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21.3 Pregnancy outcome and growth of children exposed to ivermectin in utero: a retrospective community based study in Uganda.

21.4 Training more CDDs using Kinship “Umuna” structure to strengthen the sustainability of CDTI in Delta, Enugu and Anambra States CDTI Projects, Nigeria

22 Review of new project proposals and 1st, 2nd, 3rd, 4th, 5th, 6th, and 7th year annual technical reports on the implementation of CDTI and Vector Elimination projects. Recommendations on 2nd, 3rd, 4th, 5th, 6th, 7th, and 8th year implementation of the projects *(Agenda item 22)*

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22.2.1 Plateau State CDTI Project (6th year report)

22.2.2 Nassarawa State CDTI Project (6th year report)

22.2.3 Enugu State CDTI Project (6th year report)

22.2.4 FCT CDTI Project (6th year report)

22.2.5 Taraba State CDTI Project (7th year report)

22.3 CHAD

22.3.1 Chad CDTI Project (6th year report)

22.4 DEMOCRATI REPUBLIC OF CONGO (DRC)

22.4.1 Bandundu CDTI Project (3rd year report)

22.5 TANZANIA

22.5.1 Tanga CDTI Project (5th year report)

22.5.2 Tukuyu CDTI Project (5th year report)

22.5.3 Kilosa CDTI Project (4th year report)

22.5.4 Mahenge CDTI Project (7th year report)

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22.5.6 Tunduru CDTI Project (1st year report)

22.5.7 NOTF HQ Support Project (7th year report)

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1 Opening: Agenda item 1

1. The twenty-second session of the Technical Consultative Committee (TCC) of the African Programme for Onchocerciasis Control (APOC) was held from 13 to 17 March 2006 at the Headquarters of APOC in Ouagadougou, Burkina Faso, under the chairmanship of Professor Ekanem Braide. With the exception of Dr. Christine Godin-Benhaim who was absent, the session was attended by all TCC members, national onchocerciasis coordinators from Chad, Congo and Ethiopia, representatives from WHO, World Bank, invited observers and consultants, APOC Management and staff of the Multi-Disease Surveillance Centre (MDSC). The list of participants is attached as Annex 1.

2. In her opening remarks, Professor Ekanem Braide, chairperson of TCC, welcomed participants to the meeting and particularly hailed the benefits of the recommendation of TCC to invite national onchocerciasis coordinators to TCC meetings on a rotational basis. She congratulated Dr. Uche Amazigo on her appointment as the new Director of APOC and looked forward to benefiting from her rich experience in the Programme.

3. Professor Braide commended the TCC colleagues who designed the new format for reviewing annual technical reports. She praised the new format which now facilitated the review of annual reports and allowed TCC to devote more time to discussing technical issues.

4. Dr. Uche Amazigo, Director of APOC, also welcomed TCC members and all participants to Ouagadougou. She informed the meeting that she will be closely assisted in her function as Director of the Programme by her close colleagues, Drs Laurent Yameogo and Mounkaïla Noma and that APOC Management will be actively involved in the TCC discussions.

5. Dr. Amazigo suggested for the consideration of TCC that:

   1) **TCC should, in future, consider putting more emphasis on the review of annual technical reports and project proposals in the March session of TCC and concentrate more on strategic issues in the September session.** TCC noted that given the cycle of implementation of CDTI projects delaying the review of technical reports or discussing strategic issues as and when they arise might jeopardize certain projects. It was discussed at length that APOC Management should support capacity-building in NOTFs to take on the review of the technical reports. This would also fall in line with a recommendation of the 2005 APOC External Evaluation that certain CDTI activities be decentralized to the countries. TCC concluded that the review of annual technical reports should be conducted in both sessions of TCC, but that the Committee will spend more time discussing technical and strategic issues in all meetings.

   2) **APOC Management be allowed to invite former TCC members to TCC sessions to share their experience.** It was agreed that experts including former TCC members could be invited to TCC session.

   3) **Each TCC member should consider visiting 2-3 countries per year to provide technical support to CDTI projects.** TCC agreed that each member of the Committee
should try to visit at least 2 countries per year to help promote CDTI activities. A list was circulated to all TCC members for them to indicate the countries they wished to visit and when.

4) In accordance with a recommendation of the 2005 APOC External Evaluation, the experience of the Community-Directed Intervention (CDI) workshops in Nigeria, Tanzania and Uganda should be extended to other countries as soon as possible and that TCC members could help co-facilitate the workshops with the aim of helping the countries to come up with a national policy paper on integration.

5) A number of APOC HQ activities including operational research be decentralized to the countries. An Operational Research Task Force (ORTF) should be established in each country to take on the review of operational research proposals in the country and report to TCC. A TCC member would be requested to attend at least one meeting per year of the ORTF. APOC Management suggest this decentralization should begin in 2006 in Cameroon, Ethiopia, Nigeria and Uganda on a pilot basis.

6) TCC should give its opinion on the future of APOC and onchocerciasis control as input for the brainstorming session of the CSA Working Group to be held from 20-21 March 2006 on the future of onchocerciasis control in Africa.

6. Dr. Laurent Toé of the MDSC, speaking on behalf of Prof. Koumaré, acting Director of MDSC, recalled the objective of the Centre which is currently providing support for the surveillance of onchocerciasis and meningitis in the ex-OCP countries. The Centre's activities will eventually expand to include other diseases such as malaria, tuberculosis and HIV/AIDS. Dr. Toé said he was convinced that the various issues outlined above by the Director of APOC for consideration by TCC will be satisfactorily dealt with during the session and wished the Committee a successful meeting.

7. On behalf of Dr. Ousmane Bangoura, Coordinator of the Onchocerciasis Unit at the World Bank, Mrs Tshiya Subayi-Cuppen expressed the pleasure of the World Bank to be involved in onchocerciasis control, not only as the Fiscal Agency but also in operational issues. She hoped to contribute positively to the discussions of the meeting.

8. Dr. Amidou Baba-Moussa, WHO Representative in Burkina Faso, reiterated the welcome to all participants on behalf of the Director-General of WHO and the Regional Director for Africa. He joined the chair in congratulating Dr. Amazigo on her appointment as Director of APOC and wished her success in her new functions.

9. Dr. Baba-Moussa stated that the current TCC session was taking place at a crucial point in APOC’s existence when important decisions about the future of the Programme needed to be taken. He said TCC would be discussing issues from the APOC 2005 External Evaluation report, operational research and many other strategic issues, and had no doubt that with the range and level of expertise within TCC all the critical issues would be dealt with thoroughly and satisfactorily. He pledged the support of WHO to TCC and wished the Committee fruitful deliberations.
2 Adoption of the Agenda: Agenda Item 2

10. The provisional agenda attached as Annex 2 was adopted with additional items on the experience of the Esse District in Cameroon in integration and resource mobilization; the requests of the APOC Director in her opening remarks, and comments on the recommendations of the APOC External Evaluation relating to TCC.

3 Matters arising from the 111th and 112th sessions of the Committee of Sponsoring Agencies (CSA): Agenda Item 3

11. Mr Abdulai Daribi, Secretary of CSA summarized the activities of the Committee and matters arising from its 111th and 112th sessions held in Amsterdam and Paris from 18-20 October and on 5 & 9 December 2005 respectively as follows:

1) Coordination of the 2005 APOC External Evaluation and the Mid-Term Review of SIZ activities and ex-OCP countries. CSA paid a special tribute to the evaluators who had worked tirelessly to undertake these very important assignments. CSA also recognized the contribution of TCC, APOC Management and other resource persons in the evaluations;

2) Inauguration of an "Oncho statue" at the Dutch Royal Tropical Institute (KIT) in Amsterdam on 18 October 2005;

3) At the inauguration ceremony, the Netherlands, representing the donor community, commended the onchocerciasis control programmes for their achievements in the control of the disease in Africa and reiterated the pledge of the donors to continue their support to APOC until the end of the programme in order to safeguard the achievements;

4) A round table discussion followed the inauguration ceremony and focused mainly on issues of sustainability of CDTI, integration and additional health interventions using CDTI as a vehicle, but with the caution not to overburden the system;

5) Having received the report of the 2005 APOC External Evaluation late, JAF could not review it and thus requested that comments on the various recommendations made by the External Evaluation Team be sent electronically to CSA Secretariat which would in turn:

a. reconcile the comments of all partners;

b. draw up a concept paper (plan of action) based on the outcomes of the evaluation (APOC Management will deal with the operational issues and CSA will handle the policy issues);

c. in concert with APOC Management, convene a meeting of partners preferably in an African country in 2006 to discuss the concept paper.

12. Following a presentation on the future of APOC made by CSA to JAF11, JAF advised that a Working Group be set up under the aegis of CSA to reflect on the following issues:
a. The future of APOC until 2010 and the modalities of an eventual extension to 2015 (weighing benefits against risks of the closure of APOC operations in 2010);

b. How to continue onchocerciasis control activities in the participating countries. Whether to go with onchocerciasis alone or expand to include other interventions in the framework of a broader integrated health intervention approach (e.g. linking with other neglected tropical diseases interventions);

c. Widening the geographical scope of APOC to include the whole of Africa where onchocerciasis is endemic (APOC, SIZ areas (after 2007), ex-OCP countries).

13. The Working Group will hold its first meeting, a brainstorming session, in Ouagadougou from 20-21 March 2006 and will prepare and present to CSA114 in summer a draft concept paper on the future of onchocerciasis control in Africa. This paper will in turn be submitted to a partners' meeting to be held some time in 2006.

14. CSA encouraged APOC Management to identify and invite candidates to complete the TCC membership in order to attain the maximum number of 12 members required.

15. JAF encouraged CSA to invite other partners (including the chair and vice chair of JAF) as well as resource persons to CSA meetings on a rotational basis to enrich its discussions.

16. CSA113 is planned to be held in Ouagadougou, Burkina Faso from 25-27 April 2006 and CSA114 is scheduled to be held in Paris in July 2006.

4 Report of JAF11: Agenda Item 4

17. Dr. Uche Amazigo reported on the highlights of the eleventh session of the Joint Action Forum (JAF) held in Paris from 6-9 December 2005. A list of the highlights is attached as Annex 3.

5 Report on the 27th meeting of the NGDO Group: Agenda Item 5

18. Dr. Tony Ukety, NGDO Group Responsible Officer (NGDO GRO), summarized the main conclusions and recommendations of the 27th session of the NGDO Group meeting held in Ouagadougou, Burkina Faso from 8 - 10 March 2006 as follows:

19. The US Fund for UNICEF again notified the NGDO Group that UNICEF/Nigeria was planning to withdraw its support to CDTI projects in 2007. In view of the fact that UNICEF currently supports the largest number of treatments in the country, the Group was very concerned about the effect of this important decision on project performance and requested TCC to address this important matter and make recommendations on the way ahead.

20. Following the curtailment of project funding in DRC, IMA will most likely not be able to support the Bas-Congo, Bandundu and Tshopo CDTI projects as of mid-2006. IMA is seeking alternative funding but cannot guarantee continued support of these three CDTI projects past June 2006. The Group expressed great concern for the future of these projects, and in view of the extreme urgency of the situation, requested TCC and APOC Management to address the matter with the Ministry of Health and other partners.
21. The Group noted that ivermectin tablets were not distributed in 2005 in Sierra Leone and in the Morogoro CDTI project in Tanzania due to financial delays. The Group reaffirmed that once CDTI activities have been launched, it was essential that treatment continue regularly and that every effort be made to avoid delay or interruption of treatment.

22. Following the improvement of the political environment in Liberia, there was a need to undertake a joint mission (World Bank - APOC Management - interested NGDOs) to assess the current status of onchocerciasis control in the country.

23. The Group recommended that APOC should help build capacity at the country level to enable countries undertake impact assessment of their own projects.

24. Since Ms Nancy Haselow will be moving to another post within HKI, the Group was obliged to review the arrangements for the Chair. It was agreed that Dr. Adrian Hopkins will continue as Chair until March 2007, with the understanding that Mr Shawn Baker, HKI Regional Director for Africa, should then take over from him, subject to ratification by the Group at the September 2006 meeting. There was still a need to nominate a Vice Chair and Dr. Hopkins has been requested to call for nominations, with the deadline being end of April 2006.

