**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABBREVIATIONS</td>
<td>v</td>
</tr>
<tr>
<td>OPENING: Agenda item 1</td>
<td>1</td>
</tr>
<tr>
<td>CHAIRMANSHP OF THE TCC: Agenda item 2</td>
<td>1</td>
</tr>
<tr>
<td>ADOPTION OF THE AGENDA: Agenda item 3</td>
<td>1</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>1</td>
</tr>
<tr>
<td>Matters arising from 115th CSA session: Agenda item 4</td>
<td>1</td>
</tr>
<tr>
<td>Matters arising from the 12th JAF meeting: Agenda item 5</td>
<td>2</td>
</tr>
<tr>
<td>Repositioning APOC- major activities in 2006: Agenda item 8</td>
<td>3</td>
</tr>
<tr>
<td>Matters arising from the 29th meeting of the NGDO Coordination Group for Onchocerciasis Control: Agenda item 6</td>
<td>3</td>
</tr>
<tr>
<td>Follow up to recommendations of 23rd TCC session: Agenda item 7</td>
<td>4</td>
</tr>
<tr>
<td>STRATEGIC AND TECHNICAL ISSUES</td>
<td>5</td>
</tr>
<tr>
<td>Report on the workshop on SAE Management in DRC: Agenda item 9</td>
<td>5</td>
</tr>
<tr>
<td>Update on Angola CDTI projects: Agenda item 10</td>
<td>5</td>
</tr>
<tr>
<td>Prospects for vector elimination in APOC countries with special emphasis on Equatorial Guinea: Agenda item 13</td>
<td>6</td>
</tr>
<tr>
<td>Strategic plan for the elimination of onchocerciasis in Uganda: Agenda item 14</td>
<td>6</td>
</tr>
<tr>
<td>Update on Macrofil: Agenda item 15</td>
<td>7</td>
</tr>
<tr>
<td>Integration of Onchocerciasis Control in the National Health System and co-implementation of Neglected Tropical Diseases (NTD) control: Agenda item 17</td>
<td>8</td>
</tr>
<tr>
<td>Review of Operational Research Proposals: Agenda item 16</td>
<td>9</td>
</tr>
<tr>
<td>Community's participation in CDTI in Chad</td>
<td>9</td>
</tr>
<tr>
<td>Absenteeism and Refusal rates in CDTI: Case Study of Bena Leka Health Zone (Kap Study)</td>
<td>10</td>
</tr>
<tr>
<td>Infectivity rate of Simulium damnosum in cross-border communities in Ogun State Nigeria: toward the establishment of entomological monitoring for Ogun State CDTI project</td>
<td>10</td>
</tr>
<tr>
<td>Studies on coverage and sustainability of Community Directed Treatment with Ivermectin (CDTI) among nomads of Taraba State, Nigeria</td>
<td>10</td>
</tr>
<tr>
<td>Inclusion of Sierra Leone as APOC country: Agenda item 18</td>
<td>11</td>
</tr>
</tbody>
</table>
Result of Phase II Study on compliance with ivermectin treatment: Agenda item 11 ......................11
Increase in School Enrolment in 3 sites following 5 years of CDTI: Agenda item 20 .................12

Generation of interest in onchocercias among young professionals in public health and medical schools.................................................................12

MANAGEMENT OF APOC TRUST FUND .................................................................13
Report on the financial management of APOC funded projects: Agenda item 21 ..................13

Technical, administrative and financial review of APOC operations in the countries: Agenda item 22 ........................................................................................................14

PROJECT REVIEWS.................................................................................................14
Report on the review by APOC Management of 1st, 2nd, 3rd, 4th, 5th, 6th, and 7th year progress reports and subsequent year budgets: Agenda item 23 ........................................14

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 the 2nd, 3rd, 4th, 5th, 6th, 7th and 8th year implementation of the projects: Agenda item 24 ................................................................................14

NIGERIA......................................................................................................................15

Proposal for vitamin A Supplementation (VAS) using CDTI in Cross River State ..................15
Proposal for integrating HIV/AIDS control into CDTI in Cross River State ........................15

TANZANIA....................................................................................................................15

Proposal on Final Assessment of Vector Elimination ..........................................................15

LIBERIA........................................................................................................................16

North West: 5th year report, South West: 2nd year report and South East: 2nd year report ....16

CAMEROON .............................................................................................................17

Littoral I: 2nd year report ............................................................................................17
Littoral II: 7th year report ............................................................................................18

North West: 3rd year report .........................................................................................19
South West I: 8th year report .....................................................................................19
South West II: 6th year report .....................................................................................19
NOTF/HQ: 8th year report ..........................................................................................20
Adamaoua II: 7th year report .....................................................................................21
Extreme North: 2nd year report ................................................................. 21
Centre 3: 8th year report ........................................................................... 22
Centre 2: 4th year report ........................................................................... 22
Centre 1: 5th year report ........................................................................... 23
East Province: 1st year report ................................................................. 24
South Province: 2nd year report ............................................................... 24
NIGERIA ................................................................................................... 25
Taraba State: 8th and 9th year report ......................................................... 25
Anambra State: 7th year report ................................................................ 26
Kaduna State: 8th year report .................................................................. 27
Zamfara State: 6th year report ................................................................. 27
Delta State: 6th year report ...................................................................... 28
Edo State: 6th year report ........................................................................ 28
Ekiti State: 5th year report ........................................................................ 29
FCT: 8th year report ................................................................................ 29
Ebonyi State: 7th and 8th year report ......................................................... 30
Cross River State: 7th year report ............................................................ 31
Adamawa State: 7th year report ............................................................... 31
Borno State: 7th year report ..................................................................... 32
Yobe State: 8th year report ...................................................................... 32
Nassarawa State: 6th and 7th year report .................................................. 33
Plateau State: 7th year report ................................................................. 33
DEMOCRATIC REPUBLIC OF CONGO (DRC) ............................................. 34
Kasai Province: 6th year report .............................................................. 34
Lualaba: 2nd year report ......................................................................... 34
Uele: 4th year report ............................................................................... 35
HEALTH IMPACT OF APOC OPERATIONS: Agenda item 12 ................. 36
VISIT OF WHO WR-BURKINA FASO ......................................................... 37
INTEGRATED COMMUNITY-DIRECTED INTERVENTION (CDI) RESEARCH-MULTI-COUNTRY STUDY: Agenda item 19 .................................................................37

Rapid mapping strategy for loa loa .................................................................................................................38

Feasibility of onchocerciasis elimination with ivermectin .............................................................38

OTHER MATTERS: Agenda item 25 .............................................................................................................39


Creation of operational research task force in countries .................................................................39

DATE AND PLACE OF TCC 25: Agenda item 26 ......................................................................................39

ANNEX 1: LIST OF PARTICIPANTS ..............................................................................................................40

ANNEX 2: AGENDA .....................................................................................................................................44

ANNEX 3: MATTERS ARISING FROM THE 29TH MEETING OF THE NGDO COORDINATION GROUP FOR ONCHOCERCIASIS CONTROL .................................................................45

ANNEX 4: IMPLEMENTATION OF TCC 23 RECOMMENDATIONS AND SUGGESTIONS ..................................................................................48
**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAF</td>
<td>Assistant Administrative Finance Officer</td>
</tr>
<tr>
<td>AE</td>
<td>Adverse Events</td>
</tr>
<tr>
<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
</tr>
<tr>
<td>ATO</td>
<td>Annual Treatment Objective</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
</tr>
<tr>
<td>CDD</td>
<td>Community-Directed Ivermectin distributor</td>
</tr>
<tr>
<td>CDI</td>
<td>Community Directed Intervention</td>
</tr>
<tr>
<td>CDTI</td>
<td>Community-Directed Treatment with Ivermectin</td>
</tr>
<tr>
<td>CSA</td>
<td>Committee of Sponsoring Agencies</td>
</tr>
<tr>
<td>CSM</td>
<td>Community Self Monitoring</td>
</tr>
<tr>
<td>DEC</td>
<td>Diethylcarbamazine</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>FLHF</td>
<td>Front Line Health Facility</td>
</tr>
<tr>
<td>GIS</td>
<td>Geographical Information System</td>
</tr>
<tr>
<td>HKI</td>
<td>Helen Keller International</td>
</tr>
<tr>
<td>HSAM</td>
<td>Health Education Sensitization Advocacy Mobilization</td>
</tr>
<tr>
<td>HQ</td>
<td>Headquarters</td>
</tr>
<tr>
<td>HW</td>
<td>Health worker</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>JAF</td>
<td>Joint Action Forum</td>
</tr>
<tr>
<td>LF</td>
<td>Lymphatic Filariasis</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Area</td>
</tr>
<tr>
<td>LOCT</td>
<td>LGA Onchocerciasis Control Team</td>
</tr>
<tr>
<td>MDP</td>
<td>Mectizan® Donation Program</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSST</td>
<td>Motion Sensitivity Screening Test</td>
</tr>
<tr>
<td>NGDO</td>
<td>Non-Governmental Development Organization</td>
</tr>
<tr>
<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NOTF</td>
<td>National Onchocerciasis Task Force</td>
</tr>
<tr>
<td>NTD</td>
<td>Neglected Tropical Diseases</td>
</tr>
<tr>
<td>PAB</td>
<td>Plan of Action and Budget</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PLERM</td>
<td>Probable Loa Encephalopathy Related to Mectizan®</td>
</tr>
<tr>
<td>SAE</td>
<td>Severe Adverse Event</td>
</tr>
<tr>
<td>SHM</td>
<td>Stake Holder Meeting</td>
</tr>
<tr>
<td>SIZ</td>
<td>Special Intervention Zones</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>SSI</td>
<td>Sight Savers International</td>
</tr>
<tr>
<td>TCC</td>
<td>Technical Consultative Committee (of APOC)</td>
</tr>
<tr>
<td>TDR</td>
<td>UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>UTG</td>
<td>Ultimate Treatment Goal</td>
</tr>
<tr>
<td>VAS</td>
<td>Vitamin A Supplementation</td>
</tr>
<tr>
<td>WHO AFRO</td>
<td>Regional Office of the WHO Africa Region</td>
</tr>
<tr>
<td>WHO/NTD</td>
<td>Neglected Tropical Diseases - department within WHO cluster of communicable diseases (WHO/NTD)</td>
</tr>
<tr>
<td>WR</td>
<td>WHO Country Representative</td>
</tr>
</tbody>
</table>
OPENING: Agenda item 1

1. The twenty-fourth session of the Technical Consultative Committee (TCC) of the African Programme for Onchocerciasis Control (APOC) was held from 12 to 16 March 2007 at the headquarters of APOC in Ouagadougou, Burkina Faso. It was officially opened by the Director of APOC, Dr Uche Amazigo who welcomed participants to Ouagadougou. She acknowledged the presence of TCC experts whose collective knowledge would be brought to bear on the discussions on APOC's strategic direction, the review of technical reports and proposals amongst many other topics. The list of participants is provided in Annex 1.

CHAIRMANSHP OF THE TCC: Agenda item 2

2. Professor Abiose was elected Chair of the TCC. She assumed her activities as Chair by expressing her appreciation to TCC members for their unanimous nomination. She pointed out that APOC was at a critical stage of its development and called upon TCC members to work as a team in giving expert advice to ensure that APOC achieves and addresses its objectives and challenges.

ADOPTION OF THE AGENDA: Agenda item 3

3. The agenda was considered and adopted with the following additions:

   (i) Generation of interest in research by training young professionals on onchocerciasis in both medical and public health schools;

   (ii) Treatment in hypo-endemic areas;

   (iii) Revision of the financial contribution in tables 13 and 14 of the Annual Technical report.

The agenda is provided as Annex 2.

INFORMATION

Matters arising from 115th CSA session: Agenda item 4

4. Dr Amazigo reported that since TCC23, three CSA sessions had taken place, one in Washington, USA in September 2006 and two in Dar-es-Salaam, Tanzania in December 2006. The CSA sessions discussed progress and challenges of APOC. The APOC Strategic Plan and budget from year 2008 to 2015, an update of APOC operations, the recommendations of TCC23, the outcomes of the partners meeting in Yaoundé and the activities of the NGDO Coordination group were presented by APOC Management to the CSA.

5. The outcome of the CSA sessions was positive and encouraging. CSA reflected on the report of the working group on the future of APOC, and gave advice on the need to revise the
document in order to allow for an extension of APOC to 2015. In line with the Yaoundé Declaration, CSA agreed that the APOC Exit Strategic Plan should be presented to and reviewed by JAF.

6. There was a concern about the epidemiological situation in some former OCP countries and consequently the CSA endorsed that APOC supports in particular, some former OCP countries: Ghana, Côte d'Ivoire and Sierra Leone as recommended by the Working Group on the Future of Onchocerciasis Control in Africa.

7. The importance of partnership was highlighted during the sessions, and CSA encouraged a closer collaboration between APOC and Vision 2020-The Right to Sight®. The Committee was informed that the World Bank might organize a donor conference in 2007, and also embark on more advocacy and donor visits in 2007 in different countries including Kuwait, Saudi Arabia and other countries in the middle east.

