility levels, together with representatives of the Ministry of Health, NOTF, NGOs and health personnel. The role of each partner was discussed and their

adherence to the process was sought. Discussions also focused on the socio-economic impact and control of onchocerciasis in Cameroon. Advocacy meetings were held with national and Regional stakeholders and APOC, Division of Operational Research, Director of NGO perspective, Regional Delegate of Public health, Littoral, Regional coordinator of Onchocerciasis control, Littoral, DMO and CBH Mbanga and Melong, Nurse in charge of FLHF, Research team.

92. A population census following the training of CHIs was carried out in each community by their health implementers; in each household and for each individual, information on age, sex, occupation and time spent in the community was collected. For adult females additional information on pregnancy or breastfeeding status was collected. The census was monitored by health personnel and the research team.

93. Doxycyclin tablets (Vibramycin), purchased from Pfizer Company through the German medical aid organization e.v. *Action Medeo*, and were distributed using a treatment regimen of one 100mg tablet per day for 42 days. Eligibility criteria for treatment included: individuals aged 12 years and above; resident in the community; not suffering from any chronic disease; excluding pregnant and breastfeeding women. The drugs were pre-packaged at community pharmacies of the FLHF in daily and weekly individual doses before commencement of treatment. Each week the CHI collected the week's dose from the FLHF staff and proceeded with a door to door treatment strategy, making sure that each participant ate something before swallowing the tablet. Treatment took place in two phases: June 2007 and July 2008 (for those who missed the treatment in phase1) and each treatment was recorded in a register.

94. Monitoring of drug intake by patients was done on a daily basis by the CHIs and on a weekly basis by staff of the FLHF and research team. Staff of the FLHF and the district medical officer addressed issues of side effects reported by CHIs. Subsequently, treatment registers were retrieved for compilation of data. Treatment records and supervision reports were used to evaluate the treatment coverage and compliance with treatment. Social scientists carried out in-depth interviews with health personnel, community leaders and community health implementers and focus-group discussions with community members to assess their attitude towards the treatment process.

95. This study was approved by the Ministry of Public Health of Cameroon which issued administrative clearance. Ethical Clearance was obtained from the institutional review board of the Tropical Medicine Research station, Kumba, Cameroon and Communities and individuals who participated in the study gave their written informed consent.

96. Results: The community members adhered massively to the process. Of the 21355 individuals counted, 17519 were eligible for treatment and 12936 were treated with doxycycline; giving therapeutic coverage of eligible population of 73.8%. Of the 12936 who started the treatment, 97.5% complied by the end of six weeks. No serious side effect was registered during the six week treatment. Side effects following doxycyclin treatment Of the 371 cases of mild side effects recorded during the treatment 270 (72.8%), the majority were well known to be associated with doxycyclin intake. Apart from one patient who received drugs to treat a swollen arm, these side effects were generally mild and subsided without any intervention or interruption of treatment.

97. Conclusions: When empowered, community health implementers can successfully deliver doxycyclin for six weeks for the treatment of onchocerciasis in areas of co-endemicity with loiasis. The therapeutic coverage and compliance treatment rate achieved, coupled with the known efficacy of doxycyclin on *O. volvulus* are indicators that the strategy of mass administration of doxycyclin can be used to control onchocerciasis in areas of co-endemicity with loiasis where ivermectin may be contra-indicated. A mathematical model should be developed, based on data generated from this study coupled with other studies on efficacy of doxycyclin on *O. volvulus* both in human host and *Simulium* vectors to define the number of rounds and the periodicity of mass administration of doxycyclin to control onchocerciasis.

98. The following conclusions were made by TCC:

- a) *TCC congratulated Dr Wanji and his team for the significant progress made in this study, which demonstrates that Doxycyclin could be used as a potential new filaricide for mass treatment of onchocerciasis in controlled conditions in specific situations such as areas of co-endemicity with loiasis and as a substitute for Ivermectin in the event of resistance;*
- b) *Concerns were raised on some public health issues such as multiple doses, side effects, effect of residual parasite load in excluded portions of the population, the possibility of resistance to other pathogens, accurate exclusion of children under 12 years, and ethical implications of exclusion of pregnant women in the absence of pregnancy tests especially for possible first trimester pregnancies. The probability of maintaining incentives for Community Health Implementers (CHIs), ideal coverage, as well as compliance in field conditions was discussed;*
- c) *TCC wished the team success as they proceed further with the development of a mathematical model, determination of ideal number of rounds of distribution and assessment of impact of mass treatment on the impact of doxycyclin on parasite development in Simulium.*

MONITORING OF THE SPECIAL COUNTRY INITIATIVE IN NIGERIA: AGENDA ITEM 14

99. TCC19 recommended that APOC funds could be made available to finance training of more CDDs and other members of the community when justified (para.203). The aim is to: strengthen projects with high CDD: Population ratio, few community supervisors and mostly concerned are projects 6th and 7th years and above. Between 2006 and 2007, through the Special Country Initiative programme, a total of US \$176,245 was allocated to ten CDTI projects in Nigeria for implementation of Phase 1 of the Initiative.

100. The objective is to maintain and/or increase geographical and therapeutic coverage by: sensitization/mobilization of communities (8,536), training of new CDDs (32,815), re-training of CDDs (47,550), training of community supervisors (29,800), training of health workers (5,833) and production of IEC materials.

101. TCC 26 recommended independent validation of reports submitted and the presentation by APOC of the analysed data from the ten projects before TCC can advise on the funding of the next 17 projects, and if necessary re-assess and revise the process. The monitoring objectives and process was carried out to assess the extent to which the activities outlined in the letter of release of funds for the SCI have been carried out and to assess the extent of involvement of NGOs and NOCP members as supervisors during the implementation of the SCI process.

102. The Independent monitors also interviewed the following people:

- (i) Onchocerciasis/CDTI Coordinator for the State;
- (ii) Director of Public Health and Disease control (or equivalent officer);
- (iii) Permanent Secretary, NGO representative;
- (iv) Any other that may become relevant to the monitoring exercise

103. In addition, with regards to Sensitization/Mobilisation and IEC production, the realisation was that all states produced IEC; numbers produced were documented in all states except in Oyo and Niger; posters and stickers for the communities, forms and CDD brochure and forms for record keeping and reporting and that IEC was deployed to communities beyond those targeted for special intervention.

104. The following conclusions and recommendations were made by the monitors:
- (i) Only 60% of SCI activities particularly the training of supervisors and new CDDs as well as the production of print materials had been carried out;
 - (ii) The release of funds for the initiative was delayed for a long period and only a proportion of it has been paid as at the time of monitoring;
 - (iii) SCI has contributed immensely to awakening and effectiveness of the project in all the States visited;
 - (iv) Involvement of NGDOs in the project contributed positively to its effectiveness: technical support for the state teams and vetting of the IEC materials;
 - (v) Some NGDOs partners also provided additional financial support (UNICEF in Oyo State).

105. Analysis of reports received so far by APOC Management from the CDTI projects that benefited from the initiative, indicates that for a few projects there is improvement the CDD:population ratio. In Abia CDTI the ratio has gone from 1:366 to 1:160 and in Cross River CDTI project from 1:430 to 1:229. Although there are a noticeable number of new CDDs trained (16,360 out of 37,167 trained) only 46% of CDDs training target has been achieved.

106. APOC Management recognizes that there have been many challenges in the implementation of the special country initiative. Main challenges include failure by projects which benefited from this initiative to send financial returns to management, inability of projects to reach agreed targets especially the training of CDDs and community supervisors and the fact that independent supervisors were not always used by projects. As September 2009 reports had only been received from six projects: *Abia, Cross River, Kogi, Oyo, Taraba and Kwara*.

107. The following recommendations and conclusions were made by the TCC :

- a) *TCC recognizes the value of the objective of the Special Country Initiative, however, the results from the monitoring done by the independent experts team are not encouraging for several reasons:*
 - *Only 39.3% of US \$ 97,212.51 released to projects have been justified;*
 - *6 out of 10 projects were not able to reach half of CDD training target;*
 - *8 out of 10 projects did not reach half of Community Supervisor training target;*
- b) *The NOTF should clarify the utilization of funds released for each project and identify the level where unjustified funds are kept (with bank written proof);*
- c) *Funding of other projects should stop until the situation is clarified;*
- d) *In future, NGO partners must be informed about planned activities and funds released to projects.*

PROGRESS IN ONCHOCERCIASIS CONTROL AND FEASIBILITY OF CO-IMPLEMENTATION OF NTDS IN CHAD: AGENDA ITEM 15

108. CDTI started in Chad in 1998 and takes place in 7 Regions of the Equatorial zone (in 19 health districts covering 231 health zones). AFRICARE and OPC have been partners since 2003. Local NGDOS are: Bureau d'Etudes de Liaison des Actions Caritatives de Développement, World Vision, Entente des Missions Evangéliques au Tchad and MID Baptiste Mission.

109. The Plans of action available describe the CDTI activities at all levels (Regions, Health Districts, Health zones). CDTI is under the direct control of decentralised structures (Regional DSR)/MCD and

heads of health zones) and is managed in an integrated manner at PMA). The awareness of communities is good (which is apparent from the levels of therapeutic and geographic coverage which have been 81% and 100% respectively over the last two years. The CDDs are self-motivated although there are differences from one community to another). They have established fora for community self-monitoring.

110. The rate of therapeutic coverage has been more than 80% since 2007; all the endemic areas are covered by CDTI projects with 100% geographic coverage since 2001. The rate of implementation of treatment objectives and training are high, at 100% since 2007. The ratio of CDDs to population has been improved from 1:385 to 1:124 between 2006 and 2008. The level of knowledge of the disease by communities has increased overall.

111. Specific activities carried out in 2009 include, monitoring treatment coverage, evaluation of the impact of ivermectin treatment, however, the large extent and remoteness makes coordination of the project zone and follow-up of activities difficult.

112. Challenges and outstanding issues: The workload of CDDs is high because of the movement (transfers) of health workers, there is need to put CDTI in new places; the low logistic capacity of Health Districts and Health zones hinders better supervision; lack of sufficient material for sensitisation at all levels; insufficient monitoring of onchocerciasis; existence of other NTDs in the health zone of CDTI; insufficient management tools (treatment registers) and creation of two decentralised coordination posts at Moundou and Sarh.

113. Solutions to be considered are: training of additional CDDs (to reduce the workload); training is planned for new health workers; reinforce the logistic capacity of decentralised coordination and of districts in order to facilitate their work of the supervisor; reinforcing the visibility of PNLO with audio-visual equipment, IEC, advocacy and social mobilization and strengthening partnerships for the development of other activities for control of NTDs.

114. The following conclusions were made by TCC:

- a) *TCC congratulated Chad on their impressive achievement, including more than 80% therapeutic coverage in the last two years and the involvement of several local NGOs in CDTI and co-implementation. TCC commended the Government for developing a national policy on using CDDs for other community-based activities which provide incentives and encouraged the project to involve communities in decision-making on incentives and also train more CDDs in order to achieve the desired target and reduce demand for incentives.*
- b) *TCC also encourages other countries to reflect on the example of Chad in developing similar national policies, noting the importance of retraining as an essential element of the CDTI approach, as well as community self-monitoring.*

MANAGEMENT OF APOC TRUST FUND

REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS: AGENDA ITEM 16

115. TCC members were informed that the total Programme budget for year 2009 was increased by US \$6 Million during the last 125th CSA session. Instead of US \$6,904,585 announced during the last TCC, a revised total amount of US \$9,467,585 has been budgeted for funding 117 projects in 2009 and other

programmes in 4 Ex-OCP countries. As of 31st August 2009, US \$7,447,314 has been released/obligated for 112 national projects (106 CDTI projects and 6 HQ support projects) and 4 Ex-OCP countries.

116. Overall, 67% of new APOC global budget (US \$26,490 000) has been implemented, as of 31st August 2009, to support national projects, 4 ex-OCP countries, to fund technical assistance and consultants, training activities, personnel services, contracts, statutory meetings, travel, administrative support to WHO/AFRO/HQ/Country Offices, supplies & equipments, and operating costs.

117. During the presentation, it was pointed out that the amount allocated to the contracts/other research was under spent and effort needs to be put in place for consumption of operational research budget. Special remarks have been made on some operational and financial issues such as:

- (i) Delay in transmission of signed DFC by NOTF that affected the release of the first instalment of the fund to projects. On the other hand, a lack or late submission of financial report is also delaying the release of the second and last instalment of fund to projects;
- (ii) APOC finance regulations remain unchanged when the MoH keeps changing their financial process by opening a pool bank account as agreed through the SWAp funding process. APOC Management needs to meet this new challenge by aligning its regulations;
- (iii) A new standard format for submission of project PAB was updated for year 2010 and shared with the National programmes but they failed to meet the dead line of submission of 2010 PAB that should be used for the DFC/LoA preparation planned for early October 2009.

REVIEW OF FINANCIAL: AGENDA ITEM 17

118. The status of DFC/LoA agreements for Projects as of 31/08/09 was presented; a total of 117 PABs for DFC/LoA were expected of which 113 have been received, 112 PABs had been revised and the DFCs prepared. One PAB was on standby for technical reasons whilst a further 3 were on standby for projects not yet launched.

119. The number of financial returns not yet submitted by 31/12/08 was 897. Five hundred and eighty four 584 (65% of the total) were received during 2009 whilst 313 (35%) were still not received.

120. Regarding the status of financial monthly returns analysis, by 31/08/2009, 1549 monthly returns had been received and 404 analysed at the AAF/country level and 195 at the HQ/APOC level whilst 861 returns have not yet been received. Fifty-eight projects receive red cards because their monthly returns are more than 5 months late.

121. In conclusion, there was a low rate of regular submission of financial returns by the Projects, a lack of submission of the summary DFC reporting format (GSM requirement). There is a high workload of financial staff for the analysis of financial returns at APOC Headquarters, and it would therefore be desirable to have more involvement of AAF in financial returns retrieval & review at country level. There is a need for re-training of project teams on financial management, and it has been noted that there are many discrepancies in Table No.13 of the Technical report regarding Trust Fund disclosure.