25. The 28th session of the NGDO Group will be jointly held with the 4th session of LF NGDO Network in Geneva from 5 to 8 September 2006.

26. With regard to the possible withdrawal of support of the US Fund for UNICEF to CDTI projects in Nigeria, it was remarked that the link between ivermectin treatment and epilepsy in children could be used to persuade UNICEF to continue support to onchocerciasis control. TCC suggested that APOC should arrange for joint missions to Nigeria, ideally with the participation of one TCC member, to try to look for other financing mechanisms in support of CDTI activities.

27. The NGDO Group's recommendation for APOC to help countries build capacity to enable them to undertake impact assessment of their projects generated an extensive discussion in TCC around the lack of baseline data in some countries, particularly of socioeconomic data. TCC recognized the importance of analyzing and publishing as soon as possible available data on phase I and II impact assessment of APOC operations for advocacy purposes (see results of the study presented in section 12).

6 35th Mectizan Expert Committee/Albendazole Coordination (MEC/AC) meeting: Agenda Item 6

28. Dr. Mary Alleman of the Mectizan Donation Program (MDP) reported on the highlights from the 35th Mectizan Expert Committee/Albendazole Coordination (MEC/AC) meeting held in London from 10 - 12 January 2006. The highlights essentially focused on (1) SAEs (most of which occurred in Cameroon and DRC); (2) measures put in place for the management of future SAEs; (3) ongoing TDR studies relating to the occurrence of SAEs; studies on interruption of transmission and the MEC recommendation to establish a Task Force as a facilitating forum for the consideration of future scenarios for onchocerciasis control in Africa. Details of the highlights are attached as Annex 4.
29. With regard to SAEs, TCC requested that the frequency of SAEs be presented separately for *Loa loa* endemic areas.

7 Follow-up on the recommendations of TCC 21: Agenda Item 7

30. Dr. Laurent Yameogo, Coordinator of the Office of the Director of APOC, updated the Committee on the status of implementation of the recommendations of TCC21. He reported that most of the recommendations had been implemented and the few remaining were in the process of implementation.

8 Update on operational research: Agenda Item 16

31. Dr. Hans Remme of TDR presented an update on operational research activities. A new spatial model combining the results of RAPLOA data and the Environmental Risk Model has been developed by Prof. Diggle. A version suitable for local use that identifies zones with high risk of SAEs has now been generated and needs to be adapted to identify areas where standard ivermectin treatment can be instituted.

32. Very preliminary data on vector infectivity from the study on the feasibility of elimination of transmission in Mali, Senegal and Guinea-Bissau show zero *O. volvulus* 3rd stage larvae in the head (L3h) larvae among 1000 parous flies and are thus consistent with the criteria for interruption of transmission (1 L3h among 1000 parous flies).

33. The Year 1 data from the multi-country study on the Community-Directed Intervention (CDI) process have been analyzed and revealed that:

   1) Vitamin A delivery can in principle be integrated, but in practice this was difficult because of the integration of its delivery with NID/polio campaign;
   2) Case finding and referral to DOTS were successfully integrated into CDTI, but the specific role of CDDs needs further definition;
   3) The major priority for most communities is malaria. Integration of Home Management of Malaria is in principle possible. For instance, the percentage of children receiving appropriate treatment of fever within 24 hours of onset increased by more than 50% from baseline through integration with CDTI in Uganda;
   4) CDI start-up and implementation is feasible but depends on the presence of appropriate materials for respective interventions. For instance, integration of ITN distribution did not happen since essentially ITNs were not available for distribution;
   5) There is a strong community ownership for CDI;
   6) There is a strong acceptance by the Ministry of Health and other partners;
   7) Communities support integrated delivery of interventions.
   8) The effectiveness and efficiency of CDI need to be further assessed.

34. Meetings have been held with the principal investigators and the Ministries of Health of Cameroon and Nigeria to review the implications of the preliminary findings.


9 Update on Macrofil: Agenda Item 17

35. Dr. Annette Kuesel of TDR presented the status of the clinical development of moxidectin and requirements for sites for the Phase 3 study. Moxidectin clinical development was reinitiated after (1) additional relevant safety data obtained by Wyeth, the manufacturer of the drug, confirmed moxidectin as a very safe drug candidate for evaluation in humans, (2) the WHO/TDR informal consultation came to the conclusion that there was no reason not to initiate the first study of moxidectin in subjects infected with *O. volvulus* as soon as possible and (3) the Food and Drug Administration (FDA) approved a new animal formulation of moxidectin.

36. The first study in subjects infected with *O. volvulus* will be an inpatient-outpatient study in Hohoe, Ghana that will provide data on the safety, microfilaricidal efficacy and long-term skin microfilariae-suppressing effect of moxidectin. Based on safety and microfilaricidal efficacy data from that study, a multi-country study in 1300 subjects infected with *O. volvulus*, either not previously exposed or not exposed to more than three treatments of ivermectin, will be initiated.

* *** *

37. The site requirements in terms of types of subjects, study team qualifications and GCP requirements were presented and TCC was asked to suggest potential study sites to Dr. Kuesel.

38. Dr. Kuesel asked for feedback on the impact of data showing that giving moxidectin to subjects on treatment with antimalarials, anti-TB or ARV does not affect the safety or efficacy of either drug on (1) enrolment rates for the study and (2) practice of community-based treatment. It was explained that based on the prevalence of these diseases in oncho-endemic areas, having drug interaction data as soon as possible will be helpful for further clinical development and invaluable for potential use of moxidectin for onchocerciasis control.

10 Update on vector elimination activities with special emphasis on the Tukuyu and Bioko focus: Agenda Item 10

10.1 Tukuyu Focus

39. As recommended by TCC19, the second and final larviciding campaign to eliminate the vector was carried out from July to October 2005. Prospection of rivers was done and blackflies caught before, during and after the campaign. The results showed a return of female biting flies. Despite the 2003 and 2005 larviciding campaigns, *Simulium thyolense* and *S. damnosum*, Kasyabone type can still be found in the focus.

10.2 Mpamba-Nkusi Focus

40. On the recommendation of TCC20, ground larviciding continued in 2005 in the last *S. neavei* breeding site pockets (River Mutunguru and tributaries). Only 2 *S. neavei* adults...
were caught in the focus in 2005. Crabs captured in 2005 in the main focus of Mpamba Nkusi were positive for pre-imaginal stages of the vector.

41. TCC therefore recommended that larvicide should continue in 2006 in those reinvaded areas of the Rivers Mpamba, Rwabutuji and Nkusi Rivers where the vector breeds and requested that the next report should contain information on CDTI activities in the focus.

10.3 Itwara Focus

42. Entomological surveillance continued in 2005 as recommended by TCC20. The focus has been free of the vector (S. neavei) since 1997. No pre-imaginal stages of the vector was found in the 11046 crabs examined and no adult fly was captured.

43. TCC encouraged the team to continue surveillance pending certification of elimination and requested that the 2006 report should contain information on the CDTI activities in the districts of Kabarole (therapeutic coverage in 2004 = 77%) and of Kyenjojo (therapeutic coverage in 2004 = 74%).

10.4 Bioko Focus

44. The main activities undertaken in 2005 in the Bioko Focus were prospection of breeding sites, updating of dosing sites, larvicide and evaluation of the larviciding campaign.

45. Preparations for the 2005 campaign were done in 2004 and consisted in carrying out susceptibility tests and river trials of Temephos phytargri. Aerial and ground larviciding were conducted from 31 January to 15 May 2005, followed by the evaluation of the campaign from May to December 2005. It should be noted that no biting female of the S. damnosum s.l. was caught in the focus from April to December 2005.

46. TCC recommended that evaluation of the larviciding in the Bioko focus should be continued in 2006 and requested that the 2006 report should also contain information on the ongoing CDTI activities in the focus.

11 CDTI and National Integration Policy and Strategy for the Control of Malaria and Other Vector-borne Diseases: The Ethiopia Case

47. Dr. J. Daddi presented an overview of the Ethiopian National Health Policy (NHP) and the way CDTI is integrated into the national health system. The NHP aims at decentralizing the health services and focusing them on the needs of the rural poor.

48. Dr. Daddi reported that CDTI had, from the start, been integrated into the health sector development programme, in particular into malaria control at all levels with the Onchocerciasis Task Force (OTF) coordinators at the different levels (national, regional, zonal, woreda (611), kebeles (15000)) chosen from among the staff of the existing malaria units. Of the 12.4 million Ethiopians at risk of malaria, 4.9 million live in areas hyper- or meso-endemic for onchocerciasis. Integration allows resources to be used across diseases (e.g. APOC vehicles can be used for other disease control activities when they are not
being used for CDTI) and has allowed CDTI to go ahead as scheduled in 2005 when APOC funds arrived late.

49. Integrated activities included:
   1) training on several diseases;
   2) monitoring and evaluation;
   3) involvement of CDDs and community supervisors in ITN distribution, polio, NIDs and EOS;
   4) integration of CDTI-related performance of healthcare workers (HCW) into performance assessment.

50. To ensure sustainability of CDTI, some measures have been put in place:
   1) training of more CDDs to achieve around 2CDDs / 20 households;
   2) discouragement of incentives paid to CDDs by CDTI projects but encouragement of payment of CDDs by other programmes;
   3) involvement in CDTI activities of health care workers at the base;
   4) training and retraining of health care workers at the next higher level of the health care system;
   5) involvement of other sectors to support CDTI activities (teachers and development agents);
   6) ensuring that CDTI is included in Woreda health strategic plans.

51. Integration is however faced with a number of challenges including the heavy workload on the HCW, which is further burdened by the amount of reporting required by APOC. In addition, the financial procedures imposed by APOC Management are not consistent with the integrated system in Ethiopia. There is need therefore to:
   1) simplify the reporting and administrative procedures for planning, implementation and periodic reporting in order to promote integration;
   2) further empower NOTF's and WR's offices with regard to CDTI activities;
   3) redefine roles and responsibilities of TCC with respect to the objective of promoting integration.

   * * *

52. TCC commended the Ethiopian delegation for sharing its experience on integration which will, no doubt, be useful to other countries. TCC members who recently visited some CDTI projects in Ethiopia acknowledged the impressive level of integration of CDTI into other disease control activities. It was, however, remarked that although the pooled resources system in Ethiopia had great advantages, it made it difficult to evaluate sustainability using the current sustainability evaluation indicators of APOC.

53. As to what was the role of academic institutions in integration, it was explained that two members of the NOTF are from universities, and would presumably ensure that the CDTI philosophy is disseminated to health and medical students through the training curriculum.

12 Impact of APOC operation on clinical manifestations of Onchocerciasis: Phases I and II: Agenda Item 11

54. Dr. Michel Boussinesq presented the results of the long-term impact assessment of APOC operations carried out in 13 sites across 8 countries. The study consisted of three cross-
sectional surveys to be conducted at 5-year intervals (Phase I: 1998-2000, Phase II: 2004-2005 and Phase III: 2009-2010) of representative samples of the population (drawn at random after census of the total population).

55. The study is intended to test the hypothesis that regular treatment with ivermectin will:

1) Reduce severe itching;
2) Prevent development of onchocercal skin disease or regress early skin lesions;
3) Prevent or delay progression of onchocercal eye lesions and blindness and regress early stages of ocular lesions;
4) Lead to reduction in transmission potential (entomological indices);
5) Lead to improvement in the quality of life in the community.

56. Data from the first and second surveys conducted in 13 sites (Nigeria (3), Cameroon (2), CAR (2), DRC (2), Sudan (1), Uganda (1), Tanzania (1) and Ethiopia (1)) were presented. The sites in DRC, CAR, Gabon and Tanzania did not undergo the planned 5 years of CDTI, so the data from these sites do not contribute valid data to the assessment of the impact of 5-yearly CDTI treatments.

57. Across all sites, a reduction in skin and eye lesions was found between Phase I and II, and the extent of reduction depending on the type of lesion.

58. Entomological assessment is still ongoing as well as discussions on the most appropriate indicators for assessing the impact of CDTI activities.

59. It was suggested that to obtain data on the impact of 5 years of CDTI, data from only those sites that actually have undergone 5 years of CDTI with good coverage needed to be analyzed. These data would provide the information requested by JAF and donors. In addition, an analysis that stratifies by number of treatments individuals have actually received may provide valuable information.

