AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)

REPORT OF THE THIRTY-FOURTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC)

Ouagadougou, 12 – 16 March 2012
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<tbody>
<tr>
<td>ABR</td>
<td>Annual Betting Rate</td>
</tr>
<tr>
<td>AfDB</td>
<td>African Development Bank</td>
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<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
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<tr>
<td>ATO</td>
<td>Annual Treatment Objective</td>
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<td>ATP</td>
<td>Annual Treatment Potential</td>
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<tr>
<td>A.WOL</td>
<td>Anti-Wolbachia</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>CDD</td>
<td>Community-Directed Distributor</td>
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<td>CDI</td>
<td>Community-Directed Intervention</td>
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<td>CDTI</td>
<td>Community-Directed Treatment with Ivermectin</td>
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<tr>
<td>CMFL</td>
<td>Community Microfilarial Load</td>
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<tr>
<td>CSM</td>
<td>Community Self Monitoring</td>
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<tr>
<td>DEC</td>
<td>Diethylcarbamazine</td>
</tr>
<tr>
<td>DOLF</td>
<td>Death to Onchocerciasis and Lymphatic Filariasis</td>
</tr>
<tr>
<td>FACE</td>
<td>Funding Authorization and Certification of Expenditure</td>
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<tr>
<td>FLHF</td>
<td>Front Line Health Facility</td>
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<tr>
<td>GPELF</td>
<td>Global Programme for Elimination of Lymphatic Filariasis</td>
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<tr>
<td>HKI</td>
<td>Helen Keller International</td>
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<tr>
<td>HR</td>
<td>Human Resource</td>
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<tr>
<td>HSAM</td>
<td>Health Education Sensitisation Advocacy Mobilisation</td>
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<tr>
<td>HQ</td>
<td>Headquarters</td>
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<tr>
<td>HW</td>
<td>Health worker</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>IPM</td>
<td>Independent Participatory Monitoring</td>
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<tr>
<td>JAF</td>
<td>Joint Action Forum</td>
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<tr>
<td>LF</td>
<td>Lymphatic Filariasis</td>
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<td>LGA</td>
<td>Local Government Area</td>
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<td>LTS</td>
<td>Lohmann Therapy Systems</td>
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<td>MDA</td>
<td>Mass Drug Administration</td>
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<td>MDP</td>
<td>Mectizan® Donation Program</td>
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<td>MF</td>
<td>Microfilaria</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NGDO</td>
<td>Non-Governmental Development Organization</td>
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<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NOTF</td>
<td>National Onchocerciasis Task-Force</td>
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<td>NTD</td>
<td>Neglected Tropical Diseases</td>
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<td>PAB</td>
<td>Plan of Action and Budget</td>
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<tr>
<td>PCT</td>
<td>Preventive Chemotherapy Treatment</td>
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<tr>
<td>PI</td>
<td>Principal Investigator</td>
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<tr>
<td>PNLO</td>
<td>Programme Nationale de Lutte Contre l’Onchocercose</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>RAPLOA</td>
<td>Rapid assessment procedure of <em>Loa loa</em></td>
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<td>RPRG</td>
<td>Regional Programme Reporting Group</td>
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<tr>
<td>SAE</td>
<td>Severe Adverse Events</td>
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<tr>
<td>SCI</td>
<td>Special Country Initiative</td>
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<td>SHM</td>
<td>Stake Holder Meeting</td>
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<td>SIZ</td>
<td>Special Intervention Zone</td>
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<tr>
<td>SS</td>
<td>Sight Savers</td>
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<td>TCC</td>
<td>Technical Consultative Committee (of APOC)</td>
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<tr>
<td>UTG</td>
<td>Ultimate Treatment Goal</td>
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<tr>
<td>VAS</td>
<td>Vitamin A Supplementation</td>
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<tr>
<td>WHO AFRO</td>
<td>Regional Office of the WHO Africa Region</td>
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<tr>
<td>WHO/NTD</td>
<td>Neglected Tropical Diseases – department within WHO cluster of communicate</td>
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1. OPENING: Agenda Item 1

1. The Director of APOC, Dr Paul Samson Lusamba Dikassa warmly welcomed all the participants of TCC34 to Ouagadougou and acknowledged the presence of Dr Michael Thiede, newly elected to TCC. He informed TCC that Dr R.O. Essomba, also a newly elected member of TCC was expected. Dr Lusamba recognized the presence of Dr Ricardo Thomson, Chair of LF RPRG and Dr Amadou Garba of AFRO/NTD. He appreciated the presence of APOC Technical Advisors for the invaluable guidance and advice they could give to APOC Management. Dr Lusamba was pleased to announce the presence of the Representative of the World Bank, Dr Andy Tembon. He also acknowledged the presence of Dr Naomie Pitchouna Awaca Uvon the newly appointed National Coordinator for DRC. He briefed TCC on the main outcomes of the JAF17 session held in December 2011, in Kuwait city, at which three priority issues were highlighted. Firstly, JAF agreed in principle not to close APOC in 2015 as planned and asked the APOC management to submit a 10-year strategic plan. Secondly, JAF requested APOC through the TCC to provide guidance on how to obtain diagnostic tools for elimination and to look at alternative approaches to treatment in problematic areas. Thirdly, JAF emphasized that the APOC CDTI strategy could contribute to co-implementation of other interventions for the control of NTDs. The TCC was informed that a detailed presentation of matters arising from JAF17 would be considered under agenda item 4. He wished the meeting successful deliberations and added that the discussions and outcomes of TCC were crucial to the future of the programme.

2. Professor Homeida, Chair of TCC, warmly welcomed TCC members and acknowledged the presence of Dr Adrian Hopkins expressing his confidence that Dr Hopkin's knowledge of control/elimination of both Onchocerciasis and LF would be very useful and would add value to the deliberations of TCC34. For the meeting to gain more time to discuss strategic and technical issues which are crucial for the future of APOC and the paradigm shift to elimination, he appealed to members to devise ways to shorten the presentation of reviews of Annual Technical Reports. He asked the participants to introduce themselves as there were invited guests as well as new members. A full list of participants is appended as Annex 1.

3. The World Bank Representative at the TCC34 informed participants that the Board of the World Bank was briefed about APOC, its progress and the way forward on 1 March 2012, in the presence of the Vice-Presidents for Africa and Human Development. The outcome from this briefing included the following:

   (i) At country level, the Bank will extend resources to help countries build strong community health services that deliver services to the poor including NTDs interventions.

   (ii) At the Regional level, the Bank will provide fiscal and fiduciary oversight to the ongoing Trust Fund through 2025 and coordinate with donors to extend the Trust Fund for all the 7 NTDs that require preventable chemotherapy.

4. Participants at the TCC34 also were shown the River blindness film (https://www.youtube.com/watch?v=27F0mH5g-AY) that had been prepared and screened at the last JAF17 in Kuwait city, Kuwait in December 2011.

5. TCC appreciated the presence of the World Bank representative at the TCC34 and praised the film which was very clear and to the point. TCC34 took note of the World Bank Board briefing about APOC and NTDs especially as APOC moves from control to elimination of Onchocerciasis and emphasizes co-implementation.

6. The Chair permitted the UN Security Officer to give a briefing on the security situation in Ouagadougou.
2. ADOPTION OF THE AGENDA: Agenda Item 2

7. The provisional agenda was adopted with minor changes. The agenda is appended as Annex 2.

8. TCC requested that the report of this meeting should be shared in sufficient time for it to be reviewed and adopted in addition to follow-up of key recommendations.

INFORMATION

3. CSA: MATTERS ARISING FROM THE 134TH AND 135TH CSA SESSIONS: Agenda Item 3

9. Dr Paul Lusamba reported on the outcome of the CSA134 session which was held from 6-8 October 2011 in Accra Ghana and the CSA 135 session held from 11-15 December in Kuwait City, Kuwait. The main issues arising form CSA 134 are summarized below:

   (i) On criteria and guidelines for the certification of elimination of onchocerciasis the CSA requested APOC Management to send a formal letter requesting the review of the guidelines for certification to the WHO Director-General.

   (ii) CSA requested that a timetable showing onchocerciasis elimination for each of APOC’s participating countries should be developed

   (iii) CSA requested that the Regional Programme Review Group (RPRG), the technical body of the LF programme be invited to attend the APOC TCC in March 2012 to discuss technical matters relating to stopping ivermectin treatment for the elimination of onchocerciasis and better coordination with the LF programme.

   (iv) On challenges of coordination, partnership and community ownership posed by the co-implementation of NTD control, CSA requested APOC Management to be proactive and carry out high level advocacy among stakeholders as well as sensitization on the core philosophy, objectives and approaches of CDTI implementation, demonstrating the track record of its success in reaching rural populations, and the importance of it sustainability.

   (v) With regards to TCC Membership, Dr Onyeze of AFRO/NTD was requested to consult the WHO database and help identify epidemiologists. CSA members were also asked to identify suitable candidates.

10. The CSA 135th session was held before and after JAF and reviewed the outcomes of JAF 17 and highlighted the following issues:

   (i) The need to formulate a clear definition of elimination of onchocerciasis and co-implementation in consultation with AFRO.

   (ii) APOC should develop a comprehensive 10-year plan (2016-2025) with costing for presentation to JAF18.

   (iii) Develop an institutional structure that spells out how APOC plans to work with the NTD group.

   (iv) CSA requested the World Bank and AfDB to prepare guidelines to assist APOC on how to assess and present Government contributions and pledges for partners.
11. TCC thanked APOC Management for the update and raised the following several issues:

(i) To respond to JAF decision on the need to formulate a clear definition of elimination TCC agreed to maintain the definition agreed earlier as it is in TCC30 report which is “The reduction of infection and transmission to the extent that interventions can be stopped, but post-intervention surveillance is still necessary.”

(ii) With regards to the linkage between APOC and NTDs, TCC welcomed the presence of a representative of AFRO/NTD at this meeting and wished this representation at TCC meetings continue in order to reinforce collaboration between APOC and AFRO/NTDs.

4. MATTERS ARISING FROM THE JOINT ACTION FORUM (JAF) 17TH SESSION/DECISIONS: Agenda item 4

12. Dr Lusamba presented a summary of JAF17 session held from 12-14 December 2011 in Kuwait City, Kuwait. The meeting was hosted by the Kuwait Fund under the hospitality of Kuwait Government. The main outcomes of the session are presented below:

(a) On WHO Progress Report:

(i) JAF encouraged APOC Management to scale-up the use of alternative approaches including twice-yearly treatments with ivermectin where appropriate to speed-up elimination in problematic areas, and also to address cross-border issues.

(b) On country reports:

(i) Concerning treatment in low Onchocerciasis endemic areas, collaboration between the Onchocerciasis and LF programmes and the need for new diagnostic tools were stressed. JAF asked for feedback on progress made to be presented at its next session (JAF 18) based on recommendations of the TCC.

(ii) Re-infection as a result of cross-border migration and/or fly movements are examples of the need for collaboration among countries. JAF requested implementation of cross-border collaboration including meetings, plans of action and joint interventions.

(iii) It was noted that understanding governments’ financial contributions remains a complex issue which requires expertise. JAF instructed APOC Management to engage experts to assess countries’ government’s financial contributions.

(c) On the report of the Technical Consultative Committee (TCC):

(i) Noting the limited number of operational research proposals received by APOC for TCC review, it was recognized that there is inadequate expertise in drafting such research proposals at country level in most cases. JAF therefore requested TCC and APOC Management to provide technical assistance to the countries.

(ii) Regarding the nodding syndrome which is associated with Onchocerciasis in some countries, there is a need for TCC guidance. JAF decided that countries with nodding syndrome should contact APOC to request technical assistance for research on the syndrome.
(d) Status of Onchocerciasis Control in former OCP countries:

(i) JAF decided that appropriate actions should be taken by the concerned countries with the support of APOC and any other partners to delineate the areas to be covered and launch/intensify ivermectin treatments.

(e) Elimination of Onchocerciasis transmission in Africa:

(i) JAF reiterated the need to consider alternative approaches including twice yearly treatment with ivermectin to speed up elimination in problematic areas.

(f) Future of APOC:

(i) JAF agreed that APOC should not close in 2015 as that would be untimely, given that none of the 31 endemic countries would have achieved elimination by that date.

(ii) JAF reaffirmed its endorsement for the Programme to pursue the elimination of onchocerciasis in Africa as well as co-implementation of preventive chemotherapy interventions for other selected NTDs in the context of increased support to community-level health systems strengthening. The Forum therefore requested the CSA and APOC Management to submit a detailed new plan of action with costs reflecting the new expanded strategic direction for the programme beyond 2015 for consideration by JAF18.

(g) Current research with APOC and TDR collaboration:

(i) JAF decided that further decisions on moxidectin development await the results of the Phase 3 study, expected for third quarter of 2012. If the analysis of this study favours the further development of moxidectin, then APOC and TDR should initiate a search for a new partner for licensing and potential donors.

(h) Report of the NGDO Coordination Group for Onchocerciasis Control

(i) JAF noted the consequences posed by the delays in drugs supply. JAF reiterated the need for increased government and community support for early procurement of NTD drugs.

13. TCC commended APOC Management for the update on the JAF17 session and made the following remarks on operational research:

(i) TCC noted that stimulation of the operational research is a problem that should be dealt with by TCC and APOC Management.

(ii) TCC proposed that a sub-committee should be commissioned to meet and propose measures to be taken.

(iii) TCC suggested adopting a proactive approach to support National Coordinators on operational research.
5. NGDOS: MATTERS ARISING FROM THE NGDO/NTD NETWORK MEETING: Agenda item 5

14. Dr Ukety shared with TCC the outcomes of the 2nd session of the NTD/NGDO Network held in September 2011 in Nairobi, Kenya. The Network reiterated its commitment to using its expertise and capacity to continue to strengthen health systems in Africa, bridge the gap between school and community-based approaches for Schistosomiasis/STH interventions, collect and share data on integrated NTD interventions and eye care and improve coordination between the onchocerciasis and LF control programmes. The Network was encouraged by the formation of the NTD Regional Advisory Groups within the WHO/AFRO/NTD programme and acknowledged the importance of morbidity management in NTD control. TCC was informed that the next NTD/NGDO Network meeting was scheduled for 4-6 September 2012 in Sydney, Australia.

15. Dr Ukety then highlighted the outcomes of the NGDO Coordination Group for Onchocerciasis Control which took place from 8-9 March 2012 in Ouagadougou, Burkina Faso. The Group recommended strengthening cross-border activities in close collaboration with regional organisations and stressed the need for harmonizing treatment across borders and increased involvement of partners in advocacy for cross-border activities. The Group welcomed the in-country partnership initiative to provide assistance to partners with limited funding, highlighted the need to strengthen NOTFs and encouraged APOC to post more Technical Advisors to DRC. The appointment of Dr Naomi Awaca Uvon as the new National Coordinator to DRC was well received. The UK Coalition against NTDs was thanked for the high level and successful advocacy and its support to the London Declaration on NTDs. TCC was informed that the 40th NGDO Group session would be held on 3 September 2012 in Sydney, Australia.

16. TCC thanked Dr Ukety for the update and made the following remarks:

(i) The cross-border activities should be carried out collaboratively by health services at the peripheral level with the assistance of MOH and other partners;
(ii) TCC suggested that there should be task forces for NTDs similar to the Onchocerciasis Task Force in each of the countries.


17. Dr Yameogo presented a summary of the status of implementation of TCC33 recommendations. The full presentation on the implementation of the recommendations and key actions of TCC 33 are appended as Annex 3. Key actions that have been initiated or completed by APOC Management as a follow-up to the recommendations of TCC33 are outlined below:

(i) Strategic and technical issues
(ii) CDTI projects and technical issues
(iii) Other matters

18. Further to the presentation, TCC commended APOC management for steps taken to implement most of its recommendations and made the following suggestions:

(i) TCC suggested that adequate time should be allocated for the review and adoption of the meeting report in subsequent meetings;
(ii) TCC pointed out the importance of joint country visits between APOC management, NGDO partners and TCC members, and that it would be useful to resume the exercise. APOC management should select the countries that require technical and/or advocacy assistance, specify the needs and TCC would nominate members to undertake or participate in the visits.
19. With regard to regional organisations collaboration with countries to strengthen cross-border activities, TCC was informed by AFRO/NTD representative, Dr Amadou Garba, of two planned NTD workshops in Harare and Ouagadougou for East and West Africa respectively.

