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<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
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<td>ATO</td>
<td>Annual Treatment Objective</td>
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<td>AWOL</td>
<td>Anti-Wolbachia</td>
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<td>CBO</td>
<td>Community-Based Organisation</td>
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<td>CDD</td>
<td>Community-Directed Distributor</td>
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<td>CDI</td>
<td>Community-Directed Intervention</td>
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<td>CDTI</td>
<td>Community-Directed Treatment with Ivermectin</td>
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<td>CMFL</td>
<td>Community Microfilarial Load</td>
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<td>CSM</td>
<td>Community Self Monitoring</td>
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<td>DOLF</td>
<td>Death to Onchocerciasis and Lymphatic Filariasis</td>
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<td>HKI</td>
<td>Helen Keller International</td>
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<tr>
<td>DEC</td>
<td>Diethylcarbamazine</td>
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<tr>
<td>FLHF</td>
<td>Front Line Health Facility</td>
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<td>GPELF</td>
<td>Global Programme for Elimination of Lymphatic Filariasis</td>
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<tr>
<td>HR</td>
<td>Human Resource</td>
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<td>HSAM</td>
<td>Health Education Sensitisation Advocacy Mobilisation</td>
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<td>HQ</td>
<td>Headquarters</td>
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<tr>
<td>HW</td>
<td>Health worker</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<td>IPM</td>
<td>Independent Participatory Monitoring</td>
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<td>JAF</td>
<td>Joint Action Forum</td>
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<td>LF</td>
<td>Lymphatic Filariasis</td>
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<td>LGA</td>
<td>Local Government Area (in Nigeria)</td>
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<td>LTS</td>
<td>Lohmann Therapy Systems</td>
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<td>MDA</td>
<td>Mass Drug Administration</td>
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<td>MDP</td>
<td>Mectizan® Donation Program</td>
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<td>MF</td>
<td>Microfilaria</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NGDO</td>
<td>Non-Governmental Development Organization</td>
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<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
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<td>NOTF</td>
<td>National Onchocerciasis Task-Force</td>
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<td>NTD</td>
<td>Neglected Tropical Diseases</td>
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<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<td>PAB</td>
<td>Plan of Action and Budget</td>
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<td>PCT</td>
<td>Preventive Chemotherapy Treatment</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>RAPLOA</td>
<td>Rapid assessment procedure of Loa loa</td>
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<td>RPRG</td>
<td>Regional Programme Reporting Group (LF)</td>
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<td>SAE</td>
<td>Severe Adverse Events</td>
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<td>SCI</td>
<td>Special Country Initiative</td>
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<td>SHM</td>
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<td>Technical Consultative Committee (of APOC)</td>
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<td>UTG</td>
<td>Ultimate Treatment Goal</td>
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<td>VAS</td>
<td>Vitamin A Supplementation</td>
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<td>WHO/AFRO</td>
<td>WHO Regional Office for Africa</td>
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<tr>
<td>WHO/NTD</td>
<td>Neglected Tropical Diseases – department within WHO cluster of communicable diseases (WHO/NTD)</td>
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OPENING: Agenda Item 1

1. The new Director of APOC, Dr Jean-Baptiste Roungou, welcomed partipants to the 37th session of the TCC. He said he was very grateful for the attendance of TCC members despite their busy schedules and declared that APOC was at a turning point since the decision of JAFIT to shift from control to elimination, a decision which has important implications and challenges, some of which are:

   (i) The elimination goal implies the change of scope, necessitating hypo-endemic areas to be taken on board. A concept note on how to deal with the hypo-endemic areas, developed by the Management was being submitted to the TCC for consideration. The intention is to prepare a project proposal for mobilization of resources;

   (ii) CDTI will remain the main strategy but other strategies will be explored to accelerate the elimination goal. A draft document that will suggest additional effective strategies will be submitted to the next TCC meeting for consideration;

   (iii) Twice yearly round of treatment will be implemented to accelerate the elimination in problematic areas if necessary and cost effective;

   (iv) To respond to legitimate concern from the donors about projects with poor performance, such situations need to be studied carefully and solutions proposed;

   (v) Adequate entomological interventions should receive more attention;

   (vi) The need to strengthen research capacity at countries’ levels. Ex-OCP strategy will be adopted to publish data available, associating scientists and university researchers in the drafting of publications;

   (vii) During the transition period there is need to revise the boundaries of CDTI projects to ascertain that projects cover entire areas, as the just ended 63rd Regional Committee decided that APOC should be extended to take over LF and provide support to other PCT-NTDs;

   (viii) The need for providing more effective technical supports to large countries like Nigeria, DRC, Ethiopia, Angola, Tanzania.

2. He assured the committee of his availability and willingness to listen to their views and suggestions to help keep the Programme moving. He wished a successful deliberation to the TCC.

3. The Chair welcomed the new Director whom he said is not new to the APOC Programme. He hoped that APOC would continue its progress towards elimination and that a real change would be seen. He also welcomed all the TCC members, advisors and representatives of the countries’ TRC of Cameroon, Malawi, Nigeria and Uganda.

4. The address was followed by a briefing by the UN Security Officer on the security situation in Burkina Faso and Ouagadougou in particular. In a nutshell, Ouagadougou is safe despite some pick pockets as in any big towns.
5. Followed the introduction of participants, the final list of whom is appended as annex 1.

ADOPTION OF THE AGENDA: AGENDA Item 2

6. The provisional agenda was adopted with the inclusion of the following two items added under the presentation of MDP on the Mectizan Expert Committee meeting:

i) “Filling the Gaps”: Operational Research for the NTDs, Bill and Melinda Gate Foundation funded NTD grant;

ii) Evaluation of the status of LF in areas with ivermectin distribution for Onchocerciasis, an operational research from the US Centers for Disease Control and Prevention.

7. The final agenda is appended as annex 2.

INFORMATION

MATTERS ARISING FROM CSA 140TH AND 141ST SESSIONS : Agenda Items 3

8. Dr Roungou, Director of APOC, presented a summary of matters arising from CSA140 and 141. Six main points were highlighted in his briefing:

(i) **The Concept Note:** As requested by JAF18 and agreed by CSA 140, a draft Concept Note with four scenarios was developed by APOC and discussed during CSA141 extended to countries, donors NGOs and other partners in Tunisia. CSA141 agreed that a revised concept note be drafted based on revised scenario 2.

(ii) **The Strategic Plan: Based on the concept note:** CSA141 requested APOC to draft a Strategic Plan for the period 2016-2025. A team of consultants was appointed to draft the plan which will be submitted to CSA 142 in Paris.

(iii) **External Evaluation of the structures of the Programme and its management:** The External evaluation will address the negative perceptions some partners have on APOC, especially on its staff and the organization of statutory meetings. TOR has been circulated and consultants to be recruited will attend the next JAF to understand the concept before the evaluation in 2014 and results presented to JAF20 in December 2014.

(iv) **Assessment of Government contributions:** A tool has been developed and will be pretested in some countries. Its piloting is in process in few countries. The tool will be presented to JAF19 to seek JAF’s permission to continue the pilot trial in order to collect enough data to make sure that a releable baseline data on government contribution is available for assessing government contributions later.

(v) **Epidemiological evaluations:** The aim was to find out how Epidemiological evaluations to be conducted will help in defining boundaries. More entomological assessments should be carried out also.
(vi) Concerns about the financing of the Programme: Concern was expressed about the shortfall in the financing of the Programme which is being currently implemented with a reduced control budget. Dr Roungou informed TCC that proposals will be drafted for mobilization of resources.

TCC Comments

9. TCC thanked Dr Roungou for a clear presentation. The committee was happy to note that APOC will be taking up LF and will contribute to other PCT-NTDs and hoped that the linkage would include the morbidity management aspect of LF. The committee welcome the composition of the team which will draft the Strategic Plan of Action and Budget but observed that a specialist with a strong Oncho background was mission from the team. TCC underscored the importance of having the External Evaluation of APOC Management and the results of the evaluation of governments contributions before the drafting of the the Strategic Plan of Action and Budget. TCC also observed that the 2025 target of the new APOC while the WHO/AFRO/NTDs target is 2020.

10. The committee was reassured that the morbidity management is taken care of since APOC is expected to incorporate LF and that the 2020 target for NTDs was based on the Regional Road map and the London Declaration while the 2025 was taken into consideration based on TCC’s expert advice. The Committee was informed that the epidemiological evaluation data belong to the countries and should be send to the countries while strengthening the national capacity for management of these data. Any request for these data should be addressed to the countries who will release them as they wish.