122. The initial budget approved by JAF14 was US\$ 20.49 million. The additional budget approved by the 125th CSA was US \$ 6 million, and the total 2009 budget was US\$ 26.49 million.

REVIEWS

REVIEW OF 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH AND 12TH YEAR ANNUAL TECHNICAL REPORTS: AGENDA ITEM 18

Summary Budgets of Submitted Research proposals

No	Research Proposal	Amount (US\$)*
1.	Pilot test large scale of fly nuisance control using palm oil (<i>Elaeis guineensis</i>) based cream in river basins of Côte d'Ivoire. (CFA 12,000,900)	26,324
2.	Study of Ivermectin impact on Onchocerciasis transmission in the various foci in Côte d'Ivoire during the post-crisis period. (CFA 8,872,600)	19,462
3.	Study of blackfly infectivity in the original area of Oncho control in Côte d'Ivoire. (CFA 9,532,050)	20,909
4.	Comparative efficacy of different methods of protection against blackfly nuisance in the forest and savannah areas of Côte d'Ivoire. (CFA 9,481,182)	20,797
5.	Adoption of CDTI strategy in post crisis Côte d'Ivoire. (CFA 9,897,157)	21,710
Total (1)+(2)+(3)+(4)+(5)		109, 202

* Calculated at an exchange rate of 455.89 CFA= \$1

CAMEROON PROJECTS:

NOTF (Cameroon), 10th year Technical Report.

123. *TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation:*

Report-related:

- (i) Avoid cut-and-paste practice;
- (ii) For the executive summary, try as much as possible to limit to a page, and avoid adding tables;
- (iii) Keep to one numbering style, and avoid labelling tables with the same number;
- (iv) To the extent feasible, explain the relevance of the information provided.

Project-related:

- (i) Indicate vector control policy and role of NGO partner “Yaoundé Initiative Foundation” in vector control;
- (ii) Explain why distribution is sometimes carried out in the rainy season;
- (iii) Draw up a table in annexe to spell out fund disbursement to CDDs, for motivation according to projects;
- (iv) Provide fund disbursement difficulty detail, and also advocacy actions undertaken toward the Ministry of Finance, so as to carry out high-level advocacy with APOC;
- (v) Give detailed information on the urban prescribers of Mectizan, and screening and/or diagnosis and monitoring modalities of these persons;

- (vi) Provide information on audio-visual equipment matters and follow-up with respect to funding providers, and who disburses funds, so as to understand the issue at stake;
- (vii) Explain what NOTF means by “decentralisation of CDD incentive management” adopted by the Ministry of Health;
- (viii) Regarding SAE monitoring, it might be appropriate to conduct medical follow-up of the patients in question, 3 months after being discharged from hospital.

124. It is recommended that the report be accepted, with the project taking into account the suggestions for improvement made. TCC recommended that Dr Ntep be congratulated on her award of the Order of Merit of Cameroon.

North Province CDTI Project (Cameroon) 6th year Technical Report (re-submission)

125. The presentation of the report is of average quality. On the whole the project performed well and has had a good rate of therapeutic and geographic coverage for 5 years.

126. TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation:

Report-related

- (i) There is inconsistency in the figures for CDDs trained given in the analytical summary and those given in Table 5;
- (ii) Table 14 on costs is missing;
- (iii) The analytical summary does not report the essential data such as geographical coverage, the total population of the project zone, the total number of communities in meso- and hyper-endemic areas, the current total number of CDDs and female CDDs or numbers trained or recycled during the reporting period.

Project-related:

- (i) On the whole, the project performed well and had a good therapeutic and geographic coverage 5 years ago as the activities reported were conducted in 2004.

Recommendation to the project Coordinator

- (i) To improve ratio of population /CDDs,
- (ii) To improve the participation of women in CDTI,
- (iii) To improve the rate of release of funds from the Region,
- (iv) Ownership and provision of motivation of CDDs by the community.

CONGO PROJECTS

Congo Extension CDTI Project (Congo) 4th year Annual Technical Report (re-submission).

127. This was a good report but almost identical to that submitted to TCC 28 with no precise responses to the questions asked in TCC 26 or 28. TCC understands that the basic information may not change from one year to another. The report indicates that the only variables are on performance, which is changing annually. Changes in constraints, opportunities and activities conducted etc are also expected.

128. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report Related:

- (i) The project managers must make an effort to avoid copy and paste;
- (ii) A precise map of the actual project area (rather than of the whole of Congo) should be provided in the next report submitted to TCC;
- (iii) Provide information on the progress with mapping of LF in the Congo.

Congo Extension CDTI Project (Congo) 5th year Technical Report

129. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report-related:

- (i) The document is very well written and presented in line with TCC-recommended format;
- (ii) Figures are well presented and commented upon.

Project-related:

- (i) CDTI performance is palpable through a therapeutic coverage of 84.6% in 2008,
- (ii) The communities' financial contribution toward CDTI activities is appreciable,
- (iii) TCC encourages the project to maintain therapeutic coverage.

LIBERIA PROJECTS

South Western CDTI Project (Liberia) 3rd year Technical Report.

This was a fairly well-presented report for a young project in a post-conflict country.

131. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Check for consistency with the figures provided,
- (ii) Make adequate plan,
- (iii) Review table 13.

Project related:

- (i) Intensify advocacy to national level for better funding and integration of CDTI into PHC;
- (ii) Conduct CSM training before the sustainability plan;
- (iii) Develop 3-year sustainability plan and submit it in 2009;
- (iv) Increase the ratio CDD/population and women participation;
- (v) Increase to 100% GC;
- (vi) Provide additional information on the \$20,000 budgeted and released by the MoH during the reporting period and its use;
- (vii) Inform APOC and MDP on the staff change.

South East CDTI Project (Liberia) 3rd year technical report.

132. This was a concise and well-written report showing commitment of project implementers in a post-conflict situation.

133. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Information should be provided on all the outstanding issues raised by TCC 26 which were not addressed in the report;
- (ii) Report on the outcome of advocacy visit carried out during the reporting period;
- (iii) Provide information on financial contribution in Year 1 and 2;
- (iv) Provide information on the reason for poor utilization of approved budget.

Project related:

- (i) Provide explanation why total population is used as Ultimate treatment goal;
- (ii) Reduce CDD: Community member ratio;
- (iii) Increase the number of Health staff involved in CDTI;
- (iv) Shorten the wide spread period in the implementation of timeline activities;
- (v) Increase geographic coverage at both district and county level;
- (vi) Request for APOC Evaluation of the sustainability of the project;
- (vii) Conduct CSM and SHM to improve community involvement and supervision;
- (viii) Sustain advocacy to ensure that in the Basic packages of health policy of the MOHSW, onchocerciasis- ivermectin drug programme is included;
- (ix) Improve on capacity for the utilization of approved budget.

NIGERIA PROJECTS

Bauchi CDTI Project (Nigeria) 6th year Technical Report

134. The report is well-written, detailed and contains most of the required information. Progress was made in implementing TCC28 recommendations although two remain outstanding. Commendable achievements in partnership, advocacy, integration into PHC, involvement of traditional rulers as CDDs, attainment of a good CDD: population ratio and in training of HR. Although involvement of women is still low, the efforts being made are commendable.

135. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Report related recommendations to be addressed in the next Annual Technical Report

Project related:

- (i) Carry out annual census update and include all eligible communities;
- (ii) Advocacy for the release of counterpart funds;
- (iii) Encourage communities to be involved in supervision of CDTI activities;
- (iv) Improve on therapeutic coverage;
- (v) Train all health staff on CDTI;

- (vi) Train in CSM and conduct CSM and SHM:
- (vii) All partners to improve on release of budgeted fund;
- (viii) Follow-up on loss of drugs and seek reassurance that internal controls will be strengthened to avoid future reoccurrence.

Recommendations to APOC

- (i) Replace capital equipment; this is a six year project;
- (ii) Address constraints for release of APOC funds.

NOTF/HQ Project (Nigeria) 11th year Technical Report.

136. This is a well-written comprehensive and informative report with several issues raised including among others; Poor performance of some projects with low geographic and therapeutic coverage and poor counterpart funding. Effort at integration is commendable and should be encouraged. The 2-year work-plans for 2008 and 2009 were provided

137. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) NOTF to fully investigate reports submitted by projects so far, identify where reports are missing and ensure such reports are submitted to APOC.

Project related:

- (i) Again advise projects to shorten the period of CDTI activities and avoid the rainy season;
- (ii) Train more CDDs who carry out the drug distribution;
- (iii) NOCP should focus on states with low geographic and therapeutic coverage, Akwa Ibom, Bauchi Benue, Kwara, Niger, Ogun and Osun to ensure they improve, Note and disseminate the fact that target is now 80% for therapeutic coverage and 100% geographic coverage critical for interruption of transmission;
- (iv) NOCP HQ should support projects to institute/upscale CSM and SHM, which is currently in place only in 50% LGAs;
- (v) Effort at improving counterpart funding in projects is essential, but NOTF and projects should also explore other funding sources;
- (vi) Nigeria should begin to put in place a national drug distribution system and storage facility instead of depending on partners.

Akwa Ibom CDTI Project (Nigeria) 4th year Technical Report

138. A fairly well-written report providing useful information on the performance of this CDTI Project. This project seems to have been overfunded and did not justify the financial investment put into it. The project highlights 3 strengths and 12 challenges including inadequate logistics. It did not show that the project leadership understands the philosophy of APOC very well.

139. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report Related:

- (i) Ensure endorsement of report by all key stakeholders,
- (ii) Provide details on financial support by NGDO partner,
- (iii) Conduct CSM and SHM to improve community involvement and supervision.

Project related:

- (i) Increase and sustain at least 80% therapeutic coverage,
- (ii) Train more CDDs,
- (iii) Intensify community mobilization and sensitization,
- (iv) Initiate CSM and SHM.

Recommendation to APOC

- (i) It may be necessary for APOC to stop funding this project until a decision on the way forward is proposed by NOTF/Nigeria.

Akwa Ibom CDTI Project (Nigeria) 5th year Technical Report

140. The report was fairly well-written but project not doing well. Therapeutic coverage of 67% is not good enough for a project that has only 26,408 persons in 13 communities in 2 LGAs to treat. High rate of absentees and refusals (Total 2888 (10%)) reflects poor planning and inadequate community sensitisation and mobilization. Amount spent per person per treatment (\$2.67) is quite high for a project that is not in a conflict zone. Available trained manpower is inadequate with only 20 (6%) out of 337 health workers in the area are involved in CDTI and 1CDD serving 419 persons.

141. ***TCC recommends that NOTF conduct a comprehensive appraisal of implementation of CDTI in Akwa Ibom State and report back to TCC through APOC latest by October 20, 2009. Meanwhile APOC should suspend funding of the project till this assignment is concluded.***

142. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Respond to previous TCC recommendations;
- (ii) Reconcile figures in the Executive summary and Table 13 on the proportion of budget released;
- (iii) Provide information on what the balance of \$ 4,603 was used for;
- (iv) Provide accurate figures under Number in stock and Number used/persons treated on Table 10.

Project related:

- (i) De-emphasize monetary incentives for CDDs;
- (ii) Conduct mass sensitisation and mobilization of communities towards more active involvement in CDTI activities and ownership;
- (iii) Submit sustainability plan;
- (iv) Implement recommendations from sustainability evaluation;
- (v) Reduce amount spent per treatment;
- (vi) Initiate integration of CDTI into PHC;
- (vii) Train all health staff in project area on CDTI and involve them in the programme. This will take care of problems arising from frequent transfers;
- (viii) Intensify efforts in identifying more CBOs and VHCs and provide them with training and CDTI IEC materials;

- (ix) NGDO should devolve ordering and storing of Mectizan to state;
- (x) Intensify monitoring of CDTI activities at all levels;
- (xi) Use checklist during supervision;
- (xii) NOCP should closely monitor this project especially regarding accuracy in dosage, record keeping, and utilization of funds.

SOUTH SUDAN PROJECT

East Bahr El Ghazal CDTI project (Southern Sudan) 3rd year Technical Report

143. This project has achieved commendable improvement in coverage. However, most of previous TCC recommendations have not been exhaustively addressed. Community mobilization and sensitization need to be intensified to improve the CDD: population ratio and participation of community in CDTI activities particularly supervision.

144. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Subsequent reports should be carefully vetted before submission to avoid grammatical and typographical errors;
- (ii) Reduce volume of challenges in the Executive Summary.

Project related:

- (i) Delineate all hyper and meso-endemic villages,
- (ii) Increase number of CDDs in the project,
- (iii) Increase number of FLHF staff involved in CDTI,
- (iv) Retrain FLHF staff and CDDs on record keeping,
- (v) Intensify community mobilization and sensitization,
- (vi) Carry out monitoring and evaluation at all levels,
- (vii) Initiate integration of CDTI into PHC,
- (viii) Conduct operational research on attrition of CDDs,
- (ix) Improve on coverage,
- (x) Mobilize all communities to conduct CSM and SHM,
- (xi) Advocate for funding of project by Government.

East Equatoria CDTI Project (South Sudan) 3rd year Technical Report

145. The Quality of project implementation has improved considerably from last report. Coverage has increased; geographical coverage from 13.29% in 2007 to 80% in 2008 and Therapeutic coverage from 29.26% in 2007 to 62.4% in 2008. Progress made in advocacy is commendable. However, shortage of manpower particularly health workers on MOH payroll, poor CDD population ratio, and inaccurate calculation of number of Mectizan tablets required are challenges that should be addressed urgently.

146. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Officials endorsing the report should vet subsequent reports to reduce number of errors;
- (ii) Officer preparing the report should present challenges in a more succinct manner in the executive summary;
- (iii) Officer preparing report should avoid mixing up weaknesses and challenges in the SWOT analysis.

Project related:

- (i) Project to intensify advocacy to Government at all level to absorb CDTI staff into MOH/PHC;
- (ii) Project to initiate integration of CDTI activities into PHC;
- (iii) MOH and NGDO to assist in maintaining equipment;
- (iv) APOC should arrange for participatory independent monitoring and Mid-Term Sustainability evaluation of the project;
- (v) Project should conduct CSM and SHM;
- (vi) Project should sensitize communities on need to select and support more CDDs;
- (vii) Project to encourage communities to participate more actively in CDTI activities.