8. Dr Amazigo informed TCC members that one of the participants of CSA 15 was a pharmaceutical firm, Wyeth, which is supporting APOC and TDR with the search for a macrofilaricide, and also, pioneering and sponsoring the research on moxidectin.

Matters arising from the 12th JAF meeting: Agenda item 5

9. The TCC was informed that the 12th session of the Joint Action Forum (JAF12) was held from 5-8 December 2006 in Dar-es-Salaam, Tanzania and was officially opened by his Excellency Dr Jakaya Mrisho Kikwete, President of the United Republic of Tanzania. Prior to the opening, the participants observed a moment of silence in honor of three medical doctors, who tragically lost their lives in a plane crash while on an APOC mission on 29 October 2006, in Abuja, Nigeria.

10. Following the presentation and discussions on the future of APOC and Onchocerciasis Control in Africa, the JAF recommended:

   (i) APOC’s main objective of establishing sustainable onchocerciasis control programmes in all countries where needed, should be maintained and endorsed;

   (ii) The amendment of the MOU to allow for the extension of APOC to 2015 to enable it to fulfill its original objective, and meet new challenges to ensure sustained onchocerciasis control;

   (iii) APOC to take on an additional objective of developing the evidence base to determine when and where ivermectin treatment can be stopped and provide guidance to countries on how to prepare for, effect, and evaluate the cessation of treatment;

   (iv) APOC should promote integration and co-implementation of interventions with CDTI;

   (v) APOC should maintain the achievements of OCP by establishing appropriate regional support mechanisms including support for former OCP countries where the epidemiological situation requires urgent attention;
Financial planning and fundraising for onchocerciasis control should build on existing mechanisms and traditional donors but should also explore new funding opportunities at both country and international levels.

Repositioning APOC- major activities in 2006: Agenda item 8

11. Dr Amazigo gave a complete overview of APOC for the benefit of new TCC members. She celebrated APOC’s accomplishments in increasing treatment figures from 1.5 million in 1997 to 40.6 million in 2005, despite major challenges posed by severe adverse events (SAEs) and operational issues specific to conflict and post conflict countries. In addition to contributing towards the Millennium Development Goals, APOC operations have had a significant health impact. According to the results of a rapid health assessment modeling study, APOC operations have resulted in the reduction of onchocerciasis prevalence by 23% and troublesome itching 50% between 2000 and 2005. Current and future challenges for APOC include:

(i) Maintaining the commitment of donors to 2015;

(ii) Ensuring the sustainability of the surveillance of the disease and of CDTI, through greater responsibility of communities and true commitment of governments;

(iii) Institutionalizing inter-country collaboration to monitor cross-border transmission of infection;

(iv) Facilitating the use of CDI for other health interventions in order to scale up poverty alleviation and achievement of the MDGs.

12. Several meetings were held in 2006 to review APOC’s future and its Strategic Plan. Most significant was the establishment of a working group by CSA, which submitted recommendations to JAF 12 for approval. A list of recommendations approved by JAF 12 is provided under Agenda item 5.


Matters arising from the 29th meeting of the NGDO Coordination Group for Onchocerciasis Control: Agenda item 6

14. The first joint meeting of the NGDO Coordination Group for Onchocerciasis Control, the NGDO LF Network and International Coalition for Trachoma Control (ICTC) was hosted by Lions Club Foundation International at Doubletree Hotel in Oak Brook, Chicago, USA from 6 - 8 March 2007. The NGDO Coordination Group for Onchocerciasis Control extended their meeting to 9 March 2007. The conclusions and recommendations of the meeting were presented, with the following brought to the special attention of TCC (for a complete list see Annexe 3):
(i) The group supported efforts by Uganda and partners to eliminate onchocerciasis transmission in six foci by using a strategy of twice-per-year Mectizan® distribution and ground larviciding. The Group concluded that this was an important effort, noting that the NGDO Group was supporting this strategy of Mectizan® distribution and assessment activities in one of the Ugandan foci (Wadelai in Nebbi District) through the Merck Grant Subcommittee;

(ii) The Group recommended that studies on transmission in hypo-endemic areas, and its importance for control/elimination of onchocerciasis, needed to be conducted;

(iii) The Group thanked APOC management for the efforts and improvement in releasing APOC Trust Fund to the countries according to the fiscal year and encouraged further streamlining of the process;

(iv) Dr Adrian Hopkins handed over the Chair of the NGDO Group to Dr Danny Haddad. His term will run until March 2009, with Mr Simon Bush as Vice-Chair.

15. Dr Amazigo thanked Dr Adrian Hopkins for his contributions, especially his personal support to APOC during his term as Chair of the NGDO Coordination Group.

**Follow up to recommendations of 23rd TCC session: Agenda item 7**

16. The following actions have either been initiated or completed by APOC Management as a follow-up to TCC 23 recommendations (for a complete list see Annex:4):

(i) APOC management continues to provide NOTF coordinators and project coordinators with effective guidance and training on correct reporting of treatment coverage based on total population. Since the last TCC meeting, support has been given to the NOTFs of Burundi, Cameroon, Congo, DRC, Nigeria, Tanzania and Uganda for data collection activities which are ongoing;

(ii) NOTF/Nigeria plans to hold a workshop before the end of August 2007, to harmonize the proposed projects and share lessons learned on integration of VAS and CDTI. NGDO partners, as well as focal persons for onchocerciasis and nutrition in each state, are expected to participate;

(iii) A draft Terms of Reference for the Operational Research Task Forces in Cameroon, Uganda and Nigeria has been developed and will be circulated shortly by APOC management to TCC members for input before a final copy is submitted to the NOTFs;

(iv) APOC reported that a meeting of National Directors of Disease Control and/or Public Health, and the National Coordinators of onchocerciasis and malaria control programmes on integration had been held in February 2007, in Brazzaville Congo for Anglophone countries. The meeting for Francophone countries will be held in Ouagadougou in June 2007.
STRATEGIC AND TECHNICAL ISSUES

Report on the workshop on SAE Management in DRC: Agenda item 9

17. Dr Alleman presented a summary on the workshop that took place in Kinshasa, Democratic Republic of the Congo (DRC) in early October 2006 to review the 271 Serious Adverse Events (SAEs), following Mectizan® treatment, which were reported to MDP from DRC between March and September 2006. The workshop was convened jointly by the MDP and the NOCP of DRC, to review and analyze the clinical evolution and epidemiology of the reported cases so as to better prepare for future mass treatment cycles.

18. Upon initial review of the clinical information relating to the 271 SAE cases by MDP, it was discovered that many (approximately 50%) appeared to be minor adverse events (AEs), which in other settings would not have been classified as SAEs or required hospitalization or reporting to MDP/Merck. Further, the threshold for hospitalization was lower than in previously reported cases. In DRC, hospitalization for less than 48 hours is not considered significant from a clinical standpoint, yet hospitalization is one of the criteria for reporting an SAE following Mectizan treatment. Additional issues raised were the fact that “red eye”, or sub-conjunctival hemorrhages, and positive L. loa blood smears (regardless of intensity of infection) were commonly included in the attribution of the presented illness to Mectizan treatment. Of note, an overwhelming 75% of the cases were reported as having “red eye” following treatment with Mectizan; in a few cases, that was the only sign that triggered hospitalization.

19. The cases were reviewed in depth during the workshop. The major conclusions and recommendations of the workshop were that: 1) sub-conjunctival hemorrhage does not appear to be specific enough to be used as a screening or diagnostic sign for an imminent Probable Loa Encephalopathy Related to Mectizan® (PLERM); 2) the mere presence of L. loa mf is not enough to indicate a risk factor for a PLERM unless the intensity of infection is high; 3) the identification of SAEs at the community level should focus on patients appearing seriously ill or whose lives appear to be in danger; and 4) future mass treatment cycles should be implemented during the dry season when the road conditions are best, to avoid unnecessary hospitalization. To facilitate this, Mectizan® supply and APOC funding must be available in time. When mass treatment was undertaken during the rainy season, many people with minor or moderate SAEs were hospitalized as a precaution since poor road conditions make travel very difficult.

20. The workshop participants also concluded that the problems with identifying impending SAE cases have emphasized a need for operational research to determine: 1) the baseline prevalence of sub-conjunctival hemorrhages and incidence of sub-conjunctival hemorrhages after Mectizan® treatment; 2) the reliability of correct identification of sub-conjunctival hemorrhages by community drug distributors; and 3) the identification of early warning(s) specific to PLERM.

Update on Angola CDTI projects: Agenda item 10

21. The representative of the Mectizan Donation Program (MDP) informed the TCC that four applications for Mectizan® for Angola were currently under review at the MDP. Among the four are a re-application for supply of Mectizan® for the Lunda-Sul CDTI project area and three fresh applications for the new CDTI projects in Bengo, Kuando-Kubango, and Huila. Of
the four project areas, Bengo-Uige-Kwanza Norte CDTI is the only one located in an area where the risk of Loa loa-related SAEs is high.

22. The MDP has been corresponding with the national coordination office regarding these applications for the drug. Clarification remains pending for several issues. This includes explanations of the exact geographic area to be treated in 2007, and of the implementation of MEC/TCC guidelines in Bengo CDTI. In order to facilitate communication with the national coordination office, the MDP will invite Angola’s National Onchocerciasis Control Program coordinator and Angola’s Director of Public Health to the upcoming Mectizan Expert Committee meeting scheduled for May 2007 in Geneva. In addition, the MDP suggested that the national coordination office might benefit from technical assistance, as the new CDTI projects are prepared for launching. Moreover, the MDP requested an update from APOC regarding the status of Angola’s L. loa Technical Advisor who will be jointly supported by APOC and MDP. The MDP requested TCC’s advice on moving CDTI activities forward in Angola. Following the presentation, concerns about the slow progress of CDTI activities in Angola were raised.

23. TCC members deliberated on the matter and recommended that:

(i) APOC management recruit a Technical Advisor on CDTI implementation on a limited contract (2 -3 years) and with clear Terms of Reference. The candidate should be fluent in Portuguese and should receive adequate training in the APOC philosophy and CDTI strategy;

(ii) APOC management should undertake an advocacy visit to the highest level of government in Angola.

Prospects for vector elimination in APOC countries with special emphasis on Equatorial Guinea: Agenda item 13

24. Vector elimination activities in the Bioko focus took place in 2006. The activities were focused on the prospection of the larval breeding sites and the collection of the Simulium flies on human bait. Prospection was carried out in 151 rivers and 218 breeding sites over 225 capture days including 71 at the network points. The results were as follows:

(i) No S. damnosum s.l was collected.

The evaluation of the campaign will be continued until the end of 2008.

Strategic plan for the elimination of onchocerciasis in Uganda: Agenda item 14

25. Despite high ivermectin treatment coverage, onchocerciasis has not been eliminated as a public health and socio economic problem in Uganda. The new policy of the Ministry of Health is elimination of onchocerciasis where feasible, through semi-annual treatment with ivermectin and vector control. Four foci are targeted for elimination (Mt-Elgon, Budogo, Kigezi-Bwindi and Kashaya-Kitomi). The population in these foci is about 700,000. Epidemiological studies will continue in other areas to identify other possible isolated foci for elimination. APOC is requested to offer support in the area of identification of Simulium species, enhancement of CDTI in elimination areas, impact assessment, cross-border issues and operational research.
26. TCC members thanked the Ugandan team for an impressive presentation, as well as project partners such as the Carter Center and Sight Savers International for their financial support to the Ugandan project. APOC management expressed its willingness to help, and requested the Ugandan team to provide a clear plan of action and activities for review by APOC, clearly stating the type of support (financial or technical) needed.

27. Following the discussion on the strategic plan for the elimination of onchocerciasis in Uganda, the question about APOC’s support for mass treatment in areas that were hypo-endemic for onchocerciasis arose.

28. **TCC recommended that:**

   (i) APOC continue to focus its resources on reaching high therapeutic coverage with ivermectin in meso-/hyper-endemic areas, and providing CDTI projects with support for clinic-based treatment in hypo-endemic areas;

   (ii) Mass treatment with ivermectin in areas hypo-endemic for onchocerciasis and co-endemic for loiasis should be avoided since the risk of L. loa-related SAEs may outweigh the benefit of treatment.

29. TCC also agreed, after counsel from TDR, that an onchocerciasis endemic area should always be described according to its pre-intervention endemicity, using the expression “pre-control endemicity”. Endemic areas should be categorized, always according to their potential endemicity in the absence of intervention.

**Update on Macrofil: Agenda item 15**

30. Clinical testing of the new DEC patch with transdermal technology has been completed; this includes the histological evaluation of 4 mm skin punches from the site of patch application. The patch is applied in less than 10 seconds. It is safe and results in lower frequency of severe local itching and whole body itching than the OCP patch test used as positive control. The skin reaction is different from that of the OCP test and is best characterized as an outline lesion across the whole area of the patch, and is less intense and of shorter duration than the lesion induced by the OCP test. It should be read at 24 hours post-application. In subjects negative at 24 hours, the patch should be re-applied and re-read 6 hours later. This needs to be considered during the training. It will be a challenge to validate this test against a 'gold standard' (skin snipping) which, while quantitative, is potentially less sensitive than the patch itself. Appropriate expertise needs to be involved in the planning of the protocol and data analysis. Validation needs to take into account the potential for false positives in areas co-endemic for other parasites sensitive to diethylcarbamazine.