TCC: FOLLOW UP OF KEY RECOMMENDATIONS OF THE THIRTY-SIXTH SESSION: Agenda Item 4

11. Dr Yameogo presented a summary of the status of implementation of the TCC36 recommendations. The full text is appended as annex 3.

12. TCC commended APOC Management for a thorough presentation and for the actions taken. However, taking into account the difficulties encountered in the implementation of the recommendations in Angola and noting that it is a recurrent problem, the committee made the following suggestions:

(i) The WHO Regional Director for Africa should be contacted to assist in removing the bottleneck to the implementation of activities in Angola;

(ii) APOC Management should continue working with the WHO Representative and other partners at country level to clearly make a case.

13. Regarding the countries’ participation in JAF19, TCC was informed that advocacy meetings were held with the Ministers of Equatorial Guinea, Chad, Angola, the Congo and DRC, not only to advocate for their participation but also for their contribution to the Trust Fund of APOC and Nigeria was given as an example of a participating country contributing to the Trust Fund.

14. TCC suggested that a one-page information document on APOC, JAF19 and elimination of onchocerciasis and other PCT/NTDs be prepared and sent to the Ministers of Health with the invitation letter. This should be done through the WRs in the countries, preferably by the Regional Director of WHO, instructing them to encourage active participation of the Ministers. A letter by the Regional Director to the Permanent Secretary of the African Union for the Ministers of Health would also be of
paramount importance. MDP is willing to facilitate the participation of some Ministers from countries facing difficulties.

STRATEGIC AND TECHNICAL ISSUES

FEASIBILITY OF ELIMINATION OF ONCHOCERCIASIS INFECTION AND INTERRUPTION OF TRANSMISSION: Agenda item 5

i) Elimination of Onchocerciasis with ivermectin in Africa:

a) Update on endemic countries - Epidemiological evaluation results: Chad, Benin, Equatorial Guinea, Ethiopia, Mali, Niger and Togo

15. Since December 2012, epidemiological evaluations have been implemented in seven countries namely Chad, Benin, Equatorial Guinea, Ethiopia, Mali, Niger and Togo. Data from Benin and Mali are not yet available for data processing in Ouagadougou. Epidemiological evaluation was planned for March 2013 in selected villages in Togo. In the overall, epidemiological evaluations have been conducted 119 villages distributed in five countries (Chad, Equatorial Guinea, Ethiopia, Niger and Togo). A total of 30,808 people were examined out which 97 were Onchocerciasis microfilaria (mf) carriers, corresponding to a prevalence of 0.31%, ranging from 0.00% to 5.53%.

TCC comments

16. The committee thanked Dr Noma for the presentation and was pleased to note the promising results in Chad. Based on APOC request to review the process of implementing phase 1a (10 villages) evaluation to look for the trend towards elimination of onchocerciasis infection and phase 1b (20 villages) to confirm that the breakpoint has been reached and ivermectin treatment can be safely stopped. A sub-committee set up recommended to continue with the existing protocol and agreed to enable APOC to sample in phase 1a at least 30 villages to enable early start of entomological evaluation when parasitological evaluation results indicate trend towards elimination of Onchocerciasis infection.

17. TCC was informed that under the pressure of some NGDOs, some countries are stopping treatment, e.g. Uganda, Sudan and Plateau Nassarawa in Nigeria. The committee recalled the different steps leading to stopping treatment and observed that in the spirit of partnership, there should be an effective coordination between stakeholders regarding the decision to stop treatment, as APOC has invested a lot of funds in CDTI activities; TCC as the technical body should be consulted on any decision to stop treatment.

18. The Committee encouraged APOC to increase the pool of national experts to strengthen country-level capacity building for the implementation of epidemiological and entomological evaluations.

b) Delineation of treatment boundaries.

19. An update on the delineation of treatment boundaries was presented by Mr Zoure. With the shift from control to elimination, APOC embarked in the collection of additional baseline data in order to decide whether to extend treatment for onchocerciasis elimination to areas previously declared hypo-endemic (nodule prevalence < 20%) when the objective was the control of onchocerciasis. Data
collection was done through integrated surveys that include skin biopsy for *Onchocerca volvulus* microfilariae, nodule palpation for onchocerciasis nodule and thick blood film method for *loa loa* microfilariae.

20. Nine countries were identified for the conduct of the surveys (Burundi, Cameroon, CAR, Chad, DRC, Equatorial Guinea, Ethiopia, Mozambique and Nigeria). Surveys have been implemented in Burundi (20 villages), Cameroon (22 villages in Littoral and South regions) and Chad (23 villages). Surveys will be completed in Equatorial Guinea and Cameroon (Centre and East regions) by November 2013. The remaining five countries will be covered in 2014.

21. In Cameroon, the standardized prevalence of *Onchocerca volvulus* microfilariae ranged from 0% to 4.8% in the South region and from 0.7% to 10.8% in the Littoral region. The village with 10.8% prevalence is located in Edea health district where the REMO kriging map estimated the nodule prevalence to be between 15% and 20%. Treatment for onchocerciasis may be indicated in the Littoral region in areas where the REMO kriging map estimates that *Onchocerca volvulus* microfilariae is higher than 10% (Edea health district in particular); however, entomological assessment is useful to confirm source of infection. Lymphatic filariasis is endemic in the Littoral region and distribution of Albendazole + Ivermectin would have been indicated if prevalence of *loa loa* was not high. There is no need for extension of treatment in the South region.

22. In Chad, only 2 villages out of the 23 had people with *Onchocerca volvulus* microfilariae; one person in each of the two village was positive. The standardized prevalence of microfilaria in all villages remained 0. There is no need for extension of treatment, however additional villages should be selected and surveyed in Benoye, Deresia, Laï, Bohobe and Bou Kebir districts during the forthcoming phase 1a and phase 1b epidemiological evaluations.

23. In Burundi, only 2 villages out of the 20 had 1 person each with *Onchocerca volvulus* microfilariae. The standardized prevalence of microfilariae in the two villages were 0.2% and 0.3%. There is no need for extension of treatment; however the forthcoming phase 1a epidemiological surveys should include villages selected outside the current ivermectin treatment area at the borderlines of Bururi and Rutana CDTI projects.

24. Nodule palpation data collected during the surveys were briefly presented while the indepth analysis is still to be done and presented to TCC38. The reading of thick blood film slides collected in Cameroon and Chad for *loa loa* infection is still going on.

**TCC comments:**

25. TCC commended APOC management for the exercise and observed that the presentation provided information necessary to clarify hypo-endemic areas and that it is important to specify if these areas were hypo-endemic before treatment or after treatment. However, ivermectin distribution should not be carried out in hypo-endemic areas endemic with *loa loa*. In these areas, Doxycycline could be used on a test and treat basis. The committee also noted that the nodule prevalence in Burundi was very high and do not tally with the microfilariae prevalence data. There is need to ensure that the nodule palpation method is standardized.

26. The committee acknowledged that entomological parameters, particularly mapping of vector breeding sites, are important in the delineation of treatment boundaries through the selection of first line villages for parasitological surveys.
27. Regarding the request of MDP to have epidemiological data including RAPLOA data not older than five years, it was noted that RAPLOA data in all the countries are less than five years old as the exercise was carried out in the countries between 2009 and 2011, including areas where ivermectin distribution was not on going.

c) Concept Note on Elimination of onchocerciasis in all hypo-endemic areas by 2020.

28. Dr Afework presented a concept note on elimination of onchocerciasis in all hypo-endemic areas by 2020 for TCC’s input.

29. Following the JAF’s decision to shift from control to elimination of onchocerciasis in Africa, there was a need to include under treatment those hypoendemic areas that were not targeted by MDA. An initiative was taken up by APOC management in June 2013 to develop a concept note for elimination of Onchocerciasis in the hypoendemic areas in Africa by 2020 with the aim of preparing a proposal for resource mobilization to accelerate the elimination of onchocerciasis in hypoendemic areas. The presentation highlighted the following aspect: (i) background and the rational of the initiative; (ii) the burden and extent of onchocerciasis in hypoendemic areas; (iii) evidence of elimination of onchocerciasis from modeling and empirical observations; (iv) the challenges and opportunities. The project targets addressing 25 million people in APOC (24.5 million) and ex-OCP (0.5 million) to be covered by ivermectin treatment. He also highlighted the importance of collaboration with LF programme in Africa as the two diseases are co-endemic, including hypoendemic areas. Most important challenges highlighted were: the reviewing of target areas for mass treatment and delineation of transmission zones, establishing new programmes in the new areas, community compliance, Loa loa co-endemicity, cross border issues and the link with LF programme. He also highlighted that APOC already started delineating activities and partial mapping has been completed in Burundi, Chad and Cameroon. The presentation also talked about objectives, strategies and important activities and an indicative financial requirement. As a next step, once the concept note is finalized with TCC and experts inputs, a detailed plan of action and budget will be prepared.