SSOTF/HQ (South Sudan) 3rd year Technical Report

147. This is a well-written report of a project in a country just emerging from conflict. The provision of an enabling environment is key to overall improvement in implementation of projects, but this is dependent on external factors. Although some staff members have been placed on the payroll, the number is still grossly inadequate and key staff still needed, as is more training of front line facility staff. CSM and SHM training still not done in spite of a previous TCC recommendation. The technical advisor needs to involve programme staff in supervision for sustainability.

148. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Project to correct the data in executive summary on communities targeted for treatment;
- (ii) Improve on quality of map provided under general information;
- (iii) Correct /account for the shortfall of 2,000 tablets in table 5;
- (iv) They should also provide explanation for lower total population in 2008 as compared to 2007.

Recommendations to the project:

- (i) Activities should be carried out in the dry season and priority should be given to training of health centre staff;
- (ii) TCC reiterates that training on CSM and SHM should be carried out as part of CDTI training, as these activities are part and parcel of CDTI;
- (iii) There is need to maintain some presence in states which do not have CDTI offices to improve interest, funding and commitment to CDTI;

Recommendations to APOC:

- (i) Report of coverage monitoring exercise should be provided to SSOTF secretariat by APOC management;
- (ii) Funds to be released in time to enable implementation of activities in dry season as planned.

Upper Nile CDTI Project (Southern Sudan) 3rd year Technical Report

149. This is a year 3 report of a project in an ecologically difficult post-conflict area. The main problems encountered include difficult access, delay in the release of purchased vehicle and late arrival of APOC funds. CDTI activities were conducted in the rainy season resulting in the loss of Mectizan consignment meant for one district to flooding. The reduction in total population even though number of villages increased was not explained.

150. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Use landscape only for tables to make report easier to read;
- (ii) Correct data in table 2 as meso-endemic population of 257,481 plus hyper-endemic 357,513 add up to 614,994 and not the 482,155 indicated;
- (iii) Correct table 3 to reflect correct number of Mectizan tablets received, lost and Remaining;
- (iv) Indicate who does supervision and avoid unnecessary changes in reporting format.

Project related:

- (i) Train CDDs well to ensure they give the drug correctly by height, and on CDTI philosophy to reduce expectation of incentive or employ other innovative ways like using same people for paying and non-paying community activities;
- (ii) Ensure monitoring checklist is produced in adequate numbers and used;
- (iii) CSM and SHM should be included in routine CDTI training and commenced as soon as security situation permits.

Recommendation to APOC:

- (i) Release the vehicle for field work and ensure funds get to the field in the dry season.

West Bahr El Ghazal CDTI Project (South Sudan) 3rd year Technical Report

151. This a concise and well-written report showing key achievements like the absorption of PCO and 8 county supervisors into the ministry of health, increase in geographic coverage and therapeutic coverage and the reduction of CDD: Community ratio from 5116 in year 2007 to 1017 in 2008.

152. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

Report Related:

- (i) Information should be provided on year 1 report as requested by TCC 28;
- (ii) Provide information on very low Annual treatment objective for year 2008;
- (iii) Provide more information on the international NGO interested in supporting Raja and Aweil West counties and intended areas of support;
- (iv) Provide more information on consistent underutilization of APOC approved budget.

Project Related:

- (i) Ensure early commencement of CDTI activities,
- (ii) Update census in all the counties,
- (iii) Increase geographic and therapeutic coverages,
- (iv) Reduce CDD community member ratio to 1CDD:100 community members,
- (v) Mobilize and sensitize communities on their roles and criteria for CDD selection,
- (vi) Conduct CSM and SHM to improve community involvement and supervision,
- (vii) Sustain advocacy on absorption of remaining CDTI staff, and
- (viii) CDTI into the Health service system.

West Equatoria CDTI Project (South Sudan) 4th year Technical Report 2008

153. This is a fourth year report with an informative summary. Although progress has been made since 2004, both geographic and therapeutic coverage remain very low: 79% and 60%, respectively. This was primarily due to security problems. Despite some progress relevant to previous recommendations, further efforts should be made.

154. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

Project-related:

- (i) Improve treatment coverage;
- (ii) Further increase the number of CDDs;
- (iii) Increase the participation of female community members in CDTI activities.

Report-related:

- (i) The total number of communities in the entire project area has decreased from 697 communities (365 meso- and 332 hyper-endemic) in 2007 to 683 communities (417 meso- and 266 hyper-endemic) in 2008. No explanation was given for this;
- (ii) The project is therefore requested to explain why there was this decrease and the significant fluctuation in the number of meso- and hyper-endemic communities;
- (iii) TCC strongly recommends that the project conducts a census

CROSS-CUTTING OBSERVATIONS ON THE SUDAN PROJECTS:

155. TCC noted with satisfaction improvement in quality of programme implementation following the engagement of a Technical Adviser to Sudan. TCC recommended that NOTF should intensify advocacy to Government for absorption of CDTI workers into Ministry of Health, maintenance of equipment, and release of counterpart funds. NOTF should ensure that projects conduct SHM and CSM, improve on CDD ratio, initiate integration and conclude census. APOC assured TCC that independent participatory monitoring and sustainability evaluation of CDTI projects in Sudan is about to commence. TCC requested APOC to conclusively resolve problems faced by the projects in receiving APOC funds.

DEMOCRATIC REPUBLIC OF CONGO (DRC) PROJECTS

Bandundu CDTI Project (DRC) 6th year Technical Report DRC

156. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) The document is generally well-written and easy to read;
- (ii) Responses have been given to all the recommendations of TCC27;
- (iii) The summary is concise, complete and coherent in relation to the data given in the report;
- (iv) The report however has some gaps:
 - Tables 4 and 5: calculations need to be verified;
 - In 2006 the therapeutic coverage was 66% (minimum 44% at Panzi and maximum 75% at Kasshibanda); this doesn't appear in Table 9 and needs to be verified and completed;
 - Table 13: complete this with data for years 3 and 4;
- (v) The number of expired tablets is high, without any explanation (8,3970);
- (vi) Complete the information on the number of tablets remaining (p42: year 2006)

Project related:

- (i) Geographical coverage has been 100% since 2007;
- (ii) The average therapeutic coverage is increasing annually (24%, 51%, 63%, 73% and 74.5%);
- (iii) The ratio of CDD:population is still high at 1CDD;225 pers;
- (iv) Coverage of CSM (4%) is clearly insufficient for a project in its fifth year. It is the same for IPM of which no activity has yet been conducted;
- (v) The fact that the only vehicle is in a defective state risks affecting the supervision, which is increasingly limited to the edges of the project.

157. The following recommendations were made by TCC :

- a. ***TCC draws the attention of the project to the fact that the weaknesses identified must be corrected in the next report. It therefore requests the project to: i) verify the calculations of different tables of the report ii) complete all sections of different tables iii) increase the number of CSM and IPM exercises iv) train a maximum of CDDs in order to reduce the workload which is currently 1CDD/225 pers. v) pursue advocacy to increase the financial participation of the State; vi) Follow-up the sensitisation/advocacy to reduce the number of absentees and refusals; vii) provide the data for Vitamin A supplementation and mass distribution of albendazole.***

Equateur-Kiri CDTI Project (DRC) 4th year Technical Report

158. The report is well-written and provides the needed information to assess project performance. This is a project in its 4th year, but at its 3rd Mectizan distribution in 8 of the 11 health zones. Project should be congratulated for the proportion of women CDDs and their participation in project activities.

159. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

Report-related:

- (i) Revisit Table 10,
- (ii) Explain why the project could not cover 100% of health areas of the programme,
- (iii) Give details of problems relating to bad management of drugs.

Project-related:

- (i) There is obviously a problem of planning;
- (ii) Undertake Mectizan distribution planning over 2 months at most, and avoid long periods during rainy season;
- (iii) Do planning of activities adapted to field realities;
- (iv) Intensify and review strategy of advocacy toward political and administrative authorities, with a view to obtaining expected results, such as financial support from government;
- (v) Emphasize importance of data collection from CDDs and nurses who train them;
- (vi) Improve CDD/population ratio to 1 CDD/100 persons;
- (vii) Improve geographic coverage to 100% as well as therapeutic coverage to at least 80%;
- (viii) Manage drugs well, and avoid high rate of loss/waste???
- (ix) Do training on CSM, SHM at all levels. Recommendation to APOC: APOC should make a high level mission to the country to look into administrative/logistic difficulties.

Lubutu CDTI Project (DRC) 2nd year Technical Report

160. The report is well-written.

161. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Executive summary does not give key data such as total population, population covered, UTG and ATO;
- (ii) Tables 6 and 9 are incomplete and contain errors.

Project related:

- (i) The project started well, but much needs to be done to:
 - Encourage the populations to get more involved in the process of choosing supervisors from the community, as well as more female CDDs;
 - Improve treatment coverage by extending activities to other districts.
 - Carry out blood tests systematically in case of SAEs.

TCC recommendations:

- a. ***TCC recommends that the coordination office do the necessary corrections and take the above remarks into account for subsequent reports;***
- b. ***TCC also recommends that blood tests are indispensable because of the risk of SAEs. TCC accepts the report subject to corrections recommended above.***

Masisi Walikale CDTI Project (DRC) 1st year Technical Report (re-submission)

162. Though this report is being re-submitted, it still has a lot of lapses. Recommendations of TCC28 have not been adequately addressed.

163. Furthermore, it appears that the report seems to cover a period which is different from the one for which the previous report was rejected, despite the fact that the authors of the report had mentioned on the cover page that the reporting period was 2007.

164. ***TCC considered the report and returns it, requesting that the following recommendations and suggestions be taken account of to improve reporting and project implementation***

Report related:

- (i) Data are mixed up and this makes assessment of the project almost impossible.

Project related:

- (i) No treatment was done during the reporting period, and yet an amount of \$36,272 \$ was spent.

TCC Recommendations:

- a. ***Re-write the report, while limiting it to activities and expenditure of the 2007 period, which corresponds to the first year of the project. All activities and expenditure in 2008 must be included in the report of the 2nd year to be submitted to APOC Management for review at TCC 30.***
- b. ***APOC Management can give technical assistance to the project. Meanwhile financing should be suspended until the situation is properly addressed.***

Mongala CDTI Project (DRC) 4th year Technical Report

165. Generally, the report is well-written, and previous TCC recommendations and remarks were taken into account.

166. ***TCC accepted the report with the following recommendations and suggestions for improving the reporting.***

Report-related:

- (i) Need to indicate total number of CDDs in executive summary;
- (ii) Standardize 2006 geographic and therapeutic values for 2006 with those in the initial report examined by TCC26;
- (iii) Specify the number of communities that have community members as supervisors (table 4).

Projected related:

- (i) Project's performance is rather average, hence project officers must redouble efforts to enhance the involvement of female CDDs;
- (ii) Improve community participation in incentive packages for CDDs;
- (iii) Hasten CSM process and the drawing up of sustainability plans;
- (iv) Find adequate solutions to the various problems identified during supervision, namely, lack of planning in more than 50% of the areas.

NOTF HQ Project (DRC) 9th year Technical Report

167. ***TCC accepted the report with the following recommendations and suggestions for improving reporting***

Report related:

- (i) summary needs to be improved by leaving out too many tables and sections;
- (ii) The report does not make for easy reading because a lot of figures are not properly arranged;
- (iii) There are many important tables but many of them are incomplete and not commented upon;
- (iv) There is very little comparative analysis among the 20 projects.

Recommendations for future reports:

- (i) Provide an executive summary with all key figures, without tables or sections;
- (ii) Give the “total” at the end of each table;
- (iii) Conduct comparative analysis of the projects, by undertaking some relevant categorization;
- (iv) Make sure figures agree between tables, by reviewing documents well;
- (v) Explain why CSM is not conducted in none of the projects.

Rutshuru-Goma CDTI Project (DRC) 3rd year Technical Report

168. ***TCC accepted the report with the following recommendations and suggestions for improving reporting.***

169. TCC regrets that treatment has not been able to be organised due to the fact that Mectizan did not arrive on time and due to non disbursement of the second instalment of funds from APOC. It seems that this was due to a delay in placing the order for Mectizan on the part of the project and to a delay in submitting the plan of action and budget to APOC for the funding and lack of a report on previous expenditure to APOC. However, it seems that the amount received was greater than that indicated in the report (US \$44,000).

170. The report was too concise and without much detail on the reasons for the delay in arrival of Mectizan and the fact that activities were not conducted (the term insecurity is not sufficient). TCC would have liked to have information, on the development of the situation between the end of 2008 and August 2009 and on factors affecting the treatment campaign for 2009.

Ubangui Nord CDTI Project (DRC) 4th year Technical Report

171. TCC congratulates project managers for the good performance achieved in the 5 health zones treated. The Committee is full of praise for the efforts made enabling a good ratio of CDD/population to be attained, which is good for sustainability. It equally congratulates the project for the excellent organisation that allowed for early screening and optimal management of SAEs, given the circumstances. Table reporting information on each SAE case is informative, which was appreciated. TCC believes the cost per person treated, though still high, is acceptable for the third year of treatment in an area that is co-endemic for onchocerciasis-*Loa loa*. TCC appreciates the very high quality of the report itself and the illustrations in it.

172. TCC observes that the Congolese government’s financial contribution to this project is greater than what is given to other projects. However, this assistance needs to be further increased.

173. TCC recommends that APOC Management should ensure that fund disbursement problems are resolved so as to enable the project to increase geographic coverage. Project and APOC Management could also hold discussions so as to improve the computer and office equipment situation. Community sensitization activities should continue to motivate CDDs.

CROSS-CUTTING OBSERVATIONS ON DRC PROJECTS (SAEs)

174. TCC noted, following the examination of technical reports received from DRC that the incidence of SAEs in certain projects was still high, and that in a significant number of cases these SAEs resulted in fatality. It noted that the management of SAEs varied greatly from one project to another. It has equally been informed that Dr Virgile Kikaya, in charge of managing this problem in the western part of the country, is no longer in post in DRC.