STRATEGIC AND TECHNICAL ISSUES

7. WORKSHOP ON CDI STRATEGY INCLUSION IN THE CURRICULA OF 15 NIGERIAN FACULTIES OF MEDICINE, HEALTH SCIENCES AND NURSING SCHOOLS: Agenda Item 7

20. Dr Fobi gave a brief introduction of the background to the CDI curriculum module as an APOC initiative to develop 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. In 2009, in Abuja, 18 Universities agreed to pre-test the module for inclusion in their respective curricula. In 2010, following a high level meeting of vice-chancellors, deans and senior academics from nine Eastern and Southern African countries, held in Nairobi, 16 faculties of medicine, health sciences and nursing schools adopted the curriculum and accepted to pre-test it. In addition, a workshop was held for 12 faculties of medicine, health sciences and nursing schools in Sudan which adopted the curriculum and accepted to pre-test it. Members were presented with a roadmap of the status of activities for adoption of the CDI curriculum and training module in West Africa.

21. Dr Sobela updated TCC on the outcome of a workshop on integrating the CDI curriculum and training module into the programmes of faculties of medicine, schools of health sciences and nursing schools, held in Akure Ondo State, Nigeria from 29/11 to 01/12/11. The workshop, which had 44 Participants from 12 institutions, concluded that most of the institutions would present their proposals for piloting testing of the curriculum in the 2012/2013 academic sessions. All the institutions were willing to carry out pilot testing, and agreed that CDI should be integrated into the continued professional development programmes of their various professional groups and in their various postgraduate curricula and APOC should use the opportunity of the continued professional development programmes to train those who are already out of school in CDI skills.

22. It was noted that the curriculum has been presented to senior academic representatives of about 64 training institutions in 19 countries across Africa. Other achievements included the fact that 13 universities and schools received financial support from APOC to start the process, of the production of the 1st draft of the CDI Handbook. Implementation reports were received from IRSP/Benin, Burkina Faso, Nigeria, Senegal, Togo and preparatory activities are on-going for Burundi and DRC. A few challenges experienced included the introduction of a new curriculum in higher education institutions (stand alone or integrated in other existing programmes, procedures for accreditation) monitoring and evaluation (outcome and impact) and high turn-over of those sensitized and trained.

23. APOC informed the TCC of its 2012 work-plan for inclusion of the CDI strategy in the curriculum of the universities including the finalization of the CDI handbook.

24. The linkage of operational research to the curriculum was perceived as something which could be mandated as a provision from the onset. However, since some universities are less informed about CDI and others require permission to add a new subject into the curricula, a workshop to sensitize the universities is planned to enable the higher authorities to understand and plan for such inclusion. Noting that inclusion of the CDI curriculum into medical institutions is evidence of sustaining the CDTI strategy, there was a debate about whether the curriculum should be introduced in higher institutions as a stand alone module or integrated into other programmes. It was made clear that the handbook was a standard book for all universities because the students are evaluated upon it and that there are on-going discussions to determine if and where the handbook
can be integrated. Notably, TCC enquired if APOC had links with Universities in the USA that have already adopted the CDI strategy. APOC Management informed TCC that there was on-going correspondence with these universities.

25. TCC thanked APOC Management for the remarkable achievement and made the following remarks:

(i) TCC asked APOC Management to finalize the CDI handbook, incorporating the suggestions of the Abuja and Nairobi workshops before posting it on the website.

(ii) TCC encouraged APOC to continue efforts to involve all institutions including private ones in CDI strategy inclusion in the curricula of faculties of medicine, health sciences and nursing schools.

(iii) In view of the difficulties being encountered in developing research proposals, it was suggested that inclusion of operational research into the curricula, initially with a provision for funding, would be an incentive for students’ research theses/dissertations.

8. EIGHTH NOTF MEETING: Agenda item 8

26. Dr Noma reported on the outcome of the 8th meeting of the National Onchocerciasis Task Forces (NOTFs) held from 26-30 September 2011 in Ouagadougou, Burkina Faso. The meeting provided an update on the control activities that use CDTI as their primary strategy. It also examined data on the financial contributions made by governments and NGDOs to support control activities, and considered data on the distribution of ivermectin, the training of health workers and CDDs, and co-implementation of control activities for other neglected diseases including other commodities for other health interventions (e.g. distribution of long-lasting impregnated nets) together with those of onchocerciasis. It provided a forum for discussion of strategic issues, including elimination, the status of epidemiological and entomological evaluation and technical support provided to countries. It was noted that out of a total of 144,834 communities targeted, 138,448 were treated, giving a remarkable geographical coverage of 96%. Out of a total population of 99 million, 75 million people were treated thus achieving a 76% therapeutic coverage of the 107 APOC projects.

27. With the paradigm shift from control to elimination and in line with the JAF recommendation to consider all endemic African countries together regarding the goal of elimination, TCC was informed of the proposal to hold a joint meeting for APOC and ex-OCP countries.

28. TCC thanked Dr Noma for the update and suggested that if a joint NOTF meeting is being planned to accommodate both APOC and Ex-OCP countries, attention should be drawn to the following issues:

(i) The agenda for the NOTF meetings should have a roadmap with clear objectives and outcomes;

(ii) The participants should be informed well in advance of what is required of them to make adequate preparation for the meeting; and

(iii) The meeting would benefit from having representatives of AFRO/NTD Programme.
9. FEASIBILITY OF ELIMINATION OF ONCHOCERCIASIS INFECTION AND INTERRUPTION OF TRANSMISSION: Agenda item 9

9.1 Elimination of Onchocerciasis with ivermectin in Africa:

a) Update on APOC Countries

APOC Consultative workshop on Onchocerciasis elimination

29. Dr Noma presented TCC with an update of the outcomes of the APOC Consultative workshop on onchocerciasis elimination held from 5-9 March 2012, in Ouagadougou, Burkina Faso. The objectives of the workshop were to revise treatment boundaries and expand treatment, where needed, to achieve elimination; assess progress towards elimination thresholds in all APOC projects (phase 1a); prepare for stopping treatment in projects that are approaching thresholds (phase 1b); and stop treatment where justified; and develop national and project onchocerciasis elimination plans. The expected outcomes included strategy, guidelines and implementation plans for revising treatment boundaries; selection of sites and survey villages for phase 1a evaluations in 2012; detailed guidelines for phase 1b evaluations and procedures; and implementation plans for stopping treatment and procedures and formats for national and project elimination plans.

30. TCC commended APOC management for the feedback on the meeting.

Guidelines for revising ivermectin treatment boundaries within the context of elimination

31. Dr Hans Remme presented the proposed guidelines for revising ivermectin treatment boundaries within the context of elimination. These guidelines had been developed during a workshop held the preceding week with experts from 11 APOC countries, including the national coordinators for onchocerciasis and LF. The proposed guidelines emphasised that in order to achieve onchocerciasis elimination, ivermectin treatment needs to cover all areas where there is sustained local transmission. The vast majority of onchocerciasis transmission areas in Africa are already covered by CDTI for onchocerciasis control or ongoing/planned treatment for lymphatic filariasis elimination. The algorithm in this document aims to identify the remaining untreated areas where there might be sustained local onchocerciasis transmission in the absence of local ivermectin treatment and where ivermectin treatment is therefore needed. The starting point for the algorithm is the distribution of onchocerciasis in APOC countries according to the results of the spatial analysis of data from REMO surveys in over 14,000 villages. The workshop participants were not aware of any isolated onchocerciasis focus in Africa where the prevalence of MF was not at least 20% in some villages and the prevalence of nodules in adults was not at least 10% in some villages. Taking into account false positives with nodule palpation in non-endemic areas, the participants agreed to retain a threshold of 5% nodule prevalence as the level below which it is unlikely that there would be local onchocerciasis transmission that would be able to sustain itself.

32. The algorithm is used to delineate using a GIS the remaining areas where ivermectin treatment is needed for the purpose of onchocerciasis elimination. In step 1 the areas currently under CDTI are displayed and the few untreated high risk areas (with nodule prevalence > 20%) identified in order to accelerate their inclusion in CDTI. In step 2 the latest map for ongoing/planned LF treatment is overlaid, and the remaining untreated areas identified. Step 3 then determines where in these untreated areas further surveys are required to detect possible foci with sustained local transmission. This step is guided by a decision chart that takes into account whether the pre-control prevalence of nodules > 5% and whether the area is isolated or bordering on a CDTI project. It is assumed that in isolated areas with a nodule prevalence < 5% there are no local transmission zones, and thus no need for ivermectin treatment, but this hypothesis will be tested in the field.
33. Further surveys, if needed, would use the skin snip method (or other diagnostics of active infection if available/validated) together with nodule palpation following the standard epidemiological evaluation protocol of APOC, but limited to examination of adults above the age of 20 years. It was noted that ivermectin cannot be used in areas that are hypoendemic for onchocerciasis but hyperendemic for loiasis.

34. TCC was informed that the next step would be to develop a document which detailed written guidelines based on the workshop outcomes, prepare an implementation plan and submit this for review to TCC in September 2012.

35. TCC commended Dr Remme for the presentation and made the following remarks:

   (i) The group had designed an algorithm for the identification of areas that were not under treatment to assist decision-making for areas that should be treated. TCC endorsed the direction of this work and the hypothesis for the algorithm and decision-making table, which will be tested.

   (ii) The scenario for areas with a nodule prevalence of less than 5% will be validated in the following year.

   (iii) It was noted that nodule prevalence was not the most appropriate indicator for low level infection but still tells a lot about residual transmission.

   (iv) TCC suggested that it would be useful to do LF surveys at the same time as epidemiological surveys for onchocerciasis where the two diseases are co-endemic and even provide support for treating against LF.

   (v) TCC noted the suggestion that LF mapping should be carried out in collaboration with the AFRO/NTD Programme.

**Epidemiological evaluations of the long-term impact of ivermectin treatment**

36. Dr Afework presented an update on epidemiological evaluations of the long-term impact of ivermectin treatment - progress towards the elimination endpoint. The criteria for selection of the first evaluation sites required that the project has had at least 10 years of ivermectin treatment, is relatively isolated and has a high level of pre-treatment endemicity. The result of epidemiological evaluations conducted since the last TCC session (Tanzania and Nigeria) were presented and showed satisfactory results. Results of the epidemiological surveys between 2009 and 2011 indicated that out of a total of 31 sites, 27 showed satisfactory progress, while only 4 showed unsatisfactory progress. It was noted that out of the 12 sites where elimination is probably already achieved 7.4 million people are free from the risk of infection.

**Epidemiological evaluation for Phase 1a**

37. TCC was also informed of the planned epidemiological evaluation for Phase 1a, in 2012. The objective of Phase 1a is to assess the decline in infection levels towards breakpoints. Twenty six (26) projects were proposed, however 24 were selected from within (Burundi, Cameroon, Chad, CAR, Congo, DRC, Nigeria, Sudan and Tanzania). The criteria for selecting Phase 1a required that the project has many years of ivermectin treatment and a high level of pre-treatment endemicity. The sampling procedure and methodology considered villages with at least >70% therapeutic coverage, one sample village within 30 km along the breeding site and in bigger villages to randomly sample sub-villages closer to the river. TCC was presented with examples of the sites selected.
38. TCC thanked Dr Afework for the two presentations and made the following suggestions:

(i) In Nigeria where there are areas with persistent insecurity it might be necessary to use alternative strategies such as bringing people to secure places, train them and send them back to undertake the survey; and prioritise areas in the south where there is no security problem;

(ii) TCC reiterated the need for more acceptable diagnostic tools and asked APOC Management to continue following up on the release of DEC patch test;

(iii) In order to reduce the percentage of refusals during skin-snipping, the replacement of punches should be considered after 500 – 600 snips.

**Preparation for stopping ivermectin treatment in Phase 1b**

39. Dr Noma presented to the TCC a description of preparations for stopping ivermectin treatment in Phase 1b. The aim of Phase 1b evaluation is to collect epidemiological and entomological data to enable stopping ivermectin treatment safely. The methodology for the preparation for stopping ivermectin treatment in Phase 1b includes (i) a larger sample size (more villages to be surveyed) to ensure that treatment can be safely stopped throughout these areas, (ii) delineation of the exact areas where it is intended to stop treatment and (iii) epidemiological and entomological evaluations will be needed to assess residual infection and transmission levels throughout the area and confirm that these are below defined elimination thresholds. Phase 1b evaluation areas should first be evaluated epidemiologically (considering transmission zones) then administrative areas should be looked at the operational level. It is important not to stop treatment if a focus shares boundaries with other transmission zones where phase 1a results were not satisfactory. The foci in the boundary area need to be assessed. Based on the fact that transmission zones may be different from administrative areas and that transmission zones with different levels of prevalence may border each other, the phase 1b evaluation may be wider than the area in which treatment will stop operationally.

40. Sampling of villages should primarily be guided by flight range (20-30 km radius was suggested but entomologists should come up with a clear guidance based on variations of vector species) and river basins. It was also noted that villages which were included in phase 1a should be excluded from assessment in phase 1b. However, if the phase 1a prevalence was above threshold (>5%) and there is a long time lapse between the two phases, these villages could be included in phase 1b. Skin-snips should be done in adults of 20 years and above since phase 1b is aimed at checking the absence of infections. Where there is LF and Onchocerciasis co-endemicity, there is a need to incorporate LF epidemiological assessment in phase 1b. This would help to determine the subsequent steps towards stopping treatment. Community preparation ought to start early enough in areas where treatment is intended to stop. Therefore, there is need to develop a communication strategy.

**Countries/Projects format for elaboration of Onchocerciasis elimination plan**

41. Dr Noma presented TCC with a framework for national onchocerciasis elimination plans with proposed elements and a standard format, highlighting the need for national workshops for preparation of elimination plans, providing general information, analysis of the situation, a conceptual framework of the plan to eliminate onchocerciasis, objectives, strategic priority, implementation plan, plan for maintaining achievements and strengthening health system and budget.

42. TCC endorsed the study to continue.
9.2 Evaluation of geographic coverage – Draft protocol

43. Mr Zoure presented a protocol for monitoring geographical coverage of onchocerciasis "transmission zones" and identifying communities eligible for mass treatment that are not receiving treatment. The APOC TCC defined geographical coverage as the number of communities treated in a given year divided by the total number of meso/hyper-endemic communities as identified by REMO in the project area (this should be expressed as a percentage). In the case of this study, this definition should be modified as “The number of communities treated in a given year divided by the total number of endemic communities in the onchocerciasis “transmission zone” as identified by REMO in the project area (expressed as a percentage)”. The study will provide information on the exact delineation of areas being treated with IVM either for onchocerciasis or LF, location and names of communities eligible for ivermectin treatment that are not being treated, spatial distribution of communities and health facilities/institutions, the human resources available at community level for the implementation of CDTI will be known.

44. The districts and communities to be visited should fall entirely or partially in the onchocerciasis transmission zone and all communities recognized by the district medical office as under his responsibility, regardless of their ivermectin treatment status or onchocerciasis endemicity. Data are to be gathered through key informants interviews, documentary review and recording of geographic coordinates using Geographic Positioning Systems instruments (GPS). TCC was presented with a sample of geographic coverage survey forms and the reporting format. Data are to be collected at regional, district, health facility and community levels.

45. TCC endorsed this exercise, noting that if some communities are not treated elimination will not be achieved. It was also noted that this work provided a good example that could be used to strengthen other health programmes.

46. TCC suggested that information on hydrographic basins should be included in the data base to help entomological surveys.

47. TCC also noted that it would be useful to come back to areas found to be untreated two to three years later and check if they are treated.

48. TCC noted with concern the proposed area of extension of CDTI in Ethiopia and suggested that REMO be done in all unmapped areas considered potentially endemic for onchocerciasis in the country.