TCC Comments

30. TCC thanked Dr Afework for the presentation and proposed that the concept note be matched with the concept note on the future of APOC which is being discussed. TCC observed that the concept note needed to be re-packaged with additional information to support why earmarking hypoendemic areas for treatment with a clear methodology, targeting 2014 and 2015 while the concept note on the future of APOC will cover 2016-2025. There is need to specify in the concept note that the hypoendemic areas are the hypo-endemic areas which were existing when APOC started its activities 18 years ago.

31. TCC further observed that there is need to initiate activities in hypo-endemic areas from now up to 2015 after which all elimination activities will be addressed through the 2016-2025 elimination strategy. Two activities will be undertaken during this period: (i) use the existing algorithm to delineate hypo-endemic areas and establish interventions in areas that have not been treated; and (ii) identify breeding sites in the hypo-endemic areas.
ii) Entomological studies:

a) Update on delineation of transmission zones

32. Prof Boakye updated the TCC on the delineation of transmission zones through vector species identification in the context of elimination of onchocerciasis. The report indicated that there is a three-step process using cytotaxonomy to delineate transmission zones.

33. The first activity reported on was the sampling for larvae of members of the *Simulium damnosum* complex. It was mentioned that selection of countries and sites for the activities was done in consultation with the EVE unit to take into consideration the epidemiological results. The countries selected were Ethiopia, DRC, Sudan, South Sudan, Burundi and Congo. The numbers of candidates selected from the countries were provided. Due to overlap in some activities between transmission assessment and those for delineation of transmission zones, particularly identification of larval breeding sites, this activity is now being planned together. Sampling has so far been done in seven States in Nigeria, in Chad, Congo and Côte d'Ivoire and samples have been received at APOC. Sampling is now planned for Ethiopia, DRC, Sudan, South Sudan, Burundi and Northern region of Cameroon.

34. The second and third steps in the process of delineation of transmission zones using cytotaxonomy were identification of samples collected and the analysis and development of maps (species distribution and delineation zone). Identifications have been done for rainy and dry seasons in 3 regions of Cameroon, rainy season from 3 States and dry season from 1 State in Nigeria, dry season samples from Chad and Central African Republic and samples from a special study (test of insecticide) in Togo. Results of these identifications were provided. The analysis of the inversion frequencies was used to develop the current delineation zones between Cameroon, Chad, CAR and Nigeria for *S. damnosum* s.s., *S. mengense* and *S. squamosum*.

35. Based on the analysis a transmission zone for *S. damnosum* s.s. that covers Northern Cameroon and Chad descends a bit into Central African Republic was described. Further data is however needed to determine the southern limits in Cameroon since no sampling has been done in the Adamawa Region. It was mentioned that there may be more than one transmission zone for this species in Nigeria.

36. *S. mengense* has two interbreeding forms limited only to some rivers in South West and North West regions of Cameroon and could be an important vector involved in local transmission.

37. *S. squamosum* is widely distributed in South West and North West regions of Cameroon, CAR and Nigeria but appear to be made up of local populations across its range even within one country.

38. TCC was informed about the progress on molecular markers for mapping vector migration in the context of onchocerciasis elimination: two strategies are currently being pursued which are (1) to construct an enriched DNA library and screen against a panel of (larval) populations of various vector blackfly species to find microsatellite markers with suitable levels of variation and (2) screening the gene sequences from the Blackfly Genome Project for biomarkers for adult sibling species identification or population markers of vector migration. To develop microsatellite markers samples are to be sent to Prof. Rory Post in October, 2013. Some progress on the Blackfly Genome Project was reported to TCC: The preliminary sequencing for 3 species; *S. squamosum* (from Prof. Rory Post), and then *S. tholense* and *S. yahense* (from APOC). Also The Genome Center at Baylor University and
funded by the National Human Genome Research Institute has been assigned to undertake full genome sequencing and transcriptomes (mRNA sequencing) of several of the major onchocerciasis vectors.

TCC Comments:

39. TCC commended Prof Boakye for the presentation and appreciated the remarkable achievement within a year. Recognizing the huge task ahead and the dwindling number of entomologists, especially cytotaxonomists and re-emphasizing the urgent need of having a map of characterization of different species in APOC programme areas, the committee recommended the following:

(i) A road map should be developed with timeframe for activities;

(ii) Training of entomologists. The job of cytotaxonomists should be given due consideration. Young researchers from universities could be trained. Channels of vice-chancellors at the universities could be used for reaching these young researchers;

(iii) Owing to the limited number of entomologists, the use of university researchers for such activities could be considered;

(iv) Efforts should be made to prioritize the countries in carrying out activities, with countries having bigger foci first. Countries should also be determined by category, e.g. those having means to carry on the study first, those having knowledge but not having means and those which are important but having no means and knowledge in the entomology activities;

(v) Entomology and Epidemiology teams in APOC should work closely;

(vi) The entomology aspect should be put in the concept note on the future of APOC with clear definition of requirements.

40. TCC endorsed the work and recommended it to continue.

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

41. Dr Toé updated the TCC on the black fly trapping, noting the progress made towards its implementation in the countries. The results of field experiments carried out in Burkina Faso and Nigeria have shown the following:

(i) Traps can collect several species of Simulidae in Africa such as *S. damnosum* sl, *S. squamosum* and *S. soubrense* Beffa form;

(ii) Traps can collect up to 250% of the number collected by vector collectors;

(iii) Research is ongoing on the determination of the physiological age of the vectors collected by the trap.

42. Notable evolutions were made in the quality of the bait used in addition to the carbon dioxide to attract *S. damnosum* flies. Electroantennogram assays allowed the screening of the components of the human scent reducing the number of compounds identified from 198 to 45. Experiments carried out on *S. damnosum* at Bodajugu in Burkina Faso on the electroantennogram and the olfactometer
determined that the principal compounds for this species are Hexanoic acid and Octanoic acid. In the next rounds of experiments, these two compounds will be integrated in a slow releasing support to obtain a lure that is specific to S. damnosum.

43. Experiments were carried to obtain a design of a trap that is locally manufactured and which maintains the same ability to collect S. damnosum. The cost of the present platform and the components is $20.00.

44. The study is presently orientated towards the transfer to field teams in countries. In Nigeria, a transfer was made to Carter Centre and another one is planned to the National team. Burkina Faso will be the next country.

TCC comments:
(i) The utility of the study is indicated by the need of having a new more efficient tool for entomological monitoring and surveillance;
(ii) The transfer of the trap to the national teams should be accelerated. The traps should be used in parallel with the human landing collection in a primary phase while continuing the research;
(iii) TCC encourage APOC to continue its collaboration with the research team.

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

45. Dr Toé updated the TCC on the latest finding of the study aiming at predicting S.damnosum breeding sites based on entomological data of the ex OCP, GPS and remote sensing data. The following information was given to TCC on the results of the work carried out to respond to the questions raised by TCC 36.

(i) Field validation was done and the model was tested again in the river basin of Bougouriba in Burkina Faso. The data obtained confirm that 100% of the sites predicted as breeding sites were found as containing S. damnosum larvae.

(ii) Analyses were done to determine the relationship between the distance to breeding site and the endemicity of onchocerciasis: it is confirmed that endemicity is function of the distance to the breeding site.

(iii) The cost of the model depends on the availability of the remote sensing data used to build the maps and their precision. There is a move from Quick bird images that cost $17 per Km² with a precision of 0.6m to Red eye images costing $1 with a precision of 5km.

(iv) A large validation of the model will involve Nigeria, Cameroon and Burkina Faso.

(v) In terms of funding, APOC collaborates only with universities and institutions but does not fund this research.

46. The focus in the future will be on reducing the cost of production of the predictive maps. The research group is sourcing for affordable and high quality remote sensing data for the detection of breeding sites.
TCC comments:

(i) The use of breeding sites modeling should be encouraged and implemented in the field to assist the entomology team in the mapping of the main areas of blackflies production and the identification of capture points. This would also support the epidemiology team with the identification of communities for epidemiological surveys.

(ii) The model should be expanded to the identification of breeding sites for other Simulidae species (e.g. S. neavei).

(iii) The model should include a parasitic component.