175. Consequently, TCC made the following recommendations: In the short-term, the NOTF of DRC must rapidly identify a motivated young doctor with clinical expertise who should replace Dr Kikaya. DRC should notify APOC management and MDP as soon as this appointment is made. Meanwhile, examination of reports coming from DRC showed that the management of SAEs was optimal in certain projects (for example, Ubangui Nord), but less satisfactory in others (for example, Lubutu, where it seems that no thick smear had been made from patients having developed SAEs). TCC recommends that an investigation be conducted to determine the reasons for these differences between projects.

- (i) Further efforts should be made to identify the treatment most appropriate for caring for people presenting SAEs. TCC recommends that experiments be conducted on the *Loa*-Baboon model developed in Cameroon.
- (ii) The Projects should be encouraged to train more staff
- (iii) The Project should attempt the managerial issues
- (iv) A TCC/APOC team should plan to visit DRC to address these issues

TANZANIA PROJECTS

Morogoro Focus CDTI Project (Tanzania) 4th year Technical Report

176. The report is well-written. The project is performing well with good coverage adequate funding by Government, and commendable achievement in integration. Participation of community in supervision is impressive and male female CDD ratio is ideal. The project exhibits high potential for sustainability. However, high numbers of absentees and refusals pose serious problem that will affect coverage and sustainability if not checked.

177. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Respond to all TCC 27 recommendations;
- (ii) Provide missing information;
- (iii) Reasons and outcome of advocacy;
- (iv) Community response to, and suggestions for improvement of, mobilization, sensitization;
- (v) Issues identified and outcome re supervision;
- (vi) Plans for full integration of CDTI into PHC;
- (vii) Number of tablets lost and expired;
- (viii) Issues identified during supervision;
- (ix) Details on outcomes of supervision at each level of CDTI implementation

Project related:

- (i) Project to upscale CSM and SHM
- (ii) Project to encourage communities to select more CDDs to reduce workload on each CDD so that lack of incentives does not become a problem in future
- (iii) Project to Intensify sensitization in communities to reduce absentees and refusals
- (iv) NOTF to encourage researchers to conduct operational research on absentees and refusals

NOTF/HQ Project (Tanzania) 10th year Technical Report

178. A fairly well-written report showing integration and promotion of the use of CDTI in ongoing NTD interventions. TCC would like to know why Mectizan was not provided for the Ruvuma CDTI project and status of Mectizan distribution. The coverages given in the report also excluded the Ruvuma project population and therefore incorrect.

179. ***TCC accepted the report with the following recommendation and suggestion for improving reporting and project implementation***

Report related:

- (i) Ensure that the approved reporting format is used and not altered in reporting;
- (ii) List of Acronyms should always be updated and explained;
- (iii) Explain why Ultimate Treatment Goal is higher than total population in the report;
- (iv) The financial/in kind support by APOC and other Partners in the current year and the last 2 years;
- (v) Percentage of Health staff involved in CDTI;
- (vi) Detailed timeline of CDTI activities;
- (vii) Reason for late commencement of distribution of Mectizan;

Project related:

- (i) Provide more information on the distribution problem and reporting in Ruvuma project;
- (ii) Correct treatment coverage by including the Ruvuma population;
- (iii) Conduct census update;
- (iv) Train more CDDs;
- (v) Increase number of communities implementing CSM and SHM.

Tunduru CDTI Project (Tanzania) 4th year Technical Report.

180. The project runs well and the report is well written. CDTI activities are fully integrated into PHC and are executed under the directive of the DMO. The commitment of CDDs and the absence or very low attrition rate is commendable. The geographic coverage is 100% since the beginning of the project, and the therapeutic coverage has increased from 70% to 81% over the four years. However, there are some inconsistencies in the timeline of activities, and a mixing / confusion in partnership and population subsections.

181. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) The project should explain the reasons why activities were not implemented according to the scheduled timeline;
- (ii) The project should use the update reporting format for future reports;
- (iii) The name of other partners involved in the project should be provided, and their role should be highlighted.

Project related:

- (i) The project should carefully elaborate the timeline and ensure that activities are implemented in logical order;
- (ii) The involvement of health staff in CDTI activity should be further increased;
- (iii) The project should complete the operational research proposal and submit it to APOC.

ETHIOPIA PROJECTS:***East Wollega CDTI Project (Ethiopia) 4th year Technical Report (re-submission)***

182. This report is a resubmission and shows an improvement on the earlier submission. The report showed that the project made great efforts in the implementation of CSM in all endemic communities and SHM in 665 communities. There was also a system in place for good management and maintenance of APOC donated capital equipment using Government funds. However, this project still needs support to increase available trained manpower especially in report writing and data management.

183. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Correct the Reporting period to indicate Jan-Dec 2008 as reflected in the report;
- (ii) Ensure that the reports are endorsed by all appropriate authorities;
- (iii) Improve on the flow of information when putting together the executive summary and ensure consistency of the figures;
- (iv) Provide information on CDD incentives and attrition;
- (v) Correct calculation errors on table 5 regarding training;
- (vi) Correct table 6 to indicate that CSM and SHM were done see table 11;
- (vii) Explain why 17,200 tablets of Mectizan were lost during distribution;
- (viii) Complete table 9 regarding treatment trend;
- (ix) Provide information on financial contributions of partners for the 3 year period.

Project related:

- (i) Follow up on funding available for the project and ensure timely disbursement and utilization;
- (ii) Improve on record keeping at all levels;
- (iii) Ensure early commencement of CDTI activities;
- (iv) Increase available manpower at all levels for CDTI activities

West Wollega CDTI Project (Ethiopia) 4th year Technical Report (re-submission)

184. The report is satisfactory although it could be improved. Non-implemented TCC recommendations are fairly minor but they show a lack of attention to requested detail. The strengths of the project include; involvement of health staff, a good CDD: population ratio, consistently high therapeutic coverage, strong supervision and integration.

185. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) The Table on financial contributions for the current and past two years should be fully completed as required;
- (ii) Data on refusals and absenteeism should be reported in the standard table;
- (iii) Separate out discussion on women's participation from that of CDD attrition;
- (iv) Include a bit more discussion on sensitisation and mobilisation activities. It is likely that more than is reported is being accomplished.

Project related:

- (i) NOTF to decide on project management arrangements following the separation of West Wollega into two;
- (ii) The need for a more planned approach to advocacy; advocacy issues to be well defined, decision makers well targeted, outcomes monitored and reported.

COTE D'IVOIRE PROJECT

Cote d'Ivoire CDTI Project (Comoe, Bandama, Sassandra, Cavally and tributaries) 1st year Technical Report

186. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

Report related:

- (i) Easy-to-read report, but not quite in line with TCC format;
- (ii) Reporting period spans two years;
- (iii) No executive summary;
- (iv) Inadequate description of project area;
- (v) Number of health workers in project area not indicated;
- (vi) Not all partners are mentioned, and the role of each of them needs to be specified
- (vii) Distribution of communities involved in treatments in meso/hyper-endemic areas not conducted;
- (viii) Advocacy carried out, but problems/constraints not mentioned; same goes for suggestions for improvement;
- (ix) Sensitisation/mobilisation done, but no indication given about the communities' reaction; the same goes for suggestions for improvement.
- (x) Tables 4 and 5 need to be checked and/or completed;
- (xi) Lack of information on: a) number of refusals and absentees, b) number of wasted, expired or remaining tablets, c) cost per person treated.

Project-related:

- (i) Geographic coverage (26.16%) and TC (19.63%) are still low, since not all communities are taken into account;
- (ii) For communities treated in 2008, average TC is 73.18%;
- (iii) No SAEs;
- (iv) Quality training given to CDTI actors;
- (v) Supervision done during treatment;
- (vi) Population adheres to treatment;
- (vii) Political will lead to establishing government budget line for PNL Cé operations.

TCC Recommendations:

- a. *TCC congratulates PNL Cé leadership for keeping its commitments, by forwarding this report after visit of two TCC members in March 2009.*
- b. *TCC exhorts the project to: - extend treatment to the entire meso and hyper-endemic areas of Cote d'Ivoire, - continue entomo-epidemiological surveys to obtain updated data on the onchocerciasis situation.*
- c. *TCC accepts this report and recommends that the project must in subsequent ones;*
 - (i) *Take into account report-related weakness mentioned above;*
 - (ii) *Conduct advocacy toward government for field activities to be financed by the state;*
 - (iii) *Raise communities' awareness to take charge of CDD incentives;*
 - (iv) *Train CDDs well so as to enable them better undertake census and to ensure better drug management.*

ANGOLA PROJECT

Moxico CDTI Project (Angola) 2nd year Technical Report.

187. Despite the circumstances surrounding the project management, the report presents important information for project evaluation.

188. ***TCC accepted the report with the following recommendation and suggestion for improving reporting and project implementation***

Report related:

- (i) Projects should be commended for their implementation,
- (ii) Make sure tables are well filled out (Table 7),
- (iii) Describe and clearly note number of endemic communes under CDTI out of the total of 9.

Project related:

- (i) Project should be lauded for achieving a ratio of 1 CDD/113 persons;
- (ii) Determine treatment period to coincide with the dry season;
- (iii) Intensify mobilisation and sensitisation;
- (iv) Intensify advocacy toward political and administrative authorities for effective integration of CDTI in PHC, and to ensure actual and regular disbursement of budgeted funds;
- (v) Enhance awareness-raising efforts in view of support to CDDs;
- (vi) Revisit demographic and epidemiological surveys;
- (vii) Improve coverage: 100% geographic and at least 80% therapeutic, latest by the next two years.

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

CAMEROON PROJECTS

South-West I CDTI project (Cameroon) 10th year Technical Report (re-submission)

189. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

190. In this re-submission, all previous TCC recommendations have been taken into account. Corrections have been made regarding:

- (i) The total population of the meso/hyper endemic zone;
- (ii) The number of health centres;
- (iii) The number of meso/hyper endemic communities;
- (iv) The Ultimate Therapeutic Goal;
- (v) The therapeutic coverage;
- (vi) Numbers of refusals and absentees;
- (vii) The number of Mectizan tablets remaining

191. The duration of activities was explained. The results of advocacy, reaction of communities to sensitisation and the strengths, weaknesses and challenges which were absent in the first report have been provided.

Centre II CDTI project (Cameroon) 7th year Technical Report (re-submission)

192. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

193. This was a re-submission for a project situated at the border of the forest and savanna zone which is co-endemic for onchocerciasis and loiasis. The report is well written and provides all the necessary information to evaluate the project. The project performance has been good: with a therapeutic coverage of 80.6% and geographical coverage of 100%. Precise responses were given to the various recommendations which led to the rejection of the report by TCC28.

Report related:

- (i) It should be made clear in the report that the project is in its 9th year but 8th mass distribution and 7th year of APOC financing;
- (ii) Avoid planning distribution during the rainy season;
- (iii) Provide more information on the implementation of the sustainability plan submitted in 2005.

Centre III CDTI project (Cameroon) 10th year Technical Report (re-submission)

194. ***TCC accepted the report with the following recommendation and suggestion for improving reporting and project implementation***

195. This re-submitted report is practically identical to that submitted to TCC28. The only differences are:

- (i) The change from 1 to 0 of the number of SAEs in Table 7;
- (ii) A 4 line paragraph on page 21 explaining that 444,444 tablets remaining from the previous treatment campaign are included in the 684,500 tablets mentioned in Table 9. The other questions asked by TCC28 are only addressed in the section: "Follow up recommendations of TCC28". It would have been preferable to include the responses in the report itself. The reply to the question concerning Vitamin A supplementation is satisfactory. However, an explanation on the reasons for abandoning co-implementation of Vitamin A supplementation with CDTI would have been of interest.

196. The response to the question on incentives owed to CDDs was for 2007. No response was given for 2008, the period covered by the present report.

197. The reply to the question concerning the section "Others" in Table 13 is not clear. What does the phrase "the costs in relation to unrelated activities" «les dépenses y relatives concernent les activités non liées» mean?

198. Despite the inadequacy of responses given to certain questions from TCC28, the report was acceptable. The points for which the responses were not satisfactory should be answered carefully in the next report.

North Province CDTI project (Cameroon), 7th year technical report.

199. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Produce a simple and understandable table on the timeline of activities,
- (ii) Produce a more complete table on the management of Mectizan,
- (iii) Provide more precise information on CSM, the RPP and the sustainability plan.

Project related:

- (i) Good rates of therapeutic and geographic coverage,
- (ii) Greater involvement of women in CDTI,
- (iii) An improved ratio of CDDs//population,
- (iv) Improvement in the rate of release of funds budgeted from the State.

Recommendations for the Project:

- (i) The coordination must make efforts in the areas of ownership and motivation of CDDs by communities.

CENTRAL AFRICAN REPUBLIC PROJECTS:

CDTI Project (CAR) 7th year Technical Report:

200. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

201. The presentation of the report is of average quality.

Report related:

- (i) There is no analytical summary;
- (ii) Essential data are missing in the description of the project;
- (iii) There are mistakes in the estimation of the Ultimate Treatment Goal and also errors in the definition of the period covered by the project.

Project related:

202. **Regarding activities, the project performed poorly with rather low rates of geographic coverage. But** the problem of conflict and insecurity are extenuating circumstances. The project managers must make efforts to:

- (i) Improve the rates of therapeutic and geographic coverage,
- (ii) Improve the involvement of women in CDTI,
- (iii) Improve the ratios of CDDs/population,
- (iv) Make efforts for greater integration of CDTI activities,
- (v) Further develop the concept of CDTI in the endemic zones,
- (vi) Intensify advocacy, IEC, Sensitisation and mobilisation,
- (vii) Prepare sustainability plan.

203. TCC recommends that sending an analytical summary to APOC Management should be a condition of acceptance of the report. A revised version including a proper estimate of the UTG and the analytical summary to TCC should be a condition of acceptance of the report.

204. *TCC recommends that the report is accepted* subject to APOC Management receiving a well written executive summary and correction of errors as indicated by the reviewer

CHAD PROJECT

CDTI Project (Chad) 9th year Technical Report.

205. The document is very well written and presented, according to the format recommended by TCC. The figures are well presented and are referred to. The activities carried out indicated:

- (i) Very good CDTI performance, translated into therapeutic coverage which has risen from 39% in 1998 to 81% in 2008;
- (ii) CSM was undertaken in 2140 communities, which is an appreciable number.

206. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

207. There is a small error of calculation in Table 13 column An1.

- (i) Make a summary without sections or sub-titles;
- (ii) Make Tables using Excel (and not calculators) to avoid some errors of calculation such as those in Table 13.

CONGO PROJECT

CDTI project (Congo) 8th year Technical Report.

208. The document is presented according to the format recommended by TCC. It is well-written and easy to read. The information given is detailed and the explanations are generally clear.

209. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

210. The project is required to explain:

- (i) The ratio of male to female CDDs of 3.94% in 2007 and of 6% in 2008,
- (ii) The number of communities having female CDDs (39.4% in 2007 and 255 in 2008,
- (iii) 1 CDD for 239 persons in 2007 and 1 : 275 in 2008,
- (iv) A cost per person treated of US \$1.81 in 2008 compared with \$0.02 in 2007.

Project related:

- (i) Despite rumours, an average therapeutic coverage of 74.2% was achieved;
- (ii) Geographic coverage has been 100% since 2004;
- (iii) Adherence of the community members has been achieved.

TCC Recommendations:

- a. ***TCC draws the attention of the project to the fact that the weaknesses identified must be corrected in the next report;***
- b. ***The project report in regard to factors that determine the low therapeutic coverage in the communities must be available for the next TCC even though the data are already analysed;***
- c. ***TCC requests the project to look into solutions to increase the number of women CDDs;***
- d. ***TCC requests the project to take action to adequately monitor future treatment of LF in the zones that are only endemic for loiasis.***

EQUATORIAL GUINEA

Bioko CDTI Project (Equatorial Guinea) 7th year Technical Report (Resubmission)

211. All previous TCC recommendations have been taken into account. Corrections have been made, notably for:

- (i) Endorsement of the report by all the responsible people,
- (ii) Production of information on the project,
- (iii) Ensuring the report is complete.

212. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

213. For the next report, the project must paginate the report, provide data on CSM and IPM provide results and suggestions for an improvement of certain activities (advocacy, sensitisation and mobilisation, supervision) and include ivermectin in the national supply system for medicines, if it is functional.

LIBERIA PROJECT

North West CDTI Project (Liberia) 7th year Technical Report.

214. A fairly well-written report but it appears the project is unable to ensure early disbursement of funds to the counties and still has prolonged period of implementation of timeline of activities.

215. ***TCC accepted the report with the following recommendation and suggestion for improving reporting and project implementation***

216. The following issues were raised:

- (i) Provide information on capital equipment provided by the partners,
- (ii) Provide information on financial contribution by partners in Year 1 and 2,
- (iii) Increase the number of Health workers involved in CDTI,
- (iv) Increase the number of community supervisors,
- (v) Train more CDDs to reduce CDD:Community member ratio,
- (vi) Train more Health Centre staff and ensure their involvement in CDTI,
- (vii) Increase and stabilize geographic and therapeutic coverages,
- (viii) Intensify advocacy to ensure that CDTI is included in PHC budget,
- (ix) Promote the use of CDI strategy by other health programmes.

NIGERIA PROJECT

Ogun State CDTI Project (Nigeria) 7th year Technical Report.

217. The report is well written. It appears that over the past 7 years, the geographic coverage of the project has fluctuated up to 100%, with a progressive increase of therapeutic coverage up to 83% in 2007. However, there was a decrease of treatment in 2008, with only 88% and 65% of geographic and therapeutic coverage, respectively. Apparently this was due to the inadequacy of Mectizan tablets obtained by the project. No information is provided on the reason why drugs were not delivered by MDP as requested by the project. The reason why drug was not delivered was because a letter was written by the supporting NGDO indicating that some Mectizan was sold in the open market. An NOTF mission to Ogun verified that it was a misrepresentation of the situation. The NGDO was requested by NOTF to write back to MDP and clarify this misrepresentation. This has resolved the issue.

218. TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.

Project-related:

- (i) Efforts should be made to avoid similar problems related to matters of Mectizan procurement in future;
- (ii) The project should endeavour and intensify efforts to rapidly increase both geographic and treatment coverage;

- (iii) The activities should be better planned; and the timing for different activities should be carefully addressed;
- (iv) Efforts should be made on sustainability and integration.

Report-related:

- (i) The use of the remaining drugs should be clearly explained, with detailed numbers;
- (ii) Table should be corrected / revised with relevant data of financial contributions of the last three years; i.e. Year 5, Year 6 and Year 7.

TANZANIA PROJECTS

Mahenge CDTI Project (Tanzania) 10th year Technical Report.

219. The report could be better written. All TCC26 recommendations were implemented. Project performed well with regard to the number of female CDDs, high therapeutic coverage, CSM and SHMs, release of budgeted funds by all partners including district councils and in integration.

220. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Health staff involved in CDTI; 35% not 70%;
- (ii) Advocacy; specify policy makers targeted, the reasons meeting each of them and list outcomes of advocacy;
- (iii) Sensitisation; distinguish between media and other forms of communication.

Project related:

- (i) Increase the number of health workers trained in CDTI and aim to train all health workers in the project area;
- (ii) Intensify mobilisation and sensitisation to address the issue of high number of refusals and absentees;
- (iii) Train more CDDs to improve on the CDD:population ratio;
- (iv) Discuss with partners the need for replacement or at least repair of the non functional capital equipment.

Kilosa CDTI project (Tanzania) 7th year Technical Report

221. A concise and well-written report showing commitment of project implementers especially in supervision, community self-monitoring and integration into PHC and other health interventions.

222. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation***

Report related:

- (i) Ensure that report is endorsed by the relevant partners;
- (ii) List of Acronyms should always be updated and explained;
- (iii) Provide confirmation that ratio of male to female trained CDDs is 1:1;
- (iv) Provide information on the reason for consistent underutilization of APOC approved funds and recommendation on improvement.

Project related:

- (i) APOC and NGDO should ensure early release of funds;
- (ii) Train more CDDs to reduce CDD: Community member ratio;
- (iii) Produce more IEC materials and intensify community mobilization in order to reduce absentees and refusals;
- (iv) APOC need to consider the replacement of old capital equipments and provide additional motorcycle for the project;
- (v) Conduct CSM and SHM to improve community involvement and supervision in the remaining communities.

Tanga Focus Project (Tanzania) 8th year Technical Report.

223. This is a good project with a high potential for sustainability. Willingness of CDDs to continue working with little or no incentives is commendable. The project has facilitated CSM and SHM in all communities, achieved good coverage with minimal wastage /loss of Mectizan tablets, and mobilized adequate resources for CDTI activities.

224. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Subsequent reports should be vetted carefully to avoid grammatical and typographical errors;
- (ii) Clarify non existence of NGDO and yet funding from NGDO recorded.

Project related:

- (i) Intensify monitoring and evaluation at all levels,
- (ii) Carry out sustainability evaluation and submit sustainability plan,
- (iii) Retrain FLHF staff and CDDs on record keeping,
- (iv) Institute good performance awards for CDDs.

Tukuyu CDTI Project (Tanzania) 8th year Technical Report.

225. The report is well-written. All TCC28 recommendations were implemented. Commendable achievements in the number of female CDDs, high therapeutic coverage, CSM and SHMs and 100% release of funds by the NGDO partner and district councils.

226. ***TCC accepted the report with the following recommendations and suggestions for improving reporting and project implementation.***

Report related:

- (i) Revise total population to include population of endemic communities and not population of districts;
- (ii) Advocacy; include reason for and outcome of advocacy;
- (iii) Community involvement; comment on CDD incentives and attrition rates.

Project related:

- (i) Increase the number of health workers trained in CDTI and aim to train all health workers in the project area;
- (ii) Address the issue of high number of refusals and absentees;
- (iii) To arrange for internal monitoring to be carried out.

OTHER MATTERS: AGENDA ITEM 19

Awards to best project Coordinators:

227. Following further discussions to clarify the *'Awards to project Coordinators or to the Project'*, TCC set up a sub-committee to work on the details of *who* should receive the annual award. The TCC members made reference to TCC28 report, pg 51, and the following recommendations were tabled:

- (i) ***On whether the award should be given to an individual or the project, the committee recommended:***
 - a) That the award should be institution-based and not given to an individual;
 - b) That the Preamble, the Selection Process and the sources of information remain as stated on page 51 of TCC28 report;
 - c) That (i) "Having served in the same position for at least 3 years" be removed from the Nomination criteria.
- (ii) ***On whether the award should be restricted to the National level or go down to the lower level, the committee recommended that:***
 - a) APOC restricts this award to the National level, but state clearly for which projects performance the award is given;
 - b) Authorities at the national level should be encouraged to organise similar awards for the lower levels;
 - c) Some guidance can be provided.

228. ***TCC recommends that the award should be institution based and not given to individuals.***

229. Initial discussions have started on this issue and the group will continue communication by email and provide information to TCC 30.

Geographical coverage:

230. In the framework of preparing for elimination of onchocerciasis transmission where feasible in APOC countries, APOC management informed TCC of actions being taken to ensure that all endemic communities/villages are under ivermectin treatment. In a number of countries, including Cameroon, Congo, Equatorial Guinea, Ethiopia, Nigeria, Tanzania, Chad, Uganda, Burundi, independent scientists were identified to work closely with the project and health centre staff to identify and take coordinates of all endemic villages. The activity, undertaken with technical guidance and financial support of APOC, has been completed in Equatorial Guinea and is progressing well in Cameroon and Nigeria, whilst adjustments were requested from other countries to improve the effectiveness of the exercise. A complete database of all onchocerciasis endemic communities with their coordinates will be available at the end of the process to facilitate the work of other disease control programmes and partners.

231. TCC stressed the importance of the activity as the programme progresses towards shrinking the Onchocerciasis map of Africa. It encourages APOC management and countries to conclude the activity and wish to be regularly updated on the progress made in that respect.

Revised format for technical report:

232. The revised format for technical reports was presented and TCC made some amendments especially table 14. The amended table is *annexe 4*.

233. ***TCC recommended that the format be sent to countries for pretesting and the results be presented during the next TCC.***

Co-implementation sub-committee:

234. Co-implementation must involve a national political process. To this effect, a strategic document incorporating detailed action plans must be prepared, taking into account specificities of each disease involved.

- a.* Co-implementation is underway in a number of countries. It is anticipated that co-implementation may reduce the cost of NTD control, however that remains to be demonstrated.

Recommendation:

235. *TCC recommends that studies be carried out to evaluate the economic benefits of co-implementing control activities, taking into account various epidemiological situations.*

- b.* An essential condition for co-implementation is that precise mapping of each of the targeted diseases must be available.

Recommendation:

236. *In this context, TCC recommends that APOC encourages the implementation of surveys using rapid evaluation methods: ICT tests for lymphatic filariasis, questionnaires or other methods for schistosomiasis etc.*

- c.* Meanwhile it is inevitable that joining together several programmes on the foundation of a single NTD programme may create management problems and conflicts.

Recommendation:

237. *TCC recommends that the process of co-implementation be lead with the greatest of care in order that the co-implementation doesn't become counter-productive with respect to onchocerciasis control.*

Operational Research Proposal guidelines and format

238. TCC agreed that guidelines for writing operational research proposals would be produced by a group comprising Prof M.S. Traoré, Prof S. Traoré and Prof Tchuem Tchuente, who will work together by email and present a report to TCC30.

TCC comments on Audi-visual documentary on CDD

239. TCC members commended APOC management for the production of the audio-visual documentary that acknowledges the role of Community-Directed Distributors (CDDs) in CDTI projects success across Africa. TCC suggested some amendments which should be effected during final editing of the documentary. TCC members also expressed the need for APOC to mass produce this audio-visual documentary and make it available to CDTI projects and partners for wider dissemination.

DATE AND PLACE OF THE THIRTIETH SESSION OF THE TCC: AGENDA ITEM 20

240. The 30th session of the TCC will take place from 8-13 March and TCC 31st session from 13-18 September 2010, both in Ouagadougou, Burkina Faso.

CLOSURE OF THE SESSION: AGENDA ITEM 21

241. In her closing remarks, the chair thanked all participants, interpreters and rapporteurs for their support, noting that the session had been outstanding and provided very useful ideas, information, statistics and vision towards onchocerciasis elimination and integrated co-implementation of NTDs. The chair expressed appreciation and gratitude to the World Bank for their dedication to onchocerciasis control in Africa.

242. Finally, she thanked the APOC management for the efficient organisation, adding that, the Director was greatly missed, but the meeting had gone very well in the capable hands of her staff, and she looked forward to seeing each and everyone in the next meeting.

243. On behalf of all the participants, Dr Kisito of MDP thanked the chair for her leadership attributes, and wished all participants a safe journey back home.