9.3 Entomological studies:

a) Revised Study Protocol:

49. Dr Philippon presented to the TCC on behalf of the Entomological Group, a draft protocol on the entomological assessment of interruption on onchocerciasis transmission in the APOC countries, following the JAF recommendation 1) to launch further epidemiological evaluations and assessment of progress towards elimination in APOC countries, and 2) request for confirmation of zero infection rates by means of results of transmission assessment. Therefore, a standardized entomological protocol was to be prepared and agreed upon by experts. The proposed protocols are based on the OCP initial protocols which were used over almost three decades to monitor and predict the impact of vector control, and are still used in ex-OCP countries for assessing the level of transmission. The major component of the study will be entomological investigations based on standardized catches and dissections of man-biting females of *Simulium* spp. molecular analysis of bulk catches as well as pool screening. All the related techniques have been explained in great detail in two manuals published by OCP in 2002 for training of entomologists and technicians.
50. The overall objective is to assess the degree of interruption of *Onchocerca volvulus* transmission by *Simulium* flies. TCC was also informed of the methodology and criteria used to select catching points (CPs) and timing of catches (bulk and standardized catches). Larval populations of *S. damnosum* s.l. should be sampled periodically over the full study period on the nearest breeding sites to the CP; collected larvae should be preserved for further cytological examination. Training, selection of catching points and timing of catching are very important for these entomological studies.

51. TCC was also informed of the importance of the timing of fly catches which is to be carried out during three consecutive days on each CP. «Bulk catching» on days 1 and 2, standardized captures-dissections on day 3. The flies are to be collected from 7 am to 6 pm with one hour lunch break. There should be Weekly or bi-weekly catches must be done at each CP. Catches must cover the whole period of fly production (4-5 months up to year round). The study should be conducted over two consecutive years.

52. It is important to note that L3 parasites collected in *Simulium* flies during standardized dissections are identified by probes specific to *Onchocerca* species, but inside the *O. volvulus* species group, the distinction is only possible between “savanna” and “forest” strains, and only in West Africa. For vector identification, it was noted that all infective blackflies found during standardized dissections are identified at the MDSC DNA Lab using the hetero-duplex analysis technique.

53. TCC thanked the entomological working group for the protocol and observed that for the entomological studies, catches should be synchronized with the period of ivermectin treatment, considering that they should cover the peak of the transmission period and that it is recommended to treat human populations before the peak of the transmission season.

54. Considering the foreseeable need for expertise in the detection of vector infectivity through pool screening and for molecular identification of flies and parasites, the Committee was informed by the APOC Management about the newly established DNA laboratories in Jos in Nigeria, Khartoum in Sudan, and Kampala in Uganda, which are already performing screening under the overall supervision of Prof. Tom Unnasch. Projects are being developed by the Carter Center to establish the same type of laboratories in Ethiopia under the same supervisor. These DNA laboratories could be connected with the MDSC central one, in collaboration with Pr T. Unnasch.

55. The Committee also noted that it would be useful to conduct a literature review of the seasonality of onchocerciasis transmission in the APOC areas by the entomological working group which should, where necessary, get complimentary data. The protocol was therefore adopted by TCC with minor amendments.

b) **Update on activities conducted in Nigeria, Chad and Uganda**

56. An update on entomological studies carried out in Chad, Nigeria and Uganda in 2011 was presented by Dr Laurent Yaméogo. TCC was informed that budget to carry out advocacy and sensitization and to train technicians was received from five countries, four had been approved and one is under review. Sixteen (16) people were trained in Nigeria and fourteen (14) people in Chad also benefited from the exercise. Overall, preliminary results from Nigeria were satisfactory in all the sites as no infective fly with *O. volvulus* was captured. Chad presented insufficient data due probably to drought. Assistance would be given for the identification of suitable catching points if the rainy season is better in 2012. Uganda would need the visit of an entomologist to review the situation and ensure that the data are recorded and sent to APOC management together with the samples collected. Although funds were transferred to Tanzania, no field activity was undertaken in 2012. Plans have been made therefore to assist Tanzania and Cameroon in launching the activities in March/April 2012.
57. TCC noted that entomological assessments should be part of Phase 1b of the "conceptual and operational framework of onchocerciasis elimination with ivermectin treatment" where wider epidemiological evaluations would be conducted in 2012. The launching of entomological assessments in these two last countries among the first five retained therefore is timely.

58. TCC thanked APOC management for the update on the activities conducted in Nigeria, Chad and Uganda. TCC was also pleased to note that entomological activities for transmission assessment in APOC countries have been initiated, and that Prof Daniel Boakye will be joining APOC for six months starting from 1st April 2012 to assist with the implementation of the entomological work.

c) Update on the delineation of transmission zones

59. In response to JAF15 recommendation to determine when and where ivermectin treatment can be safely stopped and to provide guidance to countries on preparing to stop ivermectin treatment where feasible, APOC developed a conceptual and operational framework of onchocerciasis elimination with ivermectin treatment which included understanding of transmission zones. Based on this, the importance of vector migration and establishment as a concept to delineate transmission zones was proposed by Prof. Daniel Boakye. The re-invasion phenomenon in the OCP countries was presented as an example of how wide transmission zones could be, and that species distribution maps alone are not sufficient to determine transmission zones. There was a need for species population markers which could be used to follow various populations of the same species and their distribution. TCC was informed of the available tools for this exercise, which were morpho-taxonomy, molecular markers and cytotaxonomy and of their limitations. Cytotaxonomy is the current preferred method but there is a lack of expertise in APOC countries thus the need for a strategy to train cytotaxonomy technicians within the countries who could undertake species identification across seasons, develop species identification maps and analysis to develop transmission zone maps was adopted. Ten technicians have now been trained in Nigeria and three in Malawi. Some limitations of this strategy are that it is slow and sampling does not cover a wide area, hence it is not suitable for a quick delineation of transmission zones. A new strategy that takes an in-depth situational analysis that will help put in place a good strategy for a better delineation of the transmission zones within a shorter time period is being developed in close collaboration with APOC-EVE unit. This will help to determine priority areas for cytotaxonomic studies. This requires a functional cytotaxonomy unit in APOC with a full-time staff member to lead and develop the first distribution maps for priority areas by August - September 2012.

60. TCC thanked Professor Boakye for the update and noted that his knowledge and experience would be valuable to the elimination agenda and to the programme as a whole. TCC raised a question concerning distribution maps for species and maps to delineate transmission zones. The Committee was informed that the transmission zone maps are based on variations in populations of the same species.

d) Update on black fly trapping and other studies related to Onchocerciasis

61. Dr Unnasch updated TCC on black fly trapping and other studies related to onchocerciasis. He stated that entomological surveillance requires the analysis of large numbers of insects in areas where control efforts have been successful and infectious insects are rare. This process involves three distinct challenges. First, one must identify where the insects are plentiful; second one must collect large numbers of insects; and third one must have an efficient method to screen the insects collected.

62. To address the first challenge, a remote sensing model to predict the location of breeding sites for the savanna dwelling sibling species of S. damnosum s.l. was recently developed. This model is based upon extraction of spectral data characteristic of S. damnosum breeding sites (fast flowing water over a pre-Cambrian rock substrate) coupled with stream vegetation and a moderate altitude gradient. This model was tested in both Burkina Faso and Uganda, by using a Kriging...
process to predict the location of potential breeding habitat followed by ground-based verification of the predicted habitats. All (100%) of the sites predicted as containing breeding habitat in Burkina Faso were found to contain *S. damnosum* larvae, while 92% of the sites predicted as breeding sites in Uganda contained larvae. The ability to accurately predict *S. damnosum* riverine breeding habitats will be useful in mapping at risk communities in conflict ridden areas and in more precisely delineating transmission zones for onchocerciasis elsewhere.

63. To address the second challenge, a programme was recently initiated to develop a trap that will efficiently collect black fly vector species of onchocerciasis. The group is concentrating on isolating chemical attractants for these flies, both those secreted by the human host and those secreted by ovipositing black flies, using a combination of chemical fractionation and behavioural and electrochemical assays. These approaches, together with associated field studies have resulted in the development of a human lure baited trap that is as effective as human landing for the collection of *Simulium ochraceum*, a major vector for onchocerciasis in Latin America. Similar field studies of trap prototypes are currently underway in Burkina Faso.

64. Screening large numbers of flies can be efficiently accomplished by using pool screening strategies when the prevalence of infection in the vector population, pool size (and consequently the number of insects that may be screened) is limited only by the biochemical capabilities of the assays. Recently, a method based upon magnetic capture of *O. volvulus* DNA from homogenates of vector black flies that improves the efficiency of the pool screening process was developed. This results in a 2-4 fold increase in the number of flies that may be tested per pool, reducing labour costs by 75% and reagent costs by 20-60%. This new method will make screening the large number of flies needed to certify elimination more efficient and economical.

65. TCC thanked Dr Unnasch for the informative presentation and looks forward to the method being put into use.

9.4 Elimination of *O. volvulus* infection: New diagnostics of PATH

66. Drs Gonzalo Domingo and Tala de los Santos provided an update on the development of the Ov16 rapid test as a tool to monitor onchocerciasis elimination. Data on the performance of the current test developed at PATH were presented based on a total of 235 specimens generously provided by Tom Unnasch and Tom Nutman. The data shows that the rapid test performs as well as an ELISA test detecting IgG4 antibodies to the antigen Ov16. The data also showed that the test detected Ov-16 specific IgG4 in 89% of mf positive specimens, although this is based on a limited number of specimens. It was discussed during the question and answer time that the correlation with mf positivity will vary from population to population based on endemicity and target age group. PATH also presented a timeline for the next steps of development, engagement with a manufacturer, and evaluation of the test in (a) the alpha stage at the NIH laboratories (b) through field studies of an early beta prototype. As next steps (a) PATH is looking forward to attending the upcoming Kilosa surveillance activity to inform product design inputs, and is grateful for this opportunity; (b) PATH will be engaging with APOC to design field studies that will address outstanding questions regarding the application of the Ov16 test to assess elimination; (c) PATH is working with APOC to forecast potential demand for Ov16 rapid tests for monitoring elimination; and (d) PATH continues to work with APOC to measure environmental conditions (temperature and humidity) that are experienced during surveillance trips.

67. TCC thanked PATH for the new diagnostics in the framework of elimination of *O. volvulus* infection and looked forward to receiving more update.

9.5 Perspectives of Lymphatic Filariasis (LF) and Onchocerciasis elimination

68. Dr Gary Weil made a presentation on the perspectives of lymphatic filariasis and onchocerciasis elimination. The first part of the presentation focused on perspectives related to elimination programmes. The message here was that given recent increases in resources, new goals,
and high expectations from funding agencies, it is now a good time to re-examine strategies that were designed for a different era. Traditional LF control programmes were based on mass screening by night blood testing and selective treatment of persons with microfilaremia. Technical advances in treatment and diagnostics led to a paradigm shift from disease control to elimination. The Global Programme to Eliminate Lymphatic Filariasis (GPELF) is largely based on mass drug administration (selective screening to establish endemicity, and mass administration of drugs (MDA) that have been generously donated by large drug companies. Initiated in 2000, GPELF rapidly scaled up to become the largest infectious disease intervention programme ever attempted based on MDA. In contrast to the situation for LF, the paradigm shift from disease control to elimination for onchocerciasis resulted from conceptual advances and recent success stories from the field rather than from important technical advances. Further improvements in therapy (short course anti-*Wolbachia* treatment, new drugs such as Flubendazole, or repeated treatment with Ivermectin/Albendazole as mentioned below) and diagnostic tools could significantly improve prospects for success.

69. Several ideas were discussed by TCC regarding onchocerciasis elimination in Africa:

(i) Should APOC be redesigned and rebranded as APOE (the African Programme for Onchocerciasis Elimination) or APEF (African Programme for Elimination of Filariasis)? APEF would focus on elimination of the three major filarial diseases in Africa (LF, Onchocerciasis, and Loiasis).

(ii) The need for new mapping of hypo-endemic areas and for further discussions and applied research on endpoints for onchocerciasis elimination programs.

(iii) A visit to a district health office and to villages receiving Ivermectin prompted a discussion of ways that ComDT might be improved in that area.

(iv) Alternative strategies for MDA using current and future drugs for onchocerciasis elimination in Africa.

70. This was followed by a discussion of several key issues that are important for LF elimination programmes in Africa:

(i) Compliance is not only an issue for individuals and families but also for all levels of public health system. Data were presented on the impact of systematic non-compliance in LF elimination programmes.

(ii) Mapping data for LF are incomplete or inaccurate for many African countries. There is need for finely grained maps of LF endemicity (with IUs smaller than districts) to better delineate areas of overlap with loiasis and Onchocerciasis. Microfilaria testing should be performed to corroborate positive antigen test results from all areas not previously known to be LF endemic.

(iii) LF programmes should be integrated and coordinated with other public health programmes including malaria control (ITN, IRS) and other NTDs. However, smart integration retains focus needed to achieve LF elimination. The lesson from the elimination of smallpox is that elimination is infinitely preferable to control when this is an option.

(iv) More full time staff is required to manage and steer GPELF.

71. The second part of Dr Weil’s presentation summarized ongoing and/or planned applied field research projects related to LF and Onchocerciasis elimination. “Research to eliminate lymphatic filariasis” (supported by NIH) is testing provisional endpoints and enhanced surveillance methods in Sri Lanka. Early results suggest that antibody testing of school-aged children and molecular xenodiagnosis (detection of parasite DNA in mosquitoes) may be superior to TAS
surveys (systematic antigen testing of schoolchildren) for detecting low level filariasis in communities and for post-MDA surveillance. Enhanced surveillance of hot spots (areas considered to be at high risk for persistence or resurgence of LF following cessation of MDA) is complementary to TAS surveys and feasible for some national LF elimination programmes.

72. “Optimization of chemotherapy for elimination of lymphatic filariasis and Onchocerciasis” (the DOLF project, supported by the Bill and Melinda Gates Foundation) is studying several important issues related to LF and Onchocerciasis elimination:

(i) Can accelerated MDA improve chances for meeting the target date of 2020 for LF elimination? Computer simulation studies and cost projections suggest that semi-annual MDA will reduce the time required to eliminate LF by about 50% and reduce overall programme costs (excluding the cost of donated drugs, which is unchanged). DOLF will compare annual and semi-annual MDA in 5 different endemic settings in Africa and in the Asian/Pacific regions.

(ii) What are the effects of annual and semi-annual MDA for LF on soil-transmitted helminth infections? Although STH infect people in all age groups, control programmes usually focus on school-aged children. In contrast, MDA programmes for LF treat entire populations for STH. DOLF will study this issue as part of the accelerated MDA studies mentioned above.

(iii) Can MDA with Albendazole control or eliminate LF in countries/areas with co-endemic loiasis? DOLF will perform community studies and a clinical trial to address this important question.

(iv) What are the effects of annual and semi-annual Albendazole/Ivermectin for LF on co-endemic Onchocerciasis (community study)?

(v) Are repeated doses of Albendazole with Ivermectin superior to Ivermectin alone for treatment of Onchocerciasis (clinical trial)?

73. Information from studies 4 and 5 (above) may improve prospects for onchocerciasis elimination in Africa. TCC appreciated the presentation and look forward to further developments.

9.6 LF and Onchocerciasis control/elimination Programmes’ collaboration

74. Dr Lusamba presented feedback of the Working Group proposing the establishment of a Joint AFRO-LF/RPRG – APOC/TCC subcommittee to undertake in-depth analysis of strategic issues and propose the way forward. The draft Terms of Reference for a Joint subcommittee are to identify and analyse strategic issues, develop the scope of collaboration within the integration framework, propose institutional arrangements for collaboration at country level, propose harmonization of technical approaches for (Mapping, treatment strategies, implementation of activities and logistic issues) and report to RPRG and TCC.

75. TCC thanked APOC Management and the Working Group for the initiative and endorsed the following:

(i) To establish a Joint AFRO-LF/RPRG – APOC/TCC sub-committee to undertake in-depth analysis of strategic issues and propose the way forward.

(ii) Membership will be comprised of three persons from each group (6 in total).
(iii) TCC and RPRG to designate those members.

(iv) First draft to be submitted to TCC and RPRG by end of June 2012 for review, feedback and formal adoption during August RPRG and September TCC sessions.

9.7 Twice yearly treatment in problematic areas

76. Following the decision of JAF17 encouraging APOC management to scale up the use of alternative approaches including twice-yearly treatment with ivermectin, where appropriate, to speed up elimination in problematic areas and address cross-border issues, a presentation was made showing the predicted and observed MF prevalence following 6-monthly treatment in the River Gambia basin. TCC’s guidance was sought on this matter.