31. The study evaluating the efficacy of 2 and 6 monthly doses of albendazole against Loa loa microfilaraemia has been initiated following approval by the government of Cameroon in January 2007. To date, 1500 subjects have been screened and 40 eligible subjects identified. With this rate of subject identification, dosing is anticipated to start around the end of March 2007.
32. The proof-of-concept study for the safety and efficacy of moxidectin in subjects infected with O. volvulus, taking place at OCRC, Hohoe, Ghana completed enrolment and a 30-day follow-up for all subjects in the lowest dose level cohort. The data suggest that at 2 mg for subjects weighing 80-40 kg (25-50 µg/kg), moxidectin is as microfilaricidal as ivermectin at the approved dose. The frequency and severity of adverse events were not higher across all subjects than would be expected if all subjects had been treated with ivermectin as opposed to being randomized 3:1 to moxidectin: ivermectin. TDR and Wyeth have initiated negotiations for a legal agreement for clinical development beyond the ongoing clinical study. Wyeth, the owner of moxidectin, announced at the JAF 12 that it will provide a grant to TDR to ensure that data which allows assessment of whether moxidectin has the efficacy and safety profile required can be acquired as soon as possible.

Integration of Onchocerciasis Control in the National Health System and co-implementation of Neglected Tropical Diseases (NTD) control: Agenda item 17

33. In response to a recommendation of TCC23, endorsed by JAF12, APOC organized a meeting in Brazzaville on integration of CDTI in national health systems and co-implementation of onchocerciasis control, other Neglected Tropical Diseases and Malaria, from 12-14 February 2007. This meeting was held back-to-back with the TDR meeting on research priorities on NTDs. Participants were from 10 APOC and former OCP Anglophone countries, and included national Directors of Disease control, Programme Managers/Coordinators for onchocerciasis and malaria control as well as partners.

34. The main recommendations from the meeting were:

(i) Countries should formulate national policies and plans for the control of Neglected Tropical Diseases (NTDs). These should include policies and plans for co-implementation of community-level interventions, and integration of these interventions into national health systems;

(ii) Countries should establish management structures and allocate adequate resources for the co-implementation of interventions against NTDs and malaria;

(iii) Donors and other partners should be encouraged to support co-implementation and allow flexibility of use of funds for integrated activities;

(iv) Countries and partners should explore innovative ways to empower communities in health care delivery, as this can significantly improve coverage of interventions. Where already established for onchocerciasis control, the Community-Directed Intervention approach should be used for co-implementation of NTD and malaria interventions. Other proven community-level interventions e.g. School Health Programmes, should be pursued where appropriate;

(v) To ensure evidence-based decision-making on interventions and co-implementation, there is a need for further research on delivery strategies, for pharmacovigilance of drug combinations for NTD and malaria control, improved mapping of target diseases and their overlap; and improved monitoring and evaluation;
There will be a need for inter-country collaboration to sustain the momentum, and to exchange experiences and lessons learned on integration and co-implementation. WHO should convene follow-up meetings to discuss progress of the initiative in the different countries. The first meeting should be held after one year in 2008, with subsequent meetings at 2-year intervals.

35. The TCC was also informed that:

(i) WHO/NTD department had received funding from the Bill & Melinda Gates Foundation to promote coordination of integration and co-implementation of preventive chemotherapy-based interventions over a 4-year period. The initial focus of WHO/NTD in promoting integration will include the five RTI fast-track countries and six NTD priority countries (Angola, Benin, Cameroon, CAR, Madagascar and Senegal). Data on mapping of the various diseases is necessary to determine co-endemicity and to plan integrated interventions. In this regard, WHO/NTD will embark on an integrated data management exercise aiming to aggregate, in a common database, available data on NTDs at the country level;

(ii) WHO/NTD had set up a Strategic and Technical Advisory Group (STAG) on NTDs, which will advise WHO on the control of NTDs globally. The first meeting of the STAG will be held back-to-back with a Global Partners' Meeting in WHO Geneva from 17-18 and 19-20 April 2007 respectively. The purpose of the Global Partners' Meeting is to provide a platform for all NTD control partners to meet and harmonize their strategic and operational approaches of their interventions at the country level. Future annual meetings will be held in the WHO Regions;

36. The TCC recommended that WHO should use available mapping data on onchocerciasis from APOC, which had already conducted 85% of the mapping. This will limit duplication of work and resource wastage. APOC management confirmed that, to date, no approval had been received yet from WHO to go ahead with the simultaneous treatment of ivermectin, albendazole and Praziquantel.

Review of Operational Research Proposals: Agenda item 16

Community's participation in CDTI in Chad

37. The proposal was not endorsed by the NOTF; the objectives were not well articulated which led the TCC to conclude that this was a poorly written proposal with scant information. The proposal should be rewritten taking into account the following suggestions:

(i) The NOTF should explain the rationale of this research and provide information on available logistics to conduct the research;

(ii) Two TCC members, Prof. Soungalo Traore and Dr Andre Yebakima, who offered their services in re-writing the proposal, will assist NOTF/Chad.
Absenteeism and Refusal rates in CDTI: Case Study of Bena Leka Health Zone (Kap Study)

38. The proposal was regarded as interesting as it aims at documenting the population of refusals and absentees as part of CDTI - very often the two categories are not clearly distinguished in reports. In addition, the study will provide information on factors associated with refusals. The study will be conducted in an area where CDTI has been implemented for many years. The proposal was accepted.

Infectivity rate of Simulium damnosum in cross-border communities in Ogun State Nigeria: toward the establishment of entomological monitoring for Ogun State CDTI project

39. The proposal seeks to collect baseline entomological data in Ogun State, Nigeria for one year and train local scientists; it does not indicate how activities will continue beyond one year. APOC was planning a study on the movement of the black fly between Benin and Nigeria. This was to take place in 2007. The study would address two of the proposal’s objectives. Given the foregoing, and that the University of Agriculture is located in an area identified in the APOC study, TCC recommended that the investigators submitting this proposal be invited to join the APOC study team to achieve their objectives.

Studies on coverage and sustainability of Community Directed Treatment with Ivermectin (CDTI) among nomads of Taraba State, Nigeria

40. The proposal, aims to evaluate ivermectin coverage of the nomadic population in the project area and factors that hinder or facilitate the participation of nomads in CDTI. This proposal is a resubmission, and although it has been improved, TCC made the following observations and comments:

(i) The scope of this study seems too ambitious and too broad for the amount of resources (including time, money and expertise) presented in the document and available. TCC requests the researchers to scale back the objectives to only numbers 1 and 2 and to redesign the study protocol to address those two objectives only;

(ii) Clarify is required as to whether the communities to be surveyed are ‘permanent villages’ or temporary nomadic settlements, and why the study design was devised as such. To assess coverage, a household survey among the nomads with randomly settled households is the best way to collect valid data;

(iii) Given TCC’s view regarding scaling down the objectives, an indication is required as to whether focus groups (FGs) and community meetings still be required and if so, what the difference in the data collected from FGs and community meetings will be;

(iv) Provide an estimated size of the nomadic population, number of nomad CDDs trained and actively working, and estimated coverage among the nomads (best guess). Then clarify how the sample size was determined and make adjustments based on the changed methodology;

(v) Indicate clearly the composition of each team and the skills of the investigators needed. Make a better estimate of how much time it will take
per village to collect the data including travel time between settlements and review the budget accordingly;

(vi) After revising the study protocol, expand the methods section to indicate the tools needed to collect the data and the kind of data each of the proposed tools will collect;

(vii) The revised protocol and tools addressing the above issues should be resubmitted to APOC Management as soon as possible for reconsideration. TCC members agreed to provide assistance to the investigators, as requested.

Inclusion of Sierra Leone as APOC country: Agenda item 18

41. APOC was expecting to receive an official request for membership as an APOC country from the government of Sierra Leone, however as of 13 March 2007, this had not yet been received. Once received, the request will be submitted to JAF for consideration through the Committee of Sponsoring Agencies (CSA).

Result of Phase II Study on compliance with ivermectin treatment: Agenda item 11

42. In 2005, TCC approved a feasibility study (Phase I) in Tanzania, Chad, Nigeria, Cameroon and Uganda to ascertain whether adequate record keeping existed from 1998 at the project, district and village levels to enable accurate study of compliance, since individual recall over time is unreliable.

43. Seven projects identified in the feasibility study, with districts that had distributed ivermectin annually and consecutively for 7 years from 1998, were selected for the main (Phase II) compliance study. The study sites were in Cameroon (1), Nigeria (4), and Uganda (2) with a view to having a mix of NGDO partners among the project sites. Compliance was defined as taking ivermectin annually from the time APOC-supported CDTI started or when a person became eligible for treatment. A cut off period of 10 years was chosen to ensure that individuals would have had an opportunity to comply at least 5 times. Compliance was also categorized into low (0-2 times) and high (5-8 times). A complementary set of quantitative and qualitative research instruments were employed. The quantitative instrument included village records, a household survey and individual interviews while the qualitative instruments included focus group discussion (FGD), in-depth interviews (IDI) with CDDs, Community leaders, and health workers, as well as detailed field notes.

44. The multi-country study concluded that:

(i) Villages in this study are reaching coverage targets of 65% or more;

(ii) A caveat is that these villages were included in the study because they had annual distribution and good records;

(iii) 59% of individuals included in the study complied 5 or more times with treatment;

(iv) Demographic factors associated with compliance, like age and ethnicity, will be useful to APOC in development of new IEC strategies and materials;
Perceptual factors like benefits, seriousness and discouragement can help IEC strategy and content, as these were found to influence compliance.

**Recommendations**

45. **Following the presentation, the TCC congratulated the research team and endorsed the following recommendations of the study team:**

   (i) **Documentation of compliance should be institutionalized with annual summary columns in village registers and report forms;**

   (ii) **Health education materials should be geared to specific low compliance groups and their perceptions and beliefs;**

   (iii) **Ensure that the ivermectin stays long enough (3 months) to reach low compliers (e.g. younger and more mobile people);**

   (iv) **Programs must continue to provide adequate and timely supplies of drugs to enable villagers to comply annually;**

   (v) **The Committee advised APOC management to inform countries that received the special country initiative funds to ensure they revise the IEC materials in view of the results of the compliance study.**

**Increase in School Enrolment in 3 sites following 5 years of CDTI: Agenda item 20**

46. **The result of the data of the socio-demographic aspect of the long-term impact assessment studies of APOC operations pointing to a possible increase in school enrolment in 3 sites, Gashaka (Taraba), Olamaboro (Kogi) and Ikom (Cross River) within a five-year period (1999-2004) was presented by Dr Noma. The TCC discussed the result and recommended that an in-depth study should be conducted, taking into account confounding factors, to investigate the trend in school enrolment in communities benefiting from CDTI.**

**Generation of interest in onchocerciasis among young professionals in public health and medical schools**

47. **During the discussion on operational research proposals, TCC noted that expertise in onchocerciasis research (e.g. examination of nodules/macrofilaria, identification of black fly species) is becoming rarer and could actually disappear, as the experts retire without having trained the next generation of researchers.**

48. **One factor contributing to the lack of young researchers in onchocerciasis may be the success of the onchocerciasis control programmes. This success has given the research community and funding agencies the impression that onchocerciasis will soon be a disease of the past, and thus did not require ongoing and innovative research. The fact that APOC's core mandate, in contrast to OCP's, did not include financing the training of young scientists in research, may have further contributed to onchocerciasis research becoming less visible.**

49. **The TCC discussed ways to correct this situation, i.e. to build capacity in research on onchocerciasis, particularly in Africa. APOC could sensitize universities and schools of public**
health to the need for ongoing onchocerciasis research, and ask them to identify interested students. The Director of APOC noted that except there is a change of programme mandate, financial support could not be provided from APOC Trust Fund to students. This could however be suggested to the CSA.

50. Dr. Sacko, Coordinator of Vision 2020- The Right to Sight® within WAHO/OOAS, informed TCC that WAHO gives one-year stipends to young researchers from ECOWAS countries. The curricula on onchocerciasis and onchocerciasis control in African universities and schools of public health could be expanded to raise interest in onchocerciasis control in Africa as has been done in the USA.

51. Consideration also needs to be given to the fact that expertise in onchocerciasis research can likely be maintained and renewed only if funding for onchocerciasis research provides a career comparable to research in other diseases.

52. TCC recommended that a working group be formed to discuss steps to maintain/rebuild research capacity.

**MANAGEMENT OF APOC TRUST FUND**

**Report on the financial management of APOC funded projects: Agenda item 21**

53. The Finance Officer, Ms Keïta presented to the TCC a report on countries’ management of APOC Trust Fund.

54. A total of 123 proposals for Letters of Agreement were expected from countries for 2007. 111 were received. 102 Letters of Agreement were prepared, signed, and the funds released by 28 February 2007.

55. Out of the 3032 financial returns expected from countries, 2488 were received and 2298 (92% of the received returns) analysed by the AAF at the country level and APOC HQ.

56. As of 28 February 2007, 69 projects had red cards, meaning they were more than four months late in submitting financial returns. The release of funds to these projects has been suspended pending the submission of 463 returns concerned.