244. The Twenty-ninth Session of TCC was declared closed by Prof. Adenike Abiose, TCC chair.

ANNEXES

ANNEX 1: LIST OF PARTICIPANTS 29TH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE OUAGADOUGOU, 14TH TO 19TH SEPTEMBER 2009

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ANNEX 2: FINAL ANNOTATED AGENDA

 World Health Organization		AFRICAN REGION African Programme for Onchocerciasis Control (APOC) 01 B.P. 549, Ouagadougou 01, Burkina Faso Tel: (226) 50 34 29 53; 50 34 29 59; 50 34 29 60; 50 34 36 45/46 Fax: (226) 50 34 28 75; 50 34 36 47	
TECHNICAL CONSULTATIVE COMMITTEE Twenty-ninth Session <u>Ouagadougou, 14 to 19 September 2009</u>			
FINAL ANNOTATED AGENDA			
DAY I – Monday 14 September 2009			
09:00-12:50	1. Opening	09H00-09H30	
	2. Adoption of the Agenda	09H30-09H40	
	Information		
	3. CSA: matters arising from the 124 th and 125 th sessions (Dr Yaméogo)	09H40-10H00	
	Tea Break		10H00-10H15
	4. NGDOs: matters arising from the 34 th meeting (recommendations) (Dr Olamiju)	10H15-10H35	
	5. TCC: follow-up of the key recommendations of the twenty-eighth session (Dr Yaméogo)	10H35-10H55	
	Strategic and technical issues		
	6. Meeting on curriculum and training module on the community-directed intervention (CDI strategy for Faculties of Medicine and Health Sciences (Dr Fobi))	10H55-11H15	
	7. Country visit by TCC members	11H15-12H15	
	10. Feasibility of elimination of onchocerciasis transmission in Africa:		
(i) Key points from the Informal consultation meeting on Elimination of Onchocerciasis transmission and update on the epidemiological evaluation in APOC countries (Dr Remme)	12H15-12H35		
(ii) Model predictions of elimination: strategies, assessment and critical factors (Dr Duerr)	12H35-12H50		
(iii) Vector migration and vector/parasite complexes, human migration issues (Prof Boakye)	12H50-13H10		
Lunch Break		13H10- 15H00	

15:00-18:15	11. Macrofil and Research: (i) Update on Moxidectin (Dr Kuesel) (ii) Update on the DEC Patch test and Lohmann (Dr Kuesel) (iii) Update on <i>Loa loa</i> mapping in APOC countries (Dr Noma)	15H00-15H30 15H30-16H00 16H00-16H30
	Tea Break	16H30- 16H45
	13. Study on doxycyclin in ‘Littoral 1’ project area in Cameroon: Background, objectives, methodology, findings (Dr Wanji)	16H45-17H15
	14. Monitoring Special country initiatives in Nigeria (Dr Fobi) 15. Progress in Onchocerciasis control and feasibility of co-implementation of NTDs in Chad: achievements and challenges Monitoring (Mr N. Lokemla)	17H15-17H45 17H45-18H15
DAY II – Tuesday 15 September 2009		
Reviews		
08:00-18:15	Management of APOC Trust Fund	
	16. Report on the financial management of APOC funded projects (Mr Agblewonu)	08H00-08H30
	17. Report on the review by the APOC management of 1 st , 2 nd , 3 rd , 4 th , 5 th , 6 th , 7 th , 8 th , 9 th , 10 th and 11 th year progress reports and subsequent year budgets (Mr Agblewonu)	08H30-09H00
	18. Review of new Project Proposals and 1 st , 2 nd , 3 rd , 4 th , 5 th , 6 th , 7 th , 8 th , 9 th , 10 th and 11 th year Annual Technical reports on the implementation of CDTI and Vector elimination Projects. Recommendations on the 2 nd , 3 rd , 4 th , 5 th , 6 th , 7 th , 8 th , 9 th and 10 th year implementation of the projects	09H00-09H30
	Introduction to the review exercise: Summary budget of submitted proposals (Mr Agblewonu) 18.1 NOTF/Cameroon 10 th year technical report	09H30-10H00
	Tea Break	10H00 -10H15
	18.2 North Province CDTI Project (Cameroon) 6 th year technical report (re-submission)	10H15-10H45
	18.3 Congo Extension CDTI Project (Congo) 4 th year annual technical report (re-submission)	10H45-11H15
	18.4 Congo Extension CDTI Project (Congo) 5 th year technical report	11H15-11H45
	18.5 South Western CDTI Project (Liberia) 3 rd year technical report	11H45-12H15
	18.6 South East CDTI Project (Liberia) 3 rd year technical report	12H15-12H45
	Lunch Break	12H45- 14H45
	18.7 Bauchi CDTI Project (Nigeria) 6 th year technical report	15H00-15H30
	18.8 NOTF/HQ Project (Nigeria) 11 th year technical report	15H30-16H00
18.9 Ogun State CDTI Project (Nigeria) 6 th year technical report	16H00-16H30	
Tea Break	16H30- 16H45	

	18.10 Akwa Ibom CDTI project 4 th year Technical report	16H45-17H15
	18.11 Akwa Ibom CDTI Project 5 th year technical report	17H15-17H45
	18.12 East Bahr El Ghazal CDTI Project (South Sudan) 3 rd year technical report	17H45-18H15
DAY III – Wednesday 16 September 2009		
08:00-18:45	18.13 East Equatoria CDTI Project (South Sudan) 3 rd year technical report	08H00-08H30
	18.14 SSOTF/HQ (South Sudan) 3 rd year technical report	08H30-09H00
	18.15 Upper Nile CDTI Project (South Sudan) 3 rd year technical report	09H00-09H30
	18.16 West Bahr El Ghazal CDTI Project (South Sudan) 3 rd year technical report	09H30-10H00
	Tea Break	10H00- 10H15
	18.17 West Equatoria CDTI Project (South Sudan) 4 th year technical report	10H15-10H45
	18.18 Bandundu CDTI Project (DRC) 6 th year technical report	10H45-11H15
	18.19 Equateur-Kiri CDTI Project (DRC) 4 th year technical report	11H15-11H45
	18.20 Lubutu CDTI Project (DRC) 2 nd year technical report	11H45-12H15
	18.21 Masisi Walikale CDTI Project (DRC) 1 st year technical report (re-submission)	12H15-12H45
	Lunch Break	12H45- 14H45
	18.22 Mongala CDTI Project (DRC) 4 th year technical report	15H00-15H30
	18.23 NOTF/HQ Project (DRC) 9 th year technical report	15H30-16H00
	18.24 Rutshuru-Goma CDTI Project (DRC) 3 rd year technical report	16H00-16H30
Tea Break	16H30-16H45	
18.25 Ubangi Nord CDTI Project (DRC) 4 th year technical report	16H45-17H15	
18.26 Morogoro Focus CDTI Project (Tanzania) 4 th year technical report	17H15-17H45	
18.27 NOTF/HQ Project (Tanzania) 10 th year technical report	17H45-18H15	
DAY IV – Thursday 17 September 2009		
08:00-8:00	18.28 Tunduru CDTI Project (Tanzania) 4 th year technical report	08H00-08H30
	18.29 East Wollega CDTI project (Ethiopia) 4 th year technical report (re-submission)	08H30-09H00
	18.30 West Wollega CDTI project (Ethiopia) 4 th year technical report (re-submission)	09H00-09H30
	18.31 Côte d'Ivoire CDTI project (Comoe, Bandama, Sassandra, Cavally and tributaries) 1 st year technical report	09H30-10H00

	Tea Break	10H00- 10H15
	18.32 Moxico CDTI project (Angola) 2 nd year technical report	10H15-10H45
	9. Task Force on the review of technical reports:	
	(i) Report of the Task Force of Nigeria (Prof Braide)	10H45-11H45
	(ii) Report of the Task For of Cameroon (Dr Aboutou Mr Hendji)	11H45-12H45
	Lunch Break	12H45- 14H45
	Summary of 7 th , 8 th , 9 th , and 10 th year technical reports (Dr Fobi)	15H00-16H30
	Tea Break	16H30-16H45
	Summary of 7 th , 8 th , 9 th , and 10 th year technical reports (Cont'd)	16H45-18H00
DAY V – Friday 18 September 2009		
	8. Country Exit plans: Presentations (Prof Abiose and Dr Philippon)	08H00-09H00
	12. Review of operations research proposals	09H00-10H30
	(i) Introduction to the Review of operational research proposals (Dr Leak)	
	Tea Break	10H30- 10H45
08:00-18:15	19. Other matters	
	(i) Report of the Sub-committee on Award to best project Coordinators	10H45-12H45
	20. Date and place of the thirtieth session of the TCC	12H45-13H00
	Lunch Break :	13H00- 14H45
	21. Report (Conclusions and Recommendations of TCC29)	
	Preparation of the report (Conclusions and recommendations)	15H00-16H30
	Tea Break	16H30-16H45
	Preparation of the report (Conclusions and recommendations) Cont'd	16H45-18H15
DAY VI – Saturday 19 September 2009		
08:00-12:30	Adoption of the report (conclusions and recommendations) of TCC29	08H00-10H00
	Tea Break	10:00-10:30
	Adoption of the report (conclusions and recommendations) of TCC29 (Cont'd)	10H15-12H00
	22. Closure of the session	12H00-12H30

REPORTS REVIEWED BY TCC MEMBER ONLINE

1. Centre II CDTI Project (Cameroon) 9th year technical report (**re-submission**)
2. Centre III CDTI Project (Cameroon) 9th year technical report (**re-submission**)
3. South West I CDTI Project (Cameroon) 10th year technical report (**re-submission**)
4. North Province CDTI Project (Cameroon) 10th year technical report (**re-submission**)
5. CAR CDTI Project (CAR) 7th year technical report

6. Chad CDTI Project (Chad) 9th year technical report
7. Congo CDTI Project 8th year technical report
8. Bioko CDTI Project (Eq. Guinea) 7th year technical report (**re-submission**)
9. Lofa, Bong, Nimba & Montserrado counties CDTI project (Liberia) 7th year technical report
10. Mahenge Focus CDTI Project (Tanzania) 10th year technical report
11. Tanga CDTI Project (Tanzania) 8th year technical report
12. Kilosa CDTI Project (Tanzania) 7th year technical report
13. Tukuyu CDTI Project (Tanzania) 8th year technical report

N.B: Rapporteurs: Dr Stephen LEAK
Ms Juliet OCHIENGHS

ANNEX 3: IMPLEMENTATION OF TCC 28

RECOMMENDATIONS	RESPONSES
<p>Para 7(a): TCC recommended that teams responsible for the preparation of technical reports obtain comprehensive information on contributions including salaries of health workers and other human resource involved in CDTI</p>	<p>The recommendation was shared with the NOTFs</p>
<p>Para (7b): Uganda should now conduct this activity in the two districts and commence CDTI activities. The currently approved Ugandan exit plan should therefore be updated and resubmitted to TCC for approval extending APOC's support to the two districts up to 2012 – 2015</p>	<p>APOC management made funds available to NOCP/Uganda and is following up with the country for the implementation of the activity</p>
<p>Para (11a): Where research of direct relevance to onchocerciasis control is identified, the scientists involved could be invited to TCC meetings to provide updates;</p>	<p>APOC management will see for the implementation of this recommendation when necessary</p>
<p>NOTFs should monitor and inform APOC management about research and intervention activities in onchocerciasis control zones where drug trials are taking place that might impact on on-going CDTI activities. (para 11b):</p>	<p>The information was shared with the NOTFs and it will be brought again to their attention in November, during their meeting</p>
<p>TCC recommended that awards should not be restricted to National Coordinators, but should be extended to health workers at the district and community level including CDDs. (para 13b):</p>	<p>APOC management would be pleased to have guidance from TCC on how best to implement this recommendation</p>
<p>Recommendation to the National Authorities and teams of Cameroon (para 15)</p>	<p>Response</p>
<p>(i) Address the incentive issues for CDDs that are a serious threat to CDTI in Cameroon; (ii) The need to re-launch an onchocerciasis review meeting with the support of other partners (NGDO, WHO, etc.); (iii) Optimize the Technical Review Committee of projects by reducing its membership (4 to 5) to those living in Yaoundé. This should help to reduce the project financial costs. Reports reviewed by the committee should be presented at the next TCC session; (iv) Plans for CSM and evaluations of sustainability should be put in place; (v) Provide a vehicle to the Eséka Health Delegation for supervision activities; (vi) Reinforce NOCP infrastructure and staff (vii) Promote operational research in collaboration with universities/ research institutions.</p>	<p>NOCP representatives will be asked to respond</p>
<p>Cameroon: Recommendations to APOC Management</p>	<p>Response</p>

(i) Continue to support NOCP Cameroon as far as possible in all areas where needed	APOC management has maintained its support
(ii) Provide support to NOCP Cameroon to re-launch the technical review committee prior to the 29th session of TCC.	Support was given and the report of the TRC/Cameroon will be presented to TCC29
The focal person for Cameroon, Mr Zouré, in collaboration with Dr Ntep, National Coordinator should ensure that the Cameroon Technical Review Committee meets by July 2009 and report back to TCC29 (para16)	DONE
Update on Monitoring of Drug Efficacy in Large-Scale Treatment, Moxidectin and DEC patch test:	Dr Kuesel who is on line will update TCC on these activities
Para 27. Following the presentations on Moxidectin, some observations were made: a) TCC expressed concern over the delays in completing the moxidectin studies; b) TDR encouraged looking into ways to initiate the evaluation of moxidectin in the <i>Loa loa</i> -Baboon model as soon as possible; c) TDR should make efforts to identify additional laboratories within Africa for technology transfer for the biomarker work	Dr Kuesel who is on line will update TCC on these activities
Para 29. a) TCC recommended that evaluation of the DEC patch test should be conducted on a larger scale with varying degrees of positivity; b) TCC requested APOC management to set up an agreement with the DEC patch manufacturer that provides for DEC patches at low cost; c) TCC noted that for the test to be semi-quantitative, the grading scale should be further developed and incorporated into a standard training manual.	Dr Kuesel who is on line will update TCC on these activities
Recommendations	Response
Para 49. Angola: a) To facilitate full participation by Angola in CDTI activities, TCC recommended that APOC translates all relevant documents and manuals into Portuguese. TCC agreed that technical reports on projects in the country could be submitted in Portuguese, allowing for sufficient time for their translation, before TCC sessions	The process is on course but finalized for: * Independent Participatory Monitoring tools * Annual technical reporting format * TCC/Merck Guidelines for SAEs management Mectizan application forms Presentation on CDTI implementation status in Angola

<p>b) Given that no Mass Drug Administration (MDA) was undertaken in 2008, TCC endorsed a joint high-level advocacy mission to Angola by APOC, MDP and NGOs in 2009</p>	<p>Advocacy mission was conducted in July by representatives of the three entities. Getting visa was not easy and the planned workshop did not take place</p>
<p>Para 54. Angola, Kuando-Kubango: (i) APOC management should send an example of a summary as a reference</p>	<p>Done through the temporary advisors sent for two months (July – August) by APOC management</p>
<p>Para 60. Ethiopia, Bench-Maji: (ii) APOC to arrange the 5th year evaluation; (iii) Vehicle, motorcycles and photocopier should be repaired/replaced by APOC, in this 6th year project</p>	<p>DONE Will be handled in 2010 in the framework of the implementation of the sustainability plan</p>
<p>Para 62. Ethiopia, Gambella: (i) APOC should release funds to this project promptly as recommended by TCC27</p>	<p>DONE</p>
<p>Para 64. Ethiopia, Illubabor: (i) APOC to arrange sustainability evaluation</p>	<p>DONE</p>
<p>Para 70. Ethiopia, North Gondar: (i) APOC should replace capital equipment</p>	<p>Will be considered in 2010</p>
<p>Para 84. Ethiopia: Recognizing the need to sustain the positive momentum and the gains being realised through CDTI at the community level, and acknowledging that integration is the operational framework in the country, TCC28 made the following recommendations: a. An APOC mission be made to the country for advocacy that would include re-training of all the project teams in CDTI as well as addressing the constant staff changes at the national level; In discussions at the national level, the mission should request for competent staff to be posted to manage onchocerciasis activities, and that APOC and MDP should be informed when any such staff changes are effected; b. Undertake a review of the West Wollega project with a view to assessing whether the two areas – West Wollega and Kelem Wollega should be supported by APOC to operate as separate projects, given the administrative sub-division implemented by the government; c. Special attention be paid to the projects supported by Light of the World in terms of appropriate reporting to TCC; d. The calculation of the proportion of communities with female CDDs should be refined for most of the reports: it is clear that the calculation process does not follow the formula presented in</p>	<p>Done, a report will be given by TCC members</p>