77. TCC thanked Dr Noma for the presentation and observed that the terminology “problematic areas” is vague as it might mean areas co-endemic with Loa loa or conflict areas. The problem could also be a programmatic one. TCC therefore advised that it was necessary to gather scientific evidence to really identify what constitutes a problematic area.

78. A sub-committee was formed comprising Drs Traore, Yebakima, Thomson, Thiede, Afework, Boussinesq, Gary Weil and Dr Duerr to look into the matter and report back to TCC.

9.8 Control and elimination of Onchocerciasis: thresholds, breakpoints and strategies

79. Dr. Duerr presented an update on the results of a mathematical modelling study, concluding that the annual biting rate (ABR) and the breakpoints play a critical role in the feasibility of elimination of onchocerciasis through community-directed treatment with ivermectin (CDTI). For the development of a strategy for elimination of onchocerciasis the following 5 facts need to be taken into account: 1 (ABR): A strategy which has led to elimination in a village with a particular ABR will not necessarily be successful at higher ABRs; 2 (Averages): A strategy which works 'on average' may fail for the 'worse 50%' of cases; 3 (Thresholds): CMFL or skin microfilaria level based thresholds can only be provided for a particular ABR; most probably only adult worms allow for formulating threshold criteria independent of the ABR; 4 (Time): Time (e.g. increased duration of CDTI) cannot compensate for an insufficient coverage; and 5 (Population size). A strategy which has been successful for a village with 100 people may not necessarily work in a transmission zone with 100,000 people.

80. Taking into account the variability of around a factor of 10 for many parameters due to natural variability and measurement errors, the simulations suggest three ABR dependent types of strategies which could, on average, result in elimination. 1) Elimination of onchocerciasis by CDTI is feasible in areas where the ABR is below around 10,000 bites per person and year, corresponding to a pre-control MF-prevalence of below 70% (population average), or a pre-control ATP of about less than 300 L3 per person and year. 2) Elimination requires additional efforts such as transmission season adapted treatment regimens in regions where the ABR is in the low ten thousands corresponding to a pre-control MF-prevalence between around 70% and 85% (population average), or a pre-control ATP in the order of several hundreds of L3 per person and year. 3) Even with maximum feasible treatment coverage CDTI needs to be complemented by vector control measures in regions where the ABR approaches a hundred thousand bites per person and year, corresponding to a pre-control MF-prevalence greater than 85% (population average), or a pre-control ATP in the order of thousands of L3 per person and year.

81. TCC thanked Dr Duerr for the presentation and recommended that he should be provided with a data of the epidemiological survey data by APOC Management so as to match his model/validate with the field results that are now available for many foci.
10. CONTRIBUTIONS/ROLES OF APOC IN NTD CONTROL (TCC REFLEXIONS AND GUIDANCE): Agenda item 10

82. In order to seek TCC’s guidance on the contribution of APOC in NTD control, a presentation was made by Dr Lusamba, highlighting various decisions regarding the issue; e.g. the 2007 JAF which expanded the mandate of APOC to include co-implementation with other health interventions; the 2008; JAF decision advising APOC not to enter into full-scale integrated NTD control but rather facilitate coordinated activities where appropriate and where there is a community desire to do so; and the 2011 JAF decision which reaffirmed its endorsement for the Programme to pursue the elimination of onchocerciasis in Africa as well as co-implementation of preventive chemotherapy interventions for selected NTDs in the context of increased support to community-level health system strengthening.

83. Areas in which APOC could collaborate include:

(i). Integrated mapping of NTDs,
(ii). Strengthening coordination for co-implementation,
(iii). Advocacy and resource mobilization,
(iv). CDTI structure & CDD network for the delivery of drugs and commodities,
(v). Community-level monitoring and supervision of intervention,
(vi). Introduction of CDI in the curricula of training institutions.

84. The priority diseases and health interventions are:

a) MDA-PCT for NTDs
   (i). Lymphatic filariasis
   (ii). Schistosomiasis
   (iii). Soil transmitted helminths
   (iv). Trachoma

b) Malaria control
   (i). Distribution of long-lasting insecticide treated nets
   (ii). Detection and referral of cases

c) Vitamin A Supplementation

85. TCC thanked the APOC Director for the presentation and emphasized the need for closer collaboration with AFRO/NTD. The committee recommended that APOC should document what it is doing in the field regarding integration as many partners are unaware of this.

86. TCC recommended that APOC and the AFRO/NTD Programme should work together since they belong to one WHO. In addition, APOC should provide more details on areas in which APOC could contribute most.

11. PREPARATION OF THE STRATEGIC PLAN OF ACTION AND BUDGET FOR THE POST 2015 PERIOD: Agenda item 11

87. A presentation on the various processes for the preparation of the APOC strategic plan of action and budget for the post 2015 period as well as the main outlines of the plan was made to TCC for their input.

88. JAF17 agreed that APOC should not close in 2015 as that would be untimely, given that none of the 31 endemic countries would have achieved elimination by that date and reaffirmed its endorsement for the Programme to pursue the elimination of onchocerciasis in Africa as well as
co-implementation of preventive chemotherapy interventions for other selected NTDs in the context of increased support to community-level health systems strengthening. The Forum therefore requested the CSA and APOC management to submit a detailed new plan of action budget with costs reflecting the new expanded strategic direction for the programme beyond 2015 for consideration by JAF18.

89. TCC thanked APOC Management for the presentation and requested that Management should circulate the draft Terms of Reference for the development of the Strategic plan of action and budget 2016 to 2025 to TCC members. TCC was also requested to suggest names of experts for the development of the plan.

12. MACROFIL AND RESEARCH: Agenda item 12

90. Dr. Kuesel provided an update on research activities covered in the APOC-TDR agreement on jointly supported research (referred to for historical reasons as ‘MACROFIL agreement) and on the negotiations with Lohmann Therapy Systems (LTS).

12.1 Update on moxidectin development and Ivermectin Response Marker project

Development of moxidectin

91. In her introductory remarks, Dr. Kuesel reviewed the steps and objectives in ‘Research and Development’ for new drugs. The decision to proceed from ‘Research’ to ‘Development’ (i.e. ‘to develop a drug’) is taken when the results from the nonclinical pharmacology and toxicology studies conducted during ‘Research’ result in the hypothesis that the drug will meet its intended Target Product Profile (TPP). During ‘Development’ an extensive series of pharmaceutical, non-clinical and clinical studies is conducted to test this hypothesis. As data from the studies emerge, they are compared with the TPP to see whether they support the hypothesis and development should be continued or not, in which case development of the drug is discontinued.

92. The refinement of moxidectin’s original TPP in response to emerging information from CDTI implementation, move towards co-implementation of control of NTDs addressed with preventive chemotherapy and regulatory requirements was reviewed as was the refined TPP relative to the data available. In summary, moxidectin is being developed as a drug, i.e. the hypothesis is tested that moxidectin is a drug which can be safely administered to ≥ 4 year olds once a year by control programmes and has an epidemiologically significantly higher effect on long term skin microfilaria levels than ivermectin (presumably due to a higher effect on the viability and/or reproductive activity of female and/or male worms). Analysis of the efficacy data with ONCHOSIM should indicate that annual moxidectin treatment will result with high probability in sustained interruption of transmission in 6 treatment rounds with 70% treatment coverage. Pharmaceutical and non-clinical data suggest that moxidectin meets its TPP and clinical data available to date suggest that moxidectin may meet its TPP.

93. Review of the Phase 2 study data by the TCC and two other scientific/technical advisory committees (Dec 2010 TDR Special Project Team, September 2011 External Advisory Committee) resulted in the recommendation that TDR needs to ensure that further delays in moxidectin development are avoided. The rationale for this recommendation is provided in TCC 32 and TCC 33 reports.

94. In contrast, JAF 17 recommended that further decisions on moxidectin development await the results of the Phase 3 study, expected for third quarter of 2012. If the analysis of this study favours the further development of moxidectin, then APOC and TDR should initiate a search for a new partner for licensing and potential donors.
95. Dr. Kuesel informed TCC, that the Phase 3 study results may not be available as recently planned in third quarter 2012 due to operational issues. Should the Phase 3 data result in the recommendation to continue moxidectin development, the best case scenario for resumption of development (paediatric study) is mid 2014.

96. TCC thanked Dr. Kuesel for the update. TCC acknowledged the JAF decision.

**Ivermectin Response Markers**

97. This project is conducted in collaboration between laboratories in Australia, Burkina Faso (MDSC), Cameroon, Canada, France, and Ghana and funded by APOC with project management provided by TDR. The primary objective is to answer the question whether long term treatment with ivermectin results in selection of *O. volvulus* with a reduced response to the embryostatic effect of ivermectin. Based on the results of year 1 of the project which included generation of a draft genome of *O. volvulus*, identification of several hundred potential markers and initiation of capacity building in the African laboratories (see TCC 33 report), the teams are now selecting the most promising markers for both ivermectin response and geographic origin for validation in Year 2. The progress report and renewal request will be assessed by a dedicated external advisory committee assembled by TDR.

98. TCC supported continuing conduct and funding of this project.

**12.2 Update on transdermal delivery technology based DEC patch test availability to APOC**

99. Dr. Kuesel reported that the discussions on the technical part of the agreement are still ongoing.

100. TCC re-emphasized its appreciation for LTS having freely provided its expertise and resources for the development of the transdermal delivery DEC patch and LTS willingness to further support APOC objectives through 'at cost' provision of the patch to APOC. However, it expressed its concern that the agreement has not yet been finalized and re-iterated the importance of the DEC patch for the evaluation activities of onchocerciasis elimination without skin-snipping hundreds of thousands of Africans over the next years.

101. TCC recommended that Director APOC write a letter to the CEO of LTS to emphasize the role the DEC patch will play during the effort to move towards elimination of onchocerciasis in Africa and to invite the CEO to participate either in a TCC meeting or an impact assessment to allow the CEO to obtain an increased appreciation of the context of the use of the DEC patch.

**13. REPORT ON THE LAST MECTIZAN EXPERT COMMITTEE MEETING:**

**Agenda item 13**

102. Dr Ogoussan reported on the 46th Mectizan Expert Committee meeting held in Paris in October 2011. He presented the mandate of MDP, the MEC/AC meeting format and the number of treatments approved for onchocerciasis and LF in 2011. A total of 140,588,709 treatments were approved by MDP for onchocerciasis in 2011 (112,856,958 for APOC, 26,408,052 for ex-OCP, 32,000 for Yemen and 1,291,699 for OEPA) and 129.8 million for LF.

103. Dr Ogoussan informed TCC of the 25th anniversary of MDP in 2012. Events of the 25th anniversary will take place during the World Health Assembly in Geneva in May 2012 and at the World Sight Day, at the Royal Geographic Society in October 2012.
104. Dr Ogoussan also presented the drafted algorithm to address treatment of Onchocerciasis in hypo-endemic areas but co-endemic for loa-loa. This algorithm was the main outcome of the loiasis scientific working group meeting held in Cameroun in February 2012.

105. TCC thanked Dr Ogoussan for the presentation and congratulated MEC and MDP on their 25th anniversary and donation of free drugs. TCC welcomed the initiative of joint ordering for the multiple drugs to avoid delays.

14. UPDATE ON REMO REFINEMENT RESULTS IN ETHIOPIA AND ANGOLA: Agenda item 14

106. An update of REMO refinement results in Angola (2008) and Ethiopia (2011) was presented by Mr Zoure. He showed maps of areas concerned with the refinement and prevalence observed in the surveyed villages. In Angola, the refinement made was in Benguela and revealed that 8 of the 9 districts of the province are endemic and treatment should be extended there. In Ethiopia where 512 villages were surveyed in 50 woredas (districts) in 10 zones, the refinement showed that treatment is to be introduced in 34 woredas. 32 of these woredas belong to zones where CDTI projects are already operating. Asosa and Kemashi are two zones where CDTI is to be newly introduced.

107. TCC thanked APOC management for the refinement and endorsed the idea that there should be two new project proposals for Ethiopia (Asosa and Kemashi) and one for Angola (Benguela) and recommended that CDTI project proposals are submitted by the two countries for the next TCC session.

108. TCC expressed concern over the presence of untreated areas in Ethiopia and noted the need to conduct REMO in other countries that could have similar problems.

15. REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA: Agenda item 15

109. Dr Leak provided a short summary of operational research undertaken through APOC funding from 2000 to the present. A small number of countries, Nigeria, Cameroon and Uganda have submitted the majority of proposals (72%). The acceptance rate is 62% and from the records available, close to US $500,000 has been disbursed. It was suggested that final reports should be collated and summarised for distribution to APOC Projects. APOC provides support to postgraduate training which is intended to build capacity within APOC Member countries for conducting operational research. The relatively small amount of money available for each proposal is considered to be a significant constraint that reduces the number of proposals submitted.

110. It was noted that the proportion of accepted proposals is probably higher than the rate for acceptance of research proposals submitted generally outside APOC. A TCC subcommittee was formed to review operational research (see item 15.2 on operational research). Two research proposals were reviewed by TCC; these were from Cameroon (1) and Uganda (1).
15.1 Reviews

a) Assessment of the impact of mass treatment with ivermectin on Loa loa in areas of co-endemicity with onchocerciasis in the APOC operational zones of Cameroon

Reviewers’ comments and conclusions:

111. The TCC after a thorough review commended the team for putting together a good proposal in response to APOC’s request and agreed that the study will provide valuable information on the Impact of Mass Ivermectin treatment on Loa loa in areas of co-endemicity with Onchocerciasis in the APOC operational zones of Cameroon.

112. TCC recommended that the proposal be rewritten to focus only on the parasitological aspect. Regarding the other aspects of the proposal, other sources of funding may be explored by the team.

113. TCC also recommended that the team should

(i) Provide information on availability of ethical clearance and consent note.
(ii) Revise the study methodology to clearly define site, study population and sampling method.
(iii) Include data collection tools and more information on the analysis.
(iv) Revise the budget to reflect only the parasitological aspect of the study.

b) Factors affecting adherence to community-directed treatment with ivermectin for onchocerciasis control in Pader District, Northern Uganda

Objectives

114. The general objective of this proposal is to identify factors that affect the intake of ivermectin among the communities affected by onchocerciasis in order to enhance the coverage for effective disease elimination in the Pader Focus. The specific objectives are to identify the socio-demographic factors that affect adherence to ivermectin treatment, establish the community/patient related factors that influence non-adherence to ivermectin MDA, assess the health system-related factors that influence non-adherence to ivermectin treatment, establish drug-related factors that influence non-adherence to ivermectin MDA, elicit views from key informants and the community on how to improve adherence to ivermectin treatment.

Assessment:

115. The introduction is appropriate and situates the topic of study within the broader context of controlling onchocerciasis in Uganda generally, and in Pader in particular. The background is well written. The team makes reference to the project coverage over the last three years, which is below the expected levels of therapeutic coverage to facilitate elimination of onchocerciasis. The problem statement is well written. The authors make a case for the study through highlighting the high prevalence of onchocerciasis (77%) and reducing treatment coverage from 89% in 2009, 65% in 2010 to 52% in 2011. Although the research questions follow closely the study objectives, they could have been stated more clearly. The hypotheses are well stated and are in line with the research questions and the study objectives. The overall objective and the specific objectives are adequate and respond to the problem to be studied.
Methodology:

116. Regarding the methodology; the study site is well described. Regarding the questionnaire, 724 people will be interviewed, 362 cases (those who have received treatment once) and an equivalent of controls (those who have received three rounds of treatment). It is important to also include persons who have never received treatment as part of the “CASE” category. Eight (8) FGDs will be conducted. The reviewers suggested that the cases should be expanded to include people who have never participated in treatment.

117. Regarding data collection and management plan, the analysis plan is well presented. The selection of the FGD participants should be done carefully so as not to mix the providers (health care workers and the CDDs) with the community members, which could lead to bias. It is also not clear why the team wants to link the data collection to the MDA period – this could complicate the process and skew the perceptions provided by the respondents.

118. Data collection instruments are perhaps the weakest part of the proposal. The questionnaire does not have questions that will identify the factors that have made the cases to stop taking drugs and the controls to continue taking drugs. The FGDs have closed questions and they would need to be reformulated in order to elicit the in-depth data anticipated. The IDI tools should also be made open-ended (in line with the comments on FGDs).

119. The team should formulate a consent form to be assented to by the study participants. The form should provide information on the study, benefits and assure the respondents of confidentiality.