57. A guideline is being prepared to accelerate the decentralization of some of the financial functions to the WHO/Country offices.

58. The attention of the committee was drawn to the fact that 12 projects had not submitted their Plans of Action & Budget (PAB) for 2007.

59. The issue of harmonizing the financial report submission format in the APOC Financial & Administrative Manual and the tables in the Annual Technical Report (Tables 13 & 14) was also brought up.

60. The TCC noted progress in the Management of the APOC Trust Fund and urged projects to submit timely returns for imprest, in order to avoid delays in the disbursement of funds for activities.
Technical, administrative and financial review of APOC operations in the countries: Agenda item 22

61. Dr Yameogo reported on the missions undertaken by APOC management from January to February 2007 to assess CDTI activities in Cameroon, DRC and Nigeria in view of the devolution of APOC operations. Each project team, made up of 2 members, one technical and the other, finance, spent 2 – 3 weeks in each project. Technical, administrative and financial issues were reviewed with project staff.

62. The mission carried out training and retraining of accountants, developed tools for financial management and advocated for support from policy makers on CDTI. Debriefing meetings were held with projects and policy makers. TCC members requested more information on the outcomes of the missions, duration, delays in accounting and reasons why government counterpart funding was not provided. TCC was informed that the final reports of the missions would be available in September to TCC 25. The Committee recommended that such missions be continued with the possibility of TCC members joining the teams.

PROJECT REVIEWS

Report on the review by APOC Management of 1st, 2nd, 3rd, 4th, 5th, 6th, and 7th year progress reports and subsequent year budgets: Agenda item 23

63. An update was given on the status of 2006 budget as of December 2006. As at the end of December 2006 the amount of US $ 6,124,255 budgeted for funding country projects had been used as follows: (i) US $3 891 035 was obligated for 100 country projects under Letters of Agreement and (ii) US $2 233 220 was obligated for other activities including study on the impact of APOC operations, studies on Compliance to ivermectin treatment & Incentives, Training, Workshops, Working Group on the Future of APOC, Partners Meeting and Resource Mobilization Workshops.

64. An overview of the projects to be implemented in 2007 was given. A total amount of US $ 6,019,400 has been budgeted for funding 118 projects and other activities in 2007. As of 28 February 2007, US $ 4,514,737 (75% of the budget) was committed for implementation of 98 national projects (93 CDTI projects and 5 HQ support projects), leaving a balance of US $1,504,663 to finance 20 national projects (14 CDTI projects, 4 Vector Elimination project, 2 HQ support projects) and other activities.

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 the 2nd, 3rd, 4th, 5th, 6th, 7th and 8th year implementation of the projects: Agenda item 24

65. Three new proposals were submitted: Vitamin A supplementation & CDTI from Cross River State in Nigeria, HIV/AIDS control & CDTI from Cross River State/ Nigeria, and Final Assessment of Vector Elimination activities in Tukuyu/Tanzania.
NIGERIA

Proposal for vitamin A Supplementation (VAS) using CDTI in Cross River State

66. This was one of the Nigerian proposals which had earlier been submitted for funding. TCC rejected the proposal as submitted for the following reasons:

   (i) The objective was not clearly indicated, although the general goal was to identify a cost-effective mechanism of delivery of vitamin A to children 6-59 months old, post-NID. It was assumed that this referred to the second annual dose for children, the first one being given during NID;

   (ii) TCC impressed on the project to address all the recommendations made in TCC23. The proposal should be updated and revised to specify objectives, time lines and VAS linkage to routine CDTI activities;

   (iii) TCC required that the proposal address gaps which needed to be filled;

   (iv) TCC recommended that investigators attend the NOTF workshop to be held later this year in Nigeria.

Proposal for integrating HIV/AIDS control into CDTI in Cross River State

67. The proposal for integrating HIV/AIDS Control into the successful community-directed treatment with Ivermectin (CDTI) in three local government areas of Cross River State was rejected because TCC unanimously agreed it is outside APOC’s mandate and recommended that investigators seek funding elsewhere.

TANZANIA

Proposal on Final Assessment of Vector Elimination

68. Two ground larviciding campaigns were carried out in the Tukuyu focus in 2003 and 2005. Cytogenetic and molecular identifications conducted in 2006 (Prof. Post), seem to indicate that *S. thyolense*, the vector in the focus, might not have survived the insecticides treatments in 2005. The main question whether the vector has really been eliminated or not.

69. The workshop on the criteria for certification of vector elimination in APOC countries noted that number of samples that were examined were small and had not been collected from the entire focus. Therefore the workshop recommended that:

   (i) The samples must be collected in the entire focus and;

   (ii) Those samples must be examined in laboratories that are familiar with the Simulium.

70. **Thus, the TCC recommended that:**

   (i) **The study be carried out without delay;**
(ii) The analysis be conducted by experienced laboratories that have a background in this type of examination;

(iii) The budget be reduced by taking into consideration the number of cycles of captures/prospections, and the logistics requested by the project and laboratories.

LIBERIA

North West: 5th year report, South West: 2nd year report and South East: 2nd year report

71. The three CDTI projects in Liberia, in essence, submitted almost identical reports for three projects. The reports were incomplete and lacked detail, making it difficult to assess whether the problem was with the performance of the projects or with the reports. Except for expenditure returns, the fifth report of North West is similar to the 2nd year technical report of South West and South East.

72. TCC recommends that each project in Liberia write a separate report using the correct project reporting format (not the NOTF summary form that was used) and that each project include specific information and data unique to that project with attention to the following:

(i) Provide a concise but complete executive summary which addresses all listed issues including population, treatment and training data, challenges and solutions, etc;

(ii) Provide a full description of the project background, including geographic (districts and villages) and administrative structure, ecology, population characteristics, etc;

(iii) Describe each of the project implementation activities (training, IEC, advocacy, supervision) in much more detail and with more accuracy (data);

(iv) Regarding the timeline of activities: Explain why training is done 3 months before distribution; this seems too early to be effective. Also explain why supervision is done only after training but before distribution – what is being supervised;

(v) Address all other issues listed in the new reporting format including, supervision, financing, drug management, challenges and suggested solutions.

73. TCC noted that there seemed to be serious issues that needed to be resolved in order to ensure an effective partnership with the assisting NGDO. The NOTF should also consider finding additional NGDO partner(s) to assist with one or two of these projects. TCC also noted that community participation seemed weak and should be actively promoted to ensure sustainability of these projects. CSM and SHM should be introduced.
Southeast Project
74. Issues requiring clarification were as follows:

(i) An explanation for the high number of absentees (105,000);

(ii) A clarification of why about 1.4 million tablets of Mectizan® were ordered and used to treat only 162,830 people situation. This comes to about 9 tablets per person treated when it should average around 3 tablets/person treated; the project should indicate how many tablets were remaining or expired.

Northwest Project
75. TCC comments were as follows:

(i) The project is requested to identify reasons for the 56% coverage. This is low for a project in the 5th year. The project should draw up a plan of action to address the situation particularly the high occurrence of absenteeism;

(ii) This is a 5th year project therefore it should be addressing integration and sustainability issues.

Southwest Project
76. General comments as noted above.

Conclusion
77. TCC made the following recommendations:

(i) All three of these reports be rejected. They should be resubmitted to the next TCC, using the correct format and they should respond to the points noted above. TCC asks APOC Management to ensure that the NOTF receives this correct reporting format;

(ii) Assistance be provided to the NOTF and the CDTI projects by APOC Management. APOC Management should hold a workshop in Liberia on CDTI and report writing, before TCC25, to assist the NOTF and project staff with project implementation and reporting. The new Liberia NOTF Coordinator should be provided with an opportunity, if possible, to visit another APOC country to gain insight through the experience and lessons learned elsewhere. The Coordinator should also attend a TCC meeting within the next year, at a time appropriate to APOC Management.

CAMEROON

Littoral I: 2nd year report

78. The report was very comprehensive, an indication that the NOTF is supporting the CDTI projects which, overall, were performing well. There are some deficiencies in the report.
The TCC recommended the NOTF:

(i) Develop better knowledge of the geographical distribution of onchocerciasis in Littoral I, since all the communities were considered meso-endemic in order to be eligible for CDTI;

(ii) Carry out better follow-up of feedback given to field actors after supervision;

(iii) Make efforts to establish linkage with Universities, for joint studies in Operational research;

(iv) Be more vigilant in monitoring and managing SAEs;

(v) Comment on the various tables in the Technical Report;

(vi) Ensure better balance in the information furnished under various items. Some of them are extensively developed, while others are scanty;

(vii) Always indicate the amount contributed by APOC.

Littoral II: 7th year report

The report was well written, and in accordance with the TCC recommended format. The project achieved good geographic coverage (100%) and therapeutic coverage (which increased from 30% in 1999 to 71.5%). Several factors accounted for this performance, among which are: the financial support from government, and community participation in CDTI and in rewarding CDDs. Special emphasis was placed on the training of CDDs and health workers. The project should, however, initiate community self-monitoring (CSM) and stakeholder meetings (SHM), which are yet to be carried out.

The TCC accepted the report and requested additional information regarding SAE cases that resulted in death. Specifically:

(i) 3 hypotheses were given as to the cause of the symptoms, but the project provided no report on the final diagnosis. A report on the final diagnosis needs to be provided;

(ii) Explain why the project stated that appropriate treatment “has been instituted” but the patient succumbed after 25 days of hospitalization. Please describe what happened;

(iii) TCC was concerned that this case was not well managed (NOTF report) and requested the project to document what happened and the measures in place to avoid a recurrence. TCC noted that only 20% of health staff participated in CDTI. It is recommended that the project train a far greater number of health staff in Littoral II project area on CDTI, including all the key hospital staff on management of SAEs.
North West: 3rd year report

82. **TCC commended the project for a very well written report. The report was accepted with the following recommendations and suggestions for improving project implementation:**

   (i) The project should explain why the number of communities changed each year over the first 3 years;
   
   (ii) The number of health personnel: only 37.89% of health personnel are involved in CDTI activities. TCC suggested that the project train more health personnel, if funds are available, to improve integration and ensure the likelihood of sustainability of CDTI;
   
   (iii) 2 villages were not treated because the CDDs abandoned their work. TCC suggested that the project undertake a mid-distribution cycle review meeting and re-deploy available resources to cover areas with poor or no treatment coverage;
   
   (iv) Absentees (81,275) and refusals (38,331) were quite high due fear of SAEs, religious beliefs and the coincidence of the distribution cycle with the farming season. TCC recommends that the project look into ways to reduce the proportion of absentees and refusals by changing the distribution period and adhering to the period decided on by the community.

South West 1: 8th year report

83. This is the 8th year technical report. It was similar to that of the previous year, sometimes, with exactly the same figures. Many activities were undertaken in hypo endemic areas, in spite of difficulties encountered in meso/hyperendemic areas. The following observations were made:

   (i) The CDD: population ratio and the proportion of female CDDs have slightly improved over the previous year;
   
   (ii) The report does not provide sufficient information on integration activities, especially with regard to the eye care programme.

84. **TCC accepted the report and requested that a more detailed and original report be submitted in future.**

South West II: 6th year report

85. The project submitted a comprehensive report indicating a year of CDTI activities with good geographic and therapeutic coverage. The project was commended for explaining in detail the constraints it faced (e.g. lack of funds, low motivation of CDDs, etc.) and the solutions implemented (e.g. integration with other programmes and plans for intensified HSAM).
The report was accepted with the following suggestions and comments

(i) A response to section 4.1 of the report should be provided to APOC management;

(ii) The project, which has been low on resources, has found ways to take advantage of available opportunities to conduct CDTI activities (e.g. use of various community gatherings for CDTI mobilization, shared use of equipment belonging to other programmes, and integration of activities with other health programmes);

(iii) The project is encouraged to continue with its plans to intensify HSAM in communities where coverage is less than 65%. The intensified HSAM should also include components for encouraging communities to support their CDDs and for reducing the number of refusals and absentees;

(iv) The project should explain why only a portion ($32,836) of released funds ($63,564) was spent during the reporting year and, what was done with the funds not spent.

NOTF/HQ: 8th year report

87. The report was comprehensive, an indication that the NOTF is supporting its CDTI projects which, overall, were performing well. There were some areas in the report which required clarification. TCC drew the attention of the NOTF to the following:

(i) Need for a better understanding of the geographical distribution of onchocerciasis in Littoral since all the communities were considered meso-endemic in order to be eligible for CDTI;

(ii) Need for a better follow-up on feedback from the supervisors in the field;

(iii) The importance of collaborating with Universities for the development of operational research;

(iv) Need for greater vigilance in the follow-up on, and management of, SAEs;

(v) Need for additional comments of different tables;

(vi) Keep balance of the information from different subject items. Some of them are detailed while others are not;

(vii) Need to regularly indicate APOC financial contributions;

(viii) Improvement on reporting by the NOTF;

(ix) The report must be endorsed (with signature) by the different persons in charge.
88. **TCC accepted the report and requested NOTF to take into consideration the above observations in order to optimize the performance of the programme and improve on reporting.**

**Adamaoua II: 7th year report**

89. The report was on the 7th year activities of the project. Efforts were made to improve the therapeutic coverage and the proportion of female CDDs. However, the number of CDDs was still insufficient, especially in the Meiganga Health District (1 CDD: 700 people in some areas).

