AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)

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

Ouagadougou, 11 – 15 March 2013

DIR/COORD/APOC/REP/TCC36
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<th>Description</th>
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<tr>
<td>AfDB</td>
<td>African Development Bank</td>
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<tr>
<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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<tr>
<td>AWOL</td>
<td>Anti-Wolbachia</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
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<tr>
<td>CDD</td>
<td>Community-Directed Distributor</td>
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<tr>
<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>DOLF</td>
<td>Death to Onchocerciasis and Lymphatic Filariasis</td>
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<tr>
<td>HKI</td>
<td>Helen Keller International</td>
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<tr>
<td>DEC</td>
<td>Diethylcarbamazine</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>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 (in Nigeria)</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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<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<tr>
<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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<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>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>PAB</td>
<td>Plan of Action and Budget</td>
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<td>PCT</td>
<td>Preventive Chemotherapy Treatment</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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<tr>
<td>RPRG</td>
<td>Regional Programme Reporting Group (LF)</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>SS</td>
<td>Sightsavers</td>
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<td>Transmission Assessment Survey (LF)</td>
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<td>TCC</td>
<td>Technical Consultative Committee (of APOC)</td>
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<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>WHO Regional Office for Africa</td>
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<tr>
<td>WHO/NTD</td>
<td>Neglected Tropical Diseases – department within WHO cluster of communicable diseases (WHO/NTD)</td>
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OPENING: Agenda Item 1

1. The Chair of TCC, Prof Homeida welcomed all the participants of TCC36 to Ouagadougou and acknowledged the dedication and contributions of Dr Paul-Samson Lusamba-Dikassa, preceding Director of APOC, who retired in December 2012. In the same spirit he appreciated Dr Stephen Leak’s good work in managing research operations in addition to supervisory role as focal point for Tanzania and Liberia project activities. He wished them both happy retirements. Noting that some of the TCC Members were absent, he encouraged the Committee to double their effort in order to accomplish the tasks in the agenda presented. He took the opportunity to welcome Dr Chris Mwikisa currently Acting Director of APOC and added that Dr Mwikisa’s experience as Chair of CSA and knowledge of working in the WHO/AFRO region is valuable for steering the Programme objectives. He appealed to the Committee to be cautious of time allocated to specific agenda item to allow time for discussions.

2. The Acting Director APOC, Dr Mwikisa also welcomed all the participants to the TCC 36 and acknowledged the presence of new comers as well as those who were participating in the meeting for the first time. He informed that he currently holds the position of Inter-country Support Teams (ISTs) Coordinator for Eastern and Southern Africa (covering 19 countries and possible inclusion of South Sudan), based in Harare, Zimbabwe. In addition he is the Chair of the CSA as mentioned earlier and interim Director of APOC. He added that, he is honored and privileged to have the opportunity to serve as Acting Director of APOC and to experience directly the programme operations. He took the opportunity to congratulate Prof Homeida upon his new position as the honorable Minister of Health (MOH) Sudan. He underscored that the vast expertise of TCC is commendable for the valued and significant recommendations made to APOC Management to achieve the set targets and milestones.

3. On elimination goal, he said that APOC has specific target to achieve onchocerciasis elimination by either 2020 or 2025, therefore the technical expertise of the TCC is significant to provide the appropriate advice to achieve the elimination milestones, including country exit plans and strategies required. He reiterated specifically, JAF18 conclusion to disseminate the two working documents (Concept Note, PAB 2016-2025) to all stakeholders to provide comments and guidance to make the documents fit for the purpose of APOC. He requested all the stakeholders to submit their input in track change mode for consideration by the APOC Secretariat. These inputs would then be reviewed at the subsequent CSA session before its final presentation to JAF19 in December 2013. He commended TCC for their long working hours and appealed to the Committee to be mindful of the time allocated for the presentations in order to complete the meeting as scheduled.

4. The address was followed by informal introduction of participants. The final list of participants is appended as annex 1.

5. The Chair gave opportunity to the UN Security Officer to brief the participants on the security situation in Ouagadougou and surrounding areas. The Security Officer advised the participants to be more vigilant with personal effects and general surrounding.

ADOPTION OF THE AGENDA: AGENDA Item 2

6. The provisional agenda was adopted without any changes. The final agenda is appended as annex 2.
MATTERS ARISING FROM CSA 138\textsuperscript{TH} AND 139\textsuperscript{TH} SESSIONS AND JAF: Agenda Items 3 and 4

7. Dr Mwikisa presented a combined summary of matters arising from the CSA and the JAF because the CSA that takes place before the JAF submits its outcomes to JAF for consideration. As well, the CSA that takes place after the JAF basically reviews the decisions of JAF and gives guidance to the Management of APOC on how to proceed. The main items of his presentation are as follows:

(i) Efforts to improve treatment coverage in Angola- Reinforce closer technical support through the recruitment/transfer of additional Technical Advisors; Advocate, support and facilitate a national meeting with stakeholders and partners including NGDOs to reinforce and relaunch CDTI activities in Angola and to build capacity at all levels on CDTI strategy;

(ii) Train and involve more Women as CDDs in CDTI.- Collate existing information on gender on APOC activities and prepare a paper to be published;

(iii) Develop co-implementation guidelines (technical and financial);

(iv) Cross border activities - Facilitate finalization of plans and their funding by APOC partnerships; support implementation of cross border joint action plans and report to JAF and prepare a document to be submitted to JAF on cross border interventions;

(v) Excellent entomological results in Benin, Guinea, Guinea Bissau, Mali, Niger and Sierra Leone) - Benin, Mali, Niger and Togo were supported financially to undertake epidemiological evaluations. Countries with good phase 1b epidemiological data will be requested to submit proposals for entomological evaluation to confirm interruption of transmission;

(vi) Government financial contributions - field visits to Cameroon and Ethiopia for data collection; Finalization workshop in Ouagadougou and to provide countries with a formula on how to standardize government contributions;

(vii) Elimination of Onchocerciasis infection in Africa and the Americas: Entomological evaluation studies - Elaborate score card; Present the score card to TCC and CSA; Facilitate meetings between OEPA and NOTFs; Implement phase 1b entomo-epidemiological evaluation in collaboration with Oncho and LF programmes; Assess the impact of ivermectin treatment on LF where Mectizan is ongoing for at least 10 years in the framework of onchoerciasis control; Publish entomo-epidemiological evaluations results and Develop Posters showing results;

(viii) Elimination of Onchocerciasis infection in Africa and the Americas; New Momentum for Neglected Tropical Disease (NTDs) Elimination - APOC strategic plan to take into account integrated approach to PCT/NTDs; Finalize TOR on collaboration with AFRO and countries on NTDs; Organize joint planning sessions; RPRG and TCC regular meetings for advise on technical issues and co-implementation; Invite other NTD Programmes to APOC meetings and participate in their meetings;
(ix) Monthly teleconferences with AFRO/NTDs; Attend stakeholders meetings in countries and global forum meetings on NTDs and Develop and share posters on best practices and collaboration;

(x) To move to CSA the budget that was presented and revise the activities with field activities;

(xi) The Concept Note and APOC Strategic Plan of Action and Budget 2016-2025 for elimination of Onchocerciasis in Africa- Electronic version to be sent to those who requested and taking into account remarks made by Countries, Donors and NGDOS.

8. Other matters discussed at CSA included:

(i) Discussions on the drug supply chain at the country level and the possible solutions to contain procurement and supply problems being faced in order to provide the manufacturers with the correct forecast;

(ii) The rebranding/ renaming of APOC to make it fit for its purpose in the elimination agenda;

(iii) On the visibility of APOC and showcasing its milestones/successes to a global audience, APOC has submitted articles to be published in the PLoS NTD and proposed to do the same in the Africa Health Monitor;

(iv) PABs 2013, Revise countries PABs giving priority to field activities and prepare a contingency plan;

(v) With regards to host country for JAF19, there are ongoing discussions for a donor to host the Forum. In the event that no donor is willing to host the JAF, the alternatives would be to host the Forum in Ouagadougou, Brazzaville or Geneva.

**TCC Comments**

9. TCC commended APOC Management for the initiative to implement the actions within their ability and made the following observations:

(i) TCC noted the importance of onchocerciasis integration with other NTD in addition to pursuance of onchocerciasis elimination with the ultimate goal but suggested that WHO/AFRO should take the lead in developing a clear strategic plan defining the roles and responsibilities of leadership;

(ii) Although TCC had previously provided their comments and inputs to the Concept Note and APOC Strategic Plan of Action and Budget 2016-2025 for elimination of Onchocerciasis in Africa, the Committee is open to review the documents in order to brand APOC to make it fit for the purpose of the 2020, 2025 elimination landmark;

(iii) TCC requested for further clarification on whether development of co-implementation guidelines would be in collaboration with WHO/AFRO or Countries. With regards to enhanced collaboration with AFRO and linkage to the countries, it was noted that the
platform of coordination is the road map and regional plans as well as the national NTD plan to guide AFRO and APOC in implementation. It was highlighted that WHO/AFRO does not have the implementation mandate but provide technical support and policy guidelines. However it is clear that collaboration will require adjustment and realignment to work together;

(iv) The Committee underscored the importance of redefining the ultimate goal for elimination by communicating clearly to the countries the timeline to meet elimination target and call upon the governments to finish the work;

(v) Noting the recurring request by the JAF to show significant increase for female CDDs, it was suggested to have a specific objective on gender on APOC activities in the APOC Strategic Plan of Action and Budget 2016-2025;

(vi) TCC also requested for the overall total amount of the 7.5% overhead cost for all the NGDOs and subsequently the amount required to reimburse the 12.5% overhead cost. The Director assured the Committee that the figures were being compiled and would be shared in the next TCC session. With the 12.5% increased overhead cost for the NGDO, the Committee hopes for increased impact on their activities in achieving onchocerciasis elimination milestones;

(vii) The Committee also noted the poor attendance of the Ministers of Health at the JAF sessions and encouraged APOC and CSA to devise means to motivate the MOHs to attend the JAF sessions. TCC was informed of the ongoing discussions at the CSA to visit countries as well as to mobilize more resources within the countries.

NGDOs: MATTERS ARISING FROM THE NGDO/NTD NETWORK MEETING: Agenda item 5

10. Dr Ukety reported on the outcome of the 41st session of the NGDO Group held in Atlanta, on 26-27 February 2013 as follows:

(i) To enrich onchocerciasis advocacy messages with respect to the London Declaration, the Group strongly recommended that onchocerciasis elimination milestones be aligned with the year 2020 NTD goals;

(ii) On drug supply forecast, MDP/Merck encouraged partners and endemic countries to properly forecast the drug needed for Oncho and LF elimination in order to inform the manufacturing needs. This is a particular issue with the rapid scale up of LF activities and consideration of twice per year treatment in some onchocerciasis endemic areas;

(iii) With regard to coordination of activities, mechanisms should be developed for better coordination and planning to reduce the number of meetings and visits to countries by different partners so that country managers are able to manage and scale up their NTD programs;

(iv) Related to new NTD research resources becoming available, the Group recognized the need to enhance national capacity to conduct research on onchocerciasis related issues. One way to do this is to identify a group of mentors/research institutions to work with national researchers at local academic institutions;
The Group reiterated the needs for the Responsible Officer of the NGDO Group to undertake more country visits in support of programmes and NOTFs, in addition to participation in APOC statutory meetings;

The Participants of the 41st meeting in the 21st year unanimously agreed to rename "the NGDO Coordination Group for Onchocerciasis Elimination";

The Group discussed and pointed out several issues and needs related to Angola, CAR, DRC, Ethiopia and South Sudan;

The 42nd session of the NGDO Coordination Group for Onchocerciasis elimination will take place alongside the NTD/NGDO Network in Brighton, the United Kingdom, 16 – 20 September 2013.

**TCC Comments**

11. The TCC commended the Group on the update and noted the importance of including country programme needs while determining operational research topics. The Committee also encouraged APOC Management to quickly find a replacement for Dr Stephen Leak, who retired and was the Officer in charge of operational research. The TCC was informed that the funding provided by the Bill and Melinda Gates for research was open and this could be an opportunity to provide suggestions on the different research proposals.

12. The Committee acknowledged the need to minimize meetings. In addition, it was recommended that country visits should be undertaken within the overall country-led activities through APOC partnership and not exclusive to particular partner.

13. With regard to fostering and strengthening collaboration among partners, the Committee reiterated the idea of holding one of the NGDO meetings in Ouagadougou in order to allow more participation from APOC staff.

14. In addition, it was pointed out that there is a need for proper coordination of NGDO partners at the international as well as at the country levels in order to promote synchronized dialogue at all levels.

15. The TCC encouraged NGDO to be more involved in cross border meetings and activities.

**TCC: FOLLOW UP OF KEY RECOMMENDATIONS OF THE THIRTY-FIFTH SESSION: Agenda Item 6**

16. Dr Noma presented a summary of the status of implementing the recommendations of the 35th session of TCC. The full text is appended as annex 3.

17. Following the presentation, TCC members commended APOC Management for the actions taken and made the following suggestions:

(i) On the feasibility of elimination of onchocerciasis infection and interruption of transmission in Africa, and the need for training high level entomologists to enhance national capacity, the committee underlined the importance of mobilizing resources to
sustain this activity. The Committee was informed that despite the high cost related to training at the high level, APOC will strive to raise the needed resources.

(ii) With regards to the development of the APOC/JRS website on OCP environmental assessment data, TCC reiterated that the same initiative would be implemented for the entomological data. APOC Management is working with website developers to ensure that the data posted are accurate before this could be taken as an example.

(iii) The Committee was pleased to learn that efforts are being made to develop and assess the use of post-treatment nodule prevalence as an indicator for comparison of REMO data and as a possibility for a less expensive method.

(iv) On the importance of closely monitoring the decisions and outcomes of the cross border meetings to ensure that actions are effectively implemented, TCC recommended to appoint a coordinator. The Committee was informed by APOC Management of the internal discussions to have one of the Units in house to take lead and also added that APOC had agreed to concentrate on implementation (rather) than facilitating the meeting.

(v) TCC was informed of the difficulties and setback in implementing CDTI activities in Angola. TCC set up a subcommittee to make recommendations and report back to the session.

(vi) TCC expressed their gratitude to APOC Management for the presentation on the status of the implementation of their recommendations but suggested that the recommendations and follow up actions should be circulated to the Members prior to the TCC meeting to allow enough time for the Members to review the actions.

STRATEGIC AND TECHNICAL ISSUES

NINTH MEETING OF NOTFs (INCLUDING APOC AND EX-OCP COUNTRIES): Agenda Item 7

18. Dr Noma presented the outcome of the 9th NOTF meeting held 24-28 September 2012. The main objectives of the meeting included: situational analysis of the activities to eliminate Onchocerciasis; review of epidemiological and entomological evaluations; review of co-implementation of multiple health interventions; elaboration of draft plan of action for Onchocerciasis elimination in Africa and preparation of JAF 18 country presentations.

19. The expected outcomes were to identify strength, weakness, cross border issues, opportunities and suggestions for the improvement of Onchocerciasis elimination in Africa; lessons from entomo-epidemiological evaluations are reviewed and ways to implement future evaluations are defined; each country has elaborated a draft plan of action for Onchocerciasis elimination and prepare countries presentations to JAF 18.

20. TCC commended APOC Management for this initiative which congregated representatives from the field to share their vast experience (challenges, lessons learnt, successes) extremely imperative for elimination of onchocerciasis.
FEASIBILITY OF ELIMINATION OF ONCHOCERCIASIS INFECTION AND INTERRUPTION OF TRANSMISSION: Agenda item 8

i) Elimination of Onchocerciasis with ivermectin in Africa:

21. Dr Hans Remme reported to the Committee the outcomes of the APOC Consultative Meeting on Onchocerciasis Elimination held in Ouagadougou from 04-08 March 2013. Four main objectives discussed included:

(i) Revision of ivermectin treatment boundaries for the purpose of elimination- procedures and implementation plan for 2013-2014;
(ii) Evaluation of epidemiological trends towards elimination (phase 1A)- review of evaluation results for 2012 and plan for 2013;
(iii) Confirmation that breakpoint has been reached and treatment can be stopped (phase 1B)- review of evaluation results for 2012 and plan for 2013;
(iv) Criteria and areas for six-monthly or alternative treatment- review of criteria and identification of possible areas for six-monthly or alternative treatment strategies.

a) Revision of ivermectin treatment boundaries for the purpose of elimination- procedures and implementation plan for 2013-2014.