Conclusions:

120. The research questions need to be refined. Cases to include those persons who have never received treatment as well as those who received treatment only once. The data collection instruments should be revised to ensure that they capture the thrust of the study, e.g. the questionnaire, in its current form, does not address the issue of non-adherence to treatment. The team should design a comprehensive consent form for the study. The budget and its justification should be relooked at paying attention to the line items and providing a comprehensive justification. The budget would need to be adjusted upwards.

121. TCC accepted the proposal but asked the team to provide the revised tools and the reviewers would provide support. The team should be asked to share the revised version of the proposal with the reviewers, including the data collection tools and the consent form.

15.2 Operational Research for APOC Sub-Committee Report (March 15, 2012)

122. Following the recommendation of JAF17 to provide assistance to countries in drafting operational research proposals, TCC formed a sub-committee to look into the matter and advise. The sub-committee was composed of Dr. Annette Kuesel, Prof. Daniel Boakye, Ms. Fatu Yumkella, Ms. Francisca Olamiju, Dr. Johnson Ngorok, Dr. Kisito Ogoussan, Dr. Stephen Leak and Dr. Mary Amuyunzu-Nyamongo (Chairing). The sub-committee met on March 15, 2012.

123. It was noted the acceptance rate of proposals was quite high; however there are some barriers to submission and acceptance of operational research proposals that need to be addressed. The following points were addressed:

- Barriers to the submission of fundable proposals for OR
- Factors hindering approval of OR proposal by the TCC
- Linking OR to the CDI training course (i.e. linking implementation to academic and research institutions)
- Reporting OR results to APOC and TCC
The impact of the research already funded by APOC (what topics are research on, how does the research inform/influence project performance and policy, how are the results disseminated/published?)

124. Operational research proposals can originate from the TCC and APOC Management or from the countries. All OR studies should be aimed at informing implementation and policy at the country-level.

125. Topics for OR identified by the sub-committee were:

- Community self monitoring (CSM);
- CDD incentives;
- Extent of the timing of MDA and its impact on transmission;
- Impact of the timing of CDTI relative to the transmission season and its impact on transmission;
- Use of MDA as a platform for education and NTD-related behaviour change;
- Opportunities that exist to coordinate treatment with LF for improved project impact;
- Appropriate communication strategies and content, more so in view of elimination.

126. Mechanisms to support country teams include:

- Submission of draft proposals to APOC, which would then be given to technical/scientific advisors to provide a review to the PIs with suggestions for finalizing the proposal before submission to TCC;
- Organize workshops that would bring together programme teams to develop proposals collectively as part of capacity building;
- Organize report writing workshops;
- Provide mentorship to country teams by TCC, APOC management and other technical advisors.

127. The sub-group suggested next steps as follows: Short-term (next 6 months):

- Compile information on the status of OR – funding, outcomes (publications, etc);
- Follow-up with all PIs for all funded projects for which final reports have not been received by APOC;
- Develop guidelines on OR (to be drafted by Dr. Leak with input from the committee members);
- Integrate a proposal development agenda in the proposal development process for CSM (funds allowing);
- Identify mentors for country teams interested or implementing OR;
- Disseminate (once more) information on OR with a view to encouraging countries to apply;
- Extract from TCC reports (over the last 5 years) knowledge gaps/research questions and communicate the same to NOTFs with a view to asking them to write proposals.

128. Next steps: medium to long-term:

- Develop a call for letters of intent (LOI) that would bring together multiple country teams for training;
- Institutionalize the review of OR survey reports as part of the TCC mandates (currently the final reports are not presented to the TCC);
- Consider the establishment of a TCC sub-Committee that can support the activities of APOC OR team where necessary instead of waiting for input during TCC sessions;
- Explore linkages with the CDI training – explore the possibility of implementing an OR as part of the training with the requirement that this is linked to existing CDTI projects and it should be jointly conducted with the project implementers as a capacity building component;
- Support in-country fundraising for OR;
- Consider increasing the funding limit to attract higher quality proposals from collaborative teams.

Recommendations:

129. Several suggestions were made: follow-up with PIs for final reports; extract knowledge gaps for the last five years from TCC reports; final reports of research should be presented to TCC; the sub-committee should continue to look at OR; OR training should have a practical element; support-in-country fundraising for OR and increase the funding limit above $20000.

130. If results are good enough they results should be published in peer-reviewed journals as a step towards getting them into wider use. It was suggested that Letters of Intent (LOI) could be submitted and reviewed before a complete proposal is developed as this could help reduce refusals. Regarding guidelines for publication it was noted that these guidelines exist for WHO and these same guidelines would apply.

16. THE NODDING DISEASE: TCC GUIDANCE ON THE WAY FORWARD WITH REGARD TO JAF DECISION: Agenda item 16

131. TCC took note of the recommendation of JAF 17 concerning the nodding syndrome (paragraph 30 of the final communiqué which stated that concerning the “nodding syndrome” (Nakalanga syndrome) associated with onchocerciasis in certain countries, some advice is waited for from TCC. JAF decided that countries affected by this syndrome should contact APOC in order to ask for technical assistance to conduct research on this problem).

132. It equally took note of a recent report presenting preliminary results of an investigation carried out by CDC in South Sudan on this subject (Nodding syndrome – South Sudan, 2011, MMWR 2012, Vol 61, No. 3, pp 52-54). The study carried out by this team indicated, despite the low numbers of people investigated (38 patients and 38 controls), that an association exists between the disease and the presence of *Onchocerca volvulus* microfilariae in the skin (P=0.002).

133. TCC discussed the following facts:

(i) The “nodding syndrome” has been a focus of intense media attention for several years (as research on the Internet shows);

(ii) It is presented as a phenomenon that appeared recently and by some as being provoked by ivermectin treatment, and which has even become the subject of political debates, notably in Uganda;

(iii) The association between onchocerciasis and epilepsy is now well documented;

(iv) The causal link between the two conditions has not been totally established;

(v) Generally, epilepsy often originates due to multi-factorial causes and that onchocerciasis may only be a co-factor among others (genetic, exposure to other pathogenic or toxic agents, malnutrition,…) that may explain the disease;
It is important to document the link between onchocerciasis epilepsy and the nodding syndrome as even if this link is still not demonstrated, it could provide an additional argument used to request funding from donors of APOC. In this sense, the media attention mentioned above may be a good thing;

An operational research proposal entitled “Effect of onchocerciasis control on the prevalence of epilepsy: a community-based study in a hyper-endemic area in West Uganda” had been submitted to APOC (TCC31, September 2010 and resubmitted to TCC 32 in March 2011); the objective of this project was to evaluate the prevalence of epilepsy in the region of Kabarole and to compare the values of prevalence observed with those obtained before the launching of CDTI activities in the region; the budget asked of APOC was $20,000; TCC32 accepted to finance this project but had asked the investigators to be more precise about some ethical and financial points concerning the methodology.

TCC made the following recommendations:

(i) Since CDC experts are investigating the phenomenon in Uganda and South Sudan, it is not necessary that APOC conducts additional activities on the subject in this country;

(ii) A group comprised of people having already worked on the subject could be formed to advise APOC on what could be done to respond to the recommendation of JAF; Dr Boussinesq and Dr Christoph Kaiser (currently in Germany) could be asked to help.

17. REMARKS BY TECHNICAL ADVISORS TO APOC MANAGEMENT:

Agenda item 17

The two technical advisors to APOC management stated that they did not have anything special to add.

MANAGEMENT OF THE APOC TRUST FUND

18. REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS: Agenda Item 18

The following update was presented to the TCC by Mr Koffi Agblewou:

(i) On the status of submission of PAB, 118 out of 120 PABs expected were received as of 12 March 2012 and DFC s being prepared for all. The PABs for the NOTF/Ethiopia was not received and Ituri Sud project has not yet been launched.

(ii) Out of the 1 404 financial returns expected 1130 were received and 274 delayed as of 12 March 2012.

(iii) About 90% of projects are in order with financial returns submission that shows an improvement as compared to 2011.

(iv) Delays occur in the submission of FACE forms by projects/countries until certification missions. This attitude should be avoided for their submission on time as per the DFC agreement.
(v) 16 out of 20 country projects teams trained on APOC revised financial and administrative procedures and FACE certification that improved the reports’ quality.

(vi) Electronic storage of decentralized financial returns at country level needs to be improved.

137. Efforts were made in PAB submission by the countries but the budgets submitted are inflated and take more time for their revision prior to approval.

19. REPORT OF THE FINANCIAL REVIEW BY APOC MANAGEMENT OF THE 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th AND 13th YEAR PROGRESS REPORTS AND SUBSEQUENT YEAR BUDGETS: Agenda Item 19

138. The following update was given by Mr Agblewonu:

(i) The total budget approved by the JAF is US$ 23,943,158 for the implementation of 116 CDTI/HQ +4 ex-OCP countries;

(ii) Amount forecasted for 2012 for the 116+4 projects was US$ 4,976,150 and a total of US$ 3,941,765 for field activities was released/earmarked for 117 out of the 120 projects;

(iii) Funding for the ex-OCP countries as of March 2012 amounted to US$ 317,170;

(iv) The rate of implementation of the overall 2012 budget is 52% including US$ 1.2 million released to NTD/AFRO within the collaboration between AFRO and APOC;

(v) Some highlights: 1st installment of funds related to year 2012 being released to 62 projects and delayed for 16 projects due to non submission of financial returns, 39 DFC being finalized, 2 PAB under review (Ituri Sud and Eq. Guinea CDTI) and 1 PAB (HQ/NOTF/Ethiopia) not yet received;

(vi) Increase of funds for specific activities in the framework of elimination and entomological evaluation but need for better accounting by projects for funds release for specific activities;

(vii) 82% of APOC projects are more than 6 years old and they are expecting capital equipment replacement but the current PAB cannot meet the requirement in the framework of the intensification of activities (US $478,909 available compared to US$ 2.5 million under review for capital equipment);

(viii) Dedicated Bank account to APOC transactions remained a challenge in most of the countries. This need the alignment of APOC financial procedures that of those countries in order to take into consideration the Paris Declaration on Aid Effectiveness (recommending to avoid creating dedicated structures for day-to-day management and implementation of aid-financed projects and programmes) and the integrated NTD programmes on board in the countries.

139. TCC thanked APOC Management for the update and made the following comments:

(i) Due to the paradigm shift from control to elimination and the need for sustained funding to implement activities, APOC was encouraged to mobilize additional resources beyond the traditional donors.
(ii) Taking into account the implementation of the initial strategic plan and its exit budget upto 2015, APOC funding is no longer appropriate to take into consideration the change of paradigm from control to elimination of onchocerciasis. Consequently, this situation affects reallocation of funds to countries’ activities. TCC suggested that governments should increase funding to bridge the financial gap to sustain implementation of the activities.

(iii) TCC suggested that APOC should prioritize funding to those countries which were more needy to enable them to move towards achieving elimination.

(iv) TCC also recommended that all expenses related to ex-OCP countries appear clearly in APOC presentations to TCC.

20. REVIEW OF NEW PROJECT PROPOSALS AND 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH, 12TH AND 13TH YEAR ANNUAL TECHNICAL REPORTS ON THE IMPLEMENTATION OF CDTI AND VECTOR ELIMINATION PROJECTS. RECOMMENDATIONS ON THE 2ND, 3RD, 4TH, 5TH, 6TH 7TH, 8TH, 9TH, 10TH, 12TH AND 13TH YEAR IMPLEMENTATION OF PROJECTS: Agenda Item 20

140. The total budget submitted for the Plan of Action for the control of NTDs in Equatorial Guinea (2010-2014) is US $3,046,948 but only 37% required from APOC (US $1,129,215).

141. The TCC thanked APOC Management for the update and suggested reduction to 10% of the required funding from APOC but instead recommended APOC to provide more technical support.

Reviews

EQUATORIAL GUINEA

National Plan of Action for the integrated control of tropical diseases

142. TCC observed that the plan was well structured and much detailed including relevant geographic, administrative, political and health-related data.

143. TCC noted that NTD mapping was completed with a fairly adequate definition of co-endemic areas and that the timeline of the activities as well as the budget were detailed.

144. A major issue is that the plan was developed for the period 2010-2014. The plan should therefore be updated.

145. TCC was informed that WHO/AFRO will be holding a workshop in Ouagadougou in April 2012 to which Equatorial Guinea is invited to attend. TCC therefore recommended that:

(i) REMO be updated in the country;
(ii) APOC’s support to be less than 10% of the total budget requested;
(iii) APOC’s support be related to the preparedness of the Country to put in place:
- Coordinating mechanisms,
- Infrastructure and human capacity for management of SAEs related to Loa loa
- Institutional arrangements showing political will;
(iv) The proposal should be resubmitted after being updated at the workshop.
BURUNDI

Bururi CDTI project 6th year annual technical report

146. This was a very good and exhaustive report with very satisfactory results stated with clarity and objectivity that ensure sustainability; weaknesses are identified and solutions are suggested by the coordinator, sometimes already implemented.

147. Two additional requests are as follows:

(i) Provide more details on geographical environment at the level of settlements, and administrative grouping (districts, hills) taking into consideration that the type and density of population which is apparently particular to Burundi could be influential factors for onchocerciasis epidemiology, particularly in the context of elimination approaches;

(ii) Document more co-implementation activities for the control of the three NTDs; at all steps of preparation, achievement and evaluation of the exercise, so that other projects may benefit from the experience of the Bururi project.

148. TCC accepted the report and encouraged the coordinator and the PNIMTNC to continue the same standards of quality and efficiency.

Rutana CDTI Project 6th year Annual Technical Report

149. This is a 6-year project but in its first year of having more than 80% of therapeutic coverage for an at risk population of 274,242 people and near the Tanzanian border.

150. TCC accepted the report with minor recommendations

Report related:

(i) It is well written with extensive data on sustainability plan and its implementation for which the project and APOC are to be commended;

(ii) TCC recommended that Table 7 and Table 11, should be reviewed to indicate the number of tablets used per person treated.

Project related:

151. The project should be encouraged for the therapeutic coverage of at least 80% and for a male/female ratio of CDDs of near 1/1.

152. TCC recommended that:

(i) Advocacy be carried out to get more IEC tools and motorbikes with APOC;

(ii) CSM sessions be conducted;

(iii) DC/population ratio be brought to approximately 1:100;

(iv) Possibility be found to replace the logistics (vehicles).
CAMEROON

NOTF/HQ 13th year annual technical report

153. This is a very good quality report, concise and informative in which all required information is provided. The executive summary provides key results regarding all the projects as well as the major challenges to be taken up. The rest of the document provides all details related to all other projects.

154. TCC very much appreciates sensitization efforts at all levels, notably towards other ministerial departments and the availability of a standard supervision form. CDD/population treated ratio varied from 1/128 in 2010 to 1/120 in 2011. Female CDD rate has changed from 10% to 20% compared to 2010.

Recommendations:

To the Project:

(i) Continue to make efforts for the setting up of CSM in all projects.
(ii) Continue efforts for improving the performance of projects whose therapeutic coverages showed a serious decrease in 2011 (Example Centre 2).

To Management of APOC:

(i) Continue to support the NOTF in carrying out planned activities in its 2012 Plan of Action.

155. TCC accepted the report.

DEMOCRATIC REPUBLIC OF CONGO

Kasongo CDTI Project 6th year Annual Technical Report

156. This project is in its 6th year of APOC funding but in its 5th year of Mectizan distribution located in a Loa-loa co-endemic area. SAEs were well managed with the occurrence of 5 cases that were well managed. The national coordination’s work should be recognized, particularly that of the focal point of the region, Dr Awaca, who is now the national director. The project is to be commended for achieving a geographic coverage of 100% and a therapeutic coverage of 80.5%. It should be noted that UFAR has been supporting the programme since its creation 6 years ago and that there has been a steady improvement of results.

Recommendations

Report related:

157. The report seems to have been hurriedly written with figures and spelling errors, some cut-and-paste that does not pay tribute to the good results achieved.