90. The report lacked detail on several issues:

   (i) SAE cases indicated in the table without any corresponding reference/detail in the text;

   (ii) Number of absentees and refusals;

   (iii) Impact of CDDs’ participation in other activities such as immunization or leprosy programmes;

   (iv) Explanation of why the ATO is calculated as 65% of the total population.

91. **The report was accepted, on the understanding that the following recommendations will be considered:**

   (i) *The report indicated that LCIF funding covered only salaries (page 11); however, it again indicated that the same source of funds was applied for other activities (page 29). This contradiction should be clarified. APOC had already allocated funds for a new vehicle for the project;*

   (ii) *The workshops on fund-raising and communication will not be funded by APOC Trust-Fund. The project was advised to look for funding from other partners such as LCIF. In addition, the project was requested to increase advocacy to the MOH so that it may increase its contribution to onchocerciasis control;*

   (iii) *The number of female CDDs was considered to be too low and the project was encouraged to increase it through training.*

**Extreme North: 2nd year report**

92. The project submitted a comprehensive and well-written report describing its Year 2 CDTI activities. The project should be commended for achieving 100% geographic coverage and 74% therapeutic coverage in two years. However, communities should be encouraged to play an active role in CDTI. The project has given a great deal of thought to how CDTI activities can be improved.
93. The report was accepted with some project and report-related comments:

**Project-related:**

(i) The project should devise strategies for reducing the number of absentees and refusals which account for 7.4% of the total population;

(ii) The project is encouraged to make efforts to increase coverage in communities with less than 65% coverage;

(iii) During the reporting period, $189,054 was released but only $118,635 was spent on activities. The project should indicate how the remaining funds have been applied.

**Report-related:**
The project is asked to use the most recent version of the reporting format.

Centre 3: 8th year report

94. This is the 8th year technical report and it is well-written. However, it was very similar to the previous report. TCC requested the project to improve the integration process and to reinforce supervision. In addition, detailed information on SAE cases needs to be provided. Information on SAEs should be consistent in the whole report (in this report, different figures are given in the table, the footnotes, and the text itself) Both Government and communities were asked to support CDDs. TCC accepted the report and requested that the report be improved, specifically, on a yearly basis.

Centre 2: 4th year report

95. TCC commended the project for the good results obtained in CDTI activities as well as in vitamin A supplementation, in a very difficult environment. The project was also congratulated for having carried out an evaluation of the therapeutic coverage and compliance. TCC regrets the sharp drop in funds allocated by the Ministry of Health and NGOs, during the past year.

96. The Committee accepted the report and recommended that the project needs to:

(i) Strengthen supervision;

(ii) Request the Government and communities to support CDD;

(iii) Seek Government support for other CDTI activities as done in 2006, especially in this high risk SAE area;

(iv) Implement the sustainability plan;

(v) Clearly differentiate in the future those CDTI activities relating to advocacy and to sensitization/mobilization;

(vi) Provide a detailed budget according to the source of funding for each activity (avoid for example MOH + APOC + HKI);
Harmonize the UTG data in different parts of the report.

Centre 1: 5th year report

97. The report indicated a year of CDTI activities with good geographic and therapeutic coverage. However, several activities in the report were the same as what was reported for Year 4. This made it difficult to appraise the current situation. Moreover, there were sections of the report for which responses were not provided.

98. The report was accepted, subject to providing responses to TCC's concerns. The project responses should be submitted to reviewers through APOC Management.

Project-related:

(i) The project is encouraged to increase the number of CDDs in order to bring the CDD: population ratio closer to 1:125. The population should be sensitized to increase the number of female CDDs;

(ii) The project should intensify CSM training to accelerate its implementation;

(iii) The project should explain why only a portion ($116,448) of released funds ($211,143) was spent during the reporting year and, what was done with the funds not spent.

Report-related:

(i) The current reporting format should be used for all technical reports in the future;

(ii) Recommendations from TCC22 need to be addressed;

(iii) Future Executive Summaries should include a brief summary of any SAEs, their management, and outcome;

(iv) A very brief description of the project area should be given, describing the population in the treatment area and the health care system. As previously recommended, the description should be more comprehensive in the future;

(v) As previously recommended, outcomes of advocacy and mobilization campaigns should be described;

(vi) The information provided with regard to supervision and equipment is exactly the same as that provided in the Year 4 report. Is the situation really the same?

(vii) Section 4.1 of the report was not completed. Does this mean that no monitoring or evaluation was conducted in 2006?

(viii) Project weaknesses, challenges, and opportunities were not provided.
East Province: 1st year report

99. TCC noted that recommendations of TCC 21 were addressed. The report was presented according to the format recommended by TCC, and the various sections were presented in a logical manner. The writing was clear, making for easy reading. Information was generally precise and detailed. Calculations in the tables were correct. However, the following points need to be improved upon:

(i) In the expenditure section, under “Other” the amount is rather high (41740 $) and required some explanation;

(ii) The personnel in the project area is sometimes said to be sufficient (p29), sometimes not (p 15). There is need for harmonization;

(iii) The geographic coverage is 100%, but the average therapeutic coverage is still below the minimum threshold of 65%. However, it increased, from 53.5% in 2005 to 62.8% in 2006. The is the need to raise coverage to a minimum of 65%.

100. TCC recommended that the report be accepted, but called on the project to:

(i) Intensify its efforts in all communities, particularly those of the HD of Bétaré-Oya and Bertoua;

(ii) Intensify sensitization of communities so as to increase the therapeutic coverage;

(iii) Finalize its proposals for an operational research;

(iv) Improve on the content of the report and carry out a second reading to avoid contradictions.

South Province: 2nd year report

101. TCC noted that the project satisfactorily addressed the recommendations of TCC 22. The report was presented according to the TCC format. Information was generally detailed (in particular the schedule of activities) and calculations in the tables were correct. TCC accepted the report, but called on the project to improve upon the following:

(i) In the summary, the emphasis should be on results (especially those on SAEs) and not on general information;

(ii) Specify possible deaths due to SAEs, and number of people with side effects;

(iii) The report does not state the difficulties encountered during advocacy, nor the possible solutions provided;

(iv) Table 7 is to be completed (numbers of refusal and absentees);
(v) Indicate whether human resources are sufficient and qualified;

(vi) Intensify sensitization in order to increase the therapeutic coverage;

(vii) Ensure that the Health District have the best equipment;

(viii) Continue lobbying the Government for the timely release of the financial contribution of the State.

NIGERIA

Taraba State: 8th and 9th year report

8th year report

102. Taraba CDTI achieved 100% geographic and 85.1% therapeutic coverage. TCC commended the project’s efforts towards integration of other interventions into CDTI. The report was accepted with the following recommendations:

(i) Involve communities in supervision;

(ii) State and LGA levels should be encouraged to release funds for CDTI;

(iii) Train more CDDs to attain a ratio of at least 1 CDD: 150 persons. The current level (1: 778 persons) is not adequate;

(iv) Supervision from SOCT and LOCT levels to FLHF and community should be emphasized;

(v) Strengthen efforts to carry out community self monitoring and stakeholders’ meetings.

9th year report

103. The project had a good geographic and therapeutic coverage. However, it faced the following challenges:

(i) Non-release of funds by the state, and LGA levels;

(ii) Few CDDs at the community level- 1 CDD: 404 persons;

(iii) Inadequate supervision from LGA to lower levels and lack of supervision from the SOCT level.

104. TCC accepted the report with the following recommendations:

(i) State and LGA levels should be encouraged to release funds for CDTI;

(ii) Need to train more CDDs at least to attain 1CDD: 100 persons. The current level of 1 CDD: 405 persons is still not adequate;
(iii) Supervision from SOCT and LOCT levels to FLHF and community should be emphasized.

Anambra State: 7th year report

105. The report covered activities from October 2004 to September 2005, but was submitted much later to TCC in September 2006. The report follows the recommended guidelines and contains most of the information required, and was therefore accepted. Some suggestions for improving the report and project are:

Report-related
(i) Report submission should be more timely (this recommendation was already made by TCC23);
(ii) The executive summary needs to be more comprehensive;
(iii) The timelines should be presented so that differences between LGAs can be seen;
(iv) Some inconsistencies and errors remain; the project is requested to review future reports more carefully, prior to submission to TCC;
(v) The project should explain the sharp decrease in the total population, and the number treated starting from 2004. Even if a census was taken to clarify total population, there is need to explain why the number treated in year 5 was higher than the total population in year 6. (TCC 23);
(vi) Review table 12 particularly the MoH, LGA and NGDO columns.

Project-related
(i) Increase the number of health workers in project area trained in CDTI;
(ii) Set realistic ATO, i.e. number of LGA, health centre/post staff trained on CDTI;
(iii) Intensify health education in Awka North, Awka South, Dunukofia, Idemili North, Orumba North and Orumba South LGAs to improve therapeutic coverages;
(iv) Improve CSM and SHM in the communities of the LGAs;
(v) Intensify advocacy with state and LGAs to solicit the release of counterpart funds;
(vi) Better planning of activities: review timeline in Table 3;
(vii) The project should consider developing and submitting an operations research proposal to APOC to assess the current IEC strategy and messages. This is important for improving advocacy to ensure adequate financing of project activities. (TCC23).
Kaduna State: 8th year report

106. A well-written comprehensive report of a mature project, which has maintained maximum geographic and therapeutic coverage since 1998. A major effort has been deployed to carry out advocacy. Sustainability plans have been written, and are being implemented and there is evidence that government at state and LGA levels, as well as communities are increasing their involvement in and support to CDTI. Communities are giving CDDs incentives, however the CDD: population ratio 1:184 should be improved to 1:100.

107. Decline in MOH contribution, from 2002 to 2005, is a source of concern but the involvement of the LGA, which is helping to deduct at source counterpart funding for onchocerciasis is encouraging. There is no CSM and SHM reported; this should have been established in this mature 8-year old project. CDTI is being integrated into PHC and there is co-implementation of activities with other disease control programmes, which is impressive.

108. The report was accepted and the project commended on maintaining 100% geographic coverage and high therapeutic coverage (above 80% in all LGAs) since 1998.

Zamfara State: 6th year report

109. This is a resubmission of the 6th year technical report of the Zamfara State CDTI Project. The report still contains some inconsistencies, but it is much improved over past reports and therefore was accepted. In future reports, the project is requested to verify all data, ensure consistency throughout the report and provide more details about activities, problems and possible solutions.

110. The project should be commended for training Islamic scholars and TBAs to reach more women in purdah with health education, for maintaining a high therapeutic coverage in the past few years and steadily improving therapeutic coverage (from 71-83%), although coverage went down to 77.79% in 2004.

111. For project improvement, TCC suggests that:

(i) The project integrates training of community supervisors into their strategy to increase community ownership, if funds are available. Otherwise APOC should provide the funds;

(ii) There is only 1 CDD per 540 persons in the project; however the range across LGAs is from 1 CDD/227 to 1 CDD/over 950 people. Project should train at least double this figure, but preferably three-five times the number of CDDs, depending on the LGA (along kinship lines) to reduce the workload of CDDs, and better ensure sustainability;

(iii) Local government should try to find funds to enable more training and supervision activities;

(iv) Project should ensure improved integration into public health service to better sustain onchocerciasis projects after the end of APOC.
Delta State: 6th year report

112. *This is a good project with a well-written report. The report was accepted with the following recommendations:*

(i) *There is need to review the ivermectin tablet inventory;*

(ii) *Improve on census taking and recording; the project should not be using estimates in year 6;*

(iii) *Ensure better therapeutic coverage in Oshimili South and Ndokwa West LGAs;*

(iv) *Ensure better coverage in areas where the therapeutic coverage was low.*

Edo State: 6th year report

113. The project needs to get a better understanding of its weaknesses and challenges. Several difficulties such as poor logistics, incentives, poor community ownership, census and attitude of health personnel need to be addressed urgently. Proactive support from the Zonal Coordinator would be beneficial. NOTF should ensure that it reviews the report before endorsement, and that the 2006 report is submitted on time.

114. *The report was accepted with some recommendations:*

**Report-related**

(i) *Provide cost per treatment;*

(ii) *Clarify contradiction in Table 6 and section 2.8;*

(iii) *Review Table 7 and census figures.*

**Project-related**

(i) *Intensify advocacy, sensitization and mobilization of policy-makers to ensure release of sufficient funds;*

(ii) *Review timeline and ensure it is realistic;*

(iii) *Ensure integration of CDTI into PHC;*

(iv) *Ensure release of funding for maintenance of motorbikes to support monitoring and supervision;*

(v) *Identify NGOs and CBOs active in the state within and outside the health sector;*

(vi) *Ensure implementation of CSM and SHM in all communities;*

(vii) *Complete implementation of the recommendations of the sustainability evaluation. It is insufficient to claim CDTI is integrated into PHC while add-on activities are ongoing in the state;*
(viii) Identify operational research issues and partners to collaborate with;

(ix) Identify unique features of the project;

(x) Check drug inventory.