60. The data obtained in Phase II from the sites that have hardly undergone any CDTI treatment may provide 'baseline data' for an impact assessment based on a longitudinal approach. A large proportion of the data has either been accepted for publication or has been prepared for submission for publication.

13 Rapid epidemiological mapping and impact of control activities in APOC countries (Agenda item 19), Update on RAPLOA and management of SAEs (Agenda item 20)

61. Dr. Mounkaila Noma, Chief of the Epidemiology and Vector Elimination Unit presented an update on the latest REMO/GIS activities in APOC.

62. REMO has been completed in Burundi and the data integrated into the GIS. REA was conducted during the RAPLOA exercises in DRC. Funds were released to refine REMO in Littoral 1 in Cameroon and Morogoro in Tanzania. As at now, the population infected is estimated at 37.3 million people and it is estimated that the population at risk will be 102 million people in 2010.
Out of 215,388 people treated in DRC (Ubangui Nord, Ubangui Sud, Tshopo and Equateur-Kiri) between January and March 2006, 318 cases of SAEs were reported.

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MDP has not received any information on the new cases of SAEs reported in DRC in January-February 2006. TCC insisted that countries had the obligation to systematically inform APOC Management and MDP simultaneously of any SAEs as they occurred.

TCC stressed that in areas with prevalence of <40% (20-39%), it was important to use RAPLOA results to determine areas where ivermectin distribution should be conducted. In this regard, TCC suggested that APOC should generate an updated onchocerciasis and loiasis endemicity map and make it publicly available.

** 14 Feasibility of study on compliance to and perceived benefits of annual ivermectin treatment (Agenda item 18) **

Dr. Bill Briegger presented the results of a feasibility study on compliance with, and perceived benefits of annual ivermectin treatment. The overall objectives of the study were to:

1) develop and test/validate appropriate simple tools to assess compliance;
2) determine factors that influence individual and village long-term compliance.

The study consisted in:

1) reviewing district and community level records;
2) assessing whether there are sufficient community-level records to measure individual compliance (i.e. correct number of tablets have been taken consistently each year since the start of the project unless contraindicated based on e.g. age, pregnancy, severe illness);
3) calculating levels of community compliance (i.e. if community members plan annual distribution) and individual compliance.

The study sites selected included those sites with at least 7 annual ivermectin treatments since launching of the CDTI project; availability of records on CDTI activities for each year at district and community level; village compliance and completeness of CDD records on treatments. A total of 17 projects were selected from Cameroon, Chad, Nigeria, Tanzania, and Uganda.

The study showed that:

1) a large-scale compliance study was feasible;
2) CDD records were important for verifying compliance;
3) The use of CDD records to calculate compliance is essential for the future study, though issues of recall are still of interest;
4) people underestimate or forget whether they were treated;
5) The study does give a hint of possible factors that may influence compliance including age and sex;
6) A future study needs to make a more concerted effort to identify and include ethnic and other minority groups;
7) Such studies are difficult in poorly managed projects with inadequate record-keeping and documentation.

70. The study also showed that there may be a correlation between the quality of CDD records and the quality of other aspects of the work of the CDD (including mobilization, follow-up of absent community members). Consequently, relying on CDD records which satisfy the minimum quality criteria as a determinant for inclusion in the study may result in an overoptimistic assessment of compliance when the data from the study are used for APOC area-wide conclusions.

71. The large-scale compliance study will evaluate whether there is a correlation between the number of consecutive treatments taken, and the subjective perception of benefit.

72. Based on the results of the feasibility study, TCC recommended that the main study on compliance with, and perceived benefits of annual ivermectin treatment should proceed.

**15 Sustainability through integration: experience in a health district in Cameroon (Agenda item 13.b)**

73. Dr. Dieudonné Eloundou, District Medical Officer of the Esse District in Cameroon reported on the experience of the Esse District in integration and resource mobilization for malaria, HIV/AIDS, tuberculosis, diarrhoea and onchocerciasis, the predominant diseases in the district.

74. Sustainability of CDTI is ensured through the integration of CDTI activities into the global district plan of action at the beginning of each year. Resource mobilization is based on a 5-year development plan and subsequently on an annual operational plan. Advocacy is carried out and funds are raised from potential partners and managed by a district management committee.

75. Since 2004, the state contribution has increased from 150 000 to 300 000 FCFA while that of HKI and APOC has decreased from 250 000 FCFA to zero. However, it has been difficult to obtain the release of government funds.

76. Prior to integration, therapeutic coverage was 69% in 2003, after integration it was 69% and 72% in 2004 and 2005, respectively.

77. From the experience of the Esse District it can be deduced that a bottom-up methodological assessment of resource requirements, formulation of operational plan with time lines and good budget governance are very important in ensuring integration and resource mobilization.

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78. TCC commended Dr. Eloundou for the achievement in integration and resource mobilization in the Esse District and for sharing his experience with TCC. The Committee encouraged other districts to learn from the Esse District experience.

79. TCC suggested that it would be useful to continue to invite district medical officers to TCC meetings to enhance capacity-building and sharing of experiences on integration of CDTI activities in their countries.
16 Nodding disease

80. Dr. Hans Remme reported on existing data from WHO on 'Nodding disease'. The information revealed that the occurrence of "Nodding disease" appears to be focused on one district in South Sudan, Mundri. 4 investigations were conducted in 2001 and 2002. Based on 87 documented cases, nodding and/or seizures are initial symptoms. Other symptoms include: severe stunting, poor sexual development, mental retardation. The age of onset was mostly found to be 9-16 years.

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81. Nodding disease may be similar to the "Nakalanga" syndrome reported in Uganda some years ago for which a link with onchocerciasis was suggested. It was observed that no more new cases were recorded when elimination of the vector from the Jinga Focus was achieved in the late 1960s. New cases have been reported in the Masindi District where ivermectin treatment is ongoing while in other districts there is a decline in incidence.

82. The link between onchocerciasis, epilepsy and ivermectin treatment is not at present clear and needs to be urgently evaluated (see section 24.5). No brain lesion was found at (computerized Tomography) (CT) scans in 5 children in Cameroon with Nakalanga in comparison to controls. In a study in Cameroon, Nakalanga and/or epilepsy cases had a higher microfilarial burden than controls. Epidemiological data on the frequency of epilepsy in relation to the endemicity of onchocerciasis are inconclusive.

83. The Nakalanga disease could have a multi-factorial cause, including onchocerciasis and nutritional factors. The focal nature of epilepsy could be due to co-factors including: (1) other epileptogenic infectious diseases (more frequent close to rivers than further away); (2) a specific strain of O. volvulus and (3) genetic predisposition.

84. It was suggested that clarifying the link between epilepsy and onchocerciasis on the one hand, and epilepsy and ivermectin treatment on the other, could provide data on another benefit of ivermectin treatment and could interest in particular donors such as UNICEF.

85. TCC recommended that:

1) APOC should commission a comprehensive epidemiological study on Nodding disease in South Sudan, to complement available data and to verify and further characterize the epidemic outbreak.

2) TCC should form a subgroup that develops operational research proposal for looking into the broader issues relating to Nodding disease, Nakalanga, epilepsy and their association with onchocerciasis and ivermectin treatment. The subgroup should consider including in the research agenda a placebo-controlled study of epileptics hospitalized for ivermectin/placebo treatment.

17 Ivermectin treatment for onchocerciasis control in urban areas>
Lessons from the programme of Congo (Agenda item 14)

86. Dr. François Missamou, National Onchocerciasis Coordinator for Congo reported on the experience of Congo in CDTI implementation in Brazzaville.
87. One of the difficulties encountered in this project was defining what constituted a 'Community' in an urban setting. For the purpose, the "administrative area" as referred to in the administrative structure of Brazzaville was used as a community and the health staff at the Integrated Health Centre was regarded as the supervisory authority.

88. Other difficulties encountered in the implementation of CDTI included:

1) misinformation of the population on the benefits and the adverse effects of ivermectin, hence refusals.
2) the authority of the leadership of the head of the "administrative area" (community) is less significant than it is at the village community level;
3) lack of interest in community-based activities in an urban setting, even of community leaders;
4) intense population movement;
5) difficulties in harmonizing days/times of treatment with the daily work schedules of the population;
6) difficulty in disseminating information - too many channels of communication (radio and TV stations from both Congo Brazzaville and Kinshasa can be received).

89. To tackle the above difficulties, the project management identified and put in place some measures including:

1) inclusion of the highest administrative and political authorities in the dissemination of information;
2) training of people working in the public media, churches, NGOs, local associations on CDTI;
3) dissemination of information to the population by health care personnel using audio-visual media, as well as by administrative, political, church, NGO, association leaders;
4) Choice of CDDs among those living permanently within the district. (about 3-4 CDDs/community). CDDs were often the heads of the administrative zone or the administrative blocks.

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90. There was concern about the therapeutic coverage at the Makélékélé site which has been constantly low. This was explained to be due to lack of support from the administrative authorities and frequent personnel turnover.

91. It was emphasized that CDTI was developed for rural areas where it has proven to be effective and efficient. The usefulness of the concept in the urban setting remained to be demonstrated. It was recognized that in the context of an urban setting people are more likely to reject treatment or health services if they are administered by non-healthcare workers. It was suggested that perhaps other strategies for ivermectin treatment in urban areas may have to be explored.

92. To resolve the problem of authority of the community leadership, it was suggested that perhaps the community should be redefined, bringing it a level below the "administrative area".
18 Challenges of CDTI implementation in Chad: highlights on data management and decentralization (Agenda item 15)

93. Mr. Lokemla Nadjilar, National Coordinator of Chad presented a report on the progress of CDTI activities in Chad. He recalled that a sustainability evaluation undertaken in 2003 revealed that the project was not making progress towards sustainability. The project was found to be vertical, health workers were uninterested and the project was characterized by serious data management problems. Today the situation reported is different. Onchocerciasis is one of 10 diseases under the national integrated disease surveillance system. It is included in the national health budget and ivermectin is on the list of essential drugs. A national policy on onchocerciasis control has been elaborated and CDTI is under the direct control of a decentralized structure.

94. Therapeutic coverage has remained about 66% since 2000. Government contribution to CDTI has increased from US$94295 in 2003 to US$111338 in 2005. However, the project faces a number of challenges: (1) increasing capacity for supervision and sensitization, (2) social mobilization across the country, (3) identifying NGDO support, (4) training of more CDDs, (5) training of health personnel and CDDs in the utilization of data collection and management methods, and (6) integration of CDTI with other interventions with technical support from APOC.

95. A special computer programme for data management has been developed for Chad. The programme is in Microsoft Access. It is easy to use, flexible and adaptable to the data management requirements of other programmes. The programme has been installed in the 7 health regions of the CDTI project and at least one person per region has been trained in its use. However, inadequate hardware, insufficient knowledge of the staff in computers and unreliable electricity supply constituted some of the challenges in the use of the data management programme.

96. TCC recommended that the computer programme developed for Chad should also be made available to all other countries for the management of their data.

19 Report on financial management of APOC funded projects (Agenda item 20)

97. In the absence of the APOC Budget and Finance Officer, the report on financial management of APOC-funded projects was presented by Dr. L. Yameogo. For the sake of the new participants in TCC, he explained the APOC process for funding CDTI projects which essentially consisted in signing Letters of Agreement (LA) between APOC and the projects, based on a plan of action and budget submitted by the projects; the release of funds is done through WHO country offices; and the obligation for the projects to send to APOC Management financial returns on the funds they received from APOC.

98. Dr. Yameogo reported that the period of validity of the Letters of Agreement is being harmonized so that all Agreements will now run from January to December of the year.

99. From a total of 102 Letters of Agreement to be signed for 2006 only 5 plans of action and budget had been received from the countries as at 28 February 2006. In order to avoid long delays in the release of funds, APOC Management has gone ahead with the drafting of 54
Letters of Agreement for projects based on the 2005 plans of action and budget received from the projects.

100. Of a total of 1666 financial returns expected for 2005, 1466 had been received and 1240 returns analyzed (561 by the AAF at the country level and 679 by APOC HQ).

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101. To reduce the workload on the APOC financial staff, it was suggested, and as also recommended by the 2005 APOC External Evaluation Team, to devolve the analysis of the financial returns to the WR's office in the countries. Temporary measures have been taken by APOC Management to help clear the existing backlog. APOC Management was also discussing with the WHO country offices to determine how some of the APOC headquarters activities could be devolved to the countries.