REVISED CONCEPT NOTE FOR THE POST 2015 PERIOD: TCC CONTRIBUTION TO THEIR FINALIZATION: Agenda Item 6

47. The revised concept for the post 2015 period was presented by the Director of APOC with background information.

TCC Comments

48. TCC acknowledged the document and made the following observations to improve it:

(i) Reformulate paragraph 38 to take into consideration the task of RPRG/TCC sub-committee;

(ii) Reorganize the specific challenges for elimination of oncho (items 6a-h of the executive summary and chapter 4 of the concept note) by hierarchy as follows:
   - New identified areas,
   - Less performing areas,
   - Conflict and post conflit areas,
   - Loa loa co-endemicity,
   - Hypo endemic areas,
   - Cross-border issues,
   - LF,
   - Evaluation and monitoring in elimination;

(iii) Communities' compliance should be added;

(iv) After paragraph 30 the document needs new structure. This should be developed;

(v) Para 6a of the executive summary and para 13 of the concept note: Include hypo-endemic areas specifying areas hypo-endemic before the start of APOC activities in 1996 and hypo-endemic areas due to APOC activities. The two situations should be dealt with in paragraph 13 with the appropriate strategy to be used. However, hypo-endemic areas should be clearly defined;

(vi) Para 6a should be written: “delineating areas hypoendemic for oncho and treating those which should be treated as part of an elimination strategy”

(vii) In para 13 and others, when figures for populations living in the hypo-endemic areas are quoted (the concept note quotes 19 million and the TCC was given 25 million by APOC), it must systematically be precised whether these figures are those which were established through the REMO surveys 16 years ago before the inception of CDTI or whether they refer to the results of recent surveys carried out by the APOC teams in the same communities in non-treated hypo-endemic areas, after many years of CDTI in the neighbouring hyper and meso-endemic areas;
(viii) Improve on LF to sell the idea that its elimination is now inseparable from that of oncho in Africa;
(ix) Reduce the background information to balance the document;
(x) Include the possibility of limited vector control activities;
(xi) Promote entomological activities;
(xii) The documents should be shared with all stakeholders and constituencies before it goes to the JAF;
(xiii) The numbering of the scenarios should change with the preferred scenario coming in at page one and the other scenarios annexed to the document.

49. A TCC sub-committee then reviewed thoroughly the concept note and provided TCC inputs to the Management of APOC.

RESEARCH ON NEW CONTROL AND SURVEILLANCE TOOLS BY COLLABORATING INSTITUTIONS: Agenda item 7

50. Dr. Kuesel reported on the research co-funded by APOC and TDR.

(i) Update on moxidectin and Target Product profile for drug for Onchocerciasis control via mass treatment

51. The data from the Phase 3 study completed in Ituri Nord, DRC (Dr. D. Bakajika), Kivu Nord, DRC (Dr. E. Kanza), the Upper Volta Region, Ghana (Dr. N. Opoku) and Lofa County, Liberia (Dr. H. Howard) have been analyzed to assess the variability of the response to ivermectin as well as 8 mg moxidectin. In each of the four study areas there were individuals whose skin microfilaria levels 1 and 12 months after treatment with ivermectin were higher than would be expected based on the criteria for 'adequate response' proposed by Awadzi et al. in 2004. Given that the study participants were from areas not yet under CDTI, this suggests that the variability of the response to ivermectin is much higher than in the small study population from Ghana based on which Dr. Awadzi et al. had developed the criteria for adequate response. Dr Kuesel concluded that response to ivermectin not meeting the criteria established by Dr. Awadzi needs to be followed up but should not be considered as indicative of possible emergence of resistance to ivermectin without further investigation.

52. Three publications on the moxidectin Phase 2 and 3 trials are in preparation as is a manuscript on ONCHOSIM modelling of drugs with different effects on the reproductive capacity and viability of O. volvulus. The moxidectin Phase 3 study data will be presented at the 2013 European and American Conferences of Tropical Medicine. Analysis of the data relative to transmission models are completed (Duerr et al model), ongoing (EpiOncho) or planned (ONCHOSIM).

(ii) Update on DEC patch and Lohmann

53. LTS is anticipating completion of the procedures for declaring 'manufacturing readiness' by mid-October. This is a pre-requisite for a signed agreement with WHO.

(iii) Identification of markers for suboptimal response of O. volvulus to ivermectin and development of a tool for monitoring emergence of O. volvulus with suboptimal response by National Control Programmes

54. Laboratories in Australia, Cameroon, Canada, France, Ghana and WHO/MDSC continue the research. In an effort to ensure that the research and development can be completed, investigators have,
in collaboration with TDR, intensified their efforts to raise funds to those APOC and TDR will be able to provide. The fact that the TCC directed the development of the strategy for ‘uptake’ of the monitoring tool by the intended users (e.g. selection of the African laboratories involved, direction to incorporate both infrastructure and personnel capacity building), that this strategy forms an integral part of the project and that TCC regularly reviews project progress is an asset for applications to funders interested in supporting ‘product development’.

TCC Comments

55. TCC re-iterated its support for these activities and applauded investigators’ efforts to raise funds for continuation of the project to identify markers of suboptimal response and to develop a tool for Control Programmes to monitor *O. volvulus* with suboptimal response to ivermectin.

REPORT ON THE MECTIZAN EXPERT COMMITTEE MEETING: Agenda item 8

56. The presentation concerns MDP strategic plan with the update of the vision which was “The Mectizan Donation Program” envisions a future free of onchocerciasis and lymphatic filariasis. Also the mandate was updated to include the elimination of onchocerciasis worldwide. The guiding principles of the strategic plan were the following: (i) Advocacy for a world free of onchocerciasis and lymphatic filariasis; (ii) Timely and adequate provision of drugs to partner countries; (iii) Safe and effective drug use; (iv) Effective partnership to achieve elimination. Finally the annual planning cycle process was presented.

57. With regard to the Loa loa scientific working group meeting held in Liverpool in March 2013, the agenda items comprised the status of SAE notification to MDP, the WHO guidelines for LF in Loa-loa endemic areas, the update on Loa-loa and LF mapping, the update on on-going research (DOLF and AWOL projects) and the way forward. As conclusion and recommendations for the meeting, new SAEs occurring after the second exposure to ivermectin, prompted the group to recommend investigating thorough treatment history of previous ivermectin and Albendazole exposure. Other recommendations related to i) More granular (micro-mapping) for Loa loa and LF and Oncho in co-endemic areas in order to inform programme treatment decision making for which a taskforce was established, ii) Identify party to summarize and create a white paper and review paper for publication, iii) Share information on the new strategy and encourage adoption in countries where working group members are active, iv) Evaluate the effectiveness of the strategy as programmes are expanding, v) Review data available on LF in Loa loa co-endemic countries.

58. The following meeting reported on was the Sub-optimal or atypical response meeting, held in Accra, Ghana April 22-24, 2013. The general conclusions stipulated that Ivermectin remains an extremely successful and effective microfilaricidal agent even in difficult programmatic situations. It can break transmission and that resistance to ivermectin does not appear to be a major global problem. Although a consensus was not reached, a tentative definition of the phenomenon called rather atypical response which is based on the expected response to ivermectin should be defined at two levels. At the community level, the atypical response should be determined by comparison with expected prevalence, intensity, and distribution of microfilarial loads as predicted by mathematical models. At the individual level, atypical responses should be determined by comparison to the mean (and distribution) of expected responses using current assessment tools (such as microfilaridermia by quantified skin snips). Nevertheless tests and protocols need to be developed to confirm Atypical responses (AR) and the impact on the programme. Strategies to address AR when it occurs need to be established, such as the use of ivermectin more effectively and alternative drugs to Ivermectin.
next step is to propose a document to APOC/TCC so as to develop a MEC/TCC guidelines for "Enhanced Implementation for the Elimination of Onchocerciasis" to share with Programme Managers.