22. Dr Afework presented a brief on the revision of ivermectin treatment boundaries for the purpose of elimination including the procedures and implementation of plan for 2013-2014. He pointed out that the plan was drawn using the decision chart algorithm in three steps: 1) to complete CDTI treatment areas for oncho; 2) LF treatment areas and 3) identifying the remaining untreated areas. He highlighted the remaining treatment areas which were classified into isolated areas and borderline areas. For the isolated areas with less than 5% no treatment is needed except clusters of nodule positive REMO villages which can be checked by MF surveys (scenario 1 - 2); with nodule prevalence of >5%, treatment may be needed and MF surveys to confirm and define treatment limits (scenario 4).

23. For the borderline areas with <5%, no treatment is needed. These areas are to be included in phase 1A/1B evaluations of CDTi project (scenario 3) and in areas with nodule prevalence rate of >5%, it would require to check current status by MF surveys in REMO villages with highest pre-control nodule prevalence.

24. Based on this decision chart and the five scenarios, different action points will be taken to map out the untreated areas. During the meeting, countries have used the above outlined methodology to identify untreated areas and mapping needs to delineate it. A total of 140 villages were selected from seven countries (Burundi, DRC, Mozambique, Ethiopia, Cameroon, CAR and Tanzania) to delineate treatment border areas to be surveyed in 2013/2014. Nigeria has started the exercise which is planned to be completed soon.

TCC Comments

25. TCC thanked Dr Afework for the presentation and APOC Management for initiating delineating of the treatment boundaries in the context of the shift from control to elimination. TCC also noted that the guideline developed for the task has been tested in some countries already.
26. TCC recommended accelerating the finalization of the mapping and the delineation work to include the at risk areas as soon as possible in the face of achieving elimination in at least 80% of the countries before 2025.


27. Dr Afework presented an update on the Phase 1a evaluation carried out between 2008-2012. A total of 58 foci have been surveyed, 719 villages and 144,419 people were examined. More specifically in 2012, Phase 1a evaluation was undertaken in 9 countries and 15 foci (162 villages) and 33,634 people were examined. The aim of this phase 1a epidemiological evaluation was to assess infection trend after treating for a number of years using ivermectin. The following projects and provinces: Cibitoke, Bubanza in Burundi, Adamawa, Plateau Nassaraawo, Osun and Ekiti in Nigeria; Ouka and Oham Pende provinces in CAR, and Logone Occidental and Moyen Chari provinces in Chad have shown elimination of the infection in the surveyed villages. In the two sites of CAR, it was observed that the level of nodule prevalence rate was disproportionately high for the current Onchocerciasis endemia level. Further analyzis will be carried out using the detailed data base once the data entry is completed.

28. In Cameroon, three projects (Adamawa, South West 1 and South West 2) have been evaluated and shown a significant progress in reducing the infection level after years of treatment. The projects are on track based on ONCHOSIM predictions but might need intensification of CDTI to accelerate elimination in the high endemic areas of South, Center and South West of Cameroon. In Tanzania: Kilosa site—A Phase 1a evaluation was conducted in 10 villages in a meso-endemic focus in Morogoro Region. The result showed that after 10 years of annual ivermectin treatment, results in most of the focus showed a significant progress except for a disappointingly high prevalence in one village located in the area with the highest pre-control endemia level, according to the available REMO data.

29. Evaluation has been undertaken in 2012 in DRC (Bas-Congo and Uele) and in Congo (the province of Pool). The results from the three sites in the two countries have shown that the infection level for the number of villages is still very high despite treating for a number of years. This unsatisfactory result needs to be investigated to find out the root cause of the persistence of high endemia levels.

30. In conclusion, out of the 15 projects evaluated in 2012, 12 of them are close to elimination of infection or are in track according to ONCHOSIM prediction. Three of the projects/sites evaluated in DRC and Congo need close follow up to understand the problem and address it. The meeting was informed that in 2013, phase 1a epidemiological evaluation will be conducted in 20 projects/foci in 9 countries.

TCC comments

31. TCC thanked APOC for the achievement in assessing onchocerciasis infection level and the decrease in the trend in a number of countries and projects but has a concern in finding some unsatisfactory results in some sites. More importantly finding of isolated villages with poor treatment history and high infection level. Low treatment coverage may be a factor, but other possible explanations should also be considered.

32. TCC discussed the disproportionately high nodule prevalence seen in CAR and asked APOC management to look into the details during the final analysis of the data.
c) **Confirmation that breakpoint has been reached and treatment can be stopped (phase 1b)-review of evaluation results for 2012 and plan for 2013.**

33. Dr Noma started the presentation by clarifying that Phase 1b epidemiological evaluations are carried out to confirm that the breakpoints have been reached and treatment can be safely stopped. In 2012, 13 sites in five countries (Chad, Malawi, Nigeria, Tanzania and Uganda) were evaluated for Phase 1b. The meeting was informed that in 2013, eight foci in six countries have been identified for Phase 1b evaluation. It was highlighted that at the moment, there is no decision to stop treatment however there is an urgent need for entomological data to make a conclusive decision.

**TCC Comments**

34. TCC acknowledged APOC initiative to carry out phase 1b evaluation in effort to determine when and where to stop treatment. Following a comprehensive discussions on the impact of LF/oncho endemic overlay in achieving elimination, TCC proposed to have clear information on LF and to synchronize the information in the interest of elimination goal.

35. TCC also emphasized the need for including Ex-OCP countries in the elimination time frame.

36. The Committee reiterated that the feasibility of using nodule prevalence as a rapid assessment method to assess the decline in infection levels after ivermectin treatment should be considered. The committee was informed that the results of the final analysis of the nodule data that have been collected during the epidemiological evaluations over the last few years, and the relationship between the prevalence of nodules and the prevalence of MF after many years of ivermectin treatment will be presented in the next session.

37. TCC noted that there is a minimal refusal to undertaking the skin nip, in APOC countries except during the hamlet farming session or among the youths.

*d) Criteria and areas for six-monthly or alternative treatment*

38. Dr Wilma Stolk reported on the results of ONCHOSIM simulations of annual versus six monthly treatments. She pointed out that to achieve elimination, it has been proposed that APOC should increase its frequency of ivermectin mass treatment from annual to 6-monthly or even higher. In an ONCHOSIM simulation study, predictions show how increasing the mass treatment frequency to 6-monthly or 3-monthly would change the remaining program duration and the number of rounds required for elimination of onchocerciasis. It was predicted that high frequency mass treatment always reduces program duration until elimination, but always costs additional treatment rounds as well. In low coverage settings, reductions in program duration may be achieved just as well by increasing coverage, which is probably a less resource-demanding option. As example, a site was considered with pre-control cmfl = 10 mf/s, where 4 treatment rounds were given, thus far with average coverage of 50%. Annual treatment would have to be continued for 10 more years to achieve elimination (i.e. 10 rounds). The remaining duration can be reduced to 6.5 years with 6-monthly treatment (2x6.5 = 13 rounds). If treatment continues annually, but with a higher coverage (65% instead of 50%), the remaining duration is 7 years (7 rounds). In areas with poor treatment coverage, the first priority is to increase the coverage to higher levels. In other areas, 6-monthly mass treatment is only worth the effort in situations where annual treatment is expected to still take a long time to achieve elimination.
TCC comments

39. On further clarification TCC was told that:

(i) the model simulates realistic compliance (taking account of 5% of people who are never treated, age patterns in compliance, and an individual inclination to participate in treatment programmes);
(ii) Costs of treatment programmes were not measured, but are proportional to the number of treatment rounds required;
(iii) It was noted that a scientific paper of this work is in preparation.

c) Identification of possible areas for alternative treatment strategies in APOC countries.

40. Dr Hans Remme presented an updated map of the predicted end year of ivermectin treatment for each APOC project. With reference to the JAF18 decision to add a new APOC objective – to eliminate onchocerciasis in at least 80% of endemic countries in Africa by 2025 - and noting that after stopping treatment three additional years support are required for post-treatment monitoring to confirm elimination, the informal consultation concluded that all projects in a country should be able to stop treatment by the year 2022 at the latest in order to achieve national elimination. The informal consultation then reviewed the updated map of treatment end dates and identified projects that may require intensification of treatment in order to meet the 2022 deadline. The meeting identified one project in Nigeria and two projects in Cameroon where intensified treatment may be indicated. However, the national onchocerciasis coordinators of these two countries recommended to first complete the phase 1A evaluations in these projects before deciding on a change in treatment strategy. Other possible projects in Ethiopia and Uganda are new projects that have already adopted six monthly treatment. The recent evaluation results for a project in Congo on the border with DRC, needs to be discussed with the NOCP and the possibility of an intensified strategy considered. Finally, in a hypoendemic focus in South East Cameroon which is hyperendemic for loiasis, CDTi cannot be used and an alternative test and treat strategy is being evaluated.

41. He shared the recommendations and conclusions of the Consultative meeting which included:

Revision of treatment boundaries:

(i) Completeness and accuracy of CDTI maps should be ensured;
(ii) Completeness and accuracy of LF treatment maps should be ensured;
(iii) The administrative boundaries of urban areas should be reviewed as the outskirts may be rural and require CDTI to achieve elimination;
(iv) For areas with nodule prevalence 5-20%, LF treatment is expected to also eliminate the low level of onchocerciasis infection. In such areas joint TAS and onchocerciasis surveys should be done when the LF programme is considering stopping treatment;
(v) For non-CDTI areas with nodule prevalence > 20%, LF treatment (if any) is predicted to be too short to achieve onchocerciasis elimination and full CDTI is needed. This should start as soon as possible;
(vi) Revision of treatment boundaries is urgent and should be completed in 2013/2014 to ensure elimination by 2022.
Specific recommendations for phase 1A/1B:

**Phase 1A**
(i) Projects with unsatisfactory results should be reviewed to help policy makers to consider necessary steps to improving project implementation;
(ii) Treatment coverage should be evaluated by in-depth situation analysis.

**Phase 1B**
(i) When planning phase 1b surveys, transmission zones should be considered, not just national and/or project boundaries;
(ii) Before deciding to continue to phase 1b, phase 1a should be completed in an entire transmission zone;
(iii) More information on the distribution of fly species is needed for determining boundaries of large transmission zones;
(iv) Phase 1b entomological surveys should take place throughout the transmission season and should be performed for at least two years;
(v) In areas co-endemic for LF that are ready for phase 1b surveys, LF surveys and phase 1b surveys should be co-implemented at the same time, though possibly using separate teams;
(vi) National programme representatives should be involved in the phase 1b surveys, for purpose of planning and follow up of field activities.

Specific recommendations on six-monthly or alternative treatment strategies:
(i) Intensification of interventions should include timely provision of information of evaluation results to national project officials, provision of additional financial resources, improving CDTI and consideration of other strategies such as increasing treatment frequency and vector control in specific settings;
(ii) Programs should resolve coverage issues before considering increasing mass treatment frequency;
(iii) Increasing mass treatment frequency should be considered if elimination cannot be achieved before 2022 by increasing mass treatment coverage;
(iv) Programmes that increase mass treatment frequency should make sure to maintain high treatment coverage.

**General:**
(i) Cross-border collaboration is necessary for defining treatment boundaries, evaluating progress towards elimination and preparing for stopping treatment;
(ii) APOC should support countries to use simple, free programmes to work with maps originally produced in ARC GIS.

ii) **Entomological studies:**

   a) **Update on :activities conducted in Cameroon, Nigeria and Uganda**

42. Dr Toe provided an update on the Entomological studies planned in phase 1b to confirm the interruption of *O. volvulus* parasite transmission. They are organized in the same site where epidemiological surveys were carried out near major breeding sites. He informed the committee that a protocol that describes the structure, the methods, the personnel required has been circulated and that preparedness on the country team is a key point in the success of the studies. Among APOC countries,
several groups exist. A group of countries composed by Nigeria, Chad and Uganda have entomological teams trained that collect flies, perform dissections and send samples to the molecular biology laboratory for analysis. The second group is composed of countries with trained teams but not yet implementing the activity: Cameroon, DR Congo, Tanzania and Malawi. The third group is composed of all the countries that have sites selected for phase 1 b. Depending on the level of preparedness a plan of activity will be defined for each country during the meeting of the entomological working group.

43. Results of Nigeria, Chad and Uganda were presented. Infectivity rates have been calculated from the molecular analysis of the flies collected. The only point where infectivity rate exceeds the threshold of 0.5/1000 flies is Kwa fall/Akamkpa in Cross River State. In Chad, two points were visited. The low number of flies did not allow to obtain significant results. In Uganda, activities were carried out in 2011 and 2012 in four vector surveillance points. The infectivity rates are above the threshold at Isango and Kathembo. In the interpretation of these data, one should keep his attention on the points where the upper limit of the confidence interval is above the threshold.

b) Update on delineation of transmission zones

44. Prof Boakye updated the TCC on the delineation of transmission zones and said that the rationale was not only to know where to treat but where there could be a problem of sources of infection and attempt to provide answers to the following question- where could the infected flies be coming from? He indicated that country visits have been made to initiate and plan delineation activities, particularly sampling of *S. damnosum* s.l. larvae within the countries with the technicians from the countries who were trained in Cameroon.

45. He informed committee that dry season sampling was done in Cameroon, Chad and CAR. In Cameroon, samples were collected from a total of 78 possible breeding sites. So far 19 of these have been received of which 17 were positive for *S. damnosum* s.l.; Chad four breeding sites were visited with three positive for *S. damnosum* s.l.; and 25 sites in Central African Republic with 17 positive.

46. The field observations showed that many sites were dry especially in the north of Cameroon and Chad; only a few rivers were still high; road conditions were much better and some sites that were negative for *S. damnosum* s.l. in the rainy season were found positive.

47. Currently, samples from the sites mentioned above are being identified. It was worth noting that the sampling in Chad showed the site of Chutes Gauthier as one of the most productive sites. The chromosomal analysis shows that *S. damnosum* s.s in CAR is different from those identified from Benue State (Nigeria) but are similar to those collected from the North Region (Cameroon) and Chad. This indicates a possible transmission zone that span northern Cameroon, North east CAR and South west Chad. No *S. soubrense* Beffa form was found in Chad or CAR samples collected and the populations of *S. squamosum* identified so far from CAR are different from those identified in Cameroon last year.

48. The planned activity for 2013 included selection of candidates (DRC, Ethiopia, Rwanda, Sudan and South Sudan, Burundi, Congo); training in Larval sampling and fixation; cytotaxonomic identifications, data analysis and development of delineation maps and training in cytotaxonomy in Ethiopia and DRC.
TCC Comments:

(i) The detailed cytotaxonomic analysis should not be done in the context of an academic exercise since it is time consuming but should be done in the context of determining possible migratory patterns and hence assist in the delineation of transmission zones.

(ii) The utility of the exercise is indicated by the current results but it is important that discussions are held with members of the EVE unit of APOC such that sampling is done to improve the use of the data for decision making.

(iii) It will also be important to examine molecular methods such as micro-satellite analysis for delineation of transmission zones.