102. The attention of APOC Management was drawn to some projects approaching their 8th year of APOC funding who still had some funds in their accounts. TCC suggested that clear guidelines be given as to how such funds should be managed by the projects. APOC Management agreed to review the issue further internally and to take stock of such projects.

103. Some projects in their 7th and 8th years have ceased to send annual reports to APOC Management although they received funding from APOC. TCC’s guidance was sought on how to get those projects to continue reporting on their CDTI activities even after APOC funding had ceased.

20 Report on review by APOC management of 1st, 2nd, 3rd, 4th, 5th, 6th, and 7th year progress reports and subsequent year budgets (Agenda item 21)

104. A total amount of US $ 6,124,255 has been budgeted for funding projects in 2006. As at 28 February 2006, US $ 2,548,122 has been committed for 54 projects (49 CDTI, 3 vector elimination, 2 HQ support projects), leaving a balance of US $ 3,576,133 to finance a total of 58 projects (52 CDTI, 5 HQ support and 1 vector elimination projects) and other field activities.

21 Review of operational research proposals

21.1 Side effects of mass treatment with ivermectin and its impact on onchocerciasis control activities in the Tshopo health district

105. The objectives of the study are not clear and the conceptual framework is not consistent with current knowledge. The authors do not correctly distinguish between serious and severe adverse events.

106. TCC recommended that the proposal be rejected, and that the reviewers should discuss it by e-mail with the authors.
21.2 Studies on coverage and sustainability of CDTI among Nomads in Taraba State.

107. The proposal addressed important issues. However several aspects of it needed to be strengthened. The background should include a literature review and analysis of all available data (including quantitative data) on which the research question is based. The method section should be revised to be able to determine coverage and assess factors influencing sustainability. It should also include a sampling frame and analysis plan.

108. **TCC recommended that the proposal be revised and resubmitted with a revised budget to the reviewers through APOC Management.**

21.3 Pregnancy outcome and growth of children exposed to ivermectin in utero: a retrospective community-based study in Uganda.

109. The proposal did not clearly describe the study area and how the 'study population' will be identified. TCC felt that the issue is outside the scope of any small scale operational research proposal and **recommended that the proposal be rejected.**

21.4 Training more CDDs using Kinship “Umunna” structure to strengthen the sustainability of CDTI in Delta, Enugu and Anambra States CDTI Projects, Nigeria

110. Three proposals were submitted for training more CDDs using the Kinship structure to strengthen the sustainability of CDTI. APOC Management requested TCC to review the proposals as operational research proposals. After review of the proposals by TCC, it was concluded that all three proposals were not operations research and should be reviewed by APOC Management as proposals for training new CDDs.

22 Review of new project proposals and 1st, 2nd, 3rd, 4th, 5th, 6th, and 7th year annual technical reports on the implementation of CDTI and Vector Elimination projects. Recommendations on 2nd, 3rd, 4th, 5th, 6th, 7th, and 8th year implementation of the projects *(Agenda item 22)*

22.1 SUDAN

22.1.1 Sudan Northern Sector CDTI Project (8th year report) - Proposal for reorganization

111. The proposal was very scanty and should have been an 8th year report rather than a proposal. The proposal was not endorsed by the relevant authorities.
112. TCC noted that two years had been lost due to delay in responding to sustainability evaluation findings. Information on project activities during this 2-year gap should have been provided. Also, handover from previous project managers was said to be difficult and slow but no explanation was provided on the efforts made to take over from the project managers.

113. The background information on the two new foci, Sundus and Koryabus, being proposed should have been provided with justification for the objective of onchocerciasis elimination.

114. **TCC rejected the report and requested the project to do the following:**

   i. **re-submit a comprehensive report of project activities with all missing information to APOC Management. The report should be endorsed by the relevant authorities;**
   
   ii. **provide more details of activities and achievements since evaluation;**
   
   iii. **provide a map of new administrative arrangements between North and South Sudan projects;**
   
   iv. **while appreciating the post-conflict situation, the budget should be scaled down to only items approved by the Abuja meeting, and reduce the number of vehicles, though distances are appreciated;**
   
   v. **provide a more detailed project sustainability plan;**
   
   vi. **provide a district sustainability plan at least for the Abu Hamad focus which is stable;**
   
   vii. **provide a role for AMST in a technical capacity.**

22.2 **NIGERIA**

22.2.1 **Plateau State CDTI Project (6th year report)**

115. The project reported that there has been some improvement in: (1) the political commitment in some LGAs; (2) availability of logistic support for supervision; and (3) awareness created and active involvement of health workers and communities. CDTI has been integrated into PHC with other neglected diseases (LF, Malaria - ITNs, and Schistosomiasis) which is commendable. Training, drug delivery and supervision are also jointly undertaken. However, financial support from state government is poor.

116. For further improvement, TCC suggested the following:

   **Report-related**
   1) **provide more information on progress made on implementation of the recommendations of the sustainability evaluation.**

   **Project-related:**
   2) **document integration of neglected diseases into CDTI and use the results to advocate for funding at state and local government levels;**
   
   3) **NOTF and APOC Management should support the project on advocacy to state government for funding of CDTI;**
   
   4) **review the UTG based on evidence;**
   
   5) **improve on geographic coverage in Bokkos and Jos East local governments;**
   
   6) **identify and address the reasons for poor therapeutic coverage in Kanke LGA;**
7) disaggregate expenditure by NGDO partner (US$ 295 000) particularly for supervising CDDs and distribution;
8) train all health staff in the project area on CDTI;
9) ensure that communities carry out CSM and SHM to strengthen community involvement, participation and sustainability;
10) improve CDD/population ratio;
11) explain the high number of Mectizan® tablets left in the field;
12) outline progress on the implementation of the sustainability plan.

117. **TCC accepted the report and requested that the above issues be fully addressed and reflected in the next report.**

### 22.2.2 Nassarawa State CDTI Project (6th year report)

118. The project submitted a comprehensive report indicating a year of CDTI activities with good geographic and therapeutic coverage. However, there were several issues in the report for which TCC requested clarification or further information:

**Report-related:**
1) the Executive Summary should be written in a more narrative format, and data therein should match those in the body of the report. The Executive Summary with the report contained statements that contradicted data in the report (e.g. training accomplishments, financial contribution by communities, etc.);
2) the outcomes and feedback given after supervision were not clearly described. Moreover, it is not clear why LGA staff train, mobilize, and supervise at the community level; this should be the responsibility of the FLHFs;
3) the financial information needs to be more clearly presented in one currency with column totals calculated correctly;
4) the timeline was difficult to interpret as most activities were indicated as having occurred for spans of 7-10 months and often during the entire reporting period (12 months). This should be clarified.

**Project-related:**
5) the eligible population provided on page 6 (732,067 people) is less than the UTG provided on page 5 (877,716). In a project like this which has had more than 8 cycles of mass treatment, the UTG and eligible population should be nearly equal;
6) it is recommended that project partners continue their efforts in advocacy to improve on the release of counterpart funds from the State and LGA;
7) the project is commended for training over 1,000 new CDDs and is encouraged to train even more new CDDs in order to reduce the population/CDD ratio. Inclusion of women in opportunities for health education is essential;
8) it should be explained why female CDDs were chosen based on socio-cultural and religious beliefs;
9) no refusals were indicated in the treatment tables, yet reasons for refusals were given in the text. The project should clarify;
10) the project should explain the significant fluctuations in the number of people treated and the total population in recent years (e.g. close to one million were treated in 2001 and 2002, while 753,227 were treated in 2005;
11) it is unclear as to why the 5.4 million Naira released by the State for CDTI was not accounted for in the financial information on pages 18 and 19 and why it was not mentioned in the response to TCC18’s recommendations on page 1;
12) CDTI is being integrated into LF, schistosomiasis and RBM. Are all of these programmes regular activities of the MOH at the State level?

119. **TCC rejected the report and requested that a revised report addressing the above issues be resubmitted to the reviewers through APOC Management**

22.2.3 Enugu State CDTI Project (6th year report)

120. The report was well-written with detailed information, but was submitted a year and a half late. The project is already in its 8th year, which makes the information provided less timely. TCC requested that efforts must be made to submit future reports on time.

121. The figures reported showed a steady increase in coverage from 2001-2004; however, the increase is mostly due to a decrease in denominator, which needs to be explained.

122. TCC was pleased to note that 95% of the Year 1 sustainability plan was implemented. For improvement of project implementation, TCC made the following suggestions:

1) census is not well done everywhere which explains the changing denominator. There is a need to establish a correct denominator. The project should allocate resources and priority to ensure a reliable denominator;
2) cost per treatment is 2 cents (it seems this does not include costing of time). The project should apply the cost study guide as an interesting case study of a mature project with high coverage. Perhaps this could be submitted to TCC as an operational research proposal;
3) suggest continuing supervision until the end of the distribution period;
4) for social mobilization purposes, it might be more effective if "Oncho day" activities could be held closer to the actual distribution time;
5) although coverage is high, more CDDs, particularly female CDDs should be trained. The ratio of 1 CDD / 261 population is not enough.

123. **TCC accepted the report and requested that the above issues be properly addressed and reflected in the next report. TCC took the opportunity to congratulate the project for its performance and encouraged it to sustain this achievement.**

22.2.4 FCT CDTI Project (6th year report)

124. This is a mature project with commendable performance. The project achieved 100% geographic coverage and a therapeutic coverage of 87% during the reporting period. The State contributed US$50 000 to the activities of the project which is a good indicator for sustainability. However, it seems that the funds received were not planned properly.

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

   i. the project should utilize some of the funds released to maintain or replace equipment.
   ii. one CDD per community is not enough, therefore more CDDs need to be trained to increase the number of CDDs per community.
iii. the project should find appropriate ways of involving women in the decision-making process.

22.2.5 Taraba State CDTI Project (7th year report)

126. For a project now in its 8th year, TCC was concerned to note a further decrease in geographic coverage from 90.2% in 2003 to 85.6% in 2004. The involvement of women in CDTI activities is also minimal (4 female CDDs out of 1803 CDDs). It is also unclear how the CDDs are involved in nutrition education and eye care services. TCC also expressed concern for the loss of 97,000 ivermectin tablets at the Ibi LGA. Lack of supervision and the non release of funds by State and LGAs were also issues of concern to TCC.

127. TCC accepted the report and recommended that the project:
   i. need to achieve and maintain 100% geographic coverage;
   ii. train more new CDDs in each community;
   iii. involve more female CDDs;
   iv. ensure the state and LGAs release funds for CDTI activities;
   v. explain how communities are involved in Vitamin A distribution, nutrition education and eye care activities.

22.3 CHAD

22.3.1 Chad CDTI Project (6th year report)

128. The project has consistently made progress in terms of therapeutic coverage, though this rate (66%) has not changed since 2002. TCC noted that the community actively participated in CDTI activities. Ivermectin delivery to the communities is integrated into the Minimum Package of Activities (PMA) and ivermectin procurement is integrated into the national essential drugs distribution network (ME). However, the project had difficulty obtaining state contribution to CDTI activities.

129. The project is commended for a well-written report.

130. TCC accepted the report and requested that the project:
   i. continue sensitization with authorities to ensure regular and timely disbursement of project funds;
   ii. solicit state assistance in addressing the problem of means of transport.
   iii. the CDD/population ratio is low (1/304). Find solutions to accelerate the training of CDDs and make an effort to increase the proportion of female CDDs;
   iv. intensify supervision in health districts;
   v. see to the harmonization of data in the next report.

22.4 DEMOCRATIC REPUBLIC OF CONGO (DRC)

22.4.1 Bandundu CDTI Project (3rd year report)

131. The report is well-written, and reflects the level of implementation of the project.
132. Overall therapeutic coverage was 63%. This could have been higher if the required quantity of ivermectin tablets was accurately estimated. To improve project implementation, TCC requested that the project:

1) pursue advocacy efforts at state level for financial support to the project;
2) sensitize the population in order to enhance women’s participation;
3) promote integration of CDDs into other health activities;
4) Look for NGO partners that are capable of giving financial support, in view of the withdrawal of IMA;
5) ensure that census of the population is correctly taken in the peripheral areas so that adequate quantities of Mectizan could be ordered;
6) apply the sustainability evaluation recommendations, especially with regard to materials and equipment.