59. The TCC was informed of the last Mectizan Expert Committee (MEC) conclusions and recommendations which are as follows:

(i) The MEC congratulated Dr. Laurent Yameogo for his decoration as "Officer of the Order of Benin" which was truly deserved following his years of work to control and eliminate onchocerciasis in Africa;

(ii) Chad: The MEC approved the application for extension to hypo-endemic areas but requests an update of prevalence studies. However, treatment is not approved in areas of loiasis;

(iii) Ethiopia: MEC approved the request for Mectizan for the two newly defined APOC projects, and extension areas. Although there is an NGDO partner for part of this area, the MEC would like reassurance about the resources available for the remaining areas;

(iv) The MEC noted the epidemiological work being undertaken by APOC on elimination strategies, treatment in Mectizan naïve areas and treatment frequency. The MEC recommends field studies as soon as possible to verify these projections but also requested APOC to quantify the expected new treatments to facilitate Mectizan forecasting;

(v) South Sudan: MEC was concerned that epidemiological data collected was not available at the Ministry. MEC requested the donors to make the information available, and reiterate the principle that epidemiological data should always be available to National MOH;

(vi) Nigeria: With regard to lymphatic filariasis, baseline data had been collected in many areas as requested but treatment was not targeting the whole IU; in many cases treatment were confined to Oncho co-endemic areas. Although some lack of direction was evident at the federal level, the States were enthusiastic. A special approval for Niger State was made following a visit with GSK. The MEC approved the ongoing Technical Support for the scaling up of LF treatment in Nigeria;

(vii) Guinea: the LF baseline surveys had been repeated with a team from Sierra Leone and confirmed the initial studies. Although some baseline surveys were negative, the MEC approved treatment in the four districts, based on the ICT results.

"Filling the Gaps": Operational Research for the NTDS

60. Following the London Declaration when donors have dramatically expanded their commitments, it was noticed that there are still technical challenges preventing countries from scaling up and scaling down mass drug administration (MDA). In order to identify major research needs, Bill and Melinda Gate Foundation (BMGF) sponsored a meeting of NTD experts in August 2011. Also, TDR sponsored research prioritization exercise for helminthes diseases. The BMGF then funded the NTD Support Center in Atlanta to address the operational research challenges facing NTD Programmes. The grant called "Filling the Gaps – OR to Ensure the Success of NTD Control and Elimination" is based on a collaborative approach to OR where by the NTD community is engaged to set priorities. The grant will also work closely with WHO to build evidence base for programmatic decision. The structure of the grant is composed of the Secretariat responsible to convene, to support and to bear the accountability for the grant. The secretariat will be engaged with the coalition for
Operational research which is the NTD community and the advisory panels for the OR overview. Finally the programme technical group will oversee the OR.

61. In order to define, the first year priorities and work plan for year 1, several consultation meetings are planned with disease-specific experts in LF, Schisto, Oncho, Trachoma and Social Scientists to prioritize research objective. The cross cutting themes drawn for the meetings are: i) modeling approaches can inform research design and programmatic decision making; ii) Improved diagnostics are critically needed to support programme decisions – our efforts are focused on translating new tools into practice, iii) Programmes need to make improved use of electronic data capturing methods. For the Onchocerciasis group the challenges are:

(i) Loa-loa and how do LF or oncho programmes affect other NTDs with regard to mapping and NTD development;
(ii) Improved integration, improved compliance, and better tools for decision making with regard to programme implementation;
(iii) Stopping points for MDA, and new tools and strategies for surveillance for the elimination and post MDA surveillance phase.

62. Each challenge will be framed as research operational, and looked in to establishing how the research will address the problem and what the research will accomplish.

TCC Comments:

63. TCC thanked Dr Ogoussan for the presentation and observed that there seems to be a change in the guidelines for treatment of LF and that countries should be informed accordingly. The committee recommended that investigation on SAEs should be implemented.

PROTOCOL FOR THE MULTI-COUNTRY STUDY ON COMMUNITY SELF MONITORING (CSM): Agenda item 9

64. A protocol development team comprising community health system strengthening experts, convened in Ouagadougou for one week protocol development activity relevant to (CSM). The activity was to respond to TCC’s call for a multi country study designed to uncover reasons for the low level of implementation of CSM and explore relationships between CSM treatment coverage, and community ownership.

65. The study design proposed is a combination of multi country, multi-disciplinary, cross sectional and comparative study, to be implemented in eight countries. The selection of countries takes into account regional and linguistic considerations. Thirteen projects are targeted to be surveyed. In each project, data will be gathered in 24 communities representing a mix of communities in which CSM is well and poorly established. The results will guide APOC in reviving and up-scaling the CSM process. The estimated budget for the study is about 1.500,000 USD.

TCC Comments:

66. TCC approved the proposal in principle and made several suggestions towards the improvement of the content and implementation.

(i) Definition of CSM: define the criteria to be considered in determining the CSM status of the projects to be reviewed;
(ii) Scope of the study: prioritize the research objectives and questions to ensure that the core questions of interest on whether and why CSM is working are captured;

(iii) Additional questions: assess community structures that enhance the potential for CSM.

(iv) Site selection: consider replacing Kwara with another project in the far North of Nigeria (e.g. Jigawa project) in order to improve the geographical spread;

(v) Study design: given that the study intends to show associations it would require a wider scope with higher cost implications;

(vi) Interpretation of the results: clarify in the proposal what decisions will be made in the event that wide inconsistencies are found between reported treatment coverage rates and the rates established by the study? How will the findings influence the categorization of the sites during data analysis?

(vii) Number of project sites: consider reducing the number of the project sites to reduce the study costs;

(viii) Use of the results: document clearly in the proposal how the results will be used.

PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE OF CDTI PROJECTS: Agenda item 10

67. Based on TCC36 recommendations in March 2013, Prof Meda presented the revised version of the protocol for independent evaluation of therapeutic coverage with ivermectin achieved by CDTI Projects. The goal of this independent evaluation is to contribute to the improvement of CDTI projects performance as a necessary step towards Onchocerciasis elimination by 2025 and the main objectives are to i) estimate through a representative community cluster sampling method the level of ivermectin treatment coverage in each target CDTI project, ii) verify the comparability of drug coverage estimates between CDDs and the independent survey, iii) assess the quality of project information system and the functioning of the CDTI project evaluated, iv) determine barriers and facilitators for a good performance of the specific CDTI project evaluated. The presentation focused on the fact that three outputs will be delivered: a tool for independent evaluators comprising all the science to be implemented every three years with a standard operating manual; a simple less expensive tool (Field manual) for programme managers self-monitoring after each ivermectin MDA.

68. He pointed out that to achieve these objectives the revised protocol proposed will combine drug coverage estimation and CDTI project functioning evaluation. The presentation highlighted different sections of the protocol comprising of (i) discrepancies between routine information system and rapid evaluation of therapeutic coverage, (ii) justification (iii) survey methods (including study design, site and population, sample size calculation and procedures), (iv) information to collect (v) fieldwork steps of planning, implementation, evaluation and reporting. The anticipated timeline and budget needed were proposed.

69. The study design is a cross-sectional survey to be repeated at least every 3-5 years based on availability of resources. The target community of the survey will be the village implementing CDTI. Because all persons in a household are to be surveyed, clusters of households should be selected in each CDTI project evaluated. Based on the epidemiological parameters and the availability of resources, between 47 and 289 clusters of households can be selected per CDTI project. This means investigating between 235 and 2023 subjects drawn at random. To select the households to be surveyed, either a list of households is available and the number of households to be surveyed per village is drawn by a simple random sampling method, or a list of households is not available and a random walk procedure will be chosen to select the households to be surveyed in the selected village.
70. A series of questionnaires will be used to collect information by interviewing the beneficiaries of the treatments and through interviews with key informants in each CDTI project. Similarly, data retrieval from the various written reports and records used to account for the operation of any CDTI project will be carried out by investigators.

71. The way forward is to develop the survey manual and the Standard Operating Procedures before pre-testing this protocol. The Field manual for ivermectin coverage self-monitoring surveys by programme managers will be finalized in collaboration with other programmes/partners.

**TCC Comments**

72. The TCC thanked Prof Meda for the presentation and the work done to produce this protocol which is a good reference tools in terms of validity. TCC endorsed the need to pre-test the proposed tool by the consultant so as to assess the feasibility of the proposed tools for monitoring treatment coverage. During the pre-test, the consultant should also collect information on the cost of monitoring coverage by other programmes (e.g. the LF programme) in an effort to rationalize the proposed cost of Euros 61,000 per project for the survey and Euros 5,000 – 10,000 per project for the self-monitoring tool that was considered rather high.

**REMARK BY TECHNICAL ADVISORS TO APOC MANAGEMENT: Agenda item 11**

73. Technical advisers made the following remarks:

(i) The international community should not to wait for ivermectin resistance before looking for appropriate drug. Efforts should be made to fund the Moxidectin project which is a serious candidate drug.

(ii) One should also be cautious not to jeopardize the efforts of APOC towards oncho elimination by slowing down its activities due to the integration of LF-Oncho and other PCT-NTDs.

(iii) Strong advocacy should be made toward the authorities at countries’ levels in order to avoid human egos.