(iv) TCC appreciated the scope of the work undertaken and suggested that alternative methods should be explored.

c) Update on black flies trapping and other studies related to onchocerciasis

49. Dr Toe presented an update on black flies trapping and noted that using humans as bait is currently the standard method for collecting onchocerciasis vectors in Africa and Latin America. To develop a trap to replace human landing collections for the monitoring and surveillance of onchocerciasis transmission, comprehensive evaluations of trap platforms were conducted to determine their ability to collect *Simulium ochraceum* and *Simulium damnosum* (both sensu lato), primary vectors of *Onchocerca volvulus* in Latin America and Africa, respectively. In Mexico, a novel trap dubbed the “Esperanza window trap” showed particular promise over other traps. When baited with carbon dioxide and BG-lure (a synthetic blend of human odour components) a pair of Esperanza window traps collected numbers of *S. ochraceum* s.l. females similar to those collected by a team of vector collectors. In Burkina Faso, the Esperanza window trap baited with worn pants and carbon dioxide also rivaled vector collectors for capturing *S. damnosum* females.

50. The study is presently orientated on the research of the component of human sweat. 45 chemical attractants for these flies are identified and their bioactivity is evaluated using electroantennogram. Using an olfactometer, the research aims to determine if the compounds are attractant or repellent. These experiments are ongoing in Mexico and will be carried out in Burkina in April 2013.

51. The preliminary field results from these different locales indicate that a simple, effective trap to replace human landing collections may be widely available in a near future for monitoring transmission of *Onchocerca volvulus*. The Esperanza window trap, when baited with chemical lures and carbon dioxide can be used to collect significant number of *Simulium damnosum* s.l.

d) Predictive *S. damnosum* habitat modeling in Burkina Faso and Northern Uganda

52. Recently a remote sensing model was developed to predict the location of breeding sites for the savanna dwelling sibling species of *S. damnosum* s.l. 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.
53. The research is now targeting delineating zones of risk surrounding breeding sites. To accomplish this objective, OCP pre-control data are utilized. It is assumed that capture points are at or close to breeding sites, and endemicity is analyzed as a function of distance from capture point. The preliminary results indicate that the risk for hyperendemic onchocerciasis extends five km from the breeding sites; a little risk >15km from a breeding site.

54. Future work to be undertaken concerns associating signature pixels with breeding site productivity, extension of approach to other vector species and developing more economical approaches to signature identification.

iii) Elimination of *O. volvulus* infection: New diagnostics of PATH

55. PATH provided an update on the development of the Ov16 rapid test. Currently PATH is scheduled to technology transfer of the test to Standard Diagnostics (SD) in the second quarter of 2013. PATH and SD expect to have final pre-market tests for evaluation in the first quarter of 2014. Currently sites in three countries have been selected for this purpose: Togo, Tanzania (with APOC) and Ghana. APOC suggested Mali and Senegal as appropriate sites for evaluation of the test in settings where elimination seems to have been achieved. Also with the imminent release of the DEC patch, it was recommended that PATH coordinate with APOC and WHO/TDR to ensure head-to-head evaluations are done, or at a minimum compatible study designs are used. PATH indicated a need for updated schedule of elimination for various APOC projects, as well as for OCP countries. Also PATH indicated three priority points of collaboration with APOC beyond current activities: (i) modeling and analysis for identifying appropriate sentinel populations, (ii) cost analysis to understand resource requirements to perform post-elimination surveillance in the context of new diagnostic test with current practices as baseline, (iii) supporting APOC in identifying priority operational research questions and mentoring in country researchers in development and implementation of operational research studies. These additional areas of collaboration depend on supplemental funding that PATH is currently seeking.

56. TCC thanked PATH for the update and looked forward to further collaboration beyond current activities for the benefit of onchocerciasis elimination. It was pointed out that for the intended application of this test it is more important to have a very high specificity than high sensitivity.

COLLABORATION BETWEEN AFRO/NTD AND APOC: REPORT OF THE FIRST MEETING OF LF/RPRG AND TCC JOINT WORKING GROUP AND PERSPECTIVES OF LF AND ONCHO ELIMINATION: Agenda item 9

57. Dr Ricardo reported to the TCC the major issues and outcomes of the Meeting of the LF-Oncho Joint Working Group (JWG) held in Ouagadougou from 9 to 10 March 2013. The General objective was to promote collaboration and coordination in the implementation of lymphatic filariasis and onchocerciasis control activities in order to maximize the resources and accelerate progress towards elimination. Specific objectives were:

(i) To work on common strategic issues for Lymphatic Filariasis and Onchocerciasis elimination;
(ii) To provide advice on common technical approaches for disease elimination;
(iii) To propose to both constituencies annual joint action plans;
(iv) To conduct joint country missions as agreed in the joint action plans.

58. The concept for the JWG establishment and operation was presented including the need for an MOU to be signed.
59. The main areas of collaboration are:

(i) Mapping of disease occurrence and interventions;
(ii) Definition of implementation units (IU);
(iii) Treatment strategy, drug supply and management;
(iv) Monitoring and Evaluation;
(v) Operational Research;
(vi) Resource allocation and management.

60. Cross-cutting issues for LF and Oncho highlighted are:

(i) Inadequate collaboration and coordination for LF and Oncho elimination;
(ii) Lack of detailed information on overlap of LF at country and IU level;
(iii) Lack of guidance on treatment strategy to accelerate elimination of LF and Oncho in co-endemic areas;
(iv) Lack of a harmonized process for decision-making on stopping MDA between LF and Oncho programmes.

61. On country specific action, the case of Nigeria showed that the country has vast areas of co-endemicity, a long running Oncho control programme and an LF programme facing challenges to scale-up. Some of the challenges include:

(i) Disease occurrence and interventions mapping: need for collaboration and coordination;
(ii) Treatment Scale Up: identify actions that will improve treatment coverage for LF;
(iii) Treatment stoppage: Discuss the stopping in Plateau and Nassarawa;
(iv) LF-Oncho M & E Integration: Capacity building for programme managers to undertake M&E;
(v) Resource mobilization for Scaling Up: To support the identification of resource gap for MDA intervention in the non CDTI LF areas.

62. The integration of LF and Oncho in Nigeria built on the Oncho structure is a proof that with enhanced collaboration and strengthen partnership, a lot can be achieved.

**TCC Comments:**

(i) TCC commended the Joint Working Group for their work, however, TCC requested for clarity on how implementation and sustained coordination would be tackled, how to convert decisions into actions and what are the means of funding;
(ii) TCC was pleased to learn that a very engaging national event was held where all the states participated in the domestication of their plans. It was a very useful exercise to analyze where the country is regarding NTD control and create the momentum for improved performance;
(iii) TCC suggested to have a platform to make consensus and concerted decisions for elimination of both diseases;
(iv) TCC recommended that LF-Oncho Joint Working Group created should become a link between RPRG and TCC, and that the decisions made by the Group be endorsed by TCC and RPRG. In addition TCC confirmed the membership of the JWG;
(v) The TCC did not find necessary for an MOU to be signed regarding the group establishment and operation. Rather, the group should establish guidelines for its operation reporting for both the TCC and RPRG about its activities and recommendations.
63. APOC Management informed the Committee of the Concept Note ‘perspective on Coordination mechanism for Regional NTD Programme in the African Region’ being finalized by AFRO and appealed for the indulgence of the Committee until it has been approved by AFRO Management. The Acting Director of APOC assured the Committee that the document would be shared in due course.

CONCEPT NOTE AND STRATEGIC PLAN OF ACTION AND BUDGET FOR THE POST 2015 PERIOD: TCC CONTRIBUTION TO THEIR FINALIZAION: Agenda item 11

64. APOC Management informed the Committee about JAF18 decision to disseminate the above mentioned document to all stakeholders for their comments and input. These inputs would then be reviewed by the CSA and subsequently presented to JAF19 for final approval.

65. TCC acknowledged the decision of JAF and agreed to provide their input for the finalization of the documents by setting up a subcommittee to collate comments from the Members and submit to APOC Management before the July CSA session.

SCORE CARD FOR MONITORING THE PROGRESS FOR NTDS CONTROL/ ELIMINATION: TCC INPUT: Agenda item 12

66. The 18th session of the Joint Action Forum (JAF) of APOC requested APOC management to develop a score card which will show the year of stopping ivermectin treatment in each of the ongoing community-directed treatment with ivermectin projects. To have the input of TCC, Dr Noma introduced the forecasting of the CSA advisory group on elimination which revealed that by the cessation of APOC operations in 2025, Onchocerciasis will be eliminated in 80% of the endemic countries in Africa. Regarding the target of 2020 for the elimination of the NTDs, according to the London declaration, onchocerciasis will be eliminated in 23 African countries. APOC Management, which has in its 2013 work plan the development of the score card, requested that the score card be issued by the next session of TCC (September 2013). Inputs for the elaboration of the score card will be based on the previous estimates of CSA advisory group on elimination, updated ivermectin treatment boundaries and epidemiological evaluations results. The proposed working agenda was accepted by TCC which indicated that the strategic document of APOC pointed out milestones for the elimination of Onchocerciasis in 2020 and 2025.

APOC AND TDR SUPPORTED RESEARCH: Agenda item 13

a) Update on moxidectin development

67. Dr. Kuesel reported on the principal data from the Phase 3 study completed in Ituri Nord, DRC (Dr. D. Bakajika), Kivu Nord, DRC (Dr. E. Kanza), the Upper Volta Region, Ghana (Dr. N. Opoku) and Lofa County, Liberia (Dr. H. Howard).

68. The late Dr. Awadzi was gratefully acknowledged as the brain behind the Phase 3 study design, study procedures and set up, training of investigators and key study staff, and as an advisor to TDR and investigators during study conduct.

69. A single oral dose of 8 mg moxidectin or ivermectin (150 µg/kg) was given to 978 and 494, respectively, males and females (≥12 years) with ≥ 10 mf/mg skin. 96.6% of moxidectin treated and
97.2% of ivermectin treated completed 12 month follow up. Only 78.0% of moxidectin and 78.5% ivermectin treated completed 18 month follow up due to a protocol amendment which abolished the 18 months visit for cost reasons after WHO became the sole study sponsor.

70. For those with a 12-month evaluation, mf/mg skin (mean ± standard deviation) pre-treatment, 1, 6, 12 and 18 months after treatment were 39.1±30.9, 0.1±0.5, 0.0±0.1, 1.3±3.0 and 4.3±8.8 in the moxidectin and 41.1±31.5, 2.3±7.0, 3.6±6.1, 9.9±12.9 and 15.3±18.3 in the ivermectin group. Prevalence of positive skin snips 1, 6, 12 and 18 months after treatment was 6.7%, 5.0%, 35.3% and 61.7% among moxidectin and 51.7%, 81.9%, 91.3% and 96.6% among ivermectin treated. Differences were statistically significant at each time point.

71. The average % reduction in skin mf levels during one year post treatment was statistically significantly higher after moxidectin (95.0±1.9) than ivermectin (84.4±15.4). Comparison with the output of the transmission model by Duerr (see TCC 34) showed that the increased efficacy of moxidectin corresponded to an increase in Threshold Biting Rate (6000 vs. 2000, note that absolute and relative TBRs would be lower in a control setting).

72. The data were compared with ONCHOSIM modeling of skin mf levels and prevalence in a clinical study-equivalent setting (single dose, 100% coverage) for ivermectin and a drug which meets the target product profile (interruption of transmission after 6 annual treatments where this cannot be achieved with ivermectin). The difference in skin mf levels between ivermectin and moxidectin treated in the study was consistent with the difference projected by this modelling.

73. The external review committee (4 TDR external advisors, 2 TCC members and 1 APOC representative) concluded that (a) moxidectin has very good potential to improve progress of onchocerciasis control towards elimination, in particular in areas which require more rapid progress than achievable with ivermectin, (b) based on veterinary experience, moxidectin could also be valuable where suboptimal response to ivermectin has been observed or may be recognized in the future, (c) severe symptomatic postural hypotension seen among ivermectin treated between days 2-4 and among moxidectin treated between days 1-3 after treatment (p<0.05 for days 1 and 2), is unlikely to be an impediment to moxidectin mass treatment.

74. The review committee recommended (a) publication of the Phase 2 and Phase 3 study data as soon as possible, (b) analysis of the Phase 3 data with ONCHOSIM to determine all possible combinations of moxidectin’s effects on macrofilaria consistent with the skin microfilaria data measured (planned, pending availability of funds), (c) development of a strategy to advocate for completion of moxidectin development, (d) putting in place everything to complete development as soon as possible with community studies conducted in parallel with the paediatric study.

75. TCC made the following observations and recommendations:

(i) TCC concurred with the conclusions and recommendations of the review committee;
(ii) TCC stressed the need for publication of the results of the studies;
(iii) TCC agreed with the CSA recommendation that TDR go ahead and identify donors, a manufacturer and a license holder;
(iv) TCC noted the JAF’s recommendation that TDR seek funding to allow completion of the development and TCC considered it as an important element for elimination of onchocerciasis.
b) Ivermectin Response Markers

76. Dr. Kuesel reported that research is continuing to determine whether the parasites identified in Ghana and Cameroon after long term CDTI which are sensitive to the microfilaricidal effect of ivermectin but respond sub-optimally to its embryostatic effect is due to selection of ‘suboptimal responder’ parasites under drug pressure. Researchers in Australia, Cameroon, Canada, France, Ghana and WHO/MDSC collaborate to determine whether a form of ivermectin resistance is emerging, and, if yes, to develop a tool for control programmes to monitor this emergence and the capacity in three African laboratories to use the tool. To date, this research has been funded by APOC with additional funds raised by some of the research groups.

77. APOC’s current resources do not allow continuing funding at the past level and thus increased funding from other sources is needed.

78. The need for funding was brought to the attention of MDP and the MEC and will be brought to the attention of the experts in April during the MDP consultative meeting on "Onchocerciasis elimination in Africa: strategies and interventions to promote rational use of ivermectin for effective mass treatment in at risk communities”.

79. External funding sources the investigators are considering include both those with and without a history of funding research critical for onchocerciasis control and/or to improve health care in Africa.

TCC Comments

80. TCC re-iterated its previous observations and recommendations and applauded investigators’ efforts to raise funds for this research.

c) Other information of interest to TCC: Investigation on the presence of Nodding syndrome in North East DRC

81. Dr. Kuesel reported the results of an initial investigation by Dr. Michel Mandro from the Bunia District Medical Inspection to determine whether Nodding Syndrome (NS) exists in North East DRC, an area which shares characteristics with the areas in Northern Uganda and South Sudan where NS is known to occur (high level of onchocerciasis, no CDTI, conflict/post conflict area, high level of poverty).

82. She informed TCC that two weeks ago, Dr. Michel Mandro visited a village in the Logo Zone de Santé where subjects for the Phase 3 study in Ituri Nord had been recruited. During clinical monitoring of the study, he had noticed a high number of people from that village with a medical history of epilepsy. The responsible nurse had informed the population of the visit. Applying the criteria for suspected, probable and confirmed nodding syndrome from the 1st international meeting on NS which took place in Uganda in 2012 (report provided to TCC) to information provided by patients or parents, suggests that may be 6 probable cases of NS in that village. The father of one patient reported that there are 10 children in the village displaying the same symptoms as his daughter. Examination of the fit of the observations with the criteria is ongoing.

83. Funds are needed for Dr. Mandro to conduct a survey in the area to confirm these results and to determine the prevalence of NS in that area.
84. Dr. Boussinesq informed TCC that researchers in the US, Uganda, Germany and Austria are working on developing a joint research protocol. Dr. Kuesel will put Dr. Mandro in touch with this group.

85. TCC encouraged Dr. Mandro to prepare a research proposal for submission to APOC which TCC will review in September.

d) Update on DEC patch test provision

86. Dr. Kuesel reported that the discussions between WHO and Lohmann Therapy System (LTS) are progressing.

87. The national coordinators and APOC technical advisors participating in the Informal Consultative Meeting on Onchocerciasis Elimination were provided with an overview of the results of the clinical and field study of the patch as well as the related TCC recommendations (large scale DEC patch evaluation to obtain further experience and data on its sensitivity and specificity). Such evaluations could be conducted in conjunction with the mapping to determine potential revision of CDTI treatment boundaries and Phase Ia surveys. The national coordinators were also informed about what countries need to do to obtain DEC patches from WHO.