133. **TCC accepted the report and requested that the project address the above issues and submit, as planned, an operational research proposal on the participation of women in CDTI.**

22.5 TANZANIA

22.5.1 Tanga CDTI Project (5th year report)

134. The project presented a well-written report which provides adequate information on all activities undertaken during the reporting period. The recommendations of TCC17 have been satisfactorily addressed. The project achieved 100% geographic and 80.3% therapeutic coverage. TCC encourages the project to keep up the good work.

135. **TCC accepted the report and requested the project to:**

   i. provide information on what actually happened to the remaining 69,002 tablets;
   ii. document the support given by communities;
   iii. provide information on monitoring;
   iv. provide more information on integration of LF and eye care;
   v. explain why the percentage of communities with female CDDs was 48 in Lushoto but 100% in Muheza and Korogwe.

22.5.2 Tukuyu CDTI Project (5th year report)

136. TCC commended the project for a well-written report using the new reporting format. The report provided comprehensive information although there were some minor inconsistencies in population data. The project is functioning well. Definite steps are being taken for post-APOC sustainability of the CDTI project using country resources from MOH and district health services in spite of lack of APOC funds. The degree of integration is very impressive; SHM and CSM seem to be well established. Both financial and non-financial contributions of communities should be acknowledged.

137. **TCC accepted the report and requested the project:**

   i. to correct data inconsistencies between tables 2 and 7;
   ii. provide data on the number of health staff involved in CDTI activities in Ileje in Table 1.
22.5.3 Kilosa CDTI Project (4th year report)

138. The report was well-written and reflected the impact of the participation in the report-writing workshop held in Tanzania. For further improvement of the report and of the overall project implementation, TCC requested the project to:

1) include responses to comments in the text of the next report, where appropriate, rather than only in the responses to the TCC section;
2) include in the project description, details on project implementation rather than simply a description of the geographical area;
3) report population data and coverage data by zone as well as total;
4) reconcile UTG figures. There are three different figures in the report: Executive Summary = 446,548; Table 1.2 (p 14) = 367,167; Table 9 (p 25) = 357,166;
5) indicate funding source for t-shirts and posters for CDDs at launch of distribution. Will this incentive for CDDs continue every year? If so, how will it be financed?
6) document the process and the results of the interesting integration activities and experience occurring in the project.

139. TCC accepted the report and requested that the above issues be addressed in future reports.

22.5.4 Mahenge CDTI Project (7th year report)

140. The project has had a progressive increase in therapeutic coverage from 30% in 1997 to 72% in 2005. Advocacy carried out by the project was successful and enabled CDTI to become a common agenda in all political and government meetings. The report was well-written although it did not capture monitoring activities and challenges.

141. To improve overall reporting and project implementation, TCC requested that the project undertake the following:

Report-related:
1) improve on the Executive Summary;
2) provide more information on implementation of the sustainability plan;
3) ensure consistency in the report;
4) link background information to project activities;
5) edit the report to improve its quality.

Project-related:
6) train and involve more health staff in the project area on CDTI;
7) improve the CDD/population ratio to 2:250;
8) take advantage of discussions on CDTI at all political and government meetings to include CDTI in the comprehensive council health plan;
9) improve health education and mobilization in the Ulanga District;
10) ensure that communities implement CSM and SHM to reduce the number of refusals and absentees;
11) carry out mop-up treatment to improve therapeutic coverage;
12) improve the quality of supervision;
13) undertake operational research to identify and address the high number of refusals and absentees;
14) document the decrease in epileptic seizures following treatment with ivermectin.
142. **TCC accepted the report and requested that the project address the above issues in its next report.**

### 22.5.5 Ruvuma CDTI Project (6th year report)

143. The project presented a well-written report that reflected the impact of Dr. Saguti’s participation in TCC meetings although it was written using the old reporting format.

144. TCC noted with satisfaction that therapeutic coverage had consistently progressed, from 53% in 1999 to 71.8% in 2005. There was also very good integration of all health services and it was interesting to note that the CDTI structure was being used for trachoma SAFE strategy.

145. **TCC accepted the report and requested that the project take the following action:**

   i. use the most recent reporting format in subsequent reports;
   
   ii. resolve the issue of ATO and UTG - ATO exceeds UTG;
   
   iii. provide reasons why Sonega community response is poorer than other districts
   
   iv. conduct cost analysis using the Financial Manual Version 1 provided to the NOTF from APOC Management as a pilot test of the instrument;

   v. provide additional information on process and outcomes of the CDTI/Trachoma integration.

### 22.5.6 Tunduru CDTI Project (1st year report)

146. For a first-year project, the report was fairly well-written. The basic CDTI implementation activities (community mobilization, community involvement, advocacy, capacity-building, etc.) were satisfactorily carried out. The level of involvement of women as CDDs is especially commendable (49.8%) with a ratio of 1CDD:100 persons. Geographic and therapeutic coverage is good for a first year project, 100% and 70% respectively.

147. Government funds from the Central Ministry of Health were not released. Only US$2 780 were released from the district.

148. TCC was concerned that a message requesting incentives from donors and the government for CDDs was likely to cause more problems in CDTI implementation by hindering the training of new CDDs and increasing CDD attrition rate.

149. **TCC accepted the report and requested that the project ensure that the Central Ministry of Health contribute cash for CDTI activities and not just salaries, if sustainability is to be attained.**

### 22.5.7 NOTF HQ Support Project (7th year report)

150. The recommendations of TCC20 have been satisfactorily addressed. The Executive Summary was well-written and gave a good insight into the support provided by NOTF headquarters. CDTI activities have been integrated into PHC and incorporated into the PRSP.

151. To further improve the report and project implementation, TCC requested the project to undertake the following:
Report-related:
1) provide a better insight into progress on implementation of the sustainability plans of the projects;
2) provide information on the activities of the vector control project;
3) ensure summation of tables in the report.

Project-related:
4) maintain the current treatment coverage;
5) identify ways of targeting women;
6) advocate for the release of the MoH contribution for CDTI activities in Mahenge and Morogoro Districts;
7) ensure that communities undertake CSM and SHM to reduce refusals and absentees;
8) encourage projects to undertake mop-up treatment, ensure the treatment of pregnant women post partum when they are eligible in order to improve therapeutic coverage;
9) monitor the implementation of the sustainability plans of the projects.

TCC accepted the report and requested that the project address the above issues in its next report.

22.5.8 Tukuyu Vector Elimination Project (7th year report)

The report covers the period from July to December 2005. Activities conducted during the period under review included preparation for the larviciding campaign (mainly updating dosing points, sensitizing the population on the campaign and insecticides), larviciding of rivers, prospection of watercourses, and catching of blackflies.

Presence of pre-imaginal stages: Prior to larviciding, out of 90 breeding sites where prospection was carried out, on the main rivers (Lufilyo, Mbaka, Kiwira, Lumbira, Kilondo and Mwali), 35 were found to be positive (38.9%) for *S. damnosum*. Out of 418 breeding sites, where prospection was carried out during larviciding, only two were positive. Three weeks after cessation of larviciding, 4 out of the 33 breeding sites which underwent prospection were positive.

Presence of biting females: Prior to larviciding, the average blackfly density in the focus was 111 bites/man/day. With the intensity of larviciding, the density dropped to 43, 17 and then 13 bites/man/day in weeks 3, 7 and 11 respectively. After the cessation of larviciding, no female blackfly was caught during the first four weeks. However, blackflies reappeared in the fifth week.

An EIA survey was carried out from 5 to 19 July 2005 to gather baseline data.

TCC noted that the outcome of the 2005 campaign was not satisfactory given the reappearance of biting females. The Kasyabone species of *Simulium damnosum* and *S. thyolense* are still found in the focus, despite the 2005 larviciding campaign.

The main cause of the unsuccessful larviciding campaign was explained to be due to new larval sites which were unknown before the campaign and which were not treated.

TCC noted that the project did not abide by the reporting requirement which was one of the conditions of TCC19 for approving the second and final larviciding campaign.
160. **TCC accepted the report and recommended that:**

   i. *in accordance with the recommendation of TCC20, APOC funding to the project should cease but that APOC Management should continue to provide technical advice as may be required by the government regarding the project;*

   ii. *APOC should assist the project in drawing up a national project protocol, in conformity with the recommendation of the 2005 APOC External Evaluation report;*

   iii. *the situation of the project should be well documented by APOC Management and presented at TCC23.*

### 22.6 CAMEROON

#### 22.6.1 Centre II CDTI Project (3rd year report)

161. Although the Executive Summary was concise and provided a brief explanation of project activities and accomplishments, it should have been written in a more narrative format.

162. The project achieved 100% geographic coverage and 74.4% therapeutic coverage. Issues identified by the project included financial support from government and communities and the management of SAEs; insufficient means of transportation, delay in the payment of CDDs by the government and difficulties in writing supervision reports.

163. **TCC accepted the report and requested that the project pursue its efforts in:**

   i. *integration;*

   ii. *reinforcing support of CDDs by the government and the communities;*

   iii. *implementing the sustainability plan;*

   iv. *providing financial figures for the two previous years covered by the report.*

#### 22.6.2 Centre III CDTI Project (6th year report)

164. The report is well-written, concise and comprehensive except that financial data for the two years preceding the reporting period are missing and should be provided.

165. The performance of the project is good with therapeutic coverage above 65% since 2002 (75.9% in 2005).

166. **TCC accepted the report and recommended that, to further improve project performance, the project should:**

   i. *make further efforts towards enhancing integration;*

   ii. *strengthen supervision;*

   iii. *secure state and community support for CDDs;*

   iv. *implement the sustainability plan.*

#### 22.6.3 South-West II CDTI Project (5th year report)

167. Although the report was fairly well-written and complete on most aspects, there were question marks instead of data in a few places and wrong data in others. The project staff and NOTF should ensure that in future a thorough review of the report is done before sending it to TCC.
168. The project should make an effort to collect and report the financial data more completely so that a cost per treatment can be calculated.

169. TCC commended the project for a steady increase in coverage over the past three years and the efforts to promote integration of other interventions with CDTI.

170. TCC agreed with the project that continued advocacy is important and supports its request to APOC to fund advocacy in Year 6, if it is included in the sustainability plan.

171. One CDD / 267 population is not enough. TCC suggested that the project double the number of CDDs, with a focus on finding and training more female CDDs.

172. TCC accepted the report and requested that the project address all the above issues in its next report

22.6.4 North-West II CDTI Project (2nd year report)

173. The report was fairly well-written but with some missing information.

174. Coverage was good for a Year 2 project (98% geographic coverage and 67% therapeutic coverage).

175. With a view to improving on the report and on overall project implementation, TCC requested that the project take the following action:

   Report-related: Provide (in the next report) missing information on:
   1) activities undertaken in January, February and December;
   2) community response to sensitization and mobilization;
   3) suggestions on how to improve sensitization and mobilization;
   4) CDD attrition;
   5) procedure for ivermectin delivery;
   6) results of CSM and SHM;
   7) integration;
   8) recalculation of data in Table 4.

   Project-related:
   9) train and use community supervisors;
   10) try to resolve the problem of 2004 motivation;
   11) encourage community motivation of CDDs;
   12) intensify sensitization to dispel rumours and fear of SAEs.

176. TCC accepted the report and requested the project to address and to report on the above issues in its next report.

22.6.5 NOTF/HQ Support Project (7th year report)

177. The report is very comprehensive and demonstrates that the NOTF is supporting its CDTI projects which, overall, are performing well. There are some deficiencies in the report for which clarification is requested.
Report-related:
1) the introduction is a continuation of the Executive Summary and gives project accomplishments for the reporting period, rather than providing a general introduction to CDTI activities in Cameroon;
2) the NOTF should provide a brief explanation of the outcomes of advocacy and mobilization in its reports;
3) some project data are missing from Table 4. With the exception of Littoral I and Adamaoua I and II, there is no explanation for the missing data;
4) totals need to be calculated in Table 5. Some data on tablets requested and received are missing without explanation;
5) Adamaoua I and Adamaoua II are included in geographic coverage values in Table 6.2, yet it was stated that data from them were not available;
6) a summary of the clinical evolution of SAE cases was not provided. This could be achieved by attaching the Annual Reports of the *Loa loa* technical advisor;
7) data are missing from Table 12.