(i) Redo tables 4 and 7 to harmonize the figures;
(ii) Clearly highlight all financial contributions including the most recent ones as with the issue of SAEs.
Project related:

(i) Maintain 100% geographic coverage and a minimum of 80% therapeutic coverage
(ii) Improve the indicators, mostly the number of CDDs/inhabitants
(iii) Consider and indicate all financial contributions.
(iv) Continue advocacy so that CDTI activities can be integrated into the minimum activities package.
(v) Repair the vehicle and motorcycles

158. TCC accepted the report with the recommendations provided above.

Masisi Walikalé CDTI Project 5th year Annual Technical Report

159. The report is well written and contains fewer errors than the previous report. The figures of UTG and Mectizan stock are to be reviewed. In addition, as in the previous reports, the coordination still does not mention the recommendations of previous TCC sessions. The performance of the project has improved with a geographic coverage of 95% and a therapeutic coverage of 73% that is not optimum; the 1 CDD/220 persons ratio and the Male/Female CDD that is 1.7 should be improved.

160. To improve the report, TCC recommends the following:

(i) Provide answers to the recommendations of previous TCC sessions,
(ii) Review the figures of the UTG and of the Mectizan stock.

161. To improve the performance of the Project, TCC requests efforts from the coordination in order to:

(i) Improve geographic coverage;
(ii) Improve female participation in CDTI;
(iii) Start the process of CSM and sustainability;
(iv) Enhance initiatives regarding CDTI co-implementation and integration at the level of PHC. Initiate operational research.

162. TCC accepted the report with the recommendations provided above.

Mongala CDTI Project 6th year Annual Technical Report

163. This is a resubmitted report following TCC33 recommendations.

164. TCC33 observations: This was a well written report, easy to read but with some inconsistencies. The major challenges for this project are the financial contribution from government and/or the intervention of other financial partners.

Recommendations by TCC33:

- Shorten and improve the presentation of section 1.1 (6 pages are too long) Idem to TCC34.
- Redo the calculation of the UTG presented in the executive summary. Idem to TCC34.
- Show the number of health workers and CDD in the executive summary. Idem to TCC34.
- Provide more information on the nature of the 4733 “political decision-makers” sensitized in the villages. Who are they exactly? Idem to TCC34.
- The organisation of Onchocerciasis Day (part 2.3 / achievement) is it a suggestion or did it taken place? If yes, provide the outcomes.
- Provide quantitative results of the mobilization (number of radio broadcasts, number of schools….)
- Check table 11 (total number of communities and number of communities having conducted CSM. 385 instead of 440) idem to TCC34.
- Clarify table 13 (a; b; c) idem 13a and 13c, 13b partial and incomprehensible.
- Develop a sustainability plan. APOC Management should continue its efforts to this end if not already done.
- Continue distribution efforts to increase therapeutic coverage.

165. TCC33: Despite difficulties in the field, the quality of this report could have been better if not at least equal to the previous report. It should be improved, completed and submitted to reviewers.

166. TCC34: Nothing was done for this resubmission. The report is submitted to National Coordinator of NOCP/DRC, who was attending TCC34, for review and to be sent back to the reviewers via APOC Management within 3 months deadline.

167. TCC rejected the report again. It is requested that the National Coordinator, attending the meeting, get involved personally in addressing corrections required and submit it to TCC35. She was also asked to draft a situation note on this project.

168. Regarding the more general situation of onchocerciasis control in DRC, TCC recommends that APOC Management continue its efforts, particularly in two directions: strengthening technical capacity by increasing the number of Technical Advisors; systematically invite the National Coordinator for TCC meetings if reports from the DRC are discussed.

GHANA

_Ghana CDTI Project 3rd year Annual Technical Report_

Reviewer’s conclusions and comments:

169. The Ghana Project continues to improve programme performance. Geographic and therapeutic coverage rates are steadily improving. The step taken by the Ghana Health Service (GHS) to get onchocerciasis control activities in the budget is commendable.

**Recommendations to improve the quality of report:**

(i) Report was not endorsed by NGDO – Please clarify;

(ii) Provide one page executive summary for 2010 and 2011. This is a requirement for the report;

(iii) Clarify whether or not a census was done and amend information on page 5 and table 7 accordingly;

(iv) Clarify whether 2nd round of treatment was done for 2011 and plans for reporting on this round;

(v) Complete table 4 – community involvement;

(vi) Provide data on coverage (geographic and therapeutic) for Northern Region and footnote to explain extremely low coverage for Denkyira West;

(vii) Clarify whether or not TOT done in 2011. If not done, to explain what activities were funded with the APOC funds provided for TOT and whether the project received any government funding for 2011;

(viii) Complete table 10 fully. Provide footnote to explain reasons for blank columns/cells.
Recommendations to improve Project Performance:

(i) To explore practical ways and strategies for treatment of all communities to achieve 100% geographic coverage and for the treatment of absentees to improve overall compliance;

(ii) The project unravelled some important issues during supervision and during IPM. The Project management should take all these into account to step up treatment compliance and overall performance.

Recommendations to APOC:

(i) To provide inputs to strengthen Ghana sustainability plan;

(ii) To follow-up reasons for bottleneck with implementing CSM;

(iii) Whether a budget line for onchocerciasis activities now exists at district and regional level. This Is An Important Sustainability Issue

170. TCC accepted the report.

NIGERIA

NOCP/HQ (Nigeria) Project 13th year Annual Technical Report

Reviewer’s comments and conclusions

171. The responses to recommendations of TCC32 were satisfactory. The NOCP has 32 CDTI Projects plus the HQ Project with a total of 36,117 communities and an at risk population of 35 million people of whom 28.8 million were treated. For over 12 years most projects reached higher than 70% therapeutic coverage.

172. This report is for 2010. Will the NOTF submit the 2011 report for the TCC 35 session in September 2012? The submission time lag makes it difficult to compare content from NOTF report with relevant content in the Nigeria Technical Review Committee report. The figures given for total population for Nigeria as a whole in the executive summary (156 million) is not consistent with the figure in the general information section (160 million)

173. Projects with difficulties due to low geographic coverage are: Niger, Abia, Osun and Kebbi States but the reasons were not discussed in detail and no solutions were provided. Over 1700 more CDDs were trained in Anambra state than planned, while Zamfara did not train any trainers nor did they train or provide refresher training for CDDs. The reasons were not discussed. For Mectizan Inventory, totals were not provided to give the overall picture. Kebi was the only state which reported expired drugs. Is there any reason for this?

174. Regarding progress towards elimination of onchocerciasis, the NOCP has held a National workshop on elimination which endorsed the steps being undertaken. States targeted for evaluation of progress towards elimination are Ekiti, Enugu, Gombe, and Yobe.

175. With respect to co-implementation of NTD control with CDTI, in 17 States LF is being integrated with onchocerciasis, schistosomiasis, malaria (ITN). However, more needs to be done to make progress with co-implementation. CSM and SHM are carried out in most States with good outcomes including improved knowledge, compensation (CDI). RAPLOA: (eye worm) has been reported in 15 communities with a prevalence of 40% being reported; this should be verified as it would be alarming if correct. The Mectizan supply chain is satisfactory.

176. The NOTF provides detailed information regarding other activities undertaken and pertinent resolutions and recommendations. It will be of interest to TCC to find out the extent to which
some of these recommendations were followed up. Given the long list of recommendations by activity, perhaps NOTF should consider prioritizing recommendations using relevant criteria (priority 1, 2, 3), and provide update on the achievement of priority 1 level indicators in the subsequent report to TCC.

177. **TCC accepted the report.**

**Review of 7th, 8th, 9th, 10th, 11th, 12th year Annual Technical Reports**

**BURUNDI**

*Cibitoke-Bubanza CDTI Project 7th year Annual Technical Report*

**Reviewer’s comments and Conclusions:**

178. The report is well written and exhaustive. The outcomes are comprehensive, well analyzed, and accompanied by proposals for improvement.

179. The results are also very good in all areas despite the relatively low endemicity. In addition to the regular CDTI, the Coordinator has integrated complementary therapies with CDTI including the distribution of Praziquantel and Mebendazole.

**Recommendations:**

180. Such a report by an informed, motivated and responsible coordinator highlighted the need to redefine certain sections of the format, to add more and target different areas for closer monitoring. The project should manage to undertake self-monitorings, M & E, CSM, RPP etc. Since an application is to be produced, a detailed map of the situation should be provided in the next report.

181. **TCC accepted the report.**

**CHAD**

*Chad CDTI Project 12th year Annual Technical Report*

182. This is a national programme in its 12th year in 2011 without support from NGDOs. It has a population at risk of 1,997,825 eligible for CDTI and living in meso and hyper-endemic areas covering 19 out of 56 districts. The programme area includes 3250 villages/communities. In 2011 the programme trained 14,712 CDDs with a ratio of 1 CDD/136 inhabitants. In 2011, the programme had 100% geographic coverage and a therapeutic coverage of 81.1%, and efficient coverage (GC = 100%; TC > 65%) for 11 years; successful implementation of capacity building of health workers over 100% at times.

**TCC’s recommendations and conclusions**

**Report related:**

183. The report is well written and allows for the review and evaluation of CDTI activities, but there are typo and figures errors that need to be checked. Also, the map has not been annexed as announced in the document.
Project related:

(i) Give the reasons why the 7.5% villages have not reached a TC > 80%.
(ii) Continue efforts to encourage all communities to conduct CSM, which must equal 100% achievement and if possible explain why all communities did not succeed in conducting CSM and take corrective action;
(iii) As regards the insufficient numbers of treatment registers, explain why, so that remedial action can be taken by APOC and partners;
(iv) Give some relevant information on the entomological evaluation and probably epidemiological evaluations conducted in the two districts;
(v) Summarize the master plan regarding onchocerciasis activities in the integration section.

184. TCC accepted the report.

DEMOCRATIC REPUBLIC OF CONGO

Katanga Sud CDTI Project 7th year Annual Technical Report

185. The report is well written, concise and understandable. The authors took into account recommendations and inconsistencies were corrected except those in table 13 on budget allocations. Project performance has improved with a therapeutic coverage of 80% and a geographic coverage of 100%; the strong involvement of women in CDTI, a women's team coordination, and a ratio of 1 CDD/103 inhabitants.

186. On the other hand, negative facts exist, including the lack of precision regarding the provincial government support and the release of the budget allocated by the State, and CSM has never been conducted. TCC recommended improving the form of future reports taking into consideration the following:

(i) Correctly fill tables 13a, b and c on the budget;
(ii) Specify if the human resources available are adequate for the implementation of the programme;
(iii) Clarify the contribution of communities in CDTI.

187. With regards to the contents, TCC recommended that the coordination makes efforts and starts the process of CSM and sustainability; Increase initiatives of CDTI co-implementation and integration into PHC; Strengthen advocacy to attract NGDOs.

188. TCC accepted the report.

EQUATORIAL GUINEA

Bioko Island CDTI Project 10th year Annual Technical Report

Reviewers’ Conclusions and recommendations:

189. This is a project in its the 10th year for which performance should have been better than that observed at present, especially given the small size of the territory concerned and the technical and considerable financial support APOC brought to the project since its acceptance.

190. The fact that this project covers part of an urban area is not an exception (this is also the case in Brazzaville and Kinshasa). But because of the coordinator’s specific situation, it is necessary to distinguish between the city of Malabo and rural areas in terms of relative population
numbers, compliance and methods of implementation of CDTI: census, supervision, and evaluation, given the low numbers of health personnel involved.

Recommendations:

Report related:

(i) Improve the presentation of the report: avoid inconsistencies in the figures, clearly,
(ii) Define the UTG and fully inform the various headings.

Project related:

(i) Enhance the performance of the project,
(ii) Increase the therapeutic coverage,
(iii) Establish a Sustainability Plan.

To National authorities:

191. The Project should seek technical and financial partnership of NGDOs, mobilize more health personnel in the implementation of CDTI activities; Train more CDDs to reduce the workload and mobilize adequate financial resources.

To APOC Management:

192. APOC management should support the national team in the development of a sustainability plan. Looking towards the elimination of the parasite after that of the vector, the Management of APOC could complete the recent epidemiological study by referring especially to the villages assessed before the start of CDTI and also take into account the city of Malabo.

193. **TCC accepted the report.**

ETHIOPIA

*Bench-Maji CDTI Project 9th year Annual Technical Report*

Reviewer’s comments and conclusions

194. The report is comprehensive and precise. Project is mature. However a few issues remain. Therapeutic coverage (73.3%) is still a problem. Reasons provided are incoherent: Inadequate number and lack of commitment by CDDs in three districts with lowest coverage delayed arrival of tablets, impact study in the previous year. Plans to remedy this are vague. Despite previous TCC recommendations no activities relating to CSM have been undertaken and the justification is unclear.

195. The report identifies issues to be addressed in the areas of supervision (2.9) and further general challenges that require attention.

196. **TCC accepted the report.**
**North Gondar CDTI Project 9th year Annual Technical Report**

Reviewer’s comments and conclusions:

Recommendations to improve the report:

- The executive summary requires some attention and should be carefully revised, e.g. proportion of female CDDs is 9.4%, male to female ratio 9.6:1, CDD to population 1:85.
- The timelines depicted in Table 3 require clarification. It is not quite clear why mobilisation of communities took place over a period of six months; further, there is an inconsistency regarding the completion of distribution (May) and supervision (July).
- The Mectizan inventory does not balance. Please check and correct.
- Project years in Table 13 are incorrect.
- M&E/sustainability planning requires clarification. Report M&E key recommendations.
- The implementation of sustainability evaluations and plans requires clarification.
- An analysis should be provided and solutions sketched for communication with APOC regarding the various problems of the project.

Recommendations to improve project implementation:

- There is still relatively low therapeutic coverage that decreased even further in 2011. It is critical for the team to ensure that they put mechanisms in place to raise this coverage to at least 80% in all sites.
- Address the low geographic coverage in Tach Arma and West Arm. It would be important for the team to provide the reasons for this.
- Address the high numbers of absentees (some explanation provided) and refusals. It may help if the team developed an OR proposal to study the high levels of refusals on some sites.

197. **TCC recommends the report should be improved and resubmitted.**

**Kaffa CDTI Project 11th year Annual Technical Report**

Reviewer’s comments and conclusions

198. TCC noted that although Kaffa-Sheka project was divided into two CDTI projects i.e. Kaffa and Sheka, similar reports were submitted, one essentially being a cut and paste of the other. It is noted that the two projects are different in (a) size- Kaffa being a much larger project than Sheka and (b) that the two projects are located in different administrative zones. It would therefore be expected that the two projects may present challenges that require different approaches.

199. **TCC does not therefore accept the reports as currently presented and advises that the reports be re-written and re-submitted to APOC management as separate annual technical reports.**

**Sheka 11th year CDTI Project Annual Report for 2011**

Reviewer’s comments and conclusions:

200. TCC noted that although Kaffa-Sheka project was divided into two CDTI projects i.e. Kaffa and Sheka, similar reports were submitted, one essentially being a cut and paste of the other. It is noted that the two projects are different in (a) size- Kaffa being a much larger project that Sheka and (b) that the two projects are located in different administrative zones. It would therefore be expected that the two projects may present challenges that require different approaches.
201. TCC does not therefore accept the reports as currently presented and advises that the reports be re-written and re-submitted to APOC management as separate Annual Technical reports.

202. APOC received an official request from Ethiopia to split the Kaffa Sheka project. TCC agreed that the Projects could be split in view of the fact that Ethiopia officially requested that.

203. **TCC rejected the report.**

*Illubabor CDTI Project 8th year Annual Technical Report*

**Reviewer’s comments and conclusions:**

204. Mainly a solid report of a mature project. The activities associated with mobilisation, sensitisation and health education as well as the underlying rationale remain vague. Better planning and documentation may be advisable.

205. There is still low attendance of female community members at health education meetings and low representation as CDDs. There was no CSM due to lack of proper and formal training, but SHMs included thorough review of performances. SHM activities should be supported.

206. Despite the full integration of CDTI, it should be important to monitor and evaluate CDTI. The report does not clearly show how integrated monitoring and supervision is designed and managed.

207. **TCC accepted the report.**

*Jimma CDTI Project 8th year Annual Technical Report*

**Reviewer’s comments and conclusions:**

208. The project is making good progress. Two of the four TCC recommendations were not adequately implemented which is not so good. These recommendations are intended to assist project staff improve on reporting and on project performance. Project staff are encouraged to pay attention to these recommendations.