(iv) The consultative process leading to transformation of APOC into a new entity for onchocerciasis and LF elimination and support to other PCT-NTDs should be as inclusive as possible. Key stakeholders involved in the fight against LF and NTDs should be invited to contribute to the development/discussion of the Concept Note and Strategic Plan in order to minimize divergent views at the JAF meeting. In the same vein, benefiting countries should be consulted well before JAF session in order to build support for the proposed transformation scenario and avoid unwarranted criticism of partners as solely leading the process.

(v) With regard to funding of NTD control activities to be carried out by the new entity, the Concept Note suggests that some countries will be funded from the Trust Fund while others would benefit from lending proposed by several bilateral, multilateral and inter-governmental donors. The Technical Advisers expressed doubt about countries’ willingness to borrow for funding NTD control activities and suggested that this is likely to compromise the success of the new entity. They advised that efforts should be made to use the Trust Fund mechanism that has contributed to APOC success.

74. TCC endorsed the remarks and thanked the advisers;
REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA: Agenda item 12

75. The introduction on operation research was made by Mr Sow, indicating the current status of proposals already approved by TCC35, follow up of TCC36 recommandations and that there is only operational research proposal received from Cameroon which is submitted to TCC 37.

i. Follow up of TCC35 recommandations :

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

76. AFRO ethical committee raised some questions which were answered by the Principal Investigators, and the revised version sent back to the AFRO Ethical committee for clearance before its financing by APOC.

   b. Determination of optimum timing for ivermectin mass administration for the elimination of onchocerciasis

77. Presumably to be reviewed again by TCC37 or simply accepted as it will come from Dr Philippon.

   c. Identification of factors responsible for CDDs attrition in Gombe State, Nigeria

78. USD 14000 has been disbursed on April 11th, 2013. mid-term Financial et technical reports are awaited. Correspondences have been sent to remind the investigators.

   d. Factors affecting adherence to CDTI in Pader District, Northern Uganda

79. USD 20,700.00 have been transferred on January 19th, 2013. mid-term financial et technical reports are awaited. Correspondence have been sent by APOC to remind the investigators.

ii. Follow-up of TCC36 recommendations

   a. Epidemiology of ocular attack of onchocerciasis in the forest areas of Cameroon (resubmission)

80. A revised protocol, taking into account TCC36 observations, has not yet been submitted to APOC for TCC review.

   b. Other operational research issues raised :

81. Four countries have been targeted by APOC (Ethiopia, DRC, Burundi & CAR) for developing a system of in-country collaboration with research institutes/Universities with the objective of improving their capacity in operational research proposals. Burundi and CAR have already responded with some proposals.

Reviews:

   a. Evaluation of onchocerciasis community directed treatment strategy in Cameroon

82. The protocol has taken into account TCC36 observations and has combined the three proposals into one which is submitted by Cameroon to TCC37.
TCC comments:

(i) The perception of the beneficiaries, service providers, and health managers as regard the strengths and the weaknesses of the community directed interventions strategy should be indicated;
(ii) The expected outcomes should be a little more elaborated;
(iii) The investigators should enriched the protocol with more bibliographical references on APOC publications relating to these topics;
(iv) The sampling techniques deserve more precision;
(v) The proposed budget is excessively high (US 77,000), the per diems for the two investigators amount to more than US 20,000;
(vi) The 24-month duration of the project is acceptable, considering the activities to be carried out.

Conclusion:

(i) Take the observations into consideration,
(ii) Include «Providing APOC with feedback regarding the conclusions»,
(iii) Drastically reduce the budget in order to comply with the APOC standards.

MANAGEMENT OF THE APOC TRUST FUND

REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS: Agenda Item 13

83. The purpose of the presentation was to inform TCC members about the status of implementation of projects planned for 2013 as well as the progress report of the overall APOC programme budget implementation.

84. It was indicated that a total number of 122 projects were planned for 2013 and four country programmes. The total amount allocated to implement the projects and country programmes was USD 5308880. As at August 2013 the financial implementation indicates that a total of USD 5011931 or 94% have been implemented.

85. On the overall implementation of the APOC budget, it was mentioned that the total approved budget by JAF in 2012 was USD 23,233,000. Out of the approved budget, only USD 19,669,723 was made available this year, the remaining balance being the amount brought forward from 2012. The total amount implemented as at August 2013 was USD 17,073,580 or 73% of the approved budget which reflects a satisfactory absorption capacity. The implementation rate per budget line was not uniform, some had achieved a good implementation rate, while others were still under implemented or registered a budget overrun.

TCC comments and Management response:

(i) TCC members expressed their concerns on the low level of implementation for Gender mainstreaming and Partnerships budget lines. The management of APOC indicated that there was a shift of priority and other activities were implemented.
(ii) TCC members also recommended deployment of vehicles to field offices to facilitate the operations.
TCC Recommendations:

(i) It was recommended to APOC management to speed up the implementation of the programme budget in general, given the fact that the financial year is drawing to a close. Since there are Gender and Partnerships related issues to be addressed, TCC recommended that the activities be urgently implemented or to reallocate resources to other competing priorities.

(ii) It was also recommended to the APOC management to consider sending vehicles to some countries (Uganda, Cameroon, etc.) where there is an urgent need for such equipment.

REPORT ON THE REVIEW BY APOC MANAGEMENT OF THE FINANCIAL CONTENT OF 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH, 12TH, 13TH and 14TH YEAR PROGRESS REPORTS AS AN INTRODUCTION TO THE REVIEW EXERCISE: Agenda Item 14

86. Given the fact that Reporting is a key element of APOC accountability framework at all levels, and is key to maintaining the commitment of Donors to continue supporting APOC Programme, it was considered important to brief the TCC members on the progress made in reporting by funded projects.

87. It was reported that a total of 1296 reports (financial returns) was expected from projects for the 2013 and previous years. Out of that total, 706 have been received and 590 are still delinquent. The chronological analysis of outstanding reports indicated that 516 reports are outstanding for more than 6 months and due from 64 projects. As a result, these projects have been red carded and are therefore no longer eligible for receiving additional funding unless the situation is regularized. A geographical distribution of projects with outstanding reports was also presented to inform TCC members about the particular projects concerned.

88. The status of FACE (Funds authorization and certification of expenditure) returns has been presented. It was noted that out of 128 reports expected as at June 2013, only 24 have been received which represents 19% return rate. It was however mentioned that more reports are expected in the coming weeks given that projects will be looking for the release of the second installment.

TCC Comments and recommendations

89. It was unanimously recognized by TCC members that the situation of outstanding reports is not acceptable. TCC recommended that reminders be sent to projects with outstanding reports through higher levels at the Ministry of Health for a better impact and follow up.

REVIEW OF 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH, 9TH, 10TH, 11TH, 12TH, 13TH, 14TH AND 15TH YEAR ANNUAL TECHNICAL REPORTS: Agenda Item 15

90. The purpose of the presentation was to raise the attention of TCC members that only one research proposal was submitted by Cameroon for their consideration. The financing plan was presented and it was indicated that out of USD 97 239 total costs, the requesting institution pledged to bring USD 20 192 while requesting APOC to come up with the remaining balance of USD 77 047.

91. TCC took note of the information.
REVIEWS

ANGOLA

Uige CDTI Project 2nd year annual technical report

92. The report is well written. The Executive Summary is too long. Areas needing improvement are:

(i) The calculation of the UTG on page 9 and at the level of tables 2 and 9;
(ii) The number of health workers of the area involved in CDTI is not reported, because table 1 is missing;
(iii) Table 2 contains column « total population of CDTI and non CDTI areas”, but this does not appear in the usual format and is a source of confusion;
(iv) The document contains table 10a and 10b, but there is only one table 10 in the usual reporting format;
(v) Table 8 reports one SAE, but its management is not mentioned afterwards.

93. The sensitization and mobilization section remains to be further developed. The CDDs’ workload is beyond their capacities. The geographic coverage is 58% (ranging between 39% in Negage and 82.9 in Quintexe). The therapeutic coverage is 36% (ranging between 25.6% in Negage and 73.3 in Bungo).

Recommendations:

(i) Shorten the summary to 1-2 pages;
(ii) Take into account in the next report points cited above in « areas needing improvement;
(iii) Upscale sensitization and mobilization activities to get better geographic and therapeutic coverages;
(iv) Use thick smear for SAE cases;
(v) Train larger number of CDDs to reduce their workload that is currently 1CCD/410 inhabitants;
(vi) Improve the management of ivermectin;
(vii) Continue advocacy to get an NGDO partner.