Table 4 - instead of calculating $B11=B10/B4*100$, the reports use $B11=B10/B9*100$ - thereby skewing the results; e. Address any other issues that might emerge during the visit	
Para 103. DRC, Katanga Nord: Recommendation for APOC (i) APOC should organize training for CSM	DONE
Para 107. DRC, Tshuapa: Recommendation to APOC (i) APOC management should make efforts to equip the project office with a computer and electrical equipment	For 2010
Para 110. DRC, Uélés: Recommendation to APOC (i) APOC should provide information to the project on the outcome of an operational research project submitted to TCC in 2004	APOC management is still looking for the information
Para 124.: a) To overcome communication problems within the country, APOC Management should also copy all the relevant sections of the TCC reports to the medical inspectors (Médecins Inspecteurs) and project coordinators by email. b) All persons presenting with SAEs, especially in difficult-to-reach and endemic areas, must receive constant support and continuous treatment. Financial and material support for SAEs management should depend on the completion of a compliance study in selected villages to assess the proportion of the population never having received ivermectin treatment. This should take place following five years of intervention. Provision of support by APOC Management and TCC will be based on the outcome of this study. c) All clinical samples from patients that have developed SAEs (blood smears, cerebral-spinal fluid and autopsy samples etc.) should be carefully preserved, preferably refrigerated. The samples should be retained for possible future examination/re-examination. d) The provision of incentives to CDDs should be at the discretion of communities, (see Annex 5 on CDTI philosophy). e) TCC insisted that all recommendations of TCC27 should be implemented	DONE Not yet implemented. CEV to confirm Recommendation shared with projects concerned and EVE unit will follow up They are in the process of being implemented
Para 128. Nigeria, Bauchi: (i) APOC should replace capital items; (ii) The next visit by TCC members should follow up on progress on implementation of the sustainability plan.	For 2010 APOC management will be pleased to have a suggestion of date for this mission

<p>Para 140. Nigeria: TCC recommended that a comparison of performance of projects of 7-10 years and projects of 10 years and above be conducted in the future and shared with TCC</p>	<p>Prof. Braide will probably respond</p>
<p>Para 148. Burundi, Rutana: APOC should explore the possibility of providing the project with additional motorbikes and bicycles to facilitate movement</p>	<p>Process on course</p>
<p>Para 152. Southern Sudan, East Equatoria: (i) APOC should conduct Year 1 independent participatory monitoring</p>	<p>All steps were taken for the exercise to start on 15 /09 – 05/10</p>
<p>Para 154. Southern Sudan, Upper Nile: Recommendation to APOC (i) APOC should conduct Year 1 independent participatory monitoring.</p>	<p>All steps taken for the exercise to start on 06 – 20/10</p>
<p>Para 160. S. Sudan, West Bahr El Ghazal: Recommendation to APOC (i) The project, which is in a post-conflict area, has a poor performance and the missing information / data makes it difficult to properly assess the project achievements. Activities were not conducted in the counties of Aweil East, South, West, and North due to problems of flight connections from Rumbek. The project suggests considering having a new CDTI Project in North Bahr El Ghazal to cover these counties</p>	<p>Not yet implemented but it is under discussion</p>
<p>Para 164. Cameroon, Adamaoua I: (i) APOC should provide the financial support requested by the project to carry out CSM in 2009 (ii) APOC should take note of the project's requirements for data collection</p>	<p>DONE DONE</p>
<p>Para 168. Cameroon, East Province: (i) APOC should financially support the evaluation of this project</p>	<p>DONE</p>
<p>Para 174. Cameroon, South Province: (i) APOC management should send a copy of an 'executive summary' as an example</p>	<p>DONE</p>
<p>Para 172. Cameroon, Littoral I: (i) Communicate to TCC29 more information on the doxycyclin project conducted in the same area as CDTI. A detailed report, with all the useful elements to analyse and follow up the observed SAEs, particularly with respect to the villages treated with doxycyclin prior to ivermectin, should also be forwarded to TCC;</p>	<p>Dr Wanji will make a presentation on the study they conducted</p>

<p>(ii) In view of the potential implication of doxycyclin treatment in areas of ivermectin distribution and as this study is being prepared for publication, TCC recommends that the Principal Investigators be invited to TCC29 to make a detailed presentation on the study.</p>	
<p>Para 194. Cameroon: a) Given the Government's policy to provide incentives to CDDs (25 CFA per person treated) TCC requests projects to indicate in future reports the specific amount allocated for this purpose from their total contribution;</p>	<p>Will be done in subsequent reports</p>
<p>b) Noting that some project reports omitted project age, TCC requests NGOs in Cameroon to adhere to the normal APOC reporting format so that all requested information is captured. For example, project age is an essential parameter for evaluating project sustainability.</p>	<p>Recommendation shared with the NOTF</p>
<p>Para 205: TCC recommended that the first award be made at JAF15, in December 2009.</p>	<p>Steps have been taken by APOC management but we are waiting for the final decision of TCC, taking into account the recommendation in para 13b discussed earlier on</p>

**ANNUAL PROJECT TECHNICAL REPORT
TO
TECHNICAL CONSULTATIVE COMMITTEE (TCC)**

ENDORSEMENT

Please confirm you have read this report by signing in the appropriate space.

OFFICERS to sign the report:

Country: _____

National Coordinator Name:

Signature:

Date:

Zonal Oncho Coordinator Name:

Signature:

Date:

NGDO Representative Name:

Signature:

Date:

This report has been prepared by Name :

Designation :

Signature :

Date :

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4.2.5. <i>To what extent has the plan been implemented.....</i>	97
4.3. <i>Integration.....</i>	97
4.3.1. <i>Ivermectin delivery mechanisms.....</i>	97
4.3.2. <i>Training.....</i>	97
4.3.3. <i>Joint supervision and monitoring with other programs.....</i>	97
4.3.4. <i>Release of funds for project activities.....</i>	97
4.3.5. <i>Is CDTI included in the PHC budget?.....</i>	97
4.3.6. <i>Describe other health programmes that are using the CDTI structure and how this was achieved. What have been the achievements?.....</i>	97
4.3.7. <i>Describe others issues considered in the integration of CDTI.....</i>	97
4.4. <i>Operational research.....</i>	100
4.4.1. <i>Summarize in not more than one half of a page the operational research undertaken in the project area within the reporting period.....</i>	100
4.4.2. <i>How were the results applied in the project?.....</i>	100
SECTION 5: Strengths, weaknesses, challenges, and opportunities.....	100
SECTION 6: Unique features of the project/other matters.....	100

ACRONYMS

APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
ATrO	Annual Training Objective
CBO	Community-Based Organization
CDD	Community-Directed Distributor
CDTI	Community-Directed Treatment with Ivermectin
CSM	Community Self-Monitoring
LGA	Local Government Area
MOH	Ministry of Health
NGDO	Non-Governmental Development Organization
NGO	Non-Governmental Organization
NOTF	National Onchocerciasis Task Force
PHC	Primary health care
REMO	Rapid Epidemiological Mapping of Onchocerciasis
SAE	Severe adverse event
SHM	Stakeholders meeting
TCC	Technical Consultative Committee (APOC scientific advisory group)
TOT	Trainer of trainers
UNICEF	United Nations Children's Fund
UTG	Ultimate Treatment Goal
WHO	World Health Organization

DEFINITIONS

- (i) Total population: the total population living in meso/hyper-endemic communities within the project area (based on REMO and census taking).
- (ii) Eligible population: calculated as 84% of the total population in meso/hyper-endemic communities in the project area.
- (iii) Annual Treatment Objective: (ATO): the estimated number of persons living in meso/hyper-endemic areas that a CDTI project intends to treat with ivermectin in a given year.
- (iv) Ultimate Treatment Goal (UTG): calculated as the maximum number of people to be treated annually in meso/hyper endemic areas within the project area, **ultimately** to be reached when the project has reached full geographic coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).
- (v) Therapeutic coverage: number of people treated in a given year over the total population (this should be expressed as a percentage).
- (vi) Geographical coverage: number of communities treated in a given year over the total number of meso/hyper-endemic communities as identified by REMO in the project area (this should be expressed as a percentage).
- (vii) Integration: delivering additional health interventions (i.e. vitamin A supplements, albendazole for LF, screening for cataract, etc.) through CDTI (using the same systems, training, supervision and personnel) in order to maximise cost-effectiveness and empower communities to solve more of their health problems. This does not include activities or interventions carried out by community distributors outside of CDTI.
- (viii) Sustainability: CDTI activities in an area are sustainable when they continue to function effectively for the foreseeable future, with high treatment coverage, integrated into the available healthcare service, with strong community ownership, using resources mobilised by the community and the government.
- (ix) Community self-monitoring (CSM): The process by which the community is empowered to oversee and monitor the performance of CDTI (or any community-based health intervention programme), with a view to ensuring that the programme is being executed in the way intended. It encourages the community to take full responsibility of ivermectin distribution and make appropriate modifications when necessary.

EXECUTIVE SUMMARY

Prepare an Executive summary of the report in not more than one page.

1. Background on treatment and population data
 - Total communities, communities treated, total population, UTG, ATO and persons treated.
2. Background on population movements.
3. Training data
 - CDDS, health workers, Total population (community) per CDD trained.
4. Challenges and how they were overcome.

SECTION 1: BACKGROUND INFORMATION

1.1. General information

1.1.1 Description of the project (briefly)

- Geographical location, topography, climate
- Population: activities, cultures, language
- Communication systems (roads...)
- Administration structure
- Health system & health care delivery (provide the number of health posts/centers in the project area if the information is available).
- Number of health staff in project area and number of health staff involved in CDTI activities.

Table 1: Number of health staff involved in CDTI (Please add more rows if necessary)

District/LGA	Number of health staff involved in CDTI activities.		
	Total Number of health staff in the entire project area B₁	Number of health staff involved in CDTI B₂	Percentage B₃=B₂/ B₁ *100
Total			

1.1.2. Partnership

- Indicate the partners involved in project implementation at all levels [MoH, NGOs (national/international), communities, local organizations, etc.]
- Describe overall working relationship among partners, clearly indicating specific areas of project activities (planning, supervision, advocacy, planning, mobilization, etc) where all partners are involved.
- State plans, if any, to mobilize the state/region/district/LGA decision-makers, NGOs, NGOs, CBOs, to assist in CDTI implementation.

1.2. Population

Table 2: Communities and population at risk in the **entire project area** whether they are treated or not during the reporting period.
(Please add more rows if necessary)

CDTI Districts/ LGAs in the entire project area	Total population in the entire project. area	Number of communities/villages in			Population of			
		Meso-endemic zone in the project area A_1	Hyper-endemic zone in the project area A_2	Total in meso/hyper- endemic zone $A_3 = A_1 + A_2$	Meso-endemic zone in the project area A_4	Hyper- endemic zone in the project area A_5	Total in meso/hyper- endemic zone $A_6 = A_4 + A_5$	Ultimate treatment Goal (UTG)
TOTAL								

*UTG = calculated as the maximum number of people to be treated annually in meso/hyper endemic areas within the project area, **ultimately** to be reached when the project has reached full geographic coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).*

Was a census for the project done during the reporting period? Yes _____ No _____

If No, what is the source of the data in the table above?

* Source :National census _____ CDD _____ Other source, specify: _____
Year : _____

If you are using the term community or village, define what constitutes the community or village. This will help understand the profile of the project area.

Is there any other information of interest about the population in the project area? If so, include it here.

SECTION 2: IMPLEMENTATION OF CDTI

2.1. *Timeline of activities*

Fill in table 3, *timeline of activities for areas treated in current year*, indicating when the key activities were implemented by the month they began and the month they ended.

2.2. Advocacy

State the number of policy/decision makers mobilized at each relevant level during the current year; the reason(s) for undertaking the advocacy and the outcome. Describe difficulties/constraints being faced and suggestions on how to improve advocacy.

2.3. Mobilization, sensitization and health education of at risk communities

Provide information on:

- The use of media and/or other local systems to disseminate information
- Mobilization and health education of communities including women and minorities
- Response of target communities/villages
- Accomplishments
- Suggest ways to improve mobilization and sensitization of the target communities.

2.4. Community involvement

Table 4: Communities participation in the CDTI (*Please add more rows if necessary*)

District/LGA	Number of communities/villages with community members as supervisors			Number of CDDs and the communities involved			Number of communities /villages with female CDDs	
	Total no. communities in the entire project area	Number with community members as supervisors	Percentage	Male CDDs	Female CDDs	Total	Number of communities with female CDDs	Percentage
	B ₄	B ₅	B ₆ = B ₅ /B ₄ *100	B ₇	B ₈	B ₉ = B ₇ +B ₈	B ₁₀	B ₁₁ = B ₁₀ /B ₄ *100
Total								

Comment on:

- Attendance of female members of the community at health education meetings
- In general, how do you rate the participation of female members of the community meetings when CDTI issues are being discussed (attendance, participation in the discussion etc).
- Incentives provided by communities for the CDDs
- Attrition of CDDs. Is attrition a problem for the project? If yes, how is it addressed?
- Other issues

2.5. Capacity building

- Describe the adequacy of available knowledgeable manpower at all levels.
- Where frequent transfers of trained staff occur, state what the project is doing, or intends to do, to remedy the situation. *(The most important issue to describe is what measures were taken to ensure adequate CDTI implementation where not enough knowledgeable manpower was available or if staff are frequently transferred during the course of the campaign).*

Table 6: Type of training undertaken
(Tick the boxes where specific training was carried out during the reporting period)

Trainees		Other Community members e.g Community supervisors	Health Workers (frontline health facilities)	MOH staff or Other	Political Leaders	Others(specify)
Type of training	CDDs					
Program management						
How to conduct Health education						
Management of SAEs						
CSM						
SHM						
Data collection						
Data analysis						
Report writing						
Others (specify)						

- Any other comments

2.6. Treatments

2.6.1. Treatment figures

- If the project is not achieving 100% geographical coverage and a minimum of 65% therapeutic coverage or the coverage rate is fluctuating, state the reasons and the plans being made to remedy this.