88. TCC made the following observations and recommendations:

(i) Availability of the LTS DEC patch in the context of the change in APOC objective from control of onchocerciasis as a public health problem to onchocerciasis elimination is becoming ever more urgent;

(ii) If possible, evaluation of the DEC patch should be conducted in conjunction with evaluation of OV16 (see report on presentation by Dr. Domingo).

REPORT ON TCC AND APOC MANAGEMENT MISSION TO ETHIOPIA: Agenda item 14

89. Dr Noma reported on TCC and APOC management mission to Ethiopia. The mission team was made up of one TCC member and two APOC staff. The objective of the mission was to support the country in developing two new CDTI proposals for Assossa and Kamashi zones, review the overall status of CDTI in the country and discuss the modalities for extending treatment to other endemic areas in two existing CDTI projects. The team had working sessions with the WHO Representative in Ethiopia, the NTD focal person at the WHO country Office and at the Ministry of Health. They also met with the Country Director and Oncho Programme Officer of the Carter Centre. It is to be noted that the Carter Centre supports six CDTI projects, while Light for the World supports two projects in Ethiopia.

90. From the discussions, the team gathered three important pieces of information: a) NTD is one of the three priority areas for the Ministry of Health, b) the NOTF of Ethiopia was not functioning very well and c) the country is already working towards developing an onchocerciasis elimination plan.

91. At the field level, the team worked with Zonal health managers to develop the specific CDTI proposals. Of relevance to CDTI, are two newly introduced policies to improve access to services. The villagization policy which brings communities together to form a larger communities and the health development army concept which clusters households into smaller networks, will ensure better treatment coverage.
20

TCC Comments

92. The Committee thanked Dr Noma for the presentation. It was noted that the Carter Center is willing to support the two projects but it is only a question of procedure. Similarly, the Centre for Neglected Tropical Diseases in Liverpool has expressed interest in supporting oncho-LF co-endemic areas. It was also noted that Light for the World’s support to two CDTI projects in Ethiopia would end in 2013. TCC strongly felt that it is necessary to help the country at this critical moment to determine the implementation strategy as some partners are forcing to introduce twice-yearly treatment.

REPORT ON THE MECTIZAN EXPERT COMMITTEE MEETING: Agenda item 15

93. Dr Ogoussan reported to the TCC on the main outcomes of the 48th MEC/AC meeting which was held in London, UK, from 9-11 October, 2012. The Meeting also coincided with the celebration of the 25th anniversary of the programme. He informed the TCC of the three country requests from Ituri Sud, DRC (Loa loa co-endemic); Ethiopia: MEC requested a new application for Mectizan and action plan with budget for twice yearly treatment to cover new identified Onchocerciasis areas; and Togo. In reporting on the SAEs in 2012, it was noted that six cases of SAEs were reported (DRC, Cameroon) and MEC recommended that LF program managers working in Loa-loa endemic areas should be informed of the possibility of SAEs in areas already under treatment for onchocerciasis, as previously non-compliant people may now present themselves for LF treatment. With regard to the training manual for family of comatose patients following an SAE, MEC/AC members recommended that the manual should be field tested during the next treatment rounds in DRC and Cameroon. Multi-stage testing should be conducted to ensure that the manual is understood by health care workers and families at all levels of literacy. The document must be translated into local languages.

94. With regards to the drug supply chain, it was highlighted that the current production line of Mectizan is reaching its limit. In order to plan further for the future, there is an urgent need for accurate Mectizan forecast and thus to: Define treatment strategies in onchocerciasis hypo-endemic areas, and populations that would be added; Establish policies for twice-yearly treatment with Mectizan and estimate the populations requiring increased frequency of treatment; Complete mapping of LF in all co-endemic areas as quickly as possible; and clearly map out overlapping areas for LF and onchocerciasis.

95. MEC thanked APOC for their report and appreciated their efforts on cross-border issues and the development of the CDI training manual. It was worth noting that OPEA’s Program Coordinating Committee (PCC) will consider stopping treatment in the NE focus of Venezuela at its upcoming meeting. If so, the Americas will achieve a 65% reduction in the population receiving Mectizan. However, political will and funding is still required for post-treatment surveillance.

96. On elimination of onchocerciasis, MEC underscored the importance of CSA and TCC to determine where and when ivermectin treatment can be stopped, the criteria for Certification of Elimination and update on research and diagnostic tools. With regards to Oncho/LF (loa loa), update was provided on the test and treat, CRFiLMT lab + Research Projects and the DOLF studies. On LF issues, the Committee was updated on activities in Guinea Conakry and Nigeria, and added that a joint mission is planned to Nigeria with AFRO and APOC to discuss the challenges.

TCC Comments

97. TCC thanked MDP for their continuous support and agreed to discuss in details the alternative treatment approaches in the next TCC session. TCC was informed that MDP would hold a
teleconference with partners to discuss support to Ethiopia. TCC suggested that the overall coordination of activities in Ethiopia should be led by APOC.

**REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA: Agenda item 16**

98. A brief introduction on the operational research was made by Mr Sow indicating that eight operational research proposals are submitted to TCC 36, five from Cameroon and three from DRC.

**Reviews**

**CAMEROON**

*a) Epidemiology of ocular attack of onchocerciasis in the forest areas of Cameroon*

99. The subject is considered of interest which will help increase the value of ivermectin. The committee however questioned if there are reference data in that Center region and realized that there is none. The committee therefore recommended that an area where there is available basic “ophthalmological” data should be selected to better appreciate the impact of ivermectin. TCC also noted the lack of precision on villages selected. Also, the opportunity to do skin snipping when the objective of the research is to appreciate ocular consequences is questioned. The chronogram of activities is not specified and technical forms attached do not reflect the condition of 10 years treatment. The budget is very high. Some budget items need to be reduced if not cancelled.

**Conclusion**

100. The title of the proposal should be reformulated with emphasis on the impact of ivermectin on ocular injuries. It should not be a general epidemiological study. The researchers should specify that there exist a reference data (onchocerciasis, ocular injuries) in the study area. The parasitological part (skin snip) is not essential and should be removed from the methodology.

101. TCC requested the investigators to review the proposal taking into consideration the above observations and send it back to APOC Management for review during the next TCC.

*b) Evaluation of onchocerciasis community directed treatment strategy in Cameroon*

102. The sampling seems to respond to the needs of the proposed study. A decision will have to be taken on site selection, either on random or in relation to specific problems identified in the local implementation of CDTI or detected through the analysis of the figures of coverage or results of epidemiological evaluation.

103. The validity and adequacy of sampling methods should preferably be reviewed by a specialist, either a demographer or a medical anthropologist. It is also to be noted that the three areas of weakness identified and proposed for study, which are all related to the behaviour of actors may not be the only possible explanations to delay CDTI progress.

104. The proposal should also be updated by using 2012 CDTI data. It should refer more precisely to the practical consequences on operations and their results on the various causes of CDTI disturbance proposed for study.
As such the proposal seems to be relevant and the scientific approach is exhaustive as long as dealing with the causes of CDTI dysfunction attributable to operators behavior.

The CV of the authors and their large scope of expertise (multidisciplinarity) may be considered as warrants of the implementation of the research project.

The budget is apparently relevant although details may be requested for “achats de prestations” and with regards to compatibility with APOC rules, the two first budget lines should be assessed by Finance services.

TCC also questioned if this proposal is not a duplication, due to the fact that there are a number of social science studies carried out by APOC in different countries.

**Conclusion – Recommendation.**

TCC requested this proposal together with the two other ones on evaluation - *be repackaged in one proposal and resubmitted to TCC with research questions well defined and broader focus.

c) **Evaluation of the approach “Community Distributor” in onchocerciasis control in Cameroon**

TCC recommends that the current proposal be put together with the two other proposals on evaluation with clearly defined topic, focus, research questions, identified gaps, comparative perspectives and new outcomes to be submitted to the next TCC meeting.

d) **Evaluation of health competencies of the populations in Cameroon regarding onchocerciasis**

Following the discussion of the presentation, the methodology seems to be simply that of Knowledge-Attitudes and Practice (KAP). It would have been important to put this survey in the context of compliance with ivermectin treatment. However, this protocol can be improved by taking into consideration the following recommendations:

(i) It is necessary to formulate a clear research question and a method of selection of sites in detail;
(ii) A detailed method for sites selection;
(iii) It would be good to consult data and review the NOCP data mainly regarding treatment compliance. This way, compare the results from sites having good treatment compliance with sites having low treatment compliance;
(iv) The duration of the project should be clearly indicated;
(v) The budget should be reviewed;
(vi) The bibliography should be completed with KAP surveys conducted in the past (Consult the PNLO records).

In conclusion, TCC recommends that the three protocols on Evaluation be combined into a single protocol with research questions put together.

e) **Acceptability of onchocerciasis treatment by the population in the Koza, Mokolo and Roua health districts in the Far North of Cameroon.**

The aim of the study is to understand the socio-cultural logics that justify the absences and refusals of onchocerciasis treatment in the three Far North health districts (Koza, Mokolo, Roua) in
order to suggest some solutions likely to limit the low compliance exhibited by the local population. TCC felt that the proposal was not very relevant and not scientifically sound. The methodology is not appropriate and the budget needs justification.

114. **TCC did not accept the proposal for funding.**

**DEMOCRATIC REPUBLIC OF THE CONGO (DRC)**

*a) Study on the causes of poor women involvement as Community Directed Distributors in health areas of Western Kasai in Democratic Republic of Congo*

115. The topic of this operational research protocol is very interesting and should be explored. The protocol has not clearly formulated a research question. The committee therefore recommends the following:

(i) Clearly formulate the research question;
(ii) Rewrite the introduction and make the research topic relevant;
(iii) Include all CDTI stakeholders in the area;
(iv) Select villages where women’s involvement is good and compare them with a site where women’s involvement is low;
(v) Include men in the survey to gather their opinions;
(vi) Qualitative variables will be better; therefore focus groups should be included in the methodology.

116. In conclusion, TCC recommends that the research team review the protocol, taking into account the above observations and resubmit it to the next TCC. It is necessary for the team to be assisted by TCC members for the drafting of this protocol.

117. **To APOC Management:** TCC recommends that APOC Management explore appropriate ways and means to set up a team in DRC for the drafting of operational research proposals.

*b) Study on the therapeutic coverage of CDTI in the mining health areas of Kamonia, Mutena and Kamuesha of the Kasai CDTI project*

118. The research subject is not too relevant and the justification is insufficient. The literature review is poor even though the objective is clearly formulated. The research hypothesis is not relevant to objectives.

119. TCC does not accept the proposal. TCC requested APOC management to find a way to build capacity in drafting operational research proposals in DRC.

*c) Study of the reliability of therapeutic coverage in the elimination context of Onchocerciasis in Democratic Republic of Congo*

120. The objective of the study is to evaluate the actual treatment coverage at the level of families, identify factors that influence them and propose solutions regarding their status.
TCC comments:
- Make the review of literature to match with the topic;
- Review the budget;
- Rewrite the first part of the proposal;
- Jargons should be explained;
- Review the approach and research questions;
- Request for support from resourceful persons in DRC for improving the proposal.

Recommendation to APOC Management:

121. TCC recommends that APOC Management provides support in capacity building training in DRC to improve the quality of country research proposals.

122. TCC did not accept the proposal and requested that it be resubmitted to TCC in September 2013 subject to the modifications requested above.

DESK REVIEW ON COMMUNITY SELF MONITORING (CSM): Agenda item 17

123. Prof Ahmedou provided an update of a desk review on the Community Self Monitoring (CSM) conducted at the level of APOC/HQ. The objectives of the desk review were to:

- identify communities implementing CSM,
- identify challenges, implementation constraints,
- provide suggestions on how CSM could be part of project implementation.

124. The methodology consisted in an analytical review of APOC database from 2009-2011, annual progress reports forwarded to APOC/HQ for TCC review from 2006-2010, reports of consultation missions carried out in Congo and Burundi in 2010, reports from think-tanks on CSM and from SHM held in Ouagadougou in 2011.

125. Major findings were:

(i) Based on APOC/HQ database regarding 15 APOC countries: 23.22% of communities conducted CSM in 2009; 22.80% in 2010; 18.65% in 2011;
(ii) Out of 525 annual technical reports reviewed, 131 (24.9%) reported data from conducted CSM;
(iii) Lack of information describing how CSM and SHM results have been used by the communities to improve the implementation of the project or are likely to do so in the future;
(iv) Adaptation of CSM to their own context by some countries, that deviates from the genuine objective and alters expected outcomes;
(v) No CSM planning at national level;
(vi) Lack of the culture of meeting;
(vii) Inappropriate fundings from national counterparts;
(viii) Requirement of incentives and unequal treatment of CDDs and monitors by other programmes;
(ix) Misunderstanding the role and concept of CSM leading to misinterpretation, application and erroneous results (e.g. Ethiopia);
Communities perceiving CSM as the responsibility of health services;

CSM progress reports are not available (communities, health workers);

Inadequate training of health workers of all levels on CSM.

126. Prof Ahmedou concluded that generally speaking, the implementation of CSM is inadequate and suggested that more in-depth multicentre study be focused by borrowing a leaf from the results of the desk review for Chad.

127. Following the desk review of the Community Self Monitoring (CSM) presented by Prof Ahmedou, Dr Sintondji reported on the fact finding visits which was carried out in Chad. The objective of the visit was to collect information documents on CSM from the field (reports, memos and any publication) on the CDTI Project at the national, regional, health districts and community levels in order to identify communities which carry CSM, the challenges they face and constraints in the implementation of the exercise and make suggestions on how CSM can be integrated into the implementation of the project.

128. The method of work was retrospective study, data collection techniques such as interviews and documents as well as data collection tools. It is worth noting that Onchocerciasis control in Chad is set up as a single project. In addition to the coordination office, the desk review team visited three health regions. Two health districts, two frontline health centers and two communities were visited in each of the health regions. Annual technical reports of 2010, 2011 and 2012 were scrutinized as well as DFCs of 2010, 2011, 2012 as well as various other progress reports.

129. The financing sources were APOC through its DFC and financing of specific activities, the national budget for which there was no information, and an NGDO supports. The analysis of CDTI DFCs of the last three years shows that a total amount of 166,078,024 XOF was provided to Chad. From that amount, 13,974,776 XOF was specifically for the implementation of CSM. According to the National Coordinator, APOC funds were sent to the regions for CDTI activities but an attempt to access justifications was in vain. No actor at the regional, district, health center levels has confirmed receipt of funds for CSM. Regarding training, no single CDTI implementer benefited from specific training on CSM. The training agenda of health facility staff on CDTI includes 45 minutes presentation on CSM. Monitoring and supervision activities did not take into account CSM and national reviews of activities are irregular and do not take CSM into account. Actors engaged in health activities have wrong perception of their roles in CSM. At the communities’ level, none of the six communities visited received CSM promotion visit even though their level of commitment is high and they are available to conduct CSM.

130. In conclusion, it is clear that, a part from the information in the annual technical reports on CSM, the field visit at the regional, district, health center and communities levels found no document as evidence of implementation of CSM by the CDTI project in Chad.

TCC comments

131. TCC thanked APOC management for the exercise and hoped it was carried out earlier in order to correct anomalies found in the field. The exercise also called for reflection on the whole concept and what need to be done in the context of elimination. The committee advised that CSM should be incorporated in new projects at the start, to become a culture within the projects. The committee also agreed that there is a need to relook the CSM activity as a whole and review the concept.
SUSTAINABILITY EVALUATION IN THE CONTEXT OF MOVING FROM CONTROL TO ELIMINATION: Agenda item 18

132. Dr Fobi presented on the sustainability evaluation of APOC CDTI Projects and said that the objective is to seek TCC’s guidance on way forward with sustainability evaluations of projects in the context of elimination. She provided a brief background as well as a framework of sustainability of APOC CDTI projects. From 2003 to date, 105 sustainability evaluations were carried out in 12 countries. Out of 99 evaluations 77 were sustainable and 28 not sustainable.