HQ Secretariat-related:
8) it is indicated in the Executive Summary that the NOTF plays a role in mobilization and supervision of CDDs. Can the NOTF explain why it is carrying out such activities instead of the local health workers?
9) monitoring for the implementation of sustainability plans in 4 project areas indicated that communities do not always understand what’s expected of them in the CDTI strategy. What is the NOTF doing to improve the situation?
10) the NOTF should do what it can to ensure that incentives promised to CDDs by the government are paid on time;
11) the national therapeutic coverages are good. The NOTF should continue to do what it can to reduce fears of side effects and to encourage communities to treat when most community members are present;
12) the NOTF should follow-up on its supervisory feedback to see how it is used by projects.

178. *TCC accepted the report and requested that the clarification requested above be sent to APOC Management.*

22.6.6 Littoral I CDTI Project (1st year report)

179. The project reported on the activities undertaken between April 2005 and March 2006. The report was scanty. TCC strongly felt that although no treatment was carried out during the period, available information on RAPLOA activities and population data for instance could have been provided. Besides, there were inconsistencies in some tables (incorrect totals).

180. TCC requested that the project should start treatment before providing a progress report.

181. *TCC rejected the report and requested that the project resubmit an appropriate report to the next TCC. The report should include information on:*

   i. the population of meso/hyper endemic areas;
   ii. the epidemiology of the onchocercal disease in the project area;
   iii. *Loa loa and the resources for managing adverse events.*
22.6.7 Littoral II CDTI Project (6th year report)

182. The report was concise, fairly complete and mostly consistent with data in the rest of the report. TCC was pleased to note that the sustainability evaluation concluded that the project was making real progress towards sustainability.

183. For the improvement of the report and the performance of the project, TCC requested the following:

**Report-related:**
1) additional details and better descriptions of activities would help to understand the project better, including more information on supervision and monitoring activities and the results; and the degree of integration into PHC and plans to improve this;
2) the project staff need to double check calculations and proof-read the whole report for consistency as a number of errors were noted therein;
3) clarification on the Mectizan tablets remaining should be provided;
4) please explain the increase in the number of communities from 2001-2002-2003, and 2005 with 100% geographic coverage each year. Were communities added or numbers redefined with better count?
5) calculation of UTG should be consistent. Please seek advice from the National Coordinator to gain a better understanding of UTG and percentage UTG achieved.

**Project-related:**
6) implement CSM in all villages with a strong introduction to CDTI to improve community ownership, if additional funding can be found;
7) extend distribution period to 2 months considering project claims that absentees were due to short period of one month, which did not allow for follow-up visits;
8) the project should work towards better integration of CDTI into PHC and also consider integrating other similar health interventions into CDTI;
9) census-taking should not cost any extra funds or very little if the CDDs update the census during distribution;
10) since the number of trained health personnel involved in CDTI has decreased from last year to now only 30%, it is suggested that the project should cross-train all (more) health staff to ensure that frequent absences from post do not affect the project;
11) the project should submit a sustainability plan as soon as possible to possibly obtain funds for capital equipment, training of more CDDs and implementation of CSM;
12) TCC suggests that additional data be collected to further analyze sustainability in Year 6 considering there was no financial support from APOC or the NGDO.

184. **TCC accepted the report and requested that the project address the above issues in its next report.**

22.6.8 South-West I CDTI Project (7th year report)

185. The report stated that there were problems inherent in all the activities, and so TCC appreciates the frankness of the author of the report. However, very few suggestions were provided as to how the difficulties might be overcome. Health staff and communities are exclusively blamed for the difficulties, though shortcomings are obvious in the area of supervision and the availability of IEC material.
186. Though therapeutic coverage rates reported are satisfactory, other data in the report suggest that these rates may not be correct. There is a clear issue of lack of supervision in the project at all the levels which partly explains the difficulties encountered.

187. It seemed, however, that project staff put in a lot of effort to include and treat hypoenemic populations. It is surprising that about 100,000 persons were treated in the hypoenemic villages. It is also surprising that all the activities were carried out in a short period, and that the CDDs were not trained on the surveillance of SAEs. The proportion of female CDDs, and the number of CDDs/population are still too low.

188. Financial data are incomplete, and information on stolen equipment should have been presented.

189. **TCC rejected the report and recommended that the issue of project leadership be brought to the attention of the various partners.**

### 22.6.9 Extreme North CDTI Project (1st year report)

190. The project submitted a report describing the CDTI activities that had been completed at the time reporting was required. It is only a partial report making it difficult to judge the project’s Year 1 accomplishments.

191. TCC noted that activities in the timeline were in logical order, but mobilization and training were planned for periods that lasted for 12 and 7 months respectively. The project should explain the extended duration of these activities. Outcomes of advocacy should be explained in the complete report. The project should also explain why health workers and other ministry of health staff are not trained in SAE management (Table 6, page 16).

192. TCC noted that students of less than 12 years of age have been chosen as CDDs since they have a greater level of literacy than adults in the project area. TCC felt that since students often leave communities for studies elsewhere, the project staff, in consultation with community members, should discuss how adults, even if illiterate, could serve as CDDs.

193. **TCC accepted the report and requested that a complete report be submitted to APOC as soon as all data are available so that the project's accomplishments can have a timely review.**

### 22.6.10 Centre I CDTI Project (4th year report)

194. The project submitted a comprehensive report indicating a year of CDTI activities with good geographic and therapeutic coverage. However, there were several issues in the report on which TCC made some comments and requested clarification or further information:

  **Report-related:**
  1) a very brief description of the project area is given explaining the population in the treatment area and the health care system. The description should be more comprehensive in the future;
  2) outcomes of advocacy and mobilization campaigns should be described in the next report.
Project-related:
3) the project is encouraged to increase the number of CDDs in order to bring the CDD/population ratio closer to 1:125;
4) the project should explain why CSM/SHM had not been implemented at the community level despite the training that had been carried out;
5) the project should explain why only a portion (US$119 008) of the released funds ($225 884) was spent during the reporting year. What was done with the funds not spent?
6) the population figures provided are from a national census of which the date is unknown. The project should explain why the CDD census is not used in reporting.

195. TCC accepted the report and requested that the requested clarification be sent to APOC Management.

22.7 UGANDA

22.7.1 Phase III CDTI Project (5th year report)

196. The project used the NOTF Secretariat reporting format and submitted a disjointed report in which information in some sections was for the NOTF headquarters and for Phases I and II. It was impossible to assess the treatment coverage over the years. Tables were either incomplete or not provided, making it impossible to assess the progress of the project. Data on absentees and refusals were not provided because of inadequate funds for collection of reports although partners provided funds. Also, communities were not trained on CSM and SHM.

197. It is uncertain whether the project is up to date in reporting since it referred to TCC 17 in its response to previous TCC recommendations.

198. TCC rejected the report and requested the project to resubmit a revised report to the next TCC with the following:

Report-related:
i. use the right format;
ii. improve on the Executive Summary, background and operational research;
iii. complete Tables 2, 8 and provide missing Tables in sections 2.3 and 4.1;
iv. provide information only for relevant districts in Phase III;
v. commence the completion of the report early;
vi. edit the report thoroughly before sending it to APOC Management.

Project-related:

vii. ensure training of community members on CSM and SHM and their implementation;
viii. integrate monitoring and supervision into the PHC system;
ix. provide the number of absentees and refusals;
x. APOC Management and NOTF to ensure annual reports are up to date.
22.7.2 Phase IV CDTI Project (5th year report)

199. The project used the NOTF secretariat reporting format making it difficult to extract the information; and many items were missing. The project should however be commended on its achievement with integration of onchocerciasis control into primary health care. Geographic coverage has been 100% and therapeutic coverage has been satisfactory over five years.

200. **TCC accepted the report and requested that:**
   
i. the project should in future use the new reporting format to ensure that all the necessary project information is provided;
   
   ii. the project should carry out advocacy to the Central Government to provide financial support in view of the limited funding support from districts related to the new tax regulations;
   
   iii. CSM and SHM should be commenced.

22.7.3 Itwara Focus Vector Elimination Project (2005 technical report)

201. The report covered the period from July to December 2005. Activities, including those carried out during the visit of Prof. GARMS, centred on the prospection of breeding sites, treatment of rivers and the catching of blackflies.

202. Between January and December, 6,688 crabs were collected: Itwara (2146), Aswa (3240) and Siisa (1302). None of these crabs had pre-imaginal stages of *S. neavei*. During the visit of Dr. Garms, 48 breeding sites were visited, and 4,358 crabs collected at Itwara (24 breeding sites, 1,775 crabs), Siisa (9 breeding sites, 776 crabs) and Aswa (12 breeding sites, 1,807 crabs). All these crabs were negative. No *S. neavei* adult was caught at Siisa, Tourist and Andrew during the entire 2005 period.

203. The focus of Itwara has been vector-free since 1997. This situation was confirmed in 2005.

204. **TCC accepted the report and recommended that:**
   
i. APOC make funds available to the project for 2006-2007.
   
   ii. APOC organize a meeting of experts to establish certification criteria on vector elimination.
   
   iii. The project should include a summary of CDTI activities in the next report.

22.7.4 Mpamba-Nkusi Vector Elimination Project (2005 technical report)

205. The report covered the period from January to December 2005. Activities conducted were basically prospection of breeding sites, river treatment and catching of blackflies. Out of 10034 crabs collected and examined in the Mpamba-Nkusi focus, 64 (0.6%) had pre-imaginal stages of *S. neavei*. During the same period, none of the 1367 crabs from the sub-foci of Nyabugando and Mutunguru were positive. Only two *S. neavei* adults were collected in the focus at Rulembo in 2005.

206. **TCC accepted the report and recommended that:**
   
i. APOC make the 2006-2007 funds available to the project;
22.8 EQUATORIAL GUINEA

22.8.1 BIOKO FOCUS (2005 technical report)

207. The report covered the period from January to December 2005.

208. The activities conducted during the period were essentially preparations for the larviciding campaign (updating larviciding points, rehabilitating access roads leading to ground larviciding points and planning of treatment rounds), weekly river treatment, prospection of watercourses for breeding sites, catching of $S.\ \text{damnosum}\ \text{s.l}$ females, and the evaluation of the impact of larviciding on non-target fauna.

209. Following larviciding, the Monthly Biting Rate (MBR) dropped from 5,904 (February) to 0 (March) in the northern part of the island and from 5,224 (February) to zero (April) in the southern part.

210. TCC noted that larviciding in 2005, seemed to have covered the entire known breeding sites of the island, hence the zero catches in the various control points from May through December 2005. However, while the 2005 results were deemed encouraging, they were short of achieving elimination. TCC accepted the report and recommended that:

i. entomological surveillance be continued;

ii. the catching points network be widened so as to cover a maximum area.

22.9 LIBERIA

22.9.1 North-West CDTI Project (4th year report)

211. The report was poorly written and did not give sufficient background to allow for determining the actual population that was treated during the reporting period. TCC requested the project to:

1) clarify the population under treatment and where the distribution occurred. Even though population figures fluctuate, the project should calculate both geographic and therapeutic coverage for the period;

2) describe the role of each partner in terms of specific CDTI activities;

3) describe the role of the NGDOs in the health services delivery system and how CDTI is incorporated into the NGDO plans and activities.

212. TCC recognized the difficult circumstances in Liberia in the post-conflict period. However, based on the information and data provided in the report, the project is considered not to be making satisfactory progress as a CDTI project.

213. TCC recommended that a joint mission of representatives of the TCC, APOC Management, the NGDO Group and the World Bank be sent to Liberia as soon as possible on a high-level advocacy visit, to help reconcile differences among the partners, and to assist in the development of a plan of action with a detailed timeline, activity
priorities and a financing strategy, particularly with respect to the national government of Liberia in order to move the project towards better project performance and sustainability.

214. It was suggested that to avoid the repeated miscalculation of coverage due to the misunderstanding of ATO and UTG, it might be easier to advise projects to use only total population and UTG in their reporting.

215. It was suggested that APOC Management consider designing a simplified reporting format especially for mature projects which are well integrated into the PHC.