209. **TCC recommended the following:**

**Recommendations to improve on report:**

(i) Include outcome of advocacy in reports;
(ii) Indicate if recommendations listed in 4.1.2 are from internal monitoring by NOTF or other;
(iii) Report on progress in implementing Yr 5 sustainability evaluation recommendations.

**Recommendations to improve on project implementation:**

(i) TCC takes note of the reduction in involvement of health workers in CDTI activities from 72% to 36%. Reasons for this should be explored and addressed;
(ii) Advocacy issues should be specific and target decision-makers likely to effect change – advocacy “to support overall CDTI activities is rather too general;”
(iii) A training or orientation of project staff on CSM should be undertaken. Alternatively, project staff could be availed with resource materials.

210. **TCC accepted the report.**
**Metekel CDTI Project 8th year Annual Technical Report**

**Reviewer’s comments and conclusions**

211. The project is commended for aligning with Government policy for aggressively working to access basic health services to ensure that adequate number of health staff is available in project Woredas.

**Recommendations to improve the report:**

(i) Section 2.6.1 of the report indicated that 12 communities missed treatment in 2011 but table 7 indicated 6 communities. Kindly verify.
(ii) Clarify the status of capital equipments to show new donations in 2011 which is not highlighted in blue as stated in the report (section: 3.1).

**Recommendations to improve Project implementation:**

(i) Ensure treatment commence on time.
(ii) Effort should be intensified to achieve 100% geographical coverage and sustained 80% and above therapeutic coverage.
(iii) Implement CSM and SHM in all endemic communities.
(iv) Regarding the Mega project underway in Guba woreda on Blue Nile riverbank and the expected influx of labourers, the Guba woreda health office should plan for their inclusion in the treatment plan for the area.

**Recommendation for APOC:**

(i) Ensure timely release of funds.

212. **TCC accepted the report.**

**East Wollega CDTI Project 7th year Annual Technical Report**

**Reviewer’s comments and conclusions:**

213. The report is not very detailed, however, the consistent high coverage is commendable as well as the effort to report on time despite the challenges.

**Recommendations:**

**Report related:**

(i) Indicate the TCC session being referred to on page 2;
(ii) Confirm that the report that was supposed to be rewritten was received by APOC.

**Project related:**

(i) Ensure important activities like CSM, HSAM are implemented to improve the performance of the Project.
(ii) Project to ensure that issues that will enhance early procurement of drugs are discussed at the NOTF as well as facilitation of early receipt of APOC funds.
(iii) Reduce the quantity of Mectizan that is wasted/lost
Recommendation for APOC:

(i) To follow closely with the project on the implication of some of the new Ethiopian health sector policy redesigning like policy planning monitoring and evaluation /PPME/ core process, balance score card and principle of one plan, one budget and one report.

214. TCC accepted the report.

West Wellega CDTI Project 7th year Annual Technical Report

Reviewer’s comments and conclusions:

215. This is an acceptable report. The team has maintained a high coverage and should be encouraged. The CDD ratio of 1:81 people is commendable.

Recommendations to improve the report:

(i) Ensure consistency between the executive summary and the body of the report.
(ii) Table 5 is incomplete – the achievement levels have not been indicated (a similar problem was identified in the 2010 report);
(iii) Ensure that the financial figures in Table 13a add up.

Recommendations to improve project implementation:

(i) Address the high number of refusals in Gidami and Walal;
(ii) Focus on villages that are not meeting the 80% therapeutic coverage (Kebe - 77 out of 448 and Seyo - 78 out of 225 villages);
(iii) Supervisors at all levels, including the health facilities, should be encouraged to use checklists that would enhance collation and reporting of supervision outcomes;
(iv) The team should conduct CSM – although people were trained no activities were implemented.
(v) The team should be encouraged to undertake OR by taking advantage of the resources available through APOC.

Recommendations to APOC:

(i) Provide information to the project team on the availability of OR funds that should be applied for separately from the project funding.

216. TCC accepted the report.

Gambella CDTI Project 7th year Annual Technical Report

Reviewer’s comments and conclusions

217. This is a fairly small project which is doing well. Coverage rates have been above 70% in 4 of 7 treatment cycles and above 80% in 3 cycles. Treatment was missed in one year (2005). As is the case with other Ethiopian projects, integration into PHC structures is strong. Treatment along kinship lines is practiced and this has increased coverage. Late arrival of Mectizan exacerbated the problem of absenteeism as treatment took place during the rainy season when people are out in the farms.
218. TCC recommends the following:

**Recommendations to improve on the report:**

(i) Include date of reporting;
(ii) Be more specific when reporting on outcomes of advocacy. “Improvement has been registered” is rather vague;
(iii) Distinguish between recommendations of internal monitoring by NOTF and the recommendations of year 5 sustainability evaluation and report on them separately.

**Recommendations to improve on project implementation:**

(i) There is still a need to put in place a strategy for reaching migratory population which has been causing high absenteeism during treatment. NOTF to work with APOC management and MDP to resolve the issue of late drug arrival.
(ii) Number of refusals is relatively high. Investigate and address the underlying causes.
(iii) Continue to lobby government to allocate funds for vehicle and equipment maintenance.

219. Reasons for delays in receipt of ivermectin were discussed. One request is made for the whole country; if it arrives late then dispatching to projects will be late. However, LF co-implementation takes place in the country and the delay is more likely to be due to late arrival of Albendazole.

220. TCC accepted the report.

MALAWI

*Malawi Extension CDTI Project 11th year Annual Technical Report*

**Reviewer’s comments and conclusions:**

221. After reviewing the Malawi Extension and Thyolo & Mwanza reports TCC observed that they were exactly the same except for the tables. It was difficult to determine which was authentic between the two. TCC did not accept the report and requested that it be rewritten to reflect the issues from the different projects.

222. TCC rejected the report because the text is copied and pasted.

*Thyolo & Mwanza CDTI Project 12th year Annual Technical Report*

**Reviewers comments and conclusions:**

223. After reviewing the Thyolo-Mwanza and Extension reports TCC observed that they were exactly the same except for the tables. It was difficult to determine which was authentic between the two. TCC did not accept the report and requested that it be rewritten to reflect the issues from the different projects.

224. However from the report the following were noted which need to be considered:

(i) Avoid cut and paste which was not well edited. Paragraph 4 on page 2 is one of the examples where the report read 2010 instead of 2011.
Recommendations to improve programme implementation:

(i) Intensify efforts to reduce the number of communities that are currently not achieving 80% therapeutic coverage.
(ii) Increase the number of communities implementing Community Self-Monitoring.
(iii) Sustain and continue to improve the quality of CDTI implementation in the project.

225. TCC did not accept the report.

21. TECHNICAL REVIEW COMMITTEE REPORTS: Agenda item 21

NIGERIA

Nigeria Technical Review Committee: Report of the Eighth meeting (TRC8)

226. Professor A.E. Idyorough representing the Chairperson of the Nigeria Technical Review Committee presented the outcome of the eighth meeting of the Nigeria Technical Review Committee (TRC8) was held in February 2012. 14 Technical Reports and 2 operational research proposals were received and reviewed. Presentations were made on the following:

- Eliminating Onchocerciasis in Taraba State – The way forward
- Activities of CBM / Vision 2020
- Advocacy & Monitoring Activities – (Zones A, B, C & D)
- Advocacy & Monitoring Activities – (NOCP HQs)
- Extent of Implementation of TRC 7 Recommendations.

(i) Eliminating Onchocerciasis in Taraba State – The way forward

227. The Geographic and therapeutic coverages from 1997 to 2010 were presented and analysed. Epidemiological assessment in the State indicated a drastic reduction in prevalence levels for most communities sampled, except for 2 communities. There was a follow-up to epidemiological assessment to resolve issues in problem communities but this was confronted by several challenges including funding. An operational research to determine ways of reaching migrant communities was recommended.

(ii) Activities of CBM / Vision 2020

228. Mr. Chris Ogoshi, Country Director of CBM made a presentation which showed that CBM supports onchocerciasis control, trachoma control, lymphatic filariasis elimination, primary eye care, vitamin A supplementation and low vision services. Challenges identified were absence of designated funds for NTD activities, inadequate counterpart funding by host governments, poor commitment to programme implementation by health workers. Future plans include prevention and control, sustainability, and integration.

(iii) Advocacy & Monitoring Activities by the Zonal Offices

229. High CDD attrition in Zone C was observed and it was recommended that this be addressed by selecting married women as CDDs. It was also observed that Kaduna State over-reported 2010 treatments by one million mostly due to mix-up of population of CDTI and LF only areas. C-Zone Coordinator was requested to follow up on this.
230. Issues raised were off-front deductions at State level during revenue disbursement to LGAs which were observed in Gombe State. This could be allocated to onchocerciasis control programme at LGAs with proper advocacy. Insecurity in Zones C & D is affecting onchocerciasis programme. Low treatment coverage was also observed in Ekiti and NOCP was asked to target the state for advocacy.

(iv) Advocacy & Monitoring Activities by NOCP/HQs

231. Household treatment coverage surveys revealed lower treatment coverage than it is being presented in annual reports. Proper monitoring of activities of CDDs and their report writing was recommended. Inadequate counterpart funds release, poor quality in training of health workers, inadequacy of IEC materials and poor record keeping were identified. NOCP was advised to carry out high-level advocacy.

(v) Extent of implementation of the 7th TRC meeting recommendations

232. Most recommendations had been addressed by NOCP. Concerning funding of training of all project accountants by the NGDOs, the NGDO Chair stated that this will be further discussed with the relevant partners.

(vi) Advocacy & Monitoring Activities by the Zonal Offices

233. The Zonal Coordinators of A, B, & D made presentations on advocacy and monitoring activities carried out at the zones. It was noted that UNICEF released funds in 2011 for rapid assessment survey in B zone as a follow up to the entomological and epidemiological surveys results of 2010 which revealed hyper-endemic communities. D zonal coordinator was requested to ensure that the capacity building of SOCTs on technical report writing in his zone is carried out.

Summary of Technical Reports

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<tr>
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A total of five indicators were judged as poor for three Projects (Taraba, Kebbi and FCT).

Operational Research Proposals Reviewed

234. The Operational research proposals reviewed by TRC8 were:

(i) Determination of optimum timing for ivermectin mass administration for the elimination of Onchocerciasis; and

(ii) Motivation of community directed distributors / volunteers in Kogi state, Nigeria

235. The problem areas identified by TRC8 were:

(i) HSAM
(ii) Training
(iii) Supervision, monitoring and evaluation
General Recommendations

To APOC:

(i) APOC should address previous recommendation of TRC that APOC should provide vehicles and office equipment for Zonal offices to enhance supervision.

(ii) In order to enhance sustainability of CDTI, TRC urges APOC to provide funds to projects for full implementation of CSM and SHM.

(iii) APOC should fund training in proposal writing. TRC can facilitate this.

To the NOCP:

(i) State Coordinators should be trained and retrained on data management to avoid mix-up of CDTI and LF elimination information especially with respect to list of communities and populations being covered.

(ii) In addition to the project technical reports to be reviewed NOCP should send to reviewers the electronic copies of previous year’s reports to enhance assessment.

(iii) The C-Zone Coordinator is to follow up and update NOCP HQs on the over-reporting of CDTI population and treatment data in Kaduna state for 2010.

236. The next meeting of TRC, (TRC9), will be held from July 10 - 14, 2012.

237. TCC explained that the recommendation of TRC7 requesting for vehicles and office equipment is already being considered by APOC along with those of other projects.

238. TCC34 endorsed the report and commended the TRC of Nigeria for the meeting.

CAMEROON

Cameroon Technical Review Committee: Report of the 6th meeting (TRC6)

239. The 6th meeting of Technical Review Committee (TRC6) of Cameroon took place in Yaounde from 23 to 24 February 2012. After expressing her gratitude to the Management of APOC for the various forms of support provided to the CDTI projects in Cameroon, Dr Aboutou began her presentation with the follow-up of the recommendations of TRC5.

Concerning APOC:

240. Regarding epidemiological and entomological evaluations in projects that have not yet undergone them, three CDTI projects were evaluated in 2011 (Centre1, Littoral2, and West). Further evaluations are planned in 2012 to assess lower levels of infection to the breakpoints (1a). Projects concerned are: Adamawa 2, (Centre 2 Centre 3), Southwest 1 and Southwest 2. An evaluation was also planned for the North project to confirm the achievement of the break point (1b).

241. As for the feedback to be made to the national authorities on evaluations carried out, reports and results of all evaluations carried out in 2011 were transmitted to the national authorities at all levels.

Concerning the NOTF:

242. Almost all the recommendations addressed to the NOTF were implemented. DRSP and ROC now attend TRC sessions and are involved in the preparation of TCR budgets. Lecturers and researchers were invited to review the operational research proposals and amendments in plenary for technical purposes. The NOTF has attended various CSM planning meetings. Regarding the
supervision and monitoring of projects at all levels, the weakness lies in the unavailability of supervision reports. Advocacy for strengthening human resources were done and posting are expected.

Concerning the Projects:

243. Most of the recommendations addressed to projects were also implemented. Regarding the development of operational research proposals, TRC6 was promised that it would be carried out after retraining by lecturers of the FMSB. Timely reception of reports, with data analysis, as well as the completeness of these reports, has improved. An innovative strategy for incentive was implemented by a project (Littoral 1) and shared at the TRC. Work is also in progress for the implementation of CSM and the supervision and internal monitoring are also underway. Strengthening (retraining) the capacity of CDTI implementers at all levels is also in progress.

244. During TCR6 meeting, 16 project reports and 05 operational research proposals were reviewed. Three reports were rejected with recommendations for resubmission: Centre 1 should provide all information required and essential for CDTI implementation while Centre 2 and Centre 3 were encouraged to resubmit their reports to the central secretariat of NOTF. It was noted that issues with the performance of the projects are alcoholism, record keeping and weak supervision.

245. Constraints noted regarding project performances include insufficiency and lack of mobility of health personnel, co-endemicity onchocerciasis/loiasis, and the isolation of some areas. Despite the issues and constraints noted opportunities exist and include a strong political will to move towards elimination, the financing of NTDs control, the decentralization of administrative services and the integration of health programmes.

246. TCC members were concerned about what will happen to projects supported in the past by Carter Center that withdrew from Cameroon. They also asked to be updated on what was done to lead the projects towards elimination.

247. TCC endorsed the report and commended the TRC for the quality of the report.

22. OTHER MATTERS: Agenda Item 22

CSM Multi-Country Assessment

248. TCC was presented with the feedback from the sub-group on CSM Multi-Country Assessment, Terms of Reference and Way Forward. It was noted that CDTI goes beyond making sure ivermectin reaches communities at risk and that with CDTI, communities also have a mandate to keep an eye on the delivery of Ivermectin and resolve challenges. This component (CSM) deepens community ownership and participation. The rationale for Multi-Country Assessment is that only 16% of communities implementing CDTI also reported implementing CSM (APOC 2010 data); country reviews have also revealed poor reporting of the process of implementation and that APOC seeks to put CSM higher on the CDTI agenda. The sub group shared the purpose and objectives of the proposed CSM multi country assessment. TCC discussed two options to guide the country selection process.

(i) Option A- To categorize countries on a regional basis, with the following countries proposed for implementation: Southern – Malawi, Eastern – Ethiopia, West (Anglophone) – Nigeria, West (Francophone) and Central – Democratic Republic of the Congo (DRC) and Cameroon for implementation and mentioned the Criteria Considered for Country Selection.
(ii) Option B – To categorize and select countries based on language: (Anglophone versus Francophone).

249. The sub-group proposed that the research team should consider PI (Independent Researcher) and at Country Level (Country Lead- Co-PI, Social Scientist and Health Economist).

250. TCC thanked the sub-group for their analysis and justification for CSM Multi Country Assessment. The final geographic scope for the study will be informed by a desk review, scheduled to take place in the next quarter.

**Recommendations by the TCC:**

- APOC to explore the possibility of conducting desk reviews at country as well as at APOC level;
- APOC to convene the proposal development workshop after a decision is reached regarding the countries in which CSM assessment will be implemented.

**Problems of the current reporting format for capturing co-implementation activities**

251. Following the review of the report on the Tukuyu CDTI Project’s 10th year at TCC33, the need for assisting project teams with reporting was earmarked because the format for reporting co-implementation activities does not allow the teams to report the data properly. It was also noted that some APOC countries, such as Tanzania, Uganda and DRC have embarked on one NTD control/elimination programme and so are co-implementing activities of NTD. Therefore, a sub-group comprising Drs Mary Amuyunzu-Nyamongo, Kisito Ogoussan and Mrs Francisca Olamiju was commissioned by TCC to look into the issue of reporting co-implementation activities.