94. TCC accepted the report.

NOTF/Angola 9th year annual technical report

95. The report is not well written and does not reflect at all the eight year efforts made by APOC in CDTI activities in Angola. The only sections written somehow are the introduction in which the absence of solution to the problems is deliberately announced and the final analysis of strengths and weaknesses.

96. The main part of the report is made up of the matrix of questions without answer and the lack of effort in providing comments.

97. The results are very poor for a project of that age and no improvement is foreseeable or detectable. The only suggested remedy is the emphasis laid by the coordinator on the remuneration of the stakeholders at the level of the Angolan cost of life.

98. TCC rejected the report.
COTE D'IVOIRE

Cote d'Ivoire CDTI Project (Comoe, Bandama, Sassandra, Cavally and their tributaries) 5th year annual technical report

99. Similar to the previous report, this is a quality report because of the way it is written and the thoroughness of data analysis. Its reading is overly time-consuming, however, and remedies are to be provided:

(i) Follow the existing framework; the coordinator’s plan has its own consistency which is not without interest, but requires an effort of compliance;
(ii) Add a table of contents;
(iii) Annex the report of epidemiological and entomological surveys (pages 43 to 101) and keep only a summary of findings in the report;
(iv) Avoid the multiplication of tables that are sometimes divergent and far from the reference text;
(v) General information is only devoted to the history of control and should be completed with factors (climate, hydrography, health facilities, etc.) which are likely to influence epidemiology and control.

100. In terms of results, a major effort of monitoring- evaluation- training was carried out in 2012, especially with the support of Sightsavers. Relevant recommendations were made to improve the inadequate investment of different categories of stakeholders and the sustainability of community and CDDs’ involvement, whose numbers are inadequate and whose motivation is weakened; the effort to solve the problems of CDDs is directed towards co-implementation agreements in the framework of the NTD projects.

101. The main concern is the considerable reduction in the number of districts treated which are only 33 out of 56 that are eligible. Given the treatment initiated in 2012 in two border districts of Burkina Faso, this would represent 15 districts that have been abandoned in 2012, compared to 2011 (46 treated) due to budget shortages (despite the intervention of Sightsavers). Cross-border strategic regions of Ghana have not been treated despite the 2012 TCC recommendations. The ordering and management of Mectizan stock seems to have been affected and it seems that outside support to districts is in the process of segmentation.

TCC Recommendations:

(i) Take stock of the exhaustive situation of treatment history by district since 2008;
(ii) Establish the minimum cost of treatment by district and district groupings (transmission zones) then undertake extensive search for national and external funding;
(iii) Ensure at least and in priority the treatments of foci continuously treated and add the treatment of the border area with Ghana;
(iv) Given the local treatment history and the evolution of security and financial situations, develop a plan of geographic and step by step treatments. Despite its good records, Côte d'Ivoire represents, in surface area, several projects of APOC type and epidemiological diversity is great; it was vainly suggested in 2008-2009 to start again with more staged steps. It is suggested to consider the relevance of dividing the Ivorian territory into Onchocerciasis projects and planning activities for each project. It should be noted that the treatment goal in 2013 limits treatment to 35 districts, which is realistic in number but raises concern about the fate of other districts;
(v) Despite budgetary difficulties, it is necessary to maintain and standardize nationwide epidemiological and entomological evaluations, whose collated results will contribute to directions of the project;
Integrate in CDTI the results regarding the pilot study of Onchocerciasis/LF co-implementation and better document this study for the TCC and APOC with the view of solving CDTI problems.

102. **TCC accepted the report.**

**DEMOCRATIC REPUBLIC OF CONGO**

*Ituri Nord CDTI Project 6th year annual technical report*

103. The report is well written. TCC congratulates the project team for their efforts.

**Recommendation to improve the project:**

(i) Continue efforts to initiate CSM at district level;
(ii) Continue efforts to increase the therapeutic coverage where it is still below 80%.

**Recommendation to the national coordination and the Management of APOC:**

(i) Allocate the necessary support (technical and financial) for the sustainability evaluation of this project.

104. **TCC accepted the report.**

*Ituri Sud CDTI Project 1st year annual technical report*

105. The report is well written as first report; however there are weaknesses (namely, conflicting figures) noted at many levels in the document.

**Recommendations to improve the report:**

(i) Indicate the number of health facilities in the summary and in the body of the report;
(ii) Harmonize all the figures. For instance, the number of villages in the total area of the project (1368 in the summary/1646 in table 2); the number of villages in the 3 (or 4) involved zones in Year 1 (486 in the summary/489 in table 2); the therapeutic coverage (100% in the summary/102% in table 7);
(iii) Review the % of health workers involved in CDTI (Table 1: 46.5% instead of 50.5%).
(iv) On page 25: "no SAE to report"; on page 26 (Table 8): description of one SAE case.

**Recommendations to improve the project:**

(i) The project should benefit from the presence of a Research Centre for Tropical Diseases that exists in the project area.
(ii) Distribute the drug in another time period of the year, instead of August-December (rainy season) which is not appropriate.
(iii) It would be good to indicate the 3 initial intervention zones in the health areas map (section 1).
(iv) Describe well the mechanism of drug order/delivery.
(v) Describe well the level of integration of PHC if that is the case.
(vi) Continue efforts to increase the therapeutic coverage.
(vii) Ensure that all the observations made for harmonizing the figures and for improving the report are taken into account. An appeal is made to the national coordination for an effective implementation of this project that is starting.

106. **TCC accepted the report.**

*Lubutu CDTI Project 6th year annual technical report*

107. Responses provided to the 4 recommendations made by TCC are satisfactory except for the one related to the drafting of the sustainability plan.

**Report related:**
(i) The report is well written.
(ii) The analytical summary is concise, easy to understand and the data match those of the report.

**Project related:**
(i) Adequate increase was noted at the level of female CDDs.
(ii) The workload is acceptable because the ratio is 1CDD/138 people.
(iii) The geographic coverage is 100% everywhere except for Ferekeni (99.1%).
(iv) The average therapeutic coverage is 76.6% (minimum: 74.9% in Punia and maximum: 80.2% in Ferekeni).
(v) The number of communities with therapeutic coverage <80% is still high (440).
(vi) Government contribution to ONCHO activities is low.

**Recommendations:**
(vii) Improve women's involvement in CDTI activities.
(viii) Upscale SCM and SHM activities.
(ix) Take necessary steps to avoid a great number of expired tablets.
(x) Continue sensitization to reduce the number of communities where the therapeutic coverage is <80%.
(xi) Develop a sustainability plan.

108. **TCC accepted the report.**

*Masisi Walikale CDTI Project 6th year annual technical report*

109. This report covers the year 2012 activities of the Masisi Walikale project in the DRC. This project is in its sixth year of APOC funding but is only at its 4th year of treatment. The project area is located in the Kivu region which is an area of insecurity because of rebellions and difficulties to access. The project is commended for its determination to continue the mass treatment.

110. However, the report has a lot of inconsistencies in some key data such as the number of CDDs and in the drug inventory. Many sections of the report are not completed and the information, although relevant, is not sometimes appropriate with respect to the quality of information required to assess the report more deeply.

**Project related:**
(i) Very few health workers are involved; those involved represent only 30%.
(ii) One of the four health zones, Pinga, has not undergone mass treatment;
(iii) The information provided about the CDDs are not really consistent, 1,332 CDDs were retrained, which implies that no new CDDs have been recruited;
The coverage is not good because in 2012 the geographic coverage was 71% (943/1332) and the therapeutic coverage was 52%. The project never reached the desired coverage during the four rounds of treatment;

45,468 absentees and too high level of refusals: 5% of population at risk;

3.3 tablets / treatment ratio is high, explain and review the numbers of tablets used for the distribution and harmonize them in the report;

Tables 4 and 5 are not consistent with the text and especially the executive summary: The column called number of trained CDDs is very confusing;

Finally, the report was not endorsed by the NOCP.

In conclusion, the report seems to have been written hastily and contains confusing information for an assessment that should be clear and definitive.

**Recommendations to improve the report:**

(i) Resume the drafting, review and harmonize the information provided in the tables and narratives;

(ii) Provide responses to all the sections of APOC form consistently and ensure that the report is endorsed properly.

**Recommendation to improve the Project:**

(i) Establish close supervision with the NOCP and develop a plan of action that is clear to make a proper projection of the needs.

**Recommendations to APOC:**

(i) Continue to support this project and be flexible with regard to the security situation in the project area.