23 Integration and future of APOC (Agenda item 13)

216. JAF11 in December 2005 requested that a Working Group of independent experts be established under the auspices of CSA to draw up a concept paper on the future of APOC and onchocerciasis control in Africa, bearing on the following issues:

1) What should be the role of APOC between now and 2010? Should onchocerciasis control remain a single disease effort, or should it be integrated within the control of other neglected tropical diseases or health interventions?
2) What are the risks of closing APOC in 2010 and what are the modalities of an eventual extension to 2015?
3) could the geographical scope of APOC be widened to cover all onchocerciasis-endemic countries in Africa?

217. As the technical consultative body of APOC, it was deemed important for TCC to make an input with regard and to this reflection before a brainstorming meeting of the Working Group which was to be held from 20 to 21 March 2006.

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218. TCC recognized that the current tendency for attracting donor funding for health development and disease control activities was through integration. The opportunities and challenges of integration, and how some donor funding impacted on integration, were debated upon at length. A subcommittee of TCC was formed to further brainstorm on the issue and its conclusions are summarized and attached as Annex 5.

219. TCC stressed the need to repackage APOC in order to sustain onchocerciasis control activities. The approach to donors need to be updated in order to capitalize on achievements and provide realistic perspectives to donors based on a detailed situational analysis. In this context, it was suggested that based on appropriate impact assessment results, the socio-economic impact of onchocerciasis control activities need to be presented, ideally by country.


24 Other Matters (Agenda item 23)

24.1 Challenges of onchocerciasis control in SIZ

220. Professor A. Abiose presented a report outlining the challenges facing onchocerciasis control in the SIZ of ex-OCP countries.

221. With the exception of Sierra Leone and Ghana, therapeutic coverage has been good. Sustainability issues included decreasing funding from governments and NGDOs; integration of CDTI into the health systems and the paucity of operational research.

222. The necessity of collaboration between all ex-OCP countries in the field of CDTI was crucial. It would also be necessary to continue support to Sierra Leone, Côte d'Ivoire and Guinea-Bissau. Therefore the need for an inter-country mechanism to strengthen support to efforts deployed by ex-OCP countries in order to maintain OCP achievements was strongly expressed. It was deemed that given the circumstances, APOC offered the most adequate platform for such mechanism.

24.2 Operational Research - the way forward

223. TCC should identify operational research questions based on its review of the project reports and provide them to APOC Management for distribution to potential researchers in the countries (NOTF, universities).

224. TCC endorsed a proposal that an Operational Research Task Force (ORTF) be formed in a few countries on a pilot basis (Nigeria, Cameroon, Uganda and Ethiopia). The ORTF will include scientists from different disciplines who will review the research proposals from their own countries and send their reports to TCC. Countries other than those noted above will continue to submit their research proposals directly to TCC for the time being.

225. To improve the quality of the proposals, TCC also endorsed a proposal to institute a 'review/mentor system', in which operational research proposals submitted to APOC will be sent to 2-4 reviewers from a list of researchers previously identified who have declared their willingness to review and provide feedback to investigators.

226. It was agreed that specific plans on how to build country capacity for research as well as for research proposal review needed to be developed.

24.3 Report from the subcommittee on format review: Tables 13 & 14

227. Professor D. McFarland presented an update on the work of the TCC subcommittee to review the relevance of Tables 13 and 14 of the annual technical reporting format. While Table 13 identifies sources of funding, Table 14 relates to the use of the funds. After due consideration, TCC agreed that Table 14 should be deleted and that Table 13 be retained but should be amended. A new reporting format for Table 13 will be provided by APOC Management to the projects.
24.4 Report from the subcommittee on incentives

228. Following a recommendation of TCC21 that a research team be commissioned to develop and implement a protocol for studying incentives and their effect on performance and potential for sustainability of CDTI projects, Dr. Katabarwa presented an update of the team whose plan of action is to:

1) to develop terms of reference for specific research tasks for understanding incentives;
2) identify projects where this study should be done;
3) identify persons who can carry out the study. Quantitative, qualitative and anthropological research skills are essential in the study.

229. A further update on the progress of the work of the team will be presented to TCC23.

24.5 Proposal of clinical study to evaluate the relationship between ivermectin treatment of *O. volvulus* infected epileptics and frequency of epileptic seizures

230. Dr. Boussinesq presented a protocol for a clinical study to evaluate the relationship between ivermectin treatment of *O. volvulus* infected epileptics and the frequency of epileptic attacks. He indicated that studies on the relationship between the endemicity of onchocerciasis and prevalence of epilepsy on the one hand, and the onchocerciasis microfilarial load in epileptics and non-epileptics on the other hand, have not resulted in consistent data on the association between onchocerciasis and epilepsy. (A study conducted by the Pasteur Centre in Cameroon shows that epileptics have higher microfilarial loads than non-epileptics when other factors are controlled for; while studies in Mali, Burkina, CAR, conducted in areas already under onchocerciasis control have not shown this relationship. Metaanalysis of different studies shows no, or only a borderline, relationship between onchocerciasis and epilepsy (Druet-Cabanac et al. 2004).

231. Ivermectin could increase the frequency of epileptic seizures due to mobilization of microfilariae, or alternatively, decrease the frequency through the reduction of microfilarial load. Data on the effect of ivermectin on the frequency of epileptic seizures (from Sudan (Homeida) and Uganda (Kipp) are conflicting. Unambiguous data are needed to appropriately determine whether epileptics should be excluded from, or included in, ivermectin treatments.

232. Given the extent of the problem of epilepsy in Africa (e.g. stigmatization, excess morbidity and mortality), a beneficial effect of ivermectin on epilepsy could have additional donor and community mobilization effect.

233. Some potential areas have been identified for the study. TCC endorsed the necessity and concept of the study and awaits an update on the status of the clinical study at TCC23.

24.6 Review of Vitamin A and CDTI proposal from NOTF/Tanzania

234. A third submission of a proposal integrating Vitamin A supplementation and CDTI in Tanzania was reviewed by TCC. Although the proposal, the aim of which is to pilot a study in two districts in order to improve sustainability of the CDTI projects had been improved upon, there was still a need to refocus the strategy, refine the objective, add some key
activities, refine the indicators and expected outputs, add a timeline and review the budget as it was not included with the proposal.

235. **TCC recommended that the proposal be accepted but that it should be redesigned to assess knowledge gaps and the cost of integration. TCC requested that APOC Management provide guidance to the project to redesign the strategy before the release of funds.**

### 25 Date and place of the twenty-third session of TCC

236. TCC23 will be held from 11-15 September 2006 in Ouagadougou, Burkina Faso.

### 26 Report (conclusions and recommendations)

237. A draft report of the meeting was scrutinized and adopted with the understanding that the suggested amendments will be reflected in the final report which will be distributed to participants at a later date. A list of conclusions and recommendations is attached as Annex 6.

### 27 Closure of the session

238. Dr. Uche Amazigo commended TCC members for the week-long accomplishment. The agenda was heavy, she remarked, but TCC as usual thoroughly and satisfactorily addressed all the issues. She thanked Prof Deborah McFarland for undertaking the very important cost per treatment study. As this was the last attendance of Prof McFarland at TCC, Dr. Amazigo and TCC colleagues paid a special tribute to her for her invaluable contribution to the work of the Committee and hoped to see her back in APOC in the near future in a different capacity.

239. Dr. Amazigo pleaded with national coordinators and TCC members to be ambassadors of onchocerciasis control. She commended the active participation of the invited observers, thanked the interpreters, rapporteurs and APOC colleagues for their contribution to the success of the meeting.

240. In her closing remarks, Prof Braide expressed appreciation to APOC Management for sending the working documents in advance to TCC members. She stated that the session was relaxed and greatly facilitated by the presence of the national coordinators. She thanked the observers for their active participation in the discussions. Prof Braide particularly thanked the interpreters for their patience in coping with the long hours of TCC deliberations. She reiterated the gratitude of the Committee to Prof McFarland who, she said would be dearly missed in TCC.
Annex 1

List of participants

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17.03.2006
APOC
Agenda

1) Opening
2) Adoption of the Agenda

Information

3) CSA: matters arising from the 111th and 112th sessions
4) JAF: matters arising from the 11th session: recommendations only
5) NGDO: matters arising from the 27th session: recommendations only
6) MEC/AC: Report on the 35th meeting; key issues only
7) TCC: follow-up of the recommendations of the twenty first session: key recommendations

Strategic and technical issues

8) Rapid epidemiological mapping and impact of control activities in APOC countries
9) Update on the RAPLOA and management of SAEs
10) Update on vector elimination activities with special emphasis on Tukuyu and Bioko Foci
11) Impact of APOC operations on clinical manifestations of Onchocerciasis: Phase I and II
12) CDTI and national integration policy and strategy for the control of Malaria and neglected diseases: the Ethiopia case
13) Integration and the future of APOC
14) Mass treatment for onchocerciasis control in urban areas: Lessons from the Onchocerciasis control Programme of Congo
15) Challenges of CDTI Implementation in Chad: highlights on data management and decentralization
16) Update on Operational Research
17) Update on MACROFIL
18) A Feasibility Study on Compliance with and Perceived Benefits of Annual Ivermectin Treatment: report of Phase I study
19) Review of operational research proposals

Management of APOC Trust Fund

20) Report on the financial management of APOC funded Projects

Reviews

21) Report on the review by the APOC Management of 1st, 2nd, 3rd, 4th ,5th, 6th and 7th year progress reports and subsequent year budgets
22) Review of new project proposal and 1st, 2nd, 3rd, 4th ,5th, 6th and 7th year annual technical reports
23) Other matters
   a. Challenges of Oncho Control in the Special Intervention Zones: brainstorming session
24) Date and place of the twenty-third session of the TCC
25) Conclusions and recommendations of TCC22
26) Closure of the session
   b. in the Special Intervention Zones: brainstorming session
27) Date and place of the twenty-third session of the TCC
28) Conclusions and recommendations of TCC22
29) Closure of the session
Decisions of the Eleventh session of the Joint Action Forum

(On major issues)

1. The Forum decided on a **gradual decentralization of APOC activities to participating countries** and called on APOC Management to develop a strategy for decentralization of its activities to the countries.

2. The Forum requested that APOC Management **establish working relationship with relevant regional organizations** which could play an important role in promoting political and financial commitment of participating countries to onchocerciasis control activities before and during the Phasing out period of APOC and thereafter.

3. **External Evaluation of APOC 2005**: JAF noted the report and requested that comments be sent by e-mail to CSA which would in turn:
   a. reconcile the comments of all partners on the evaluation report;
   b. draw up a plan of action based on the outcomes of the evaluation;
   c. convene a meeting of partners preferably in an African country in 2006.

4. **Vision for the future of onchocerciasis control in Africa**: JAF requested that a reflection paper be developed on:
   a. The future of the Programme until 2010 including the modalities of an eventual extension;
   b. Modalities of continuing control activities in the countries (transfer, integration, funding and advocacy);
   c. Control of the disease in the whole of Africa: APOC, SIZ areas (after 2007), ex-OCP countries and countries in conflict situation;
   d. Eventual financing on: (i) current availabilities, (ii) Future projections based on forecasted availabilities and anticipated budgets after 2010.

5. **Country presentations**: The forum reiterated that, in future, countries should present an **integrated budget**, i.e. should include the contributions from all partners - governments, NGDOs and APOC Trust Fund.

6. **Operational research**: The attention of the Forum was once again drawn to "**nodding disease"** and epilepsy and their possible link with onchocerciasis. JAF requested that TDR should be commissioned to undertake research on "nodding disease".

7. The results of the cost study presented to JAF showed that the **cost per treatment** with ivermectin was $0.58. JAF welcomed the study which it felt could be a useful tool for budgeting purposes and for discussions with donors. The Forum also expressed the need for the cost per treatment to be calculated separately for projects in conflict zones.

8. The Forum requested that APOC Management should encourage and continue to support countries to define **national policies on integration** and develop strategies for integrating compatible programmes.
9. JAF requested APOC to sharpen its focus on results and the impact on the populations concerned, and consequently to further strengthen surveillance, monitoring and evaluation activities.

10. The Forum also requested APOC Management to conduct periodic beneficiary assessments in a sample of projects which would provide timely information on results.