252. Two main issues informed the sub-group:

(i) Capacity of the current format to adequately capture co-implementation; and
(ii) Harmonizing reporting on co-implementation without being donor-specific and overburdening the country teams.

**(i) Capacity of the current APOC reporting format**

253. The reporting format was adjusted during TCC 29 to include a table that captures activities carried out as part of co-implementation. The sub-group proposed a simplification of the table to capture the following:

- The condition
- The activities
- The approach
- The number of districts
- Number of persons reached
- Challenges

<table>
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<th>Disease</th>
<th>Activities</th>
<th>No. of districts</th>
<th>Approach</th>
<th>No. of persons reached</th>
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</table>


(ii) Harmonizing reporting on co-implementation without being donor-specific and overburdening the country teams

254. The sub-group observed that as much as each partner provides support to the countries, there is a need to justify the support and to assess the programme processes for performance and lessons learnt. This means integrating activities of several disease specific measures that are supported by different partners. These partners, because of their own mandates, ask for specific reports in different formats. This situation may create additional burden on the NTD coordination staff in completing the same reports on different formats to different partners. One way to address this issue is to ask the countries to share the report formats of the different partners and look for similarities as well as the purposes of the information required. If similarities are few then we should look for a way of harmonizing/integrating the reporting. If the similarities are many, it would be a matter of reviewing the terms of reference of the report with APOC.

255. The sub-group therefore suggested that for the next reporting session (September 2012) projects in this situation could be asked to provide an extended executive summary to describe the co-implementation process.

256. TCC recommended that the format suggested by the sub-group will be looked at by APOC management for insertion into the reporting format. APOC is organizing a workshop to bring partners in Tanzania together, including Tanzania and some other African countries.

Country visits of TCC members

257. TCC proposed five countries namely South Sudan, CAR, DRC, Angola and Ethiopia as countries for the joint visit between TCC and APOC Management. It was also suggested that APOC Management should provide TCC members with a feedback on the process within a week.

23 DATE AND VENUE OF THE THIRTY-FIFTH AND THIRTY-SIXTH SESSIONS OF THE TCC: Agenda Item 23

258. The next session of the Technical Consultative Committee (TCC35) is to be held from 10-14 September 2012, and TCC36, from 11-15 March 2013, in Ouagadougou, Burkina Faso.

24. CLOSURE OF THE SESSION: Agenda item 25

259. Dr Andy Tembon of the World Bank, on behalf of all the participants thanked the Chair for his dedication and commitment which often steered the meeting to attaining the required outcomes. He also congratulated the Chair for his new position in the Government of Sudan and wished him every success. He said that he was honoured to attend this session of TCC.

260. In his closing remarks, the Chair observed that it was a very good meeting with the attendance of prominent scientists who contributed to constructive discussions. He thanked all the TCC members, guests from the international institutions, Technical Advisors, National Coordinators, the World Bank, APOC Management, the rapporteurs and the interpreters for their personal and collective contributions which made the meeting a success. He declared TCC34 session closed.
Annex 1. List of participants

34th SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE
Ouagadougou, 12-16 March 2012

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Annex 2: PROVISIONAL AGENDA

1. Opening
2. Adoption of the Agenda

Information

3. CSA: matters arising from the 134th and 135th sessions
4. JAF: matters arising from the 17th session: decisions
5. NGDO: matters arising from the NGDO/NTD Network Meeting: recommendations only
6. TCC: follow-up of the key recommendations of the thirty-third session

Strategic and technical issues

7. Workshop on CDI strategy inclusion in the curricula of 15 Nigerian Faculties of medicine, health sciences and nursing schools
8. 8th NOTF Meeting
9. Feasibility of elimination of Onchocerciasis infection and interruption of transmission:
   9.1. Elimination of Onchocerciasis with ivermectin in Africa
   a) Update on APOC countries
   b) Update on other Oncho endemic countries in West Africa
   9.2. Evaluation of geographic coverage – Draft protocol
   9.3. Entomological studies:
   a) Revised Study protocol;
   b) update on activities conducted in Nigeria, Chad and Uganda
   c) Update on the delineation of transmission zones
   d) Update on black flies trapping and other studies related to Onchocerciasis
   9.4. Elimination of O. volvulus infection: New diagnostics of PATH
   9.5. LF and Onchocerciasis control/elimination Programmes’ collaboration
   9.6. Perspectives of Lymphatic Filariasis (LF) and Onchocerciasis elimination (DOLF)
   9.7. Twice yearly treatment in problematic areas
   9.8. Control and elimination of Onchocerciasis: thresholds, breakpoints and strategies

10. Contributions/roles of APOC in NTDs control (TCC reflexions and guidance)
11. Preparation of the strategic plan of Action and Budget for the post 2015 period
12. Macrofil and Research:
   12.1. Update on Moxidectin and Target Product profile for drug for Onchocerciasis control via mass treatment
   12.2. Update on the DEC patch test and Lohmann
13. Report on the last Mectizan Expert Committee Meeting
14. Update on REMO refinement results in Ethiopia and Angola
15. Review of operational research proposals including the research on the impact of ivermectin on Loa loa
16. The nodding disease: TCC guidance on the way forward with regard to JAF decision
17. Remarks by Technical Advisors to APOC Management

Management of APOC Trust Fund

18. Report on the financial management of APOC funded Projects

Reviews

19. Report on the review by the APOC Management of the financial content of 1st, 2nd, 3rd, 4th ,5th, 6th and 7th, 8th, 9th, 10th, 11th, 12th, 13th years projects’ progress reports as an introduction to their technical review
20. Review of 1st, 2nd, 3rd, 4th, 5th 6th and 7th, 8th, 9th, 10th, 11th, 12th, 13th years annual technical reports
21. Technical review Committee: Nigeria and Cameroon
22. Other matters:
23. Date and place of the thirty-fifth session of the TCC
24. Conclusions and recommendations of TCC34
25. Closure of the session

DIR/COORD/APOC/09.03.2012
### Annex 3: TCC 33 Recommendation and conclusions

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<th>Subject/Topic</th>
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<th>Status of implementation</th>
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<td><strong>Activities of the NGDO Group and Follow up of TCC32 recommendations</strong></td>
<td>TCC recommended that APOC management could include Burundi in future cross-border meetings with DRC and Uganda.</td>
<td>This activity has been planned for the next 3 quarters of 2012. Malawi/Mozambique/Tanzania/Burundi Burundi and DRC will work out a collaboration plan for taking cross-border issues (Cibitoke-Bubanza treatment ongoing but Kivu in DRC is not CDTI area). Issue discussed during 5-9 March elimination meeting.</td>
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<td><strong>Community Self-Monitoring</strong></td>
<td>Conduct joint epidemiological evaluations alongside onchocerciasis evaluations to get a better idea of the distribution and impact of ivermectin on Loa loa;</td>
<td>A research proposal is submitted to TCC for review.</td>
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<td><strong>Community Self-Monitoring</strong></td>
<td>It is important to establish the impact and current situation regarding loiasis and it would be useful to publish the baseline data that exists;</td>
<td>A research proposal submitted to TCC for review – Current situation of Loiasis and validation of RAPLOA in DRC are already published</td>
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<td><strong>Community Self-Monitoring</strong></td>
<td>APOC management should obtain evidence on the value of CSM for improving CDTI implementation;</td>
<td>Discussions with Dr Yumkella and other TCC members will start during this TTC session on whom to invite for protocol development of the multi-country study recommended by TCC33</td>
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<td><strong>Community Self-Monitoring</strong></td>
<td>Review of CSM from technical reports and visit the communities in the field to collect the evidence.</td>
<td>This activity has been planned to be finalized by the last quarter of the year 2012</td>
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<td><strong>Community Self-Monitoring</strong></td>
<td>Dr Yumkella, with other TCC members to develop a protocol or terms of reference and TCC recommended that countries should apply to be a part of the study. There should be one person to coordinate the study and partners would be selected from the participating countries. The TCC subcommittee was asked to put together a semi-final ToR and budget to be submitted to APOC management</td>
<td>Dr Yumkella and the TCC subcommittee members will report on the progress made</td>
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<td><strong>Feasibility of elimination of onchocerciasis infection and interruption of transmission in Africa</strong></td>
<td>Identify practical steps to initiate the collaboration between onchocerciasis and LF Programmes and TCC recommended that the AFRO-LF/Regional Programme Review Group (RPRG) and APOC/TCC should meet to set guidelines for collaboration;</td>
<td>This 34th session will be an opportunity to deal with the recommendation</td>
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<td><strong>Macrofil and Research</strong></td>
<td>Further research to be done on using albendazole to treat LF after many years of ivermectin treatment.</td>
<td>In the context of elimination, some oncho and LF national coordinators met (5-9 March elimination meeting). However, further clarifications are needed from TCC.</td>
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<td><strong>Independent treatment coverage surveys in Centre 1</strong></td>
<td>It was recommended that APOC management should review the previous 4/5 years reports. If it appears that there is managerial weakness, such evidence would provide the rationale for the Minister to be contacted.</td>
<td>The treatment coverage survey was conducted by APOC in November 2011. The report is available in the MOH. (mean Therapeutic coverage is about 51% - range 37-72%).</td>
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<td><strong>DEC patch test:</strong></td>
<td>TCC stressed again that the availability of the DEC patch is urgent and becoming more urgent every month.</td>
<td>An update will be made by Dr Kuesel.</td>
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<td><strong>Operational Research Proposals</strong></td>
<td>TCC asked APOC to provide a summary of operational research projects and funds given from 1996 to the present, at the next meeting of TCC.</td>
<td>The summary will be provided by APOC management under agenda item 15.i</td>
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| **Training of NOTFs in management and analysis of data** | (i) TCC advised that validation of data in country should continue to be emphasised during training;  
(ii) TCC noted that the emphasis was on quantitative data but it would also be useful to include more on qualitative data and to sensitise programme managers on this aspect which could be of benefit for reporting other activities such as CSM. | Projects managers and implementers are being sensitized to record the qualitative data. |
| New project proposal | (i) TCC accepts the initiation of Ituri South (DRC) CDTI Project, but the Project should take the maximum of precautions in view of the co-endemicity of oncho/loiasis and to the high risk of SAEs  

(ii) It is essential to refine the data and the mapping of onchocerciasis in this Region;  

(iii) The treatments must be spread out over time and space, beginning by the zones less likely to be affected by SAEs;  

(iv) Collaboration between all disciplines and putting in place a plan of action for the good management of SAEs is strongly recommended;  

(v) This region must equally offer an opportunity for initiating operational research | Actions are being taken.  

The different steps are being discussed with the new Director of the NOCP/DRC and funds as well as technical assistance will be provided for the implementation of the activities |

| Geographical coverage | APOC should release report of Geographical coverage survey conducted in Nigeria to enable projects to improve coverage where necessary. | The data generated from the geographic coverage surveys undertaken in 2010 have been shared with NOCP Nigeria which they shared during their NOTF meeting in Dutse, Jigawa state in 2011. The reports of geographic coverage survey done in 2011 in Cross river, Kaduna, Nassarawa, Plateau and Yobe CDTI projects are still being finalized and the results will be shared with NOCP. |

| CSM/SHM | In order to improve project implementation, TRC/Nigeria urges APOC to assist projects to implement CSM / SHM in all CDTI communities by end of 2012. | A multi-country study on CSM and SHM planned to give better understanding on the situation on ground and how to approach countries. In the meantime recommendations from the consultations on CSM held in Ouaga in 2011 have been shared with the countries and follow up of their implementation are being made through discussions during NOTF meetings |

<p>| Sustainability | TRC/Nigeria expresses concern over non-implementation of sustainability plans by most projects. The meeting therefore urges APOC to fund monitoring of implementation of sustainability plans of projects that are 7 years and above in 2012; | Planned to identify and monitor some plans during the second quarter of 2012 |</p>
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<th>Operations research by countries</th>
<th>TRC/Nigeria observed with utmost concern that operational research proposals forwarded to APOC Management have not received adequate attention. TRC/Nigeria therefore decided to stop further review of operational research proposals until the committee receives appropriate response from APOC.</th>
<th>NOCP/Nigeria received all comments/ recommendations of TCC relating to ORs submitted by Nigeria. This was explained to the representative of TRC/Nigeria.</th>
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<td>Follow-up on TRC recommendations by projects</td>
<td>TCC noted that it is important that they should follow up on decisions made and the TRC/Nigeria are strongly recommended to have a policy for resubmission and review of rejected reports so as to resolve that situation;</td>
<td>Representative of TRC/Nigeria will update TCC.</td>
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<td>Epidemiological situation</td>
<td>TCC is concerned over the change from hypo- to hyper-endemic areas in Nigeria and requests the APOC Epidemiology Unit to validate the epidemiological evidence and verify whether this actually is the case or not;</td>
<td>In-depth analysis of REMO data was done and did not show that hypo endemic areas became hyper. APOC Management will encourage the use of this in-depth map of Nigeria.</td>
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<td>Follow-up on the implementation of TRC recommendations</td>
<td>The TRC should present a table of implementation of recommendations to future TCC meetings.</td>
<td>The representative of TRC/Nigeria will update TCC.</td>
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<td>CDTI in difficult countries</td>
<td>TCC recommends holding a workshop in Juba to discuss Loa loa issues and re-launch CDTI. Advocacy and sensitisation should be made to the highest level (President). It was noted that the same approach would be applicable for DRC and Angola in order to improve their situations.</td>
<td>Country visit and workshops are planned in April-May 2012.</td>
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<td>Discrepancy between reported and actual coverage – Littoral 2 and Centre 1</td>
<td>A recommendation concerning coverage surveys was deferred to be discussed in TCC34.</td>
<td>TCC Chair will update the meeting.</td>
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<td>Country visits by TCC members</td>
<td>TCC members are encouraged to visit sites – invitation by APOC or initiative of TCC members?</td>
<td>Attempts were made for TCC members to visit Tanzania (Dr Ogoussan and Mary Nyamongo) but due to conflicted timetables and time constraint we were not able to finalize the visit.</td>
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<td>Changing the age of projects to be reviewed by TCC from 7 to 5 years and changing the review format to present just critical issues</td>
<td>TCC members don’t want to change the age of projects to be reviewed from 7 years to 5 years. The question of reducing the format for presenting to critical issues should be an issue for the next TCC (TCC34).</td>
<td>Recommendation noted by APOC management.</td>
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<td>This would be handled by the Chair of TCC.</td>
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<td>NTD co-implementation issues</td>
<td>TCC should review the NTD reports for countries undertaking co-implementation. It was suggested that TCC members should take part in the next assessment of the Tanzania co-implementation Programme and that it could also look at the broader issue of integration. It is important for APOC to assess the process of co-implementation in Tanzania so as to draw lessons for other programmes. Such an assessment could also guide the project teams in various ways including recording and sequencing of activities. The team of Tukuyu CDTI project needs assistance with reporting. The format for reporting co-implementation does not allow them to report the data properly and needs to be adapted. (TCC sub-group to look into issues of reporting co-implementation. Noted by APOC management This activity has been planned for the 3rd quarter of 2012 so that treatment activities could be captured. This activity has been planned for the 3rd quarter of 2012 so that treatment activities could be captured TCC would address</td>
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<td>LF and Onchocerciasis collaboration</td>
<td>APOC should be represented at LF meetings and the LF coordinators should be represented at APOC meetings. It was also recommended that an APOC representative should attend meetings of the strategic NTD committee of WHO and vice-versa. Drs Kisito and Fobi will draw up a list of meetings and indicate those for which LF representatives should attend at APOC. Will be part of the discussions on collaboration Management will write to RD for DPC/AFRO This has been done. Dr Ogoussan will present the list</td>
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<td>Issue of internships for APOC</td>
<td>TCC accepts the proposal of internship and recommended that APOC should develop the criteria and methodology to apply it, including issues of finance, implications for staff time and costs and should present a plan of action to TCC. APOC should therefore correspond on this issue between the Chair and Prof Mamadou Traore. It was considered useful to include MDSC in the use of interns. In preparation; more details could be provided</td>
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