133. It was clear that sustainability evaluation is a useful exercise because it is a platform for objectively assessing a project’s performance and devising plans to improve its performance after an independent evaluation of its weaknesses and challenges. Also, evaluation reports can lead to significant changes, including the replacement of a Project Coordinator.

134. However, the issue is how the paradigm shift from control to elimination will affect sustainability evaluations, considering the fact that by 2025 some projects would have exited except DRC, CAR and South Sudan. In addition, it is still necessary to identify poorly performing projects and put in place remedial measures to improve performance. Should sustainability evaluation continue, what would be the form? What indicators should be used? What tools to be used in the context of co-implementation with PCT-NTD targeted for elimination by 2020? Will the APOC Management continue developing sustainability plans?

TCC Comments

135. The committee thanked APOC management for the presentation and noted that sustainability evaluation is necessary to measure the performance of projects. However, due to paradigm shift from control to elimination, tools for sustainability evaluation should be revised to make them adaptable and the use of the strategy in a more focused way as there is need for supervision and monitoring methods to continue till the programme ends.

PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE: Agenda item 19

136. Dr Sobela presented a draft protocol for the independent monitoring of the estimate of therapeutic coverage developed by APOC and finalized with the inputs from specialists in epidemiology and statistics during a meeting held in Ouagadougou, Burkina Faso from 18 – 20 February 2013. The purpose of the independent monitoring is to contribute to improving CDTI so as to achieve the elimination of onchocerciasis by 2025 in Africa. The main objective is to estimate the therapeutic coverage of eligible populations through a representative survey of the target communities in CDTI projects.

137. The secondary of objectives are to:

(i) Check the congruency of community indicators for monitoring therapeutic coverage with limited estimate obtained from transversal survey of households covered by CDTI;
(ii) Categorize target communities in CDTI projects according to their levels of therapeutic coverage in order to make visible those that need a particular support;
(iii) Identify factors that justify the performance and sustainability of CDTI in target communities within CDTI projects;
(iv) Determine in target communities in CDTI projects the obstacles to accessing CDTI and problems that limit performance.
138. The presentation highlighted chronologically the different sections of the protocol, including:
the investigation Plan (methodology); Ethical and regulatory considerations and communicating
findings of the survey.

139. The way forward is to finalize the protocol; prepare data collection tools; train investigators;
pre-test in two countries; independent survey for the estimate of therapeutic coverage; data processing
and analysis, draft the report and disseminate findings.

TCC Comments

140. TCC thanked APOC team for the detailed presentation of the protocol and remarked that the
estimate of therapeutic coverage is essential but the protocol as presented is too bulky and difficult to
understand. The Committee recommended that the protocol be fine-tuned by making it simpler and
practical to fit its purpose.

REMARKS BY TECHNICAL ADVISORS TO APOC MANAGEMENT: Agenda item 20

141. The Technical Advisers to APOC Management participated in the TCC session and shared their
advice on technical matters and other issues.

MANAGEMENT OF THE APOC TRUST FUND

REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS:
Agenda Item 21

142. The following update was presented to the TCC by Mr Koffi Agblewonu:

(i) Out of the 2846 financial returns expected, 2405 were received and 441 delayed as at
12/03/2013;
(ii) About 85% of projects are in order with financial returns submission;
(iii) A planned field activities and training of the projects’ staff has been scheduled for 8
countries (Ghana, Nigeria, Ethiopia, DRC, Uganda, Chad, Sudan and CAR);
(iv) As at 12th March, about 73% (88 out of 120) of projects are in order with financial
returns submission compared to the rate of 87% in March 2012;
(v) In March 2013, about 27% (32 out of 120) of projects are in red (not yet eligible to
receive the funds for year 2013) compared to 13% in March 2012 (16 out of 120);
(vi) 36% (222 out of 622) of years 2011-2012 FACEs are yet to be submitted, compared
to 65% (216 out of 333) in March 2012, showing improvement/compliance to APOC
Administrative, Financial regulations and procedures by the country projects. However,
efforts still need to be made.

REPORT ON THE REVIEW BY APOC MANAGEMENT OF THE FINANCIAL CONTENT
OF 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH, 12TH AND 13TH, YEAR PROGRESS
REPORTS AND SUBSEQUENT YEAR BUDGETS: Agenda Item 22

143. The following update was presented to the TCC by Mr Koffi Agblewonu:

(i) The total budget approved is $US 23,233,000 - JAF16: $US 16,666,400 and JAF18:
$US 6,566,600;
(ii) Amount forecasted for 2013 for the 116+4 projects was US$ 5,308,880 and a total of US$ 2,200,983 for field activities was released/earmarked for 76 out of 120 projects;

(iii) For the 2013 projects’ budget implementation, as of March 2013, a total amount of US$2,200,938 has been released to projects, including 1,968,248 released for 72/116 projects and 232 735 for CDTI and evaluation;

(iv) The Rate of implementation is 51% (as of 12 March 2013);

(v) The gap of funding for 2013 activities and contingency plan being developed is about US$ 18 Million;

(vi) Challenge to obtain DFC approval from GSC for countries which have not signed the Programme MOU;

(vii) Re-defining of projects occurred in two countries (South Sudan and Ethiopia) that required adjustment of financial processing.

144. TCC appreciated the work being undertaken by APOC Management, however the committee raised concern about the financing and suggested a few possible solutions to APOC Management or CSA:

(i) To undertake advocacy visit to traditional donors as well as expand donor umbrella by encouraging countries to become donors and approaching new donors (Arab states);

(ii) To carry out high level advocacy visit to countries to mobilize resources internally needed for sustainability and activity implementation;

(iii) To encourage governments to pay their contributions (financial tool being finalized by APOC for monitoring Government financial contributions);

(iv) To encourage countries to raise resources by holding forums under the auspices of the MOH or MOF, engaging philanthropists, local firms and companies and good will ambassadors;

(v) To repackage onchocerciasis elimination advocacy message as a solution to social and economic growth for the nation.

REVIEW OF NEW PROJECT PROPOSALS AND 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH, 12TH AND 13TH YEAR ANNUAL TECHNICAL REPORTS AND RECOMMENDATIONS ON THE 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 12TH, 13TH AND 14TH YEAR IMPLEMENTATION OF PROJECTS: Agenda Item 23

145. Mr Agblewonu presented two new proposals for Ethiopia namely Assosa and Kamashi CDTI project proposals. It is worth noting that APOC contribution required for funding is 42% of the budget (representing US$ 403,055) for Assosa CDTI project for 5 years starting from 2013 and 62% (representing US$ 496,932) for Kamashi CDTI project for 5 years starting from 2013. The total contribution of APOC alone is US$ 889 987 over the five-years period for the two projects. For year 2013, $US 182,001 is requested for the Assosa CDTI project and $US 149,387 for the Kamashi CDTI project.

REVIEWS

ETHIOPIA

Assosa CDTI Project proposal

146. REMO studies done in 2011 and 2012 showed that onchocerciasis is endemic in Assosa zone, Beninshangul/Gumuz region, in Ethiopia. The entire population -371,138 living in the seven woredas - is at risk of infection. Five of the seven woredas are also endemic for LF. The Zonal health managers
with support from the National Onchocerciasis Task Force (NOTF) have expressed interest to initiate community Directed Treatment with ivermectin (CDTI) so as to reduce the disease burden from onchocerciasis, and ultimately eliminate the disease.

The proposal submitted to APOC using APOC approved proposal format, provides adequate contextual information, to allow for in-depth analysis regarding factors that would favour CDTI and bottlenecks that may hinder successful implementation. One favourable factor is the expressed commitment by the Assossa Zonal MOH to cost share with APOC, to enable the zone implement twice yearly treatment with ivermectin. The Region and Assossa zone have pledged to meet 52% of the total 5 year budget.

**TCC Comments and Recommendations:**

(i) TCC recommends continued dialogue between the Country, APOC and the Carter Centre to explore possibilities for additional funding for the Assosa project;

(ii) There is an urgent need for Ethiopia to take steps to revive the National Onchocerciasis Task force (NOTF) to provide the required leadership at central level;

(iii) Present a realistic period in which to accomplish the various activities outlined. For instance, 3 weeks are allocated for KAP but it is not clear whether this includes the data processing, analysis and report production;

(iv) Include perceptions towards the programme and the implementation process and towards voluntarism in the KAP;

(v) Include the cost for the KAP in the budget for 2013;

(vi) Factor in periodic evaluation activities and using existing baseline data as the benchmark.

148. **TCC accepted the CDTI project proposal for funding.**

**Kamashi CDTI Project proposal**

149. REMO studies done in 2011 and 2012 confirmed that Onchocerciasis is hyperendemic in Kamashi Zone Beninshangul/Gumu region, in Ethiopia, and established that the entire population (121-248) is at risk of infection. To further estimate the level of infection, skin biopsy was also carried out in 3 villages and the biopsy revealed a mean onchocerciasis prevalence of 32.7%.

150. Zonal Health Managers have expressed interest to APOC for a joint partnership to implement community Directed Treatment with Ivermectin (CDTI), so as to reduce the disease burden, and ultimately eliminate the disease by 2020. The proposal submitted to APOC uses APOC approved proposal format. The proposal provides adequate contextual information, to allow for in-depth analysis regarding factors that would favour CDTI and bottlenecks that may hinder successful implementation. Of significance is the pledge made by the Zonal MOH to meet 38% of the five year budget, so as to facilitate Mass Drug Administration (MDA) twice a year.

**TCC comments and recommendations:**

(i) TCC recommends continued dialogue between the Country, APOC and the Carter Centre to explore possibilities for additional funding for the Kamashi project;
There is an urgent need for Ethiopia to take steps to revive the National Onchocerciasis Task force (NOTF) to provide the required leadership at central level;

Present a realistic period in which to accomplish the various activities outlined. For instance, 3 weeks are allocated for KAP but it is not clear whether this includes the data processing, analysis and report production;

Include perceptions towards the programme and the implementation process and towards voluntarism in the KAP;

Include the cost for the KAP in the budget for 2013;

Include community self-monitoring (CSM) in the proposal and plan to undertake this activity from the onset of implementation;

Pay extra attention to developing adequate capacity so as to sustain CDTI activities, given Kamashi is a new zone;

Factor in periodic evaluation activities and using existing baseline data as the benchmark.

151. **TCC accepted the Kamashi CDTI project proposal for funding.**

**CAMEROON**

*NOTF/HQ Cameroon 14th year annual technical report*

152. The report is well written and presented with all pertinent information which enables to appreciate efforts of the NOTF. The executive summary gives essential results of all the projects as well as main challenges. The rest of the document also gives details related to different projects. However, the authors should make more analysis in order to explain the up and down evolution of projects’ therapeutic coverage for 14 years. The CDD/population treated ratio has not improved. It went from 1/120 in 2011 to 1/159 in 2012. The rate of women CDDs also went from 20% to 23%, compared to 2011 figures.

153. TCC particularly appreciated efforts of sensitization at all levels, notably towards other ministerial departments as well as the existence of standardized supervision form. TCC also appreciated efforts toward conducting operational researches.

**TCC’s Recommendations**

**To the NOTF:**

(i) Continue efforts in putting in place CSM at all projects levels;

(ii) Make effort to improve the ratio of CDD/treated population as well as the involvement of women.

**To APOC Management:**

(i) Continue to help the NOTF in the implementation of activities planned in the 2012 action plans.

154. **TCC accepted the report.**
GHANA

Ghana CDTI Project 4th year annual technical report

155. The report is well written, and cohesive, which allows for reflection and analysis. The project does two rounds of treatment in 40 of the 73 endemic districts, and performance has been steadily increasing as evidenced by improved coverage rates. Therapeutic coverage rate increased from 70% in 2010 to 78.2% in 2012. The project is also strategic with its advocacy drives. In 2012, the step taken to organize seminars targeting the media and members of parliament, followed by field visits, is commendable.

156. However, there are shortcomings with the report which can no longer be ignored. The project has consistently failed to provide data in every single report since 2010 on: community involvement (table 4), Mectizan inventory (table 10), community self-monitoring –CSM (table 11) and on financial contributions (table 13). Data on all these aspects are important to APOC and TCC to assess the true performance of the project. If there are issues with getting reliable information on these indicators, then the issues should be discussed fully in the report. Non-compliance rate is also high – 10.3%.

TCC Recommendations:
(i) Complete tables 4- community involvement, table 10- Mectizan inventory, table 11 -community self-monitoring –CSM and table 13 and on financial contributions;
(ii) Take steps to reduce the number of refusals and absentees.

157. Because of the consistently missing information outlined above, TCC rejected the report and requested that it be re-submitted to the next TCC, taking into account the above observations.

GUINEA BISSAU

Guinea Bissau CDTI Project 2nd year annual technical report (resubmission)

158. This report is a resubmission which takes into consideration TCC35 recommendations, notably the format of the report and the executive summary. The project covers two health areas in the region of Bafata/Bassin of Rio Géba and 15 health areas in the region of Gabu/Bassin of Rio Corubal. The area is co-endemic with LF. Treatment started in 1990 but interrupted on several occasions. Activities started again in 2008 and this is the first report.

159. A great effort was made to comply with the format and the filling up of the sections. The executive summary enables an appropriate understanding of the project that is located in a post-conflict and Oncho/LF co-endemicity area.

160. TCC made the following recommendations to the project:
(i) Continue to make effort by filling up all the sections (namely tables 4, 5 and the financial components). Get the report endorsed by an NGDO Partner;
(ii) Continue the efforts in CDDs and Health workers training to improve the indicators; Existing;
(iii) Continue to carry out entomological surveillance activities.
To APOC:

(i) APOC Management should maintain its assistance, notably through the presence of its Technical Adviser in the country.

161. **TCC accepted the report.**

*Guinea Bissau CDTI Project 3*rd* year annual technical report (resubmission)*

162. This is a resubmitted report with good quality and encouraging project results. It is necessary to continue to mobilize administrative officials and religious leaders so as to increase geographic and therapeutic coverage. Enumerated shortcomings and challenges should be taken into consideration.

163. TCC commends the national team and APOC Technical Adviser for the joint efforts that contributed to improving the quality of the report and field results.

**TCC Recommendations to the country:**

(i) TCC expressed its concern regarding the lack of government financial contribution; this constitutes a serious threat to the project sustainability;

(ii) TCC urges the Project manager to send the financial reports to APOC Management, after being made aware of the difficulties met by APOC in getting the assessments and supporting documents for expenses carried out.

**TCC Recommendation to APOC Management:**

(i) TCC recommends that APOC Management maintains its assistance to this project;

(ii) APOC Management is also urged to provide as soon as possible the TCC with the results of measurements of transmission which were obtained from entomological material collected in the country for pool screening.

164. **TCC accepted the report.**

**BURUNDI**

*Cibitoke-Bubanza CDTI Project 8*th* year annual technical report*

165. This is an excellent report, well presented, very comprehensive, clear and informative with analysis accompanying many result tables. The only thing missing in the report is the provision of a geographic map indicating hydrographic network giving hydrologic information that will serve to introduce entomological studies. The implementation activities are conducted with competence, effectiveness and good judgment. CDTI results are good and the first epidemiological evaluation has confirmed it. The project seems to be on good track towards elimination. Soil transmitted helminthiasis and Schistosomiasis control seems to be well integrated despite the adverse self-appraisal by the author himself. There should be an improvement on the ivermectin distribution period which should coincide with the season of maximum availability of populations.

166. Other risks identified by the Coordinator which threaten the achievements of the ultimate project objective are budget restrictions, weakness of external and country partnerships, as well as CDDs attrition due incentives of more rewarding programmes. Palliative measures proposed
in the report should be implemented in order to give all the changes of success to this exemplary project.