11. JAF encouraged APOC Management and countries to include in their reporting of APOC activities impact indicators.
35th Mectizan Expert Committee/Albendazole Coordination (MEC/AC) meeting

1. Dr. Mary Alleman of the Mectizan Donation Program (MDP) reported on the highlights from the 35th Mectizan Expert Committee/Albendazole Coordination (MEC/AC) meeting held in London from 10 - 12 January 2006:

   (i) SAE data from 1988-2004 show a cumulative incidence of 1.3 cases per million treatments. The majority of these cases were from Cameroon (71%) and DRC (21%), almost all of which were from Loa loa endemic areas. In 2005, 53 SAEs were reported; 49 occurred in populations being treated with ivermectin for the first time in Cameroon, and four occurred in DRC in areas where mass treatment has been ongoing.

   (ii) MEC approved two new Mectizan mass treatment programs: Rutshuru-Goma, DRC and Littoral I, Cameroon. With regard to Littoral I, the MEC recommended that mass treatment begin in the health districts of Loum, Manjo, and Nkongsamba in Year 1 since the prevalence of L. loa in them is lower than in the remaining health districts of the project area. Moreover, the MEC made the Littoral I approval with the understanding that the program had plans to fully implement the MEC/TCC guidelines for treatment with Mectizan in areas co-endemic for onchocerciasis and loiasis.

   (iii) MEC was informed that DRC had appointed two L. loa technical advisors whose work is being co-financed by MDP and APOC. The MEC endorsed MDP’s plans to support the appointment of a similar post(s) in Angola with joint support from APOC.

   (iv) MEC recognizes that there is an increasing amount of data becoming available on onchocerciasis and its transmission after a number of years of Mectizan treatment; the ongoing TDR study in the former-OCP region is of particular interest in this context. MEC recommended that a Task Force be established by MEC as a facilitating forum for the consideration of future scenarios of long-term onchocerciasis control in Africa, taking into account sub-regional circumstances and opportunities for effective interruption of transmission. The Task Force should work in close collaboration with TDR and APOC and other interested parties; it could possibly have its first meeting in late 2007.

   (v) After a re-review and discussion of the available data by a sub-group of the MEC/AC, the MEC/AC concluded that, there is neither a biological rationale nor available data to suggest that the addition of albendazole to Mectizan would increase the number or severity of adverse reactions if the two drugs were to be used together to treat populations co-endemic for onchocerciasis, LF, and loiasis. However, for optimal safety when the combination of albendazole and Mectizan is first utilized in such co-endemic or potentially co-endemic areas, enhanced pharmacovigilance would be appropriate.
Based on these assessments and in view of the well recognized inverse relationship between the number of cycles of Mectizan treatment and the incidence of SAEs seen in populations with any of these filarial infections, the specifics of the enhanced pharmacovigilance required need not be the same for all loa/LF/hyper-meso onchocerciasis co-endemic or potentially co-endemic areas. The MEC/AC recommended the following:

- In those areas that have already received 2 or more cycles of Mectizan treatment with good coverage, the level of *L. loa* microfilaraemia is likely to be reduced far below levels associated with encephalopathy and other SAEs. Consequently, it can be recommended that the addition of albendazole could proceed with *enhanced passive surveillance* as currently recommended for Mectizan administration for onchocerciasis in Loa-endemic areas.

- In areas that have received no previous Mectizan treatment, 1 round of prior treatment or have had poor prior coverage, *active surveillance* similar to that employed at the initiation of the global LF elimination programme should be undertaken until a minimum of 15,000 individuals have been assessed. Based on the prior data from Cameroon, statistical considerations indicate that this number of individuals would permit the detection of any significant increase in SAEs that might be associated with the addition of albendazole to Mectizan in such Loa-endemic areas. *If no increase is seen during this active surveillance, enhanced passive surveillance could then be instituted.*

A report was provided to MEC regarding the development of ONCHOSIM-Cameroon by investigators at Erasmus University in Rotterdam. ONCHOSIM-Cameroon is a mathematical simulation model, based on ONCHOSIM, fitted with data from 3-monthly and 12-monthly ivermectin treatment schedules from the Mbam River (Cameroon) trial (Gardon et al. Lancet 2002). The model indicates, for all of the various treatment scenarios studied, that onchocerciasis prevalence and CMFL are dramatically reduced during the period of treatment but that both will eventually increase within a few years after treatment ceases, even where compliance is 100%. Moreover, the model indicates that there would be a high reduction in morbidity for prolonged periods but that elimination of onchocerciasis in similar settings will be difficult even after 10 rounds of treatment.

The 36th MEC/AC meeting is tentatively scheduled for the week of 30 October 2006 in Atlanta.
Summary of the conclusions of the subcommittee of TCC on the future of onchocerciasis control in Africa

1. **Should APOC maintain its single disease focus or be expanded to include control of other neglected tropical diseases and other health interventions?** It was recalled that APOC activities are already integrated to varying degrees at the operational level in the countries. CDI approach and CDTI facilities are being utilized for the integration of other activities such as lymphatic filariasis, schistosomiasis, guinea worm eradication, Vitamin A supplementation, immunization, eye care, malaria bednet distribution and population census updates. It was cautioned that the shift towards integration should be done cautiously (1) to avoid obliterating APOC’s achievements and its strategic advantage and (2) to address a number of challenges such as country policy on integration, scope of integration, risk of overburdening communities and the concerns about possible drug interactions.

2. **APOC needs to be repackaged and its role redefined to make it a proactive advocate for facilitating, catalyzing, enabling and promoting the appropriate use of CDI to increase access to health services.** APOC should be repositioned within the context of global, regional and country trends and goals by documenting and publishing its experience and relevance in integration; and its contribution to poverty alleviation as espoused through the Millenium Development Goals (MDGs), the New Partnership for Development (NEPAD), etc. APOC should also assist countries in assessing the levels of integration and existing gaps and to identify areas where the CDTI strategy could facilitate health achievements on a country-specific basis. Countries should be responsible for integration and should be encouraged to ensure that onchocerciasis control remains on the national health delivery agenda.

3. **Should APOC activities come to an end in 2010 as planned or be extended till 2015?** About 40% of projects are yet to start implementation. 3 main reasons explain the need for an extension until 2015: (1) it took longer than expected to refine and implement CDTI in all countries; (2) civil unrest in some countries has delayed the implementation of projects in those countries. There is therefore need to continue support to those countries to enable them establish control activities; and (3) complications arising from Severe Adverse Events (SAEs) due to the co-endemicity of onchocerciasis and *Loa loa* and the need to adequately address the issue of SAEs before the withdrawal of APOC.

4. **It is suggested that APOC should withdraw support from countries gradually and systematically based on an assessment of each country's capacity.** APOC should also gradually shift its support from individual projects to the country as a whole. An extension until 2015 of APOC activities should be used to focus on CDTI implementation in the post-conflict countries. APOC should continue advocacy for support to onchocerciasis control in those countries who no longer receive support from APOC and to create opportunities for countries to share their experiences.
5. **What should be the role of APOC in ex-OCP countries?** The need for an intercountry mechanism to strengthen support to ex-OCP countries in order to maintain OCP's achievements has been highlighted in several presentations over the years. TCC felt that APOC offers the most adequate platform to assume a coordinating role for onchocerciasis control in all endemic countries in Africa and should be working with MDSC to ensure adequate surveillance, documentation and sharing of best practices with all onchocerciasis-endemic countries.

6. **Decentralization of APOC activities:** is necessary and desired; and particularly preferable in the phasing out period of APOC. However, this should occur only after building and/or enhancing the capacity of countries in such areas as data collection and analysis; the use of the results for policy decision-making and the improvement of programme implementation; the conduct of high quality operational research; maximizing the use of existing resources and establishing structures necessary for decentralization. To achieve this, the roles of TCCs, NOTFs and APOC management need to be redefined accordingly. TCC will need to focus on technical issues on sustainability and CDTI; NOTFs should handle among others, project oversight and reviews whereas APOC Management should concentrate on coordination, collecting and sharing of experiences.
Annex 6

Conclusions and recommendations

Conclusions

1. TCC concluded that the review of annual technical reports should be conducted in both sessions of TCC, but that the Committee will spend more time discussing technical and strategic issues in all meetings.

2. It was agreed that experts including former TCC members could be invited to TCC sessions.

3. TCC agreed that each member of the Committee should try to visit at least 2 countries per year to help promote CDTI activities.

4. TCC endorsed the request of APOC Management that the experience of the Community-Directed Intervention (CDI) workshops in Nigeria, Tanzania and Uganda should be extended to other countries as soon as possible and that TCC members should help co-facilitate the workshops.

5. TCC endorsed the request of APOC Management that a number of APOC HQ activities including operational research be decentralized to the countries beginning in 2006. The Committee also endorsed that an Operational Research Task Force (ORTF) should be established in each country (beginning with Cameroon, Ethiopia, Nigeria and Uganda on a pilot basis) to take on the review of operational research proposals in the country and report to TCC.

6. With regard to the possible withdrawal of support of the US Fund for UNICEF to CDTI projects in Nigeria, TCC suggested that APOC should arrange for joint missions to Nigeria, ideally with participation of one TCC member, to try to look for other financing mechanisms in support of CDTI activities

7. TCC discussed extensively the lack of baseline data in some countries, particularly of socioeconomic data and recognized the importance of analyzing and publishing as soon as possible available data on phase I and II impact assessment of APOC operations for advocacy purposes.

8. To improve the quality of operational research proposals, TCC endorsed a proposal to institute a 'review/mentor system', in which operational research proposals submitted to APOC will be sent to 2-4 reviewers from a list of researchers previously identified.

9. TCC endorsed the necessity and concept of a clinical study to evaluate the relationship between ivermectin treatment of *O. volvulus* infected epileptics and frequency of epileptic attacks and awaits an update on the status of the study at TCC23.

10. TCC23 will be held from 11-15 September 2006 in Ouagadougou, Burkina Faso.
11. TCC reviewed a total of 38 reports (31 annual reports and 7 operational research proposals). 26 annual reports were accepted and 5 reports were rejected. The Committee also recommended the acceptance of 1 operational research proposal, the rejection of 2 proposals, a resubmission of 1 proposal and that 3 proposals should be reviewed by APOC Management as they did not constitute operational research proposals.

Special requests/suggestions

12. TCC requested that the frequency of SAEs be presented separately for *Loa loa* endemic areas.

13. TCC stressed that in areas with prevalence of <40% (20-39%), RAPLOA results should be used to determine areas where ivermectin distribution should be conducted. In this regard, TCC suggested that APOC should generate an updated onchocerciasis and loiasis endemicity map and make it publicly available.

14. TCC suggested that it would be useful to continue to invite district medical officers to TCC meetings to enhance capacity building and sharing of experiences on integration of CDTI.

15. To reduce the workload on the APOC financial staff, it was suggested the analysis of the financial returns from projects be devolved to the WR's office in the countries. APOC Management was in the process of discussing with the WHO country offices to determine how some activities could be devolved to the countries as recommended by the 2005 APOC External Evaluation Team.

16. TCC suggested that clear guidelines be given as to how remaining APOC funds of projects approaching their 8th year of APOC funding should be managed by the projects. APOC Management agreed to review the issue further internally and to take stock of such projects.

17. It was suggested that to avoid the repeated miscalculation of coverage due to the misunderstanding of ATO and UTG, it might be easier to advise projects to use only total population and UTG in their reporting.

Recommendations

18. TCC recommended that larviciding should continue in 2006 in the Bioko Focus and in the Mpamba Nkusi Focus in the reinvaded areas of the rivers Mpamba, Rwabutuji and Nkusi where the vector breeds.

19. Based on the results of the feasibility study, TCC recommended that the study on compliance to, and perceived benefits of, annual ivermectin treatment should proceed.

20. TCC recommended that APOC should commission a comprehensive epidemiological study on Nodding disease in South Sudan, to complement available data and to verify and further characterize the epidemic outbreak. TCC should also form a subgroup that develops operational research proposal for looking into the broader issues relating to Nodding disease, Nakalanga, epilepsy and association with onchocerciasis and ivermectin treatment.
21. TCC recommended that the computer programme for data management developed for Chad should eventually be made available to all other countries as well.

22. TCC recommended that the issue of project leadership in the South-West I CDTI project should be brought to the attention of the various partners.

23. TCC recommended that a high level advocacy mission, comprising representatives of the TCC, APOC management, the NGDO Coordination Group and the World Bank, be sent to Liberia as soon as possible to help reconcile differences among partners, and to assist in the development of a plan of action.