Table 7: Treatment and SAEs by district/LGA in all areas at risk (*Please add more rows if necessary*)

District /LGA	Communities/Villages				Population				Number of persons who refused the treatment	Number of absentees	Number of communities with < 80% therapeutic coverage	Number of SAEs	Number of serious adverse events (SAEs) referred to the health post/hospital
	Total # of communities/villages in the meso/hyper-endemic areas D₁	Annual Treatment Objective D₂	Number of communities/villages treated D₃	Geographical coverage (%) D₄= D₃/D₁*100	Total population of the meso/hyper-endemic areas D₅	Annual Treatment Objective D₆	Number of persons treated D₇	Therapeutic coverage (%) D₈= D₇/D₅*100					
TOTAL													

Formula for computing therapeutic and geographical coverages

Therapeutic coverage rate (%) = $\frac{\text{Number of people treated} \times 100}{\text{Total population living in meso/hyper-endemic communities within the project area}}$

Geographical coverage rate (%) = $\frac{\text{Number of communities/villages treated} \times 100}{\text{Total number of meso/hyper-endemic communities as identified by REMO in the project area}}$

ATO coverage rate (%) = $\frac{\text{Number of people treated} \times 100}{\text{Annual Treatment Objective}}$

% UTG achieved = $\frac{\text{Number of people treated} \times 100}{\text{Total number of people to be treated in meso/hyper-endemic areas within the project area (UTG)}}$

ATO = The estimated number of people living in meso/hyper-endemic areas that a CDTI project intends to treat with ivermectin in a given year.

UTG = The maximum number of people to be treated in meso/hyper-endemic areas within the project area, ultimately to be reached when the project has reached full geographical coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).

2.6.2 What are the causes of absenteeism?

2.6.3 What are the reasons for refusals?

2.6.4 Briefly describe all known and verified serious adverse events (SAEs) that occurred during the reporting period and provide (in table 8) the required information when available.

- Parasitologist trained?
- Existence of microscope?
- In case the project did not have any cases of serious adverse events (SAE) during this reporting period, please tick in the box.

No SAE case to report

2.6.5. Trend of treatment achievement from CDTI project inception to the current year

Table 9: Treatments and coverage by calendar year for the entire project area. *(Please fill in the required data)*

Please indicate the UTG for the project area: _____ (use this figure as the denominator in all UTG coverage calculations.)

YEAR	Communities/Villages					Population					UTG Coverage (%)
	Total # of communities/villages in the meso/hyper-endemic areas E₁	Annual Treatment Objective E₂	Number of communities/villages treated E₃	Geographical coverage (%) E₄ = E₃ / E₁ * 100	ATO coverage (%) E₅ = E₃ / E₂ * 100	Total population of the meso/hyper-endemic areas E₆	Annual Treatment Objective E₇	Number of persons treated E₈	Therapeutic coverage (%) E₉ = E₈ / E₆ * 100	ATO coverage (%) E₁₀ = E₈ / E₇ * 100	
1997											
1998											
1999											
2000											
2001											
2002											
2003											
2004											
2005											
2006											
2007											
2008											
2009											
2010											

2.7. Ordering, storage and delivery of ivermectin

Mectizan® ordered/applied for by – (please tick the appropriate answer)

MOH WHO UNICEF NGDO

Other (please specify): _____

Mectizan® delivered by – (please tick the appropriate answer)

MOH WHO UNICEF NGDO

Other (please specify): _____

Please describe how Mectizan® is ordered and how it gets to the communities

Table 10: Mectizan® Inventory (Please add more rows if necessary)

State /District /LGA	Number of Mectizan® tablets							
	In stock from previous year	Requested	Received	Used	Lost	Waste d	Expired	Remai ning
TOTAL								

- How are the **remaining** ivermectin tablets collected and where are they kept?
- List and briefly describe the activities under ivermectin delivery that are being carried out by health care personnel in the project area.
- Any other comments

2.8. Community self-monitoring and Stakeholders Meeting

Has any training (of trainers) for community self-monitoring been done in the project area?

If so, When?

Table 11: Community self-monitoring and Stakeholders Meeting *(Add rows if needed)*

District/ LGA	Total # of communities/villages in the entire project area	No of Communities that carried out self monitoring (CSM)	No of Communities that conducted stakeholders meeting (SHM)
TOTAL			

Describe how the results of the community self- monitoring and stakeholders meetings have affected project implementation or how they would be utilized during the next treatment cycle.

2.9. Supervision

2.9.1. Provide a flow chart of supervision hierarchy.

2.9.2. What were the main issues identified during supervision?

2.9.3. Was a supervision checklist used?

2.9.4. What were the outcomes at each level of CDTI implementation supervision?

2.9.5. Was feedback given to the person or groups supervised?

2.9.6. How was the feedback used to improve the overall performance of the project?

SECTION 3: SUPPORT TO CDTI

3.1. Equipment

Table 12: Status of equipment (Please add more rows if necessary)

Source Type of equipment	APOC		MOH		DISTRICT/ LGA		NGDO		Others	
	No.	Condition	No.	Condition	No.	Condition	No.	Condition	No.	Condition
1. Vehicle										
2. Motor cycle(s)										
3. Computer(s)										
4. Printer(s)										
5. Photocopier (s)										
6. Fax Machine(s)										
7. Others										
a)										
b)										
c)										

*Condition of the equipment (F=Functional, CNFR=Currently non-functional but repairable, WO=Written off).

How does the project intend to maintain and replace existing equipment and other materials?

3.2. Financial contributions of the partners and communities

- Fill tables 13a, 13b and 13c
- If there are problems with release of counterpart funds, how were they addressed?
- Additional comments

Table 13a : Financial contributions by all partners for the last three years

BUDGET LINE	Calendar YEAR being reported (specify the year)										
	GOVERNMENT contribution						OTHER partners' disbursement				
	Budgeted	Amounts disbursed at the following levels				% disbursed	NGDOs	Local NGDOs	Communities	Others	APOC Trust Fund
National		Regional	District	Total							
<i>I. Mobilization, advocacy, sensitization et health education</i>											
1.1. Mobilization											
1.2. Sensitization											
1.3. Advocacy											
1.4. Health education											
<i>Sub-total I</i>											
<i>II. Training</i>											
2.1. Training/retraining of CDDs											
2.2. Training/retraining of Health workers											
<i>Sub-total II</i>											
<i>III. Supervision, monitoring, Evaluation</i>											
3.1. Supervision											
3.2. Monitoring											
3.3. Evaluation											
<i>Sub-total III</i>											
<i>IV. Ivermectin distribution and management of severe adverse events</i>											
4.1. Ivermectin distribution											
4.2. Management of Severe adverse events											
<i>Sub-total IV</i>											
<i>V. Additional expenses</i>											
5.1. Salaries											
5.2. Equipment											
<i>Sub-total V</i>											
GRAND TOTAL											

Table 13b : Financial contributions by all partners for the last three years (continued)

BUDGET LINE	One (1) year previous to Calendar YEAR being reported (specify the year)									
	GOVERNMENT contribution						OTHER partners' disbursement			
	Budgeted	Amounts disbursed at the following levels				% disbursed	NGDOs	Local NGDOs	Communities	Others
	National	Regional	District	Total						
I. Mobilization, advocacy, sensitization et health education										
1.1. Mobilization										
1.2. Sensitization										
1.3. Advocacy										
1.4. Health education										
Sub-total I										
II. Training										
2.1. Training/retraining of CDDs										
2.2. Training/retraining of Health workers										
Sub-total II										
III. Supervision, monitoring, Evaluation										
3.1. Supervision										
3.2. Monitoring										
3.3. Evaluation										
Sub-total III										
IV. Ivermectin distribution and management of severe adverse events										
4.1. Ivermectin distribution										
4.2. Management of Severe adverse events										
Sub-total IV										
V. Additional expenses										
5.1. Salaries										
5.2. Equipment										
Sub-total V										
GRAND TOTAL										

Table 13c : Financial contributions by all partners for the last three years (continued)

BUDGET LINE	Two (2) years previous to Calendar YEAR being reported (specify the year)										
	GOVERNMENT contribution						OTHER partners' disbursement				
	Budgeted	Amounts disbursed at the following levels				% disbursed	NGDOs	Local NGDOs	Communities	Others	APOC Trust Fund
		National	Regional	District	Total						
<i>I. Mobilization, advocacy, sensitization et health education</i>											
1.1. Mobilization											
1.2. Sensitization											
1.3. Advocacy											
1.4. Health education											
<i>Sub-total I</i>											
<i>II. Training</i>											
2.1. Training/retraining of CDDs											
2.2. Training/retraining of Health workers											
<i>Sub-total II</i>											
<i>III. Supervision, monitoring, Evaluation</i>											
3.1. Supervision											
3.2. Monitoring											
3.3. Evaluation											
<i>Sub-total III</i>											
<i>IV. Ivermectin distribution and management of severe adverse events</i>											
4.1. Ivermectin distribution											
4.2. Management of Severe adverse events											
<i>Sub-total IV</i>											
<i>V. Additional expenses</i>											
5.1. Salaries											
5.2. Equipment											
<i>Sub-total V</i>											
GRAND TOTAL											

3.3. Other forms of community support

- Describe (indicate forms of in-kind contributions of communities if any)

3.4. Expenditure per activity

- Indicate in table 13, the amount expended during the reporting period for each activity listed. Write the amount expended in US dollars using the current United Nations exchange rate to local currency. Indicate exchange rate used here _____
- Any comments or explanations?

SECTION 4: SUSTAINABILITY OF CDTI

4.1. Internal; independent participatory monitoring; Evaluation

4.1.1 Has the project ever been evaluated/monitored? (Tick any of the following which are applicable)

_____ Year 1 Participatory Independent monitoring

_____ Mid Term Sustainability Evaluation

_____ 5 year Sustainability Evaluation

_____ Internal Monitoring by NOTF

_____ Other Evaluation by other partners

4.1.2. What were the recommendations?

4.1.3. How have they been implemented?

4.2. Sustainability of projects: plan and set targets (mandatory at Yr 3)

Was the project evaluated during the reporting period? _____

Was a sustainability plan written? _____

When was the sustainability plan submitted? _____

What arrangements have been made to sustain CDTI after APOC funding ceases in terms of:

4.2.1. Planning at all relevant levels

4.2.2. Funds

4.2.3 Transport (replacement and maintenance)

4.2.4. Other resources

4.2.5. To what extent has the plan been implemented

4.3. Integration

Outline the extent of integration of CDTI into the PHC structure and the plans for complete integration:

4.3.1. Ivermectin delivery mechanisms

4.3.2. Training

4.3.3. Joint supervision and monitoring with other programs

4.3.4. Release of funds for project activities

4.3.5. Is CDTI included in the PHC budget?

4.3.6. Describe other health programmes that are using the CDTI structure and how this was achieved. What have been the achievements?

- Fill tables 14 and 15 and provide describe other programmes that are using the CDTI structure and how this was achieved. What have been the achievements?
- For each intervention listed in table 15, explain what were the roles played by the CDDs (census, mobilization, distribution, data collection, storage, collection of drugs, referral of SAEs, etc ...)?
- Explain what are the combinations of interventions co-implemented?
- How were the interventions implemented? (at the same time?)

4.3.7. Describe others issues considered in the integration of CDTI.

Table 14 : Co-implementation

Type of control	Type of intervention	Roles played by CDDs (explain in bullet points)	Number of districts		Number of communities		Number of CDDs involved			Number of persons targeted			Number of persons reached		
			Targeted	Reached	Targeted	Reached	Males	Females	Total	Males	Females	Total	Males	Females	Total
Onchocerciasis control	• Ivermectin distribution														
Lymphatic filariasis	• Distribution of albendazole														
Schistosomiasis	• Distribution of praziquantel														
STH	• Distribution of mebendazole														
Malaria control	• Distribution of LLINs														
Malaria control	• Home management of malaria														
Malnutrition	• Vitamin A supplementation														
Trachoma	•														
Cataracts	•														
Others (specify)	•														
	•														
	•														
	•														
	•														

NB: the interventions listed in the table are just few examples

Table 15: Other programmes using CDI structure (*tick as appropriate*)

Type of control	Type of intervention	Involvement of communities in											
		Planning SHM			Implementation					Monitoring CSM	Reporting	Provision of resources	
		activities	period	mode	selection of implementers	collection of commodities	storage of commodities	distribution	supervision			In kind	financial
Onchocerciasis control	• Ivermectin distribution												
Lymphatic filariasis	• Distribution of albendazole												
Schistosomiasis	• Distribution of praziquantel												
STH	• Distribution of mebendazole												
Malaria control	• Distribution of LLINs												
Malaria control	• Home management of malaria												
Malnutrition	• Vitamin A supplementation												
Trachoma	•												
Cataracts	•												
Others (specify)	•												
	•												
	•												
	•												
	•												
	•												

NB: the interventions listed in the table are just few examples

4.4. Operational research

4.4.1. Summarize in not more than one half of a page the operational research undertaken in the project area within the reporting period.

4.4.2. How were the results applied in the project?

SECTION 5: STRENGTHS, WEAKNESSES, CHALLENGES, AND OPPORTUNITIES

- List the strengths and weaknesses of CDTI implementation process.
- List the challenges and indicate how they were addressed.

SECTION 6: UNIQUE FEATURES OF THE PROJECT/OTHER MATTERS