**Ekiti State: 5th year report**

115. The report seemed to be the same as the last annual technical report, when this should not be the case. For example, the number of refusals seems to be the same as that in the previous report. The therapeutic coverage of more than 85% is questionable. It was also noted that the number of CDDs was still very low and that the State and LGAs are not providing adequate funding for CDTI activities.

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

(i) Before sending another annual technical report, ensure that there are no inconsistencies in the data provided;

(ii) Increase the number of CDDs, encourage the selection and training of female CDDs, and improve the CDD: population ratio to less than 1 CDD: 100 persons;

(iii) Focus more on securing state and LGA funds;

(iv) Need to begin training, mentoring and involving health workers at LGA and FLHF levels;

(v) The project should have a good grasp of the denominator.

**FCT: 8th year report**

117. The quality of the report could have been improved on, if it had been adequately reviewed. Given the level of funding received from government ($83,000), one wonders why vehicles were still poorly maintained, in spite of a recommendation from TCC 22 that counterpart funds be utilized for maintenance. The declining morale of FLHF staff, CDD demotivation because of poor community support and possible relocation of the population are threats to sustainability and compliance and require urgent attention.

118. **The report was accepted with these recommendations:**

**Report-related**

(i) National and zonal Coordinators to review report;

(ii) Correct calculation; there are errors in Table 5, and Table 6 is incomplete;

(iii) Clarify contradiction in Table 12, and follow up on TCC 22 recommendations on maintenance of equipment;
Project-related

(i) Address TCC 22 recommendations i, ii and iii;
(ii) Train all health staff in the project area;
(iii) Update census in AMAC, Bwari, Kuje, Kwali and Abaji district;
(iv) Provide information on refusals, address absentees, and review drug inventory;
(v) Provide cost per treatment;
(vi) Provide information on operational research;
(vii) Begin dialogue with communities on compliance, and outline plans to address population movement.

Ebonyi State: 7th and 8th year report

7th year report

119. The report covered activities from January - December 2005, but was submitted much later to TCC in February 2007. The report conformed to the recommended format, contained most of the information required and provided a good description of the project. The project seems to put a strong emphasis on good capacity building. It reported that CDTI had been successfully institutionalized and communities have been empowered to organize and conduct treatment with little or no supervision from the upper levels.

120. TCC accepted the report with a few recommendations:

(i) The project should explain why distribution lasts 10 months;
(ii) It should give reasons why ‘Total population’ decreased, and why the denominator seems to be constantly changing;
(iii) Some inconsistencies and errors remain;
(iv) The timelines should be clearly presented so that differences between LGAs can be seen;
(v) There is the need to take a good census.

8th year report

121. The report is informative and well written. It is very similar to the year 7 report, but provides more details. TCC accepted the report with the following suggestions for improvement.

Report-related

(i) Some calculation errors and inconsistencies are found in the report, therefore, TCC suggested that project staff undertake a thorough review
before submission of any future reports. In addition, TCC requested that the project provide more information on supervision visits, purpose and results, both at the LGA and FLHF levels.

**Project-related**

(i) The project seemed to be on the right track to improving project implementation, and TCC concurred with its plans to standardize and stabilize census data and to train more CDDs along kinship lines.

**Cross River State: 7th year report**

122. The project addressed the TCC 23 recommendations. CDTI structures are used for other activities such as HIV/AIDS education, eye care, youth skill development and vitamin A supplementation.

123. **The report was accepted with some recommendations:**

   (i) *The project should provide information on human resource;*

   (ii) *Total population decreased, and denominator seems to be ever changing; this needs to be addressed;*

   (iii) *The number of female CDDs should be increased;*

   (iv) *A better estimation of ATO is required;*

   (v) *The project should give more information on previous SAE cases.*

**Adamawa State: 7th year report**

124. The report was well written. Efforts were made to advocate for counterpart funds from partners. There were however a few LGAs that need to support CDTI activities. The participation of women was poor and needed to be improved. Integration of Vitamin A distribution into CDTI should be documented.

125. **The report was accepted with some report and project-related recommendations:**

**Report-related**

(i) *Provide information on unique features of the project;*

(ii) *Provide information on integration;*

**Project-related**

(i) *Intensify advocacy with local governments to ensure release of funds;*

(ii) *Encourage active participation of women;*

(iii) *Train all health workers in project area;*

(iv) *Train additional CDDs;*
(v) Update census in Madagali, Maiha, Hong, Song, Yola South, Guyuk, Mayo Belwa, Ganye, Jada, LGAs;

(vi) Use available funding for advocacy workshop for LGA policy makers;

(vii) Encourage CDDs to mop up treatment;

(viii) Ensure that communities carry out CSM and SHM;

(ix) Review drug inventory;

(x) Improve monitoring and supervision at all levels;

(xi) Provide unit cost per treatment.

Borno State: 7th year report

126. Borno has maintained a good geographic and therapeutic coverage. However, the project has the following challenges:

(i) Non-release of funds by state and LGAs;

(ii) Inadequate number of FLHF staff;

(iii) Selection and training of more CDDs;

(iv) Obtaining funds from the government.

127. TCC accepted the report with the following recommendations:

(i) The project needs to keep encouraging the state and LGAs to budget and release funds for CDTI;

(ii) Train more FLHF staff;

(iii) Encourage communities to select more CDDs for training by the project.

Yobe State: 8th year report

128. The 8th annual report of the Yobe State Project is well-written and presented according to the form recommended by the Technical Consultative Committee. The report was accepted with the following comments:

(i) The project received $US 142,047 in 2006, about four times the amount received in 2005. Despite this increase in budget, the therapeutic coverage is still low and decrease year after another (this rate is 98% in 1997 and 77% in 2006);

(ii) The project is not effective because the number of people treated increased by only 6.26%, from 2005 to 2006;
More effort should be applied by the project to recruit more CDDs in order to stop the decrease in the therapeutic coverage rate. The project must also be proactive in attracting female CDDs.

Nassarawa State: 6th and 7th year report

6th year report

129. This second resubmission of the Year 6 report is much improved over the original and first resubmission. The report was accepted with the following report-related recommendation:

(i) The project should continue to make an effort in future reporting to ensure that data in the Executive Summary are consistent with data in the body of the report. In this report for example, the community contribution in Table 13 does not match the figures in the executive summary.

7th year report

130. It was impossible to judge the project’s Year 7 performance since the vast majority of the Year 7 technical report is word for word the same as that of Year 6. A report uniquely describing the activities of Year 7 should be submitted for review at the next TCC. In the revised report, the project should include a report on activities carried out between 1 June 2005 and 31 December 2005, in addition to those of 2006. The report was rejected because of the reasons outlined above.

131. This generated a discussion which led to the following comments:

(i) APOC was requested to continue mentoring and training country staff in project management and report writing;

(ii) In the spirit of collaboration, NGDOs and NOTFs were encouraged to provide guidance in report writing at the country level;

(iii) APOC management was requested to remind country report reviewers of their responsibility in ensuring that—reports are proof-read before signing for approval.

Plateau State: 7th year report

132. The report was well-written. The project documented the integration of other interventions into CDTI. It should share this with other programmes. It should not give up on advocacy with the state policy makers. There are 4 LGAs that need support to improve their therapeutic coverage. Additional health workers and CDDs need to be trained to support activities in these LGAs. Community self monitoring and stakeholders’ meetings would go a long way to sustain CDTI. TCC accepted the report with the following recommendations:

(i) Use documentation on the integration of neglected diseases and malaria into CDTI and its outcome to advocate for funding at state level;

(ii) Train all health staff in project area on CDTI;
(iii) Improve CDD: population ratio;
(iv) Ensure that communities carry out CSM and SHM to strengthen community involvement, participation and sustainability;
(v) Identify and address reasons for low therapeutic coverage in Bokkos, Jos East, Kanke and Panshin LGAs, and improve this coverage;
(vi) Improve on geographic coverage in Bokkos local government;
(vii) Provide cost per treatment;
(viii) APOC management to provide project with logistics.

DEMOCRATIC REPUBLIC OF CONGO (DRC)

Kasai Province: 6th year report

133. This report was rejected by TCC because of the following reasons:

(i) Although the reporting format was adhered to, there were a lot of weaknesses and inconsistency in the report which made it difficult to assess it;

(ii) The summary was not narrative and contained a series of tables that were not described in the text;

(iii) There was no endorsement by reviewers at the country level;

(iv) Tables 13 and 14 need to be corrected and completed.

Lualaba: 2nd year report

134. The report revealed the Project Coordinator’s limited knowledge of some aspects of the CDTI strategy. TCC accepted the report with these recommendations:

Report-related
(i) Include an executive summary in all future reports;
(ii) Seek technical assistance from NOTF and APOC on report writing;
(iii) Fully complete tables and avoid calculation errors;
(iv) Clarify the status of human resources.

Project-related
(i) Provide an integrated plan of action and sustainability plan;
(ii) Recruit and train more female CDDs;
(iii) **Organize community-self monitoring, stakeholders meetings and conduct follow-up and evaluation.**

*Uele: 4th year report*

135. TCC noted that the project addressed the recommendations of TCC 21. The report is presented according to the TCC format and the various parts are presented in a logical sequence, making the report easy to read. Information is generally precise and detailed, and the tables and charts in the report make it quite illustrative. Some points need to be addressed for improvement:

(i) The written comment explaining the schedule of activities is a little short;

(ii) There are some repetitions concerning the ordering and delivery of Mectizan;

(iii) The report was not endorsed at the country level.

136. For the future of the project, TCC notes that:

(i) Geographic coverage is 99.9% and the average therapeutic coverage is 75%. The therapeutic coverage is increasing (15% in 2002 to 75% in 2006);

(ii) Measures taken for the management of SAEs help to maintain (and even improve) therapeutic coverage.

137. **TCC accepted the report and called on the project to:**

(i) **Re-double efforts in awareness-raising and mobilization in order to reduce the number of refusals and absentees;**

(ii) **Encourage women to take an active part in meetings on CDTI;**

(iii) **Intensify advocacy for the government to honour its financial contribution;**

(iv) **Improve on the report by taking into account the observations made under the heading "some points for improvement";**

(v) **Rectify the statement on the evaluation. “This evaluation was postponed twice on request of the project management”;**

(vi) **Write a sustainability plan after the evaluation.**

138. In view of the weaknesses noticed when reviewing most of the technical reports, and the many difficulties experienced in DRC, TCC recommends that APOC pays particular attention to these issues.
HEALTH IMPACT OF APOC OPERATIONS: Agenda item 12

139. The results of a rapid health impact assessment (HIA) of APOC was presented. The aim was to assess the reduction in skin and eye diseases, and in the overall burden of disease in DALY’s that was achieved by 2005, and to predict the impact of a further 10 years of APOC operations.

140. Before the start of APOC, 25% and 75% of the 88.5 million target population lived in areas with savannah and forest/mixed type of onchocerciasis respectively; 5%, 30%, 33% and 31% respectively lived in non-, hypo-, meso- and hyperendemic villages; 27%, 17%, 16% and 41% had 0, 1-3, 4-6 and 7-9 rounds of CDTI respectively. Overall, the prevalence of troublesome itching, blindness and low vision were about 15.3%, 0.4% and 1.1% respectively. Predictions made by the ONCHOSIM simulation model suggest that these numbers were reduced by 50%, 23% and 12% respectively by the end of 2005. The annual loss in DALY, which was 1.7 million before APOC, was almost halved. With the continuation of APOC, and especially by including 27% APOC population not yet treated in 2005, the annual DALY loss may be reduced to 14% of its pre-APOC level by 2015.

141. The estimates from the rapid HIA are subject to considerable uncertainty, mainly because of limited data and because ONCHOSIM (which was developed for OCP) is transmission-oriented and could not within this short period be changed into a disease control-oriented APOC version. Additional field studies are required, which link mf infection status to the different clinical manifestations on an individual level. A more comprehensive analysis should consider a wider range of scenarios for coverage and compliance, and include a sensitivity analysis. It should consider the impact of CDTI on not-yet-included eye and skin problems, the side effects of ivermectin treatment, and if possible, the effects of APOC operations on health systems and socio-economic conditions. Recently-collected data (e.g. on coverage and compliance) should be used to obtain more accurate and updated predictions. The ONCHOSIM computer program has to be adapted to the APOC situation. An important question to be addressed is whether mass treatment will eventually eliminate the infection.

142. TCC recommended that the work of the research team be continued. Issues raised by TCC members include:

(i) Future simulations using the HIA be run with varying therapeutic coverage levels to determine impact;

(ii) Data from the compliance study should be incorporated in the HIA;

(iii) The inaccuracy of population census should be taken into account in the analysis;

(iv) The impact of APOC operations should be expressed in easily usable terms for the purposes of advocacy, e.g. the number of cases of blindness prevented, the number of cases of skin disease and low vision avoided.
VISIT OF WHO WR-BURKINA FASO

143. Dr Baba-Moussa, Country Representative of WHO, Burkina Faso, attended the session on Integrated Community-Directed Intervention (CDI) research, multi-country study. He briefly addressed the TCC, mentioning that he wanted to be personally involved and active in this session because of important strategic issues that would be discussed following the presentation. He observed that earlier attempts to entrust communities with the responsibility of managing their own health issues failed. However, since the 1990s, the CDTI approach has been successful in providing communities the opportunity to be involved in their own health programmes. Operational research led to this success, and it is the same operational research, which will allow us to use integrated initiatives for multi-disease control.