167. **TCC accepted the report.**

*Bururi CDTI 7th year annual technical report*

168. This project, launched in 2006, covers 3 health districts in the West and South-West of the Bururi province with a population of 373,595 inhabitants, distributed into 76 “collines” (communities) and 6 communes. Main partners are MOH, MDP, APOC, CBM and religious denominations. In 2012, geographic coverage was 100% while the therapeutic coverage of 80.5%, constantly increasing. 2282 community directed distributors (i.e. 1280 males and 998 females) were mobilized to treat 301,039 persons, i.e. 96% of ATO (313,820 persons) and 1CDD/ 131 persons. Co-implementation activities are effective: Mectizan and Albendazole in all the collines during CDTI. Major weaknesses are government financial contribution (26.4% of contribution in 2012), incentives for CDDs, lack of local NGDO. The report is well written.

**Recommendation to improve the report:**

(i) Give more information on the quality and quantity of human resources;
(ii) Provide quantitative element on advocacy;
(iii) Specify the mechanisms of integration in health system.

169. **TCC accepted the report.**

*Rutana CTDI Project 7th year annual technical report*

170. This is a 7th year project at the border with Tanzania with 100% geographic coverage and 80.7% of therapeutic coverage for a population at risk of 276,378 persons living at the border with Tanzania. The sustainability evaluation of the project was done since 2009 with an established plan which is followed up since 2010. The report is well written and the tables are well filled up this time. The Project is to be commended for the therapeutic coverage, male/female ratio of almost 1/1, and a ratio of 1 DC for 150.

**Recommendation to improve the project:**

(i) Carry out advocacy to obtain more ESA tools and a vehicle as well as a motocycle with APOC or other partners like CBM;
(ii) Find means with APOC or others partners to conduct training/re-training of health personnel.

171. **TCC accepted the report.**

**CENTRAL AFRICAN REPUBLIC (CAR)**

*CDTI Project 11th year annual technical report (resubmission)*

172. This is the resubmission of CAR CDTI 11th year project. All the recommendations made by the TCC to improve the form of the report were taken into consideration.
Recommendation to improve the performance of the project:

(i) Improve on the therapeutic and geographic coverage;
(ii) Improve the implication females in CDTI;
(iii) Improve the CD/population ratio;
(iv) Accelerate the elaboration of the communication plan;
(v) Intensify advocacy, IEC, sensitization and mobilization;
(vi) Explain why the total population is 1,603,599 in 2009 and 1,543,972 in 2010.

173. All the above recommendations should be taken into consideration in the future reports.

174. **TCC accepted the report.**

CHAD

*Chad CDTI Project 13th year annual technical report*

175. This is a national programme without NGDO support, in its 12th year of ivermectin distribution with a population at risk of de 2,086,183, living in meso and hyper endemic areas, spread over 20 of the 56 districts in the country. The programme area comprises 3,250 villages/communities.

176. It is worth underlining the following elements which can be presented as determinants of success:

(i) The concept of signing performance contracts with community volunteers who are CDDs favors the expected results obtained;
(ii) A very strong government contribution which was 65% in 2011 and 80% of the total budget of the programme;
(iii) CDTI activities are integrated into the three-year operational plan elaborated with active contribution of the NOTF in each district.

177. In 2012, 14,912 CDDs participated in the programme, giving a ratio of 1CDD for 140 persons. The geographic coverage is 100% and the therapeutic coverage is 82,4% with 118 villages (4% of villages in the project area) that had therapeutic coverage of less than 80%.

Recommendation to improve the report:

(i) The report is well written and gives details to review and evaluate CDTI activities. The writer mentioned that CDTI is used for distribution of Vit A, PEV, school screening test, draining, malaria, AIDS, tuberculosis but these were not mentioned in tables 14 and 15. It is important to fill those tables.
(ii) The results of epidemiological evaluations are mentioned this time as recommended by TCC but the consequences on the performance of the project is not mentioned.

Recommendation to improve the project:

(i) Continue efforts to obtain more than 80% coverage and bring villages which had less than 80% to that standard;
(ii) Encourage all communities to undertake CSM.
178. Since the country has a huge epidemiological data, TCC encouraged the project to write a manuscript for publication in order to document and share their experience on onchocerciasis elimination strategy in Chad. This will enable to put together a file to request from WHO the certification of elimination of Onchocerciasis in Chad.

179. **TCC accepted the report.**

**DEMOCRATIC REPUBLIC OF CONGO**

*Butembo Beni CDTI Project 7th year annual technical report.*

180. The Butembo-Beni CDTI Project is in its 7th year of implementation. It covers 9 health zones in the northern part of the North Kivu Province with 1,248,771 inhabitants distributed into 1623 villages and is characterized by quasi permanent insecurity.

181. The quality of the report is fairly good and it contains key information for the evaluation of the performance of the project. The table indicating the structure of the expenses is missing. The project performance is rather average with a therapeutic coverage (TC) of 73.7% and a geographic coverage of 95.5%; 75% of villages have a TC of less than 80%; CDD attrition is high and the CDD/population ratio is 1/357.

182. TCC recommends the coordination to make efforts in order to:
   (i) Improve CDD/population ratio;
   (ii) Improve government financial contribution and disbursement of funds;
   (iii) Reinforce the process of CSM and sustainability;
   (iv) Initiate co-implementation activities and CDTI integration activities in PHC;
   (v) Initiate operational research Project.

183. **TCC accepted the report.**

*Katanga Nord CDTI Project 7th year annual technical report*

184. The report is a complete one but mostly reduced to the essential. It will be good to know how refusal and absenteeism have been reduced drastically within a year, the causes and impact of demotivation of personnel. A search for external partner would have solved partially the consequences of insufficient government involvement in project activities and accelerate the progress toward elimination. The involvement of the project in NTD control should be presented in the next report, especially that treatment results should be split into three health subdivisions or geographic areas. The coordinator described the project’s performance as linear and positive improvement for years despite long distances to cover and the poor motivation of personnel.

185. **TCC accepted the report.**

*Kasongo CDTI Project 7th year annual technical report*

186. This is a project in its 7th year of APOC financing and sixth year distribution of Mectizan in a loa loa co-endemic area. The project should be commended for reaching and maintaining 100%
geographic and 80.05% therapeutic coverage. The NGDO, UFAR should also be congratulated for this consecutive positive outcome.

187. It is to be noted that the project covers 10 health zones with 1,325,913 persons at risk and involves 4,887 Community Directed Distributors in 2,082 villages. The ratio of men/women is 3 men CDDs for one woman CDD. Unfortunately, the ratio of CDD per person treated in at risk areas has worsened 1CDD/271persons in the previous year (2011). TCC therefore recommends the following:

**Recommendation to improve the report:**
(i) The report is well written this time, but TCC recommends redoing the filling of table 5.

**Recommendation to improve the project:**
(i) Continue to maintain 100% geographic coverage and a minimum of 80% therapeutic coverage;
(ii) Improve the indicators, especially the number of CDD/person treated;
(iii) Continue and intensify advocacy in order that CDTI activities can be integrated into minimum package of activities;
(iv) Repair the vehicle and motorcycles;
(v) The management of Mectizan is not well done and this led to expiring of a large quantity of 108,518. The project should give explanation of this situation and imperatively improve management of the drug;
(vi) Improve the ratio of 1CDD/100 persons and establish a plan for improving attrition rate at CDDs level. The attrition rate was 30% in 2011 and 40% in 2012;
(vii) Plan of doing CSM in all the villages.

188. **TCC accepted the report.**

**Lualaba CDTI Project 7th year annual technical report**

189. The Lualaba CDTI project was launched in 2004 and covers two health zones in the Katanga province: Kalamba and Kapanga. The population of the project area is 231,515 inhabitants distributed into 380 villages.

190. The report is fairly well written, concise and easy to understand but key information is missing in the executive summary relating to CDD/population and male/female CDD ratios, and to the UTGs and ATOs.

191. Similarly, data relating to the structure of expenses for the reporting period that help estimate treatment costs per person are missing.

192. The project seems to have a good performance with a therapeutic coverage constantly higher than 72% since 2006 and a geographic coverage of 100%. But this is contrasting with 20% villages that have less than 80% therapeutic coverage and a high CDD attrition rate, a CDD/population ratio of 1/315 and a very low proportion of female CDDs.

193. **TCC recommends to the coordination to make efforts in order to:**

   (i) Improve CCD/population ratio;
   (ii) Improve women participation in CDTI;
(iii) Improve disbursement rate from government budget;

(iv) Start the CSM and sustainability process;

(v) Initiate co-implementation activities and CDTI integration activities in PHC;

(vi) Initiate operational research projects;

(vii) Intensify advocacy to attract NGDOs.

194. **TCC accepted the report.**

**ETHIOPIA**

*North Gondar CDTI Project 9th year annual technical report*

195. Although this report contains most of the information required by APOC, the authors have not used the reporting format. Some of the tables are incomplete while some (e.g. the drug inventory and financial tables) have been truncated. The team has not completed the form for TCC recommendations. For ease of reviewing, the team is asked to use the current reporting format (if it does not have this form, it should notify APOC so that this can be sent).

**Recommendation to improve the report:**

(i) Use the current reporting format to report on project activities;

(ii) Complete all tables including the TCC recommendation table and follow the format provided by APOC. In addition, provide information on the number of communities and people in meso and hyper-endemic areas (Table 3 indicates N/A);

(iii) Provide explanations for areas where there is lack of information (for instance, why does the team not have information on communities with female CDDs);

(iv) Provide information on the budget for 2012 even if APOC did not remit funds to the project.

**Recommendation to improve the project:**

(i) Address the high levels of absentees and refusals in Chilga and Metema;

(ii) Ensure that all the communities in Chilga are treated (5 villages were not treated in 2012 and no explanation is provided in the report);

(iii) Undertake an operation research on the experience of bi-annual treatment in the two new sites compared to annual treatment in the five sites.

**Recommendations to APOC:**

(i) Confirm the observation that “The FMOH has launched a new policy for volunteer service in 2012. The core of the policy is that every member of the community is expected to take part in preventive and control aspects of health and it is forbidden by law paying per diems or any incentives for activities carried out at community level.”

196. **TCC accepted the report.**

*Kaffa CDTI Project 12th year annual technical report*

197. This is the 12th year cycle of the Kaffa CDTI project located in the South West of Ethiopia. The project team has responded satisfactorily to TCC recommendations, particularly increasing and maintaining therapeutic coverage to 80%. CSM has been done successfully. The project is assisted by the Carter Centre. Geographical coverage is maintained at 100% with therapeutic coverage at a 80%.
198. The project performance is good. The health system is strong with 67% out of 1310 Health Workers being involved in CDTI activity. The total population is just 1 million and treatment coverage has been successfully above 75% with UTG of 95%. The number of female CDDs is still low, about 10% of the total CDDs and this is due to far distance walk needed to reach the houses. The ratio of CDD to population is still low. Training of health workers and CDDs has been satisfactory.

Recommendation to improve the project:
(i) APOC is encouraged to release funds in time;
(ii) No operational research was done;
(iii) The project is encouraged to reduce the Mectizan wastage;
(iv) The number of refusals and absentees from ivermectin is still high (at 5%) – this should be addressed;
(v) The problems of old vehicles, 5 motorcycles have not been addressed. The project is encouraged to use government funds to repair vehicles and 5 motorcycles.

199. **TCC accepted the report.**

*Sheka CDTI Project 12th year annual technical report*

200. This is the 12th year cycle report of Sheka CDTI project located in the South Western part of Ethiopia. The project has covered 178,983 people out of 218,881, giving 82% of therapeutic coverage reaching 97% of the UTG and 100% geographical coverage. The project is maturing, however the ratio of CDD to the population is still high at 1/150 and the low ratio of female CDD, less than 20% of CDDs are females. The cooperative policy of the government i.e. five houses made in a unit to support each other will facilitate health education and ivermectin distribution. CDD attrition is not high to impede progress of the MDA. Health workers and CDD training is good. The rate of absentees and refusals is still high, it has not changed from 5%.

Recommendation to improve the report:
(i) More work is needed to maintain coverage at least 82%. Health education is to be intensified;
(ii) CSM is being conducted. The project is maintained on a very reasonable budget, mostly from MoH.

201. **TCC accepted the report.**

*Illubabor CDTI Project 9th year annual technical report*

202. In 2012, treatment was initiated in eight new endemic areas with drug administration taking place in two different times for the old and new areas respectively. TCC commends the project for consistently good performance with regards to coverage rates. As expected for a mature project, government financial contribution to the project is increasing and this is a good trend for sustainability.

Recommendation to improve the report:
(i) No consideration was given to recommendations of TCC 34. The project is advised to look into these recommendations for the sake of completeness.
**Recommendation to improve the project:**

(i) There has been a dramatic improvement in the male/female CDD ratio. The male to female CDD ratio in 2012 was 2/1 compared to 15/1 in 2011. It will be interesting and of wider value to CDTI projects and to APOC to find out what the project did exactly to increase the number of female CDDs by several folds;

(ii) The lessons learned will inform APOC’s planned publication regarding gender on APOC activities.

**203. TCC accepted the report.**

*Bench Maji CDTI Project 10th year annual technical report*

204. TCC commends the project for the steady increase in coverage rates.

**Recommendations to improve the report:**

(i) Verify the Data in table 13 on Finances. In 2011, it was reported that the NGDO partner made available over a million USD (1,739,000USD). In this 2012 report, the amount obligated by the NGDO is 22,539 USD. The project needs to double check the 2011 and 2012 data.

**Recommendations to improve the project:**

(i) Address the issues uncovered during supervision visits, especially the selection and training processes for CDDs;

(ii) Intensify sensitization to improve on treatment compliance - For 2011 and 2012 refusals and absentees accounted for about 6% of the ATO compared to 2% in 2010;

(iii) Seek assistance from APOC to improve on CSM implementation. It is strange that about 65% of communities (884 of 1354) carried out CSM and yet no community conducted SHM;

(iv) There is need for closer monitoring to minimize wastage of ivermectin tablets. Wastage figures for 2011 and 2012 are in the 4000 range, considering that the shelf life is 3 years.

**205. TCC accepted the report.**

*Jimma CDTI Project 8th year annual technical report*

206. The report is concise and reflects a good performing project that is proactive in identifying likely challenges and ensuring they are overcome. Late arrival of Mectizan was highlighted as well as high CDD attrition due to commencement of CDTI activity during farming season. The project is also Co-implementing CDTI with the Malaria programme.

**Recommendations to improve the report:**

(i) Ensure that all the relevant partners endorse the report;

(ii) Provide information on TCC comments and how they have been addressed.

**Recommendations to improve the project:**

(i) Ensure that Mectizan supply is received on time to avoid delay in treatment commencement period;
(ii) Intensify sensitization to bring back CDDs that stayed away from service due to farming season;
(iii) Implement CSM and SHM in all endemic communities.

**Recommendation to APOC:**
(i) To assist the project in order to ensure that they access 100% of budgeted funds.

207. **TCC accepted the report.**

**Meketel CDTI Project 8th year annual technical report**

208. The report is concise and reflects a good performing project that is proactive in identifying likely challenges and ensuring they are overcome. Late arrival of Mectizan was highlighted and high CDD attrition due to commencement of CDTI activity during farming season. The project is also Co-implementing CDTI with Malaria programme.

**Recommendation to improve the report:**
(i) Ensure that all the relevant partners endorse report;
(ii) Provide information on TCC comments and how they have addressed.

**Recommendation to improve project:**
(i) Ensure that Mectizan supply is received on time to avoid delay in treatment commencement period;
(ii) Intensify sensitization to bring back CDDs that stayed away from service due to farming season;
(iii) Implement CSM and SHM in all endemic communities.