144. WHO is interested in the results of the Multi-country CDI research and the study on the interruption of onchocerciasis control using ivermectin alone. Dr Baba-Moussa thanked TCC for their significant contributions to onchocerciasis control, and assured them of the support of WHO. He welcomed TCC members to Burkina Faso, and wished them a successful deliberation.

INTEGRATED COMMUNITY-DIRECTED INTERVENTION (CDI) RESEARCH- MULTI-COUNTRY STUDY: Agenda item 19

145. Dr Hans Remme presented the preliminary results of the 2nd year of the multi-country study on Integrated Community Directed Interventions. The 1st year had shown that communities and health workers were keen to use CDI for other interventions because of their positive experiences with ivermectin distribution, but that the health system could not supply the intervention materials needed to cope with the increase in demand. During the second year, the stakeholder concertation component of the CDI process was enhanced, and national level concertation meetings in each study country greatly helped to improve supply. This allowed CDI to show its potential, and the results were dramatic. Compared to control districts that received the same amount of additional supplies, but where the interventions continued to be delivered in the usual way, the coverage in the CDI districts was far superior: the percentage of children with fever receiving appropriate treatment with antimalarials within 24 hours doubled, the percentage of children sleeping under an ITN tripled, the percentage of pregnant women sleeping under an ITN quadrupled, the case detection rate for tuberculosis more than doubled, and even the percentage of children receiving Vitamin A supplementation that was already very high in the control districts was still significantly higher in the CDI district. The only exception was the DOTS completion rate that was lower in the CDI districts than in the control districts (though not statistically significant), and additional qualitative information suggested that the treatment component of the DOTS strategy is less appropriate for CDI. Preliminary economic data indicated that the total cost at the health district and first line health facility level was similar in CDI and control districts, making CDI more efficient since the coverage was much higher. Ivermectin coverage was significantly increased in the CDI districts.

146. The study concluded that CDI allows for co-implementation of multiple interventions of different degrees of complexity at the community level, and enhances integrated planning and communication at different levels of the health system. Communities could easily implement three interventions and did that more effectively than the public health systems. For similar recurrent costs at the health district and FLHF levels, the CDI process achieves higher coverage for different combinations of intervention. During the third and last year of the study,
the number of CDI interventions will be increased to five, and aspects of integration and sustainability will be further elaborated.

147. TCC commended the efforts of WHO/TDR and country research teams for the scientific demonstration of proof of concept that CDI is the way forward to revitalize primary health care in sub-Saharan Africa. This is a boost to the long-forgotten Alma-Ata declaration. TCC considers CDI as an effective strategy to deliver Vitamin A, ITNs and home-based management of malaria (HMM) and other similar interventions and recommended that this approach be used to enhance coverage of these interventions. TCC further recommended that a study be carried out on the cost-effectiveness and optimal way of introducing CDI in non-onchocerciasis areas. The Committee looks forward to receiving the report of the third year of the CDI study.

Rapid mapping strategy for loa loa

148. Dr Hans Remme presented the progress made in the analysis of RAPLOA data. TCC was informed that Dr. Peter Diggle has developed a spatial model for mapping loaiasis endemicity using all available parasitological and RAPLOA data and remote sensing data for environmental risk factors. A computer programme had also been developed for country level spatial analysis and mapping of Loa loa as and when new RAPLOA data become available. Furthermore, Prof. Diggle had offered to help APOC with preparing an updated map of loaiasis endemicity in Africa. The TCC commended Professor Diggle and his collaborators. The Committee recommended using the new spatial model to update current maps. It further suggested that APOC staff should visit Prof Diggle for training in the model and computer programme for their rapid transfer to operational use.

Feasibility of onchocerciasis elimination with ivermectin

149. Dr Remme presented a very interesting and rich report on the feasibility of the elimination of onchocerciasis in sites where treatment with ivermectin has been ongoing for many years. The aim of the study is to provide the proof of principle whether onchocerciasis elimination is feasible with ivermectin alone, and to provide the basis for decision-making on when and how to stop ivermectin distribution in an area. The study, financed by the Bill & Melinda Gates Foundation, is ongoing in three river basins in Mali and Senegal. The three river basins are Gambia, Bakoye and Faleme.

150. The data analysis workshop of this study was held back-to-back with the TCC24 meeting and this gave the opportunity to TCC members to listen to a presentation from the researchers of the results of the first phase of the study. According to the researchers, the epidemiological and entomological data from the Gambia and the Bakoye river basins show that the infection and transmission levels are extremely low and below the provisional thresholds for elimination, and distribution of ivermectin will therefore be stopped in test areas in these two river basins. In the Faleme river basin the results are less uniform, showing a gradient from North to South with results in the Northern half similar to those in the other two basins, but with prevalence of infection above the threshold in the South. TCC reviewed these results in detail and recommended that ivermectin distribution be first stopped in a test area in the centre of the study area around the catching point of Manankoto. The final decision should be taken when the results of the pool screening would become available from the MDSC laboratory. TCC commended the teams for the excellent study.
OTHER MATTERS: Agenda item 25

Revision of financial contribution in Tables 13 and 14 of the Annual Technical Report

151. Following the presentation on financial contributions in tables 13 and 14 of the Annual Technical Report, TCC agreed to maintain the current reporting format.

Creation of operational research task force in countries

152. As part of devolving APOC activities to the countries, it is proposed that the review of operational research proposals and results be conducted by participating countries with the appropriate capacity. The mandate of the Operational Research Task Force will include onchocerciasis-related research, and other neglected tropical diseases (NTDs) using the CDI strategy. In each country, the Task Force will include a staff of the WHO country office with technical expertise in NTDs. A task force representative will report to the TCC by 31 December of each year on its decisions, funding and results.

153. Following a presentation, by a subcommittee, of the Terms of Reference of the Task Force, the TCC thanked the subcommittee and recommended that it complete the task through email. The TCC requested the subcommittee to present the final version of the guidelines at the next meeting in September 2007.

DATE AND PLACE OF TCC 25: Agenda item 26

154. The 25th session of the TCC will take place from 10-14 September 2007, in Ouagadougou, Burkina Faso.
ANNEX 1: LIST OF PARTICIPANTS

TCC MEMBERS

1. Dr. Elizabeth Elhassan, Country Representative of Sight Savers International, 1 Golf Road, P.O. Box 55, Kaduna, Nigeria, Tel: (234) 62 24 83 60 or 62 24 89 73, Fax: (234) 62 24 89 73, Mobile: (234 80 53 42 71, E-mail: elizabethelhassan@yahoo.co.uk

2. Prof. Adenike Abiose, Sightcare International, P.O. Box 29771, Secretariat Main Office, Ibadan, Oyo State, Nigeria, Tel. 234- 2-8107434, Fax 1-509-5628212, Mobile 234-8037865702, E-mails: abiose@skannet.com and adenikeabioseo@yahoo.com

3. Dr. Mary Alleman, Associate Director, Mectizan® Donation Program, 750, Commerce Drive, Suite 400, Decatur, GA 30030, Atlanta, USA, Tel: (1) 404 371 1460, Fax: (1) 404 371 1138, E-mail: malleman@taskforce.org

4. Dr. Michel Boussinesq, DSS, IDR, 213 rue La Fayette, 75480 Paris Cedex 10, France, Tél: (33) 1 42 49 38 15, Email: michel.boussinesq@wanadoo.fr

5. Dr. Moses Katabarwa, The Carter Center, Global 2000, 2nd Floor, Kirbo Bldg, 1149 Ponce de Leon Av, Atlanta, GA 30306, USA, Tel: (1) 404 420 3830, direct: (1) 770 488 4511, E-mail: mkataba@emory.edu

6. Prof. Soungalo Traoré, Coordonnateur National, Programme de lutte contre l’Onchocercose, Direction de la Médecine préventive, Ministère de la Santé, 03 BP 7013 Ouagadougou 03, Burkina Faso, Tél: (226) 33 48 39, Cel: (226) 78 85 24 56, Fax: (226) 32 63 35, E-mail: pefoungo@yahoo.fr

7. Ms Nancy J. Haselow, Vice-President and Regional Director of Asia Pacific, Helen Keller International, HKI Regional Office, Phnom Penh Cambodia, E-mails: nhaselow@hki.org and nhaselow@hotmail.com

8. Prof. Louis-Albert Tchuem Tchuenté, Coordinator, National Control of Schistosomiasis and STH, Director, Centre for Schistosomiasis and Parasitology, P.O. Box 7244, Yaounde, Cameroon, Tel: (237) 221 01 83 (office); (237) 991 18 09 (Mobile) Fax: (237) 221 50 77; E-mail: tchuemtchuente@schisto.com

9. Dr. André Yébakima, Entomologiste médical, Expert OMS, Docteur d’Etat-ès Sciences, HDR, Centre de Démoustication, 97200 Fort-de-France, Martinique ; E-mail : yebakima@cg972.fr

10. Dr. Mamadou Mariko, Assistant Technique BTC/MOH, Représentation de la Coopération Technique Belge, 41 avenue Député Kayuku, B.P. 6089, Kigali (Rwanda), Mobile: 0025008765588, E-mails: mamadou_mariko@hotmail.com and mamadou.mariko@btcctb.org

11. Dr. Mamadou Souncalo Traoré, DER en Santé publique, FMPOS, B.P. 810, Bamako, Mali Tel : (223) 675 9051, E-mail: traorem@afribone.net
WHO/GENEVA

12. Dr. Tony Ukety, NGDO Coordinator for Onchocerciasis Control Chronic Diseases Prevention and Management (CPM), Department of Chronic Diseases and Health Promotion, (CHP), World Health Organization, 20 Avenue Appia, 1211 Geneva 27 Switzerland, Tel: +41-22-791-1450, Fax: +41-22-791-4772 -E-mail: uketyt@who.int

13. Ms Elizabeth Nyamayaro, Technical Officer NMH/CHP/CPM, Chronic Diseases Prevention and Management (CPM) Tel. direct: +41 22 791 5465, Fax direct: +41 22 791 4772, E-mail: nyamayaroe@who.int

14. Dr. Hans Remme, Coordinator, Science Strategy, WHO/TDR, 20 Avenue Appia, 1211 Geneva 27, Switzerland, Tel: (4122) 791 3815 – Fax: (4122) 791 4854 – E-mail: remnej@who.int

15. Dr. Annette C. Kuesel, World Health Organization, UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (WHO/TDR), 20 Avenue Appia, CH-1211 Geneve, Switzerland , Phone: +41 22 791 1541, Mobile: +41 79 596 5718, Fax: +41 22 791 4774

16. Mr. Abdulaï Daribi, Preventive Chemotherapy and Transmission Control (CDS/NTD/PCT) WHO/Geneva, E-mail: daribia@who.int

OBSERVERS

17. Dr. Richard Ndyomugyenyi, National Onchocerciasis Control Programme Secretariat, 15 Bombo Road, P.O. Box 1661, Kampala, Uganda, Fax : (256) 41 348 339

18. Mr. Tom L. Lakwo, National Onchocerciasis Control Programme (NOCP) Secretariat, P.O. Box 1661, Kampala, Uganda

ERASMUS UNIVERSITY

19. Prof. J.D.F.Habbema, Department of Public Health, building Ae room 230, ErasmusMC University Medical Center Rotterdam, P.O.Box 2040 , 3000 CA Rotterdam, The Netherlands, Tel:+31-(0)10-4638464, Fax:+31-(0)10-4638475, E-mail:j.d.f.habbema@erasmusmc.nl

20. Dr. W.A. Stolk, Department of Public Health, Erasmus MC University Medical Center Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands, Phone: +31 10 4087730 (dir) / 4638460 (secr) Fax: +31 10 4638474

WAHO

21. Dr. Doulaye SACKO, Coordonnateur de Vision 2020, World Health Organisation Ouest Africaine de la Santé, 01 B.P. 153, Bobo-Dioulasso, Burkina Faso, Tel : (226) 20 97 57 79 – Fax : (226) 20 97 57 75 –E-mail : wahooasawahooas.org, bayesack.2000@yahoo.fr
APOC COMPLIANCE STUDY TEAM

22. Dr. Bill Brieger, Senior Malaria Specialist, Associate Professor, Health Systems Program, Department of International Health, Bloomberg School of Public Health, The John Hopkins University, 615 N. Wolfe St. Room E8141, Baltimore MD 21205, Tel: 443 287 4042, Fax: 1 443 787 0217, E-mail: bbrieger@yahoo.com

23. Dr. Joseph Okeibunor, Department of Sociology/Anthropology, University of Nigeria, Nsukka, Enugu State, Fax: (234) 1 509562, E-mail: jokeibunor@yahoo.com

WHO/OUAGADOUGOU

24. Dr. Amidou Baba-Moussa, WHO Representative, 1487 Avenue d’Oubritenga, 03 B.P. 7019, Ouagadougou, Burkina Faso, Tel : (226) 50 30 65 65

MDSC

25. Dr. Mandy Kader Kondé, Director ad interim MDSC, World Health Organization, 01 P.O. Box 549, Ouagadougou, Burkina Faso

26. Mr. Rodrigue Barry, Communication et Plaidoyer, OMS/MDSC/MVP, 1487 Avenue d’Oubritenga, 03 B.P. 7019, Ouagadougou, Burkina Faso Tel : (226) 50 30 65 65, GPN : 30607

27. Dr. Laurent Toé, Responsible, Molecular Biology Laboratory, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53/59/60, Fax: (226) 50 34 28 75, E-mail: toel@oncho.oms.bf

28. Dr. Yiriba Bissan, Entomologist, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: bissany@oncho.oms.bf

ICST

29. Dr. Tiéman Diarra, Focal Person, Community-Based Interventions, ICST/Malaria, West Africa, WHO/AFRO, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53/59/60, Fax: (226) 50 34 28 75

WHO/APOC

30. Dr. Uche Amazigo, Director, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: amazigouv@oncho.oms.bf

31. Dr. Laurent Yaméogo, COORD, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: yameogol@oncho.oms.bf

32. Dr. Mounkaila Noma, Chief, Elimination of Vector (CEV), P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: nomam@oncho.oms.bf
33. Mr. Honorat Zouré, BIM, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: zoureh@oncho.oms.bf

34. Dr. Lamissa Bangali, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: bangalil@oncho.oms.bf

35. Miss Néné Keïta, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: keitano@oncho.oms.bf

36. Mr. Saïdou N’Gadjaga, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: ngadjagas@oncho.oms.bf

37. Mr. Yaovi Aholou, Administrator, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: aholouy@oncho.oms.bf

38. Mr. Samuel Odame-Bamfo, TRAD, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: bamfos@oncho.oms.bf

39. Mr. Issaka Niandou, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: niandouy@oncho.oms.bf

40. Dr. Grace Fobi, COP, P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (226) 50 34 29 53, Fax: (226) 50 34 28 75, E-mail: fobig@oncho.oms.bf
ANNEX 2: AGENDA

1. Opening
2. Chairmanship of the TCC
3. Adoption of the Agenda

Information

4. CSA: matters arising from the 115th session
5. JAF: matters arising from the 12th session: recommendations
6. NGDO: matters arising from the 29th session: recommendations only
7. TCC: follow-up of the key recommendations of the twenty third session
8. Repositioning APOC: Major activities in 2006

Strategic and technical issues

9. Report on workshop on SAE Management in DRC
10. Update on Angola CDTI Projects
11. Result of Phase II Study on compliance to ivermectin treatment
12. Health Impact of APOC operations
13. Prospects for Vector elimination in APOC countries with special emphasis on Equatorial Guinea
14. Strategic plan for elimination of onchocerciasis in Uganda
15. Update on MACROFIL
16. Review of operational research proposals
17. Integration of Onchocerciasis Control into the health systems and co-implementation of Neglected Tropical Diseases (NTD) control
18. Inclusion of Sierra Leone as APOC country
19. Integrated Community-Directed Intervention (CDI) research - Multi country study
20. Increase in school enrolment in 3 sites following 5 years of CDTI

Management of APOC Trust Fund

21. Report on the financial management of APOC funded Projects
22. Technical, administrative and financial review of APOC operations in the countries

Reviews

23. Report on the review by the APOC Management of 1st, 2nd, 3rd, 4th, 5th, 6th and 7th year progress reports and subsequent year budgets
24. Review of new project proposal and 1st, 2nd, 3rd, 4th, 5th, 6th and 7th year annual technical reports
25. Other matters
26. Date and place of the twenty-fifth session of the TCC
27. Conclusions and recommendations of TCC24
28. Closure of the session
ANNEX 3: MATTERS ARISING FROM THE 29TH MEETING OF THE NGDO COORDINATION GROUP FOR ONCHOCERCIASIS CONTROL

CONCLUSIONS AND RECOMMENDATIONS

The first joint meeting of the NGDO Coordination Group for Onchocerciasis Control, NGDO LF Network and International Coalition for Trachoma Control (ICTC) was hosted by Lions Club Foundation International at Doubletree hotel Chicago in Oak Brook, USA on 6 - 8 March 2007. The NGDO Coordination Group for Onchocerciasis Control extended their meeting to 9 March 2007. The following conclusions and recommendations came out of the meeting:

NTD and common issues

The extremely fluid political and donor situation for the Neglected Tropical Diseases (NTD) was noted by the participants. Multiple meetings pertaining to trachoma, LF, onchocerciasis, and schistosomiasis have taken place at high levels in the past 24 months that are influencing strategies, funding flows, and programmatic activities in the affected countries. The participants noted the considerable technical, financial, political, experiential and on ground resources of NGOs associated with NTD programme development. It was important for the participants to remain engaged with old and new NTD partners and to be prepared to contribute on issues related to policy, advocacy and funding. Accordingly, it was recommended by the participants that a joint technical subcommittee on NTDs be established to consider issues related to integration platforms, mapping, co-implementation, and co-administration of treatments. Mr Chip Morgan was nominated to lead and coordinate the discussions of the technical subcommittee.

It was recognized that members need to review the flexibility of their mandate in order to allow them to support other NTD initiatives.

Participants strongly endorsed the proposal from the NTD department of WHO to review mapping of the different diseases in order to simplify and facilitate the integration and co-implementation of NTDs.

Participants need to ensure that new initiatives on NTDs should take into account all the existing disease control interventions, particularly the SAFE strategy, morbidity control and rehabilitation of the blind.

Participants were in agreement that CBR groups should be involved in the development of NTD programmes at country level where appropriate. Participants also requested Dr Susan Girois to liaise with WHO to ensure that the role of NTD initiatives was referred to in the review of the WHO CBR guidelines.

The presentation by Mrs Franca Olamiju on engagement with CBOs in Nigeria evoked a great deal of discussion and interest and participants where encouraged to explore opportunities to work with CBOs in other countries in order to support NTD activities at community level.
Research has shown the importance of addressing gender issues in the development of programmes at the community level to aid their equity and sustainability. Participants were urged to ensure that these were taken into account as the NTD programmes expand and become more complex.

Participants recommended that the experience of group members in using onchocerciasis control as an entry point to primary eye care, Vitamin A supplementation and LF elimination has proved to be successful and has established community mechanism which can be used as a basis for other NTD interventions.

Participants thanked the partners who presented the new funding opportunities and expressed interest in further collaboration in order to extend NTD programmes to a greater number of countries.

Participants agreed that meetings of the three NGO groups continue at six monthly intervals for the next eighteen months to enable further in-depth discussions and networking.

**NGDO Group for Onchocerciasis Control issues:**

The group supported efforts by Uganda and partners to eliminate onchocerciasis transmission in six foci in Uganda using a strategy of twice per year Mectizan distribution and ground larviciding. The Group concluded that this was an important effort, noting that the NGDO Group was supporting this strategy of Mectizan distribution and assessment activities in one of the Ugandan foci (Wadelai in Nebbi District) through the Merck Grant Subcommittee.

The Group recommended that studies on transmission in hypo-endemic areas and its importance for control/elimination of onchocerciasis (e.g., onchocerciasis prevalence of up to 39%, or nodule prevalence of up to 19%) need to be conducted.

Members of the Group were reminded to be more accurate in reporting Ivermectin Treatment figures and other indicators, as well as respecting reporting deadlines.

Participants agreed to clearly report on NGDO expenditure and will explore ways of ensuring that this is available on an annual basis. This information is important for both APOC donors and countries while planning for onchocerciasis control funding.

The Group thanked APOC management for the efforts and improvement in releasing APOC Trust Funds to the countries according to the fiscal year and encouraged further streamlining of the process.

Following the presentation of Dr Isam Awad on onchocerciasis activities in Yemen, CSSW was officially welcomed as a new member of the NGDO group.

**LF NGDO Network issue:**

Participants proposed that a simpler programme reporting form should be designed which captures the NGDO support to national programmes and separates reporting on MDA from other activities e.g. training, morbidity control and behavioural change.
Other matters:

Participants congratulated Merck on their 20th anniversary and thanked them for their continued support to onchocerciasis control over the years.

Dr Adrian Hopkins outgoing Chair, handed over the chairmanship of the NGDO Group to Dr Danny Haddad. His term will run until March 2009, with Mr Simon Bush as Vice-Chair.

LCIF was warmly thanked by participants for their hospitality and for the logistical support.

The next meeting will be on 5-7 September 2007 in Ouagadougou, Burkina Faso.
## ANNEX 4: IMPLEMENTATION OF TCC 23 RECOMMENDATIONS AND SUGGESTIONS

<table>
<thead>
<tr>
<th>RECOMMENDATIONS</th>
<th>FOLLOW-UP ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCC recommended that an effort be made by all NOTFs and projects to ensure accurate determination and recording of total population in all communities covered by the project through improved training and supervision of CDDs. All community members, including children under five, pregnant and lactating women, and the sick must be counted and registered as part of a community’s total population. This is consistent with APOC’s target of having complete and accurate data on total population by 2008 for all onchocerciasis endemic communities. (para. 7).</td>
<td>Steps have been taken and support was given by APOC to the NOTFs of Burundi, Cameroon, Congo, DRC, Nigeria, Tanzania and Uganda for data collection activities, which are on going.</td>
</tr>
<tr>
<td>APOC Management should get from TDR, the data of the validation of RAPLOA in DRC and this data should be integrated in the final map of Loa loa in DRC. (para. 16).</td>
<td>Dr Hans REMME from TDR will provide further information.</td>
</tr>
<tr>
<td>TCC recommended that further detailed analyses be conducted to clarify the relationships between the changes in prevalence rates of the dermatological and ophthalmologic symptoms observed, and the therapeutic coverage in the various sites. Information on the therapeutic coverages obtained at each of the five treatment rounds, as assessed by the CDTI projects, will be used for the analyses (para. 43).</td>
<td>Dr M. Noma will provide further details.</td>
</tr>
<tr>
<td>TCC recommended that qualitative data be subjected to systematic analysis and linked to quantitative data. It was also recommended that the economic impact of APOC operations in CDTI projects be measured in separate studies, since the socio-demographic indicators adopted for the impact assessment studies were not designed to measure socio-economic impact. (para. 48).</td>
<td>OK for the systematic analysis of qualitative data and the link with the quantitative data. APOC Management will get in touch with the World Bank to organize the economic impact study.</td>
</tr>
<tr>
<td>TCC recommended that APOC’s plans for collecting and tracking NOTF expenditure be presented to and discussed with the NGDO Coordination Group for Onchocerciasis Control. (para. 82).</td>
<td>This needs further discussions</td>
</tr>
<tr>
<td>TCC recommended that a workshop be supported by APOC, prior to implementation,</td>
<td>There is a plan to conduct the workshop in Nigeria before the end of August 2007.</td>
</tr>
</tbody>
</table>
to harmonize the proposed projects and share lessons learned on integration of VAS and CDTI in Nigeria. It further suggested that given the incorrect information on Vitamin A in several of the proposals, a technical expert on Vitamin A should participate in the workshop. NGDO partners as well as focal persons for onchocerciasis and nutrition in each state should also participate. (para. 89)

TCC endorsed the APOC initiative on operations research Task Forces in Cameroon, Uganda and Nigeria and recommended that APOC management
• Define more precisely the terms of reference of the task force
• Ensure that each task force has guidelines for ethical conduct of studies, and for eliminating conflict of interest potentially associated with disbursement of funds by the task force. (para. 243).

A draft Terms of Reference of the task force was developed but APOC Management would be pleased to receive your input before circulating it to the NOTFs.

More time is needed to prepare the guidelines and APOC Management would appreciate input from TCC.

APOC is requested to impress on national and project coordinators the need to have all reports endorsed prior to sending them to APOC. Endorsement is obligatory for the NOTF coordinator. (para. 249)

Done. APOC Management will continue sensitizing the NOTFs on this recommendation.

TCC suggested that APOC consider periodic random post-treatment surveys to validate reported coverage data. (para. 7).

TCC welcomed the information that onchocerciasis is hypoendemic in Cabinda, approved the cessation of the Cabinda CDTI project and asked APOC management to forward this information to the NOTF of Angola. (para. 12).

TCC asked for more information to assist APOC management make a decision on the request to split the project of Lunda Norte/Lunda Sul into two for logistical reasons. Based on a review of the documentation provided, TCC endorsed the splitting of the project. (para. 13).

TCC endorsed the recommendations of the workshop, requesting that APOC approve the funds required for catching and identification operations for Tukuyu project. (para. 30).

Logistic support was mobilized for the NOTF of Nigeria by APOC and activities will start in 2007.

TCC suggested that health education be intensified, and sustainability addressed to increase social impact of APOC operations by Phase 3 of the study in 2010. Provision of
services to blind persons will have a positive impact on blindness-induced conflicts, and should therefore be a component of onchocerciasis control programmes. (para. 47).

| TCC recognizes the important role of national governments in integration and the importance of advocacy to the achievement of the objectives thereof. TCC welcomes the proposal of the Director of APOC to hold a meeting of National Public Health Directors early in 2007 on this subject and the offer by WHO/NTD to co-finance it. (para. 64) | The meeting of National Public Health Directors on integration for the Anglophone countries has been done in February 2007. The meeting for francophone countries will be held in June 2007. |