**Recommendation to APOC:**
(i) To assist the project in order to ensure that they access 100% of budgeted fund.

209. **TCC accepted the report.**

**East Wollega CDTI Project 8th year technical report**

210. This is an acceptable report and the team should be commended for achieving a CDD/Population ratio of 1/67.

**Recommendation to improve the report:**
(i) Recalculate the UTG using the correct formula. The current calculation underestimates the UTG for all the districts;
(ii) Ensure that the calculations in Table 4 are correct. For example, the proportion of communities with female CDDs is given as 7% yet it should be 32%;
(iii) Table 5 is incomplete – the achievement levels have not been indicated;
(iv) Re-do Table 9 and fill in all the gaps;
(v) Provide substantive information on advocacy (e.g. how many people were reached) and on sensitization (e.g. what media was used).
Recommendation to improve the project:
(i) Address the high number of refusals in Guto, Gida and Bako Tibe. In addition, the high number of absentees in Jimma Arjo should be addressed;
(ii) The team should be encouraged to undertake operations research by taking advantage of the resources available through APOC.

Recommendations to APOC:
(i) Provide information to the programme team on the availability of operations research funds that should be applied for separately from the project funding;
(ii) Address the issue of late remittance of funds to the project;
(iii) Supervisors at all levels, including the health staff, should be encouraged to use checklists that would enhance collation and reporting on the outcomes of supervision;
(iv) The team should be encouraged to undertake Operations Research by taking advantage of the resources available through APOC.

211. **TCC accepted the report.**

West Wollega CDTI Project 8\textsuperscript{th} year technical report

212. This is an acceptable report. The team has maintained high treatment coverage and should be encouraged. The CDD ratio of 1/70 people is commendable despite reported attrition.

Recommendation to improve the report:
(i) Recalculate the UTG using the correct formula. The current calculation underestimates the UTG for all the districts;
(ii) Table 5 is incomplete – the achievement levels have not been indicated (a similar problem was identified in the 2010 and 2011 reports). There is a row for percent achievement that has not been consistently filled;
(iii) Provide substantive information on advocacy (e.g. how many people were reached) and on sensitization (e.g. what media was used). The report presents broad statements on what was done and achieved;
(iv) Present a flow chart of supervision in sub-section 2.9.

Recommendation to improve the project:
(i) Address the decline in the proportion of health staff involved in CDTI to the current level of 89%, down from 97% in 2011. Doing so would counter the effects of frequent transfers;
(ii) Address the high number of refusals in Sadi, Gidami and Walal (a similar recommendation was made by TCC 34).

Recommendation to APOC:
(i) Provide information to the programme team on the availability of Operations Research funds that should be applied for separately from the project funding;
(ii) Address the issue of late remittance of funds to the project.

213. **TCC accepted the report.**
214. The report is fairly well written but has many grammatical errors and is not in the proper format. The current version of Tables 13, 14 and 15 are missing. Geographic coverage is good, having been maintained at 100% since 2006. Therapeutic coverage decreased from 82% in 2011 to 71.4% in 2012. There is clearly a problem of inability to cover migratory populations. This in turn has resulted in high number of absentees (8,478). It is interesting to note that incentives are not provided for CDDs, yet attrition is low.

**Recommendation to improve the report:**

(i) Use proper reporting format;
(ii) Grammatical errors should be corrected;
(iii) Calculate male to female CDDs ratio;
(iv) Calculate expenditure per treatment;
(v) Provide information on:
   - number of tablets ordered and number wasted,
   - community response to mobilization and sensitization.

**Recommendation to improve the project:**

(i) Address recommendations from previous TCC, i.e. on tackling coverage of migratory population and reducing refusals;
(ii) Conduct CSM in all communities;
(iii) Advocate for more support from government and sustain district level support.

215. **TCC accepted the report.**

**LIBERIA**

*South West CDTI Project 7th year annual technical report*

216. The project should be commended for building partnerships with local private institutions that have contributed directly to the implementation of project activities including drug distribution and providing incentives to CDDs.

**Recommendation to improve the report:**

(i) Calculate the UTG to reflect the right treatment coverage figures;
(ii) Correct Tables 2, 5 and 9 to reflect the correct figures;
(iii) Ensure that the report is edited before submission (there are many spelling and grammatical mistakes throughout the report).

**Recommendations to improve project:**

(i) Ensure that all communities are covered and for areas not reaching 100% geographic coverage assess and address the issues before the next round of treatment;
(ii) Increase the proportion of health staff involved in CDTI from the current 15%;
(iii) Increase the number of CDDs to reduce the CDD/population ratio from the current 1/285;
(iv) Invest in CSM and SHM: none was conducted during the reporting period;
(v) Make realistic estimates of the drugs required for treatment to reduce those remaining and expiring;

(vi) The report indicates that the project is verifying geographical coverage in Grand Bassa and Rivercess Counties where there appears to be over-reporting of target communities. Also the project plans to conduct geographical coverage survey and GPS mapping in 2013 to validate the coverage reported and target communities. These efforts should be implemented and the results shared with the TCC.

**Recommendations to APOC:**

(i) Consider supporting the project with equipment. The only vehicle is written off.

217. **TCC accepted the report.**

**South East CDTI Project 7th year annual technical report**

218. Overall, this project is doing well. Therapeutic coverage over the last four years ranged from 81% to 97%. The reported rate for 2012 is 84% but this does not take into account data for Sinoe County because Sinoe County was yet to submit data at the time of reporting. The project should be commended for the detailed financial information provided.

**Recommendation to improve the report:**

(i) Given that the report only represents partial data, meaningful conclusions could not be drawn. The project is encouraged to update the report after receiving data from Sinoe County.

**Recommendations to improve project:**

(i) The level of involvement of health workers in CDTI is rather low (only 11%). The project should explore possibilities to get more health workers in the project zone to take part in CDTI activities.

219. **TCC rejected the report and recommended that an updated report be sent to reviewers via APOC management.**

**North West CDTI Project 11th year annual technical report**

220. This is a concise report which is more of a progress report for 2012 activities providing partial data on treatment because treatment commenced late due to late arrival of Mectizan. The project is commended for attracting new partners and for undertaking awareness raising activities in 2012 on NTDs. However it is of concern to TCC that previous recommendations have not been dealt with. Of significance is that geographic coverage only reached 71% and therapeutic coverage – 56%. Even though the current coverage rates are based on partial data, coverage rates for previous years have been fluctuating between 50%- 80% range, implying inconsistency with regards to implementation.

**Recommendations to improve report:**

(i) The Project should re-submit a complete report to APOC after outstanding treatment data have been received.
Recommendations to improve the project:
(i) Intensify effort to increase the number of Health workers involved in CDTI implementation, and to improve the quality of training for CDDs;
(ii) Take steps to reduce attrition among CDDs and improve the participation of females as CDD. The proportion of female CDDs is still low at 23%;
(iii) Implement CSM in order to improve performance;
(iv) Ensure early commencement of Mectizan distribution;
(v) The attempt to integrate oncho activities in the health system is good. However the integration process needs to be done efficiently so as not to retard progress of oncho control.

Recommendations To APOC:
(i) This project need help to get basics in place, training, CSM and how to operate CDTI i.e. recruit more CDDs, female CDDs;
(ii) APOC to consider the replacement of project vehicles and additional motorcycles.

221. **TCC rejected the report, requesting the project to submit an updated report to the next TCC, taking into consideration the above recommendations.**

TANZANIA

*Mahenge CDTI Project 14th year annual technical report*

222. This is a good report. There is impressive achievement in co implementation/integration as well as financial support at district and community levels. There is no information on sustainability evaluation and sustainability plan. Though geographic coverage has been maintained at 100% since 2003, therapeutic coverage has been fluctuating and is 79% for 2012. Only 10 of 670 communities have attained therapeutic coverage of 80%. Of concern is the high number (22,528) of absentees.

Recommendation to improve the report:
(i) Avoid grammatical errors;
(ii) Calculate:
   - male to female CDDs ratio,
   - CDD per population,
   - expenditure per treatment.

Recommendation to improve the project:
(i) Conduct SHM and CSM in all 670 communities;
(ii) Sustain a good support at district and community levels;
(iii) Replace non functional equipment;
(iv) Conduct operational research on refusals and absentees.

223. **TCC accepted the report.**

*Tukuyu CDTI Project 12th year annual technical report*

224. This is a mature project, located in the Southern highland zones of Tanzania which is in its 12th cycle of treatment. The project team responded satisfactorily to TCC comments. It is a small focus with 115,500 to be treated. The project has done well and underwent Epidemiological evaluation, both
phases 1a & 1b where no infection was found. During the current reporting period, the project reached 100% geographical coverage with 76% therapeutic coverage, UTG of 82%. There was strong female representation – 51% of the total. Attrition rate of CDD is no problem. Good training of both CDD and health workers.

225. CSM was done with very good implementation outcome. The strong element of the project is integration of the NTD in oncho – CDTI distribution. They treated over 2 million for LF, half a million for schisto over 2 million for STH, with full community involvement. With the good results of Epidemiological evaluation, people are now reluctant to take the drug.

**Recommendation to improve the project:**

(i) The project should continue treatment till MDA is stopped by APOC.

226. *TCC accepted the report and congratulated the project for the good result.*

**Tanga CDTI Project 12th year annual technical report**

227. This is an acceptable report and the team should be commended for maintaining a good CDD/population ratio (1/118) and for limited attrition rate of CDDs.

**Recommendation to improve the report:**

(i) The report should be edited to address the numerous grammatical and spelling errors;

(ii) Clarify the reporting on the tablets: the sums do not add up - if there were 343,057 tablets in stock and they got additional 644,657 and used only 592,017 the remaining tablets should be 395,525 but not 52,463;

(iii) Revise Table 13b to reflect accurate contributions by APOC.

**Recommendation to improve the project:**

(i) Pay attention to therapeutic coverage for Lushoto where 334 out of 540 communities are not meeting the 80% threshold;

(ii) Increase the proportion of health staff involved in CDTI from the current 30.2%.

**Recommendations for APOC:**

(i) The status of replacement of equipment needs to be clarified: has this been facilitated or not? The same recommendation was made by TCC 35.

228. *TCC accepted the report.*

**TECHNICAL REVIEW COMMITTEES REPORTS: Agenda item 24**

**NIGERIA**

Nigeria Technical Review Committee: Report of the tenth meeting (TRC10)

229. Professor Braide, Chair of of the TRC of Nigeria, presented the report of the tenth Technical Review Committee meeting held in Calabar, Cross River State, Nigeria, from 11 to 15 February 2013. A total of 9 CDTI projects Technical Reports were reviewed, of which 8 (Akwa Ibom year 9, Delta year 12, FCT Year 14, Kaduna year 13, Kwara year 14, Nasarawa year 11, Nasarawa year 12 and Niger year
12) were accepted with recommendations for improving report and improving project implementation. The report from Zamfara was sent back to the project for corrections and resubmission.

230. TRC 10 observed significant improvement in quality of supervision and monitoring carried out by the NOCP and the Zonal officers. Cross cutting deficiencies were found in training, supervision, monitoring, evaluation and resources mobilization and these have persisted from TRC 3 to TRC 10. Monitoring reports by Zonal coordinators also flagged out these weaknesses.

231. APOC is commended for the provision of four wheel Hilux vehicles to 3 zones in Nigeria. APOC is requested to provide one more vehicle for the fourth zone (B Zone) in Nigeria and fund up scaling of CSM and SHM in all projects.

232. NOCP (Zonal Coordinators) should sustain current impressive monitoring and supervision of CDTI activities at the lower levels, closely monitor coverage at the community level and ensure that drug requisition/supply/use is in accordance with laid down guidelines. The NTD Steering Committee should vet drug applications before submission. NOCP should also facilitate resolution of the problem of conflicting population figures for the Kaduna CDTI project.

233. The NGDOs are encouraged to continue to build capacity of programme personnel and work within the framework of the national health plan.

234. All projects should intensify advocacy for increased counterpart funding by policy makers at all levels, conduct/implement SHM and CSM in all communities. Projects should also train members of CBOs, managers of NTD programs, NYSC members, teachers, traditional leaders and religious leaders to participate in CDTI at community level. The next meeting of the committee will hold from 8 to 12 July 2013. The venue will be indicated later.

**TCC Comments**

235. TCC accepted the report and commended TRC Nigeria for building capacity of programme managers for in-country review of technical reports. TCC also noted efforts by TRC Nigeria to track sustainability related progress of CDTI projects in the country. Technical Review Committees of other countries are encouraged to learn from the Nigerian experience.

236. **TCC accepted the report.**

**CAMEROON**

**Cameroon Technical Review Committee: Report of the 8th meeting (TRC8)**

237. Dr Mahamat, representative of TRC Cameroon presented the report of the eight Technical Review Committee meeting held from 14-15 February 2013 in Yaoundé. Participants included, in addition to the reviewers, the NOCP, Regional Delegates of Public Health, NGDOs managers, regional officials for onchocerciasis control, lectures of FMSB.

238. The objective of the session is to provide useful observations for improving CTDI projects reports of Cameroon and review operational research protocols submitted.
239. The TRC reviewed 15 CDTI projects technical reports and rejected two. The Loiasis Technical adviser presented a report on SAE cases collected during the last CDTI campaign. Eleven (11) cases of SAEs were reported including one death in Nkongsamba. It was requested that SAE cases be reported as soon as possible to allow investigations to be undertaken. It should be noted that the observation form for SAE cases has been modified.

240. The TRC also reviewed five research proposals of which four was submitted to TCC and one was requested for re-submission.

241. TRC provided the following recommendations:

**To the NOTF:**
(i) The representative of the NOTF/Cameroon in TCC36 should investigate on how to proceed regarding the conclusions to be mentioned in the review form of the technical reports.

**To South-West 2 CDTI project:**
(i) Submit a file on the forthcoming introduction of mass treatment of Mectizan in Ogarang health area, Eyumujock health district.

**To all projects:**
(i) Integrate all the recommendations and observations formulated, including the financial part and resubmit these reports within 8 days to the NOTF;
(ii) Intensify the implementation of CSM;
(iii) Improve the management of the drugs;
(iv) Systematically look for alternative means for the motivation of CDDs;
(v) Provide information on equipment and various financial contributions of the partners;
(vi) Substantially reduce the number of refusals and CDD attrition rate.

242. TRC provided the following recommendations related to operational research proposals:

**To the NOTF**
(i) Develop a form for the review of the operational research proposals;
(ii) Ensure that operational research documents are blinded prior to sending them to the reviewer.

**To the investigators of research proposals:**
(i) Data collection tools should be included in the proposal documents;
(ii) The research proposals should include investigators’ CVs;
(iii) Research topics accepted should be corrected and resubmitted to the NOTF secretariat within 8 days.

243. TCC accepted the report and commended TRC Cameroon for the efforts made to control SAEs and encouraged them to share the experience with other countries.
OTHER MATTERS: Agenda Item 25

a) Contribution of TCC to a special issue of the African health monitor on APOC

244. An explanation was provided to TCC on the special issue of the African health Monitor on APOC activities. The idea was to have elimination as a major theme and each of the unit would have to provide some titles for selection. APOC Management also mentioned that other partners were welcome to make contributions and therefore urged TCC to assist to identify the partners. It was said that the World Bank had been contacted to write on the financing of APOC. It is a quarterly production and the time line for submission is in the third quarter, however the contributions should be submitted by end of May 2013.

245. TCC suggested the following topics for consideration:

   (i) Moxidectin as a potential drug for MDA in general;
   (ii) CDI in curriculum of nursing institutions and medical institutions- Capacity building, impact assessment – APOC service to institutions;
   (iii) The impact of the recommendations and guidelines of SAEs to tackle loa loa;
   (iv) The relationship between onchocerciasis and epilepsy;
   (v) Success story of government contributions from control to elimination of Onchocerciasis in the African continent;

b) Review of TCC duration

246. The Chair observed that since there is a mechanism in place for reviewing technical reports which includes the TRCs and on line reviews, there is a need to consider reducing the number of days for TCC meetings. After assessing the number of days to spend on technical matters and reviewing technical reports, most of which having being devolved to TRCs in the countries, and after brainstorming for while on the matter, TCC requested APOC Management to reevaluate the matter according to the agenda and make the final decision.

c) TRC in DRC

247. TCC encouraged creating a TRC in DRC and requested the attendance of TCC members at the initial stage of the TRC.

d) Feedback of the sub committee on Angola

248. Recognizing that several attempts made over the years to improve the collaboration with the Angolan health authorities in the implementation of onchocerchiasis control activities were not as successful as expected to improve the collaboration with the Angolan authorities, the TCC mandated three of its members and one member of the LF RPRG in attendance to suggest the best approach and necessary actions to improve the collaboration with the Angolan Ministry of Health.

249. The group suggested the following actions:

   (i) To make a detailed documentation of all visits and attempts to visit the country, listing the major impediments for more positive outcomes;
(ii) APOC management should take the necessary measures to urgently reinforce the technical support team in the country as a way to improve the country program and collaboration with the program management at the national and provincial levels;

(iii) In view of the partners forthcoming visit to the country in June 2013 initiate preliminary contacts with the Angolan authorities and other partners involved at the regional and global levels;

(iv) High level advocacy group (APOC, WHO-AFRO-NTD, NGDOs) will try to meet with the Angolan Minister of Health during the upcoming World Health Assembly next May, in Geneva. In such a meeting, the minister will be explained about the importance of an improved engagement of the country with partners in implementing interventions for Oncho elimination. Mention will be made to the Memorandum of Understanding signed by the Ministers of Health of the African region during the Regional Committee meeting in Luanda in November 2012;

(v) APOC management should make a formal approach to the Minister of Health of Angola with a letter addressing the issue.

e) Twice yearly treatment

250. TCC requested the subcommittee on alternative approaches to provide an update on the issue as soon as possible, based on scientific and technical evidence for TCC stand.

251. The sub committee should have consultation with APOC Management on how to come up with a strategy/plan or a concept paper that TCC will adopt.

252. TCC also suggested that all members should provide suggestions to the sub committee on matters related to twice yearly treatment.

DATE AND PLACE OF THE THIRTY-SEVENTH SESSION OF THE TCC: Agenda Item 26

253. The next session of the Technical Consultative Committee (TCC37) is scheduled for 9 to 13 September 2013, in Ouagadougou, Burkina Faso.

CLOSURE OF THE SESSION: Agenda item 28

254. In closing, the Chair thanked above all the interpreters who have been very kind throughout the sessions. He also thanked all the members and advisers for their good work. He particularly thanked APOC Management for facilitating their work and making sure that things are moving. He observed that they are here to serve their own people (the communities). On this he declared the meeting closed.
Annex 1. List of participants

36th SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE
Ouagadougou, 11-15 March 2013

LIST OF PARTICIPANTS

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PRO/APOC-14.3.2013
Annex 2: TCC36 Agenda

1. Opening
2. Adoption of the Agenda

Information

3. CSA: matters arising from the 138th and 139th sessions
4. JAF: matters arising from the 18th 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-fifth session

Strategic and technical issues

7. 9th NOTF Meeting (including APOC and ex-OCP countries)
8. Feasibility of elimination of Onchocerciasis infection and interruption of transmission:
   (i) Elimination of Onchocerciasis with ivermectin in Africa
       a) Update on APOC countries
       b) Update on other Oncho endemic countries in West Africa
   (ii) Entomological studies:
       a) Update on activities conducted in Cameroon, Nigeria, and Uganda
       b) Update on the delineation of transmission zones
       c) Update on black flies trapping and other studies related to Onchocerciasis
   (iii) Elimination of O. volvulus infection: New diagnostics of PATH
10. Perspectives on Coordination mechanisms for Regional NTD Programme in the African Region
11. Concept Note and the Strategic Plan of Action and Budget for the post 2015 period: TCC contribution to their finalization
12. Score card for monitoring the progress for NTDs control/elimination: TCC input
13. APOC and TDR Supported Research:
    a) Update on Moxidectin Development
    b) Ivermectin Response Markers
    c) Other information of interest to TCC: Nodding syndrome in North East DRC
    d) Update on the DEC patch test
15. Report on the last Mectizan Expert Committee Meeting
16. Review of operational research proposals including the research on the impact of ivermectin on Loa loa
17. Desk Review on CSM
18. Sustainability evaluations in the context of moving from control to elimination
19. Protocol for independent monitoring of treatment coverage
20. Remarks by Technical Advisors to APOC Management

Management of APOC Trust Fund

21. Report on the financial management of APOC funded Projects

Reviews

22. Report on the review by the APOC Management of the financial content of 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th years projects’ progress reports as an introduction to their technical review
23. Review of New project proposals and 1st, 2nd, 3rd, 4th, 5th, 6th and 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th years annual technical reports of projects
24. Technical review Committee : Nigeria and Cameroon
25. Other matters :
   (i) Contribution of TCC to a special issue of the Global health monitor on APOC
   (ii) Review of TCC duration
   (iii) Setting up of TRC in DRC
   (iv) Feed back of the Sub-committee on Angola
   (v) Twice yearly treatment
26. Date and place of the thirty-seventh session of the TCC
27. Conclusions and recommendations of TCC
28. Closure of the session

DIR/COORD/APOC/05.03.2013
Annex 3: Follow up of the key recommendations of the 35th Session of TCC

<table>
<thead>
<tr>
<th>Subject/Topic</th>
<th>Action to be taken</th>
<th>Status of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of the NGDO/NTD network meeting</td>
<td>With regards to TCC input in the score card for monitoring the progress for NTDs, TCC acknowledged the initiative, however noted that due to time constraint they were unable to provide their input during this September session but would do so during TCC36 in March 2013</td>
<td>This is one of the TCC36 session agenda items.</td>
</tr>
<tr>
<td>Workshop on capacity building on the use of monitoring and evaluation tools</td>
<td>TCC proposed to increase capacity building and training of entomologists.</td>
<td>Selection of appropriate candidates from five APOC countries is under discussion and the capacity building plan will be finalized during the EWG meeting in April</td>
</tr>
<tr>
<td>APOC/JRS website on OCP environmental assessment data</td>
<td>The Committee hoped that the same initiative would be implemented for the entomological data too, using this example</td>
<td>Will be implemented once the environmental assessment data website is launched and funds are available</td>
</tr>
<tr>
<td>Evaluation of the inclusion of the Community-Directed Interventions (CDI) strategy in the Curricula of Faculties of medicine and health sciences</td>
<td>The committee advised APOC to establish links with research Institutions.</td>
<td>Links are being established with (11 institutions that are incorporating CDI in their curriculum) research institutions (in Burundi, Cameroon, Malawi, CAR and Senegal)</td>
</tr>
<tr>
<td>Cross border meetings</td>
<td>(i) TCC emphasized the importance of closely monitoring the decisions and outcomes of the cross border meetings to ensure that actions are effectively implemented</td>
<td>Facilitate finalization of plans and their funding by APOC partnerships; Facilitate &amp; support implementation of cross border joint action plans and report to JAF (SDD)</td>
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<td></td>
<td>(ii) TCC appealed to partners to continue to provide the needed supports to countries as well as APOC in the cross border activities</td>
<td>Prepare a document to be submitted to JAF on cross border interventions (SDD)</td>
</tr>
<tr>
<td>Feasibility of elimination of onchocerciasis infection and interruption of transmission</td>
<td>(i) TCC proposed the need to devise a plan to monitor treatment coverage by building capacity at local/national levels</td>
<td>Protocol finalization workshop held and presentation will be made under agenda item 20.</td>
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<tr>
<td></td>
<td>(ii) TCC suggested the need for a rapid evaluation tool of endemicity in treated areas.</td>
<td>The work is in progress. Documentary review underway as a first step</td>
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<tr>
<td></td>
<td>(iii) TCC also suggested developing and assessing the use of post-treatment nodule prevalence as an indicator for comparison of REMO data and as a possibility for a less expensive method</td>
<td>The liability of REMO as a comparison tool is being discussed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Logistics and equipment have been ordered;</td>
</tr>
<tr>
<td>Subject/Topic</td>
<td>Action to be taken</td>
<td>Status of implementation</td>
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<tr>
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<tr>
<td>(iv)</td>
<td>On the entomology studies, it was recommended that the needs of each country should be identified and the health staff, the authorities at all levels as well as the communities should be sensitized. Necessary logistics and equipment should be put in place.</td>
<td>Meeting will be organized in April for the entomological working group to plan for the sensitization and entomological evaluation</td>
</tr>
<tr>
<td>(v)</td>
<td>Furthermore, TCC suggested choosing for training entomology technicians from institutions already working on the subject rather than individuals who will have difficulties to be available for this activity. Therefore, TCC recommended that priority should be given to establishing relationship with specialized institutions at country level which experts could be targeted as trainers and trained accordingly.</td>
<td>APOC Management liaised with countries to identify relevant institutions and experts to be trained</td>
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<tr>
<td>(vi)</td>
<td>TCC also advised that APOC should not only give guidelines but should work in close collaboration with the countries, undertaking quality control as they don’t have sufficient capacity.</td>
<td>Technical assistance is planned for entomological assessments</td>
</tr>
<tr>
<td>(vii)</td>
<td>Emphasis should also be put in high level training of entomologists for countries where these specialists are missing or are not appropriately represented.</td>
<td>Offers will be sent to countries when funds are available</td>
</tr>
<tr>
<td>(viii)</td>
<td>Fly catchers experience should be used as control for black fly traps</td>
<td>Fly catchers have always been used as gold standard in the experiments</td>
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<tr>
<td>(ix)</td>
<td>TCC advised to be cautious in separating the different moves-ments of adults <em>Simulium damnosum</em> s.l. and their impact on transmission.</td>
<td>Well noted</td>
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<td>(x)</td>
<td>TCC raised the issue of the definition of the term “transmission zones” and the need for a more inclusive and general definition.</td>
<td>Definition already inclusive and will be more taken into account during the implementation</td>
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<td>(xi)</td>
<td>TCC further pointed out that it will be necessary to redefine the term when there is more knowledge from the on-going entomological and epidemiological evaluations.</td>
<td>Well noted</td>
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<td><strong>New diagnostics of PATH</strong></td>
<td>TCC endorsed the engagement of APOC with PATH regarding protocol development and logistics as it is in APOC’s scope to pursue test(s) that assist in certifying elimination.</td>
<td>A progress report will be presented during the present TCC session under agenda item 8.iii</td>
</tr>
<tr>
<td><strong>LF and onchocerciasis control/elimination Programmes’ collaboration</strong></td>
<td>TCC reiterated the need for close collaboration between LF and Onchocerciasis Programmes in order to meet the elimination goal and encouraged WHO/AFRO to intensify effort to make this possible.</td>
<td>Information on progress made will be provided under agenda items 9 &amp; 10</td>
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<td><strong>Current research between APOC and TDR collaboration:</strong></td>
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<td><strong>Moxidectin development</strong></td>
<td>(i) TCC supports the plan to have a technical expert review prior to presentation of the data to JAF.</td>
<td>Update to be presented under agenda item 13.i</td>
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<td>(ii) TCC nominated Mamadou Souncalo Traore and Dr Michel Boussinesq to represent and act on behalf of TCC during the technical review of the Phase 3 study data.</td>
<td>Update to be presented under agenda item 13.ii</td>
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<td><strong>DEC patch test</strong></td>
<td>(i) APOC and TDR continue to pursue the finalization of the agreement,</td>
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<td></td>
<td>(ii) 4. Director APOC visit LTS together with the TDR staff involved in the negotiations of the agreement to discuss and resolve any issues that might hold up finalization of the agreement</td>
<td>It has not been possible to breech the gap</td>
</tr>
<tr>
<td><strong>Ivermectin Response Markers</strong></td>
<td>(i) APOC with partners should breech the gap of funding the ivermectin response marker project over funding of other activities towards elimination</td>
<td>Project continue with the limited funds of APOC</td>
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<td>(ii) APOC and TDR should work to identify funds to ensure continuation of this project without funding gap related delays</td>
<td>MDP approached. Issue will be discussed at a meeting to be held in Accra in April 2013</td>
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<tr>
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<td>(iii)</td>
<td>Merck and MDP should be approached immediately for co-funding given that they should have as much interest in the results of the research as APOC and the onchocerciasis endemic countries.</td>
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<td>Nodding Syndrome</td>
<td>(i) APOC should nominate Dr. Boussinesq and Dr Kaiser as APOC and TCC advisor on matters related to nodding syndrome and to represent APOC in meetings and discussions on NS research and one of them to represent APOC on the NS Research Coordination Working Group if constituted as per the recommendations by the NS meeting participants</td>
<td>Letters sent to the two experts</td>
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<td>(ii) APOC should contribute to the NS research by providing its expertise for the proposed mapping relating to onchocerciasis endemicity and CDTI treatment history.</td>
<td>Further information on the proposed mapping needed</td>
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<td>(iii) The exact reasons for the ivermectin treatment refusals in South Sudan and their relationship to NS should be determined so that an appropriate strategy can be developed and implemented</td>
<td>Follow-up to be made after relaunching of the activities in South Sudan.</td>
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<td>(iv) Dr. Kuesel should provide the final NS meeting report to APOC for forwarding to TCC members.</td>
<td>Done</td>
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<td>Guidelines for revising ivermectin treatment boundaries within the context of Onchocerciasis elimination</td>
<td>A suggestion that more data could be collected to be used in the Onchosim model to simulate how sustainable transmission would be below the 5% nodule prevalence was made.</td>
<td>Will be reported under 8.i</td>
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<td>Country visit by APOC Management &amp; TCC members</td>
<td>(i) The need for re-launching CDTI</td>
<td>A road map is being developed</td>
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<td>South Sudan:</td>
<td>(ii) TCC endorse the development of a strategic plan incorporating all partners as a framework for operation.</td>
<td>Need further consultations with the country</td>
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<td>(iii) The need to strengthen SSOTF as well as to have a good Coordinator</td>
<td>A capacity building (training of trainers) in CDI just ended</td>
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<td>(iv) NGDOs need to get together to create a coalition to strengthen the work</td>
<td>Consultations with the Director of public health are ongoing</td>
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<td><strong>DRC</strong></td>
<td>The need for national capacity building and additional Technical Advisors. The need for APOC to develop a closer collaboration with the National Coordinator and empower the Technical Advisor to closely follow activities.</td>
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<tr>
<td><strong>Angola</strong></td>
<td>The need for APOC to develop a closer collaboration with the National Coordinator and empower the Technical Advisor to closely follow activities.</td>
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<td><strong>LF and Onchocerciasis collaboration</strong></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.</td>
<td>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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<tr>
<td><strong>Issue of internships for APOC</strong></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.</td>
<td>In preparation; more details could be provided.</td>
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<td><strong>Operational research</strong></td>
<td>TCC accepted the proposal for funding provided that additional information on sampling methods, data collection tool and ethical clearance is forwarded to APOC. The proposal had already been rejected by the Uganda TRC and was rejected by TCC35 without a review being presented as TCC agreed with and accepted the decision of the Uganda TRC. TCC accepted the proposal subject to being revised according to the suggestions made on the additional information.</td>
<td>Elements received from the principal investigator were sent to the reviewers. Principal investigator informed of the decision of TCC. Precise guidance are expected from TCC for the principal investigator.</td>
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**Note:**
- LF = LF and Onchocerciasis collaboration
- APOC = African Programme on Chronic Disease Control
- DRC = Democratic Republic of Congo
- TCC = Technical Coordination Committee
- TRC = Task Review Committee
- DPC = Directorates of Preventive and Curative Care
- AFRO = African Regional Office for the World Health Organization
- NTD = Neglected Tropical Diseases
- MDSC = Management of Development Support Committee
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<td>Elimination of onchocerciasis (Resubmission)</td>
<td>needed on the study area, the fly catching methods and protocols, fly dissectors, physical and human factors, the time frame for the research. TCC recommended that the proposal should be accepted</td>
<td>PI informed and process for funding started</td>
</tr>
<tr>
<td>d) Identification of factors responsible for CDDs attrition in Gombe State, Nigeria (Resubmission)</td>
<td>TCC accepted this proposal</td>
<td>PI informed and process for funding started</td>
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<td>e) Factors affecting adherence to CDTI in Pader district in Northern Uganda</td>
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