112. *TCC accepted the report subject to the drafting of a new report, taking into consideration the above recommendations.*

**GHANA**

*Ghana CDTI Project 4th year annual technical report (Resubmission)*

The report is well written, cohesive and comprehensive which allows for reflection and analysis. The project did two rounds of treatment in 40 of the 73 endemic districts, and performance has been steadily increasing as evidenced by coverage improved rates. Therapeutic coverage rate increased from 70% in 2010 to 78.2% in 2012 (1st round) and 79% (2nd round treatment).

**TCC Recommendations:**

**To improve quality of report:**

(i) Clarify the source of the population data. Based on the data provided in the report, no census was done (Page 9). However table 3 – timeline of activities, suggests that census update was done.

(ii) Cross check and correct funds released from APOC- The level of APOC funding reported in the executive summary (66,400 USD) does not tally with the data in table 13 (33,300USD).

**To improve the Project implementation:**

(i) Take steps to improve coverage rates for New Juaben (GC= 53.4%, TC = 49.3%).
(ii) Take steps to increase the number of female CDDs.

114. **TCC accepted the report.**

**NIGERIA**

*NOTF/HQ 15th year annual technical report*

**TCC Comments:**

115. While 1/3 of African Oncho mature projects are in Nigeria (e.g. Kaduna), NOTF is not in the mode of elimination. The report is a classical plastered in the box with tables.

(i) NOTF should have reflected on possibility of elimination in some of the old projects.
(ii) No details on what is happening on integration, e.g. Plateau & Nassarawa.
(iii) No mention of stopping treatment.
(iv) New methods need to be explained to raise counter funding.
(v) Too much dependence on NGDOs.

116. **TCC accepted the report**

**SIERRA LEONE**

*Sierra Leone CDTI Project 5th year annual technical report*

117. The report is comprehensive and does provide required information. The project achieved a Therapeutic coverage of 80% for the second year; an improved performance which should be sustained.

**Recommendations for improvement of the project:**

- Provide more information on the 420 cases of SAE reported (complete Table 8).
- Report on the Sustainability Plan and progress in implementing recommendations (could be with APOC).
- The findings of the ongoing research on factors determining successful implementation of MDAs to eliminate LF in Sierra Leone to be shared with APOC.
- Continue with ongoing efforts to increase women participation in CDTI.
- Request for support from NGDO partners to strengthen HR capacity for M & E.

**Recommendations for improvement of the report:**

- Summarize table 3 (Timelines of Activities) into one page (repeated).
- Ensure that figures on Table 10 (Mectizan Inventory) are added up.

118. **TCC accepted the report.**
SOUTH SUDAN

SSOTF/HQ 7th year annual technical report

119. This is SSOTF's 7th year report. The report is well written. However, funding and other constraints during this reporting period affected implementation of fundamental activities such as training, sensitization, advocacy, supervision, resulting in low geographic and treatment coverage rates. Treatment coverage dropped from 61% in 2011 to 43.9% in 2012.

Recommendations to Improve the quality of the report

(i) Correct the ATRO Coverage rate – ATRO coverage rate is 55.8% and not 43.9%;
(ii) Update table 13 – The data in this table shows that 32,542.40 USD were disbursed, by APOC. This data is inconsistent with data provided by APOC Finance. The report presented by APOC finance to TCC 37 indicates that the level of funding made available to SSOTF in 2012 was about 67,767 USD.

Recommendations to improve the project performance:

(i) APOC Director to make another high level visit to South Sudan to advocate for funding and other support for CDTI.
(ii) APOC to re-launch CDTI once more, to revive interest and commitment. Stakeholders will need to agree on feasible CDTI strategies for South Sudan, given the security risks, and nomadic life styles in some areas. For example, the number of absentees for 2012 was twice the number for 2011 (8870 in 2012 versus 4263 in 2011).
(iii) APOC and SSOTF to fully address the issues resulting in delay in the release of funds, to ensure availability of full funds obligated by APOC.
(iv) SSOTF to attract funding from other NGDOs in order to ensure implementation of critical CDTI activities.

120. TCC accepted the report.

East Equatoria CDTI Project 6th year annual technical report

121. The project is on the downward slide as demonstrated by drop in geographic coverage and therapeutic coverage. Project funding has significantly reduced, with the NGDO partner not providing any financial support in the reporting year. This has significantly constrained project operations. Most equipment, including project vehicle, are non-functional. Project staff cannot be expected to deliver project outputs under these conditions. Following the project re-launch, we hope to get better results.

Recommendations to improve the project

(i) The deteriorating financial support needs to be addressed urgently including approaching other interested NGDOs to join in and provide additional support.
(ii) Urgent need to repair or replace equipment, including the project vehicle, as this is constraining project operations.
(iii) Aim to train all health staff in the project area in CDTI.
(iv) Work towards increasing geographic coverage and therapeutic coverage to the acceptable target coverage rates.
(v) Minimise the number of drugs remaining and consider returning the remaining drugs to the country health stores rather than leaving them at the front line health facilities.

Recommendaions to APOC

(i) Need to complete REMO refinement and better define geographical area of the project and population to be reached.

(ii) The issue of deteriorating financial support needs to be addressed urgently including SSOTF/APOC approaching other interested NGDOs to join in and provide additional support.

122. TCC accepted the report.

TANZANIA

NOTF/HQ 14th year annual technical report

123. The report has provided useful updates on ongoing integrated NTD intervention in Tanzania. It seems however that the projects need an appraisal to ensure that an activity critical for sustenance of the gains of Onchocerciasis Elimination is maintained while integrating other NTDs.

Recommendations:

(i) There is need to improve on editing of the report before submission in order to minimize typo errors;

(ii) The NOTF will need to review how their projects are calculating ATO and UTG. For example ATO and UTG should be the same by year 4 or 5 but this is still not the case;

(iii) In Mahenge ATO was 69.5% of total population, while UTG was 84% of the total population. In Ruvuma 98% of the total population was used to calculate UTG while 92.7% was used for ATO. In Tanga, it was 80.2% for ATO and 84% for UTG;

(iv) Complete table 2.4., table 2.8.1, and table 10;

(v) Redo table 11 to provide activity details;

(vi) Provide more details on drug wastage in Ruvuma;

(vii) Provide information on integration using the new table 15 and 16 introduced by APOC;

(viii) NOCP should carry out more supportive supervision;

(ix) Retrain the trainers and supervisors at the different levels to sustain good quality implementation of the programme.

124. TCC rejected the report.

UGANDA

Phase 5 (Kitgum & Pader) 2nd year annual technical report

125. This is a comprehensive and consistent report that clearly puts the project in context, given the background of post-conflict trauma and the prevalence of the nodding disease syndrome. The project covers a population of 545,803 in three districts: Kitgum, Lamwo and Pader. Geographical coverage was 99% and second year therapeutic coverage 58%. The report also reflects on challenges and how they can be overcome.
Report related comments:
(i) Please edit the table of Contents and include a complete list of abbreviations;
(ii) Please revise table 10, which does not add up (high number in stock from previous year);
(iii) Align table 13a with amount approved for field activities in 2012;
(iv) Section 1.1.1 (Description of the project) mentions strain on health services delivery due to increase in number of administrative unit. This aspect should be included in the challenges listed in Section 5;
(v) Revise UTG and subsequent calculations from 87% to 84%;
(vi) Clarify the two cases of SAEs in Pader district and the respective (lack of) follow-up.
(vii) Given the actual challenges, Section 5 should be more comprehensive (with an emphasis on opportunities and solutions), so that it serves to inform the development of an action plan to address problematic issues;
(viii) Clarify the problems around the implementation of CSM/SHM;
(ix) Please provide information on both treatment rounds separately, e.g. coverage, number of CDDs involved, number of tablets used - and adjust tables accordingly.

Project related comments:
(i) Address the problem of relatively high tablet wastage,
(ii) Develop a plan to fully establish CSM/SHM.

Recommendation to APOC:
(i) Follow up on issues raised by the report regarding:
   a. Delivery of approved vehicle,
   b. Fund accessibility to enable approved OR; communicate with MoH.

126. **TCC accepted the report.**

**ONLINE REVIEWS**

**ANGOLA**

*Lunda Sul CDTI Project 7th year annual technical report (Resubmission)*

127. This is a 7th year project covering the 2011 activities, submitted in 2013 for the first time. This means late submission. It should be noted that the project did not use MDA in 2011. The reasons indicated are «the lack/absence of Mectizan and late allocation of project funds. As a solution, the writer recommends «the building of local capacity in timely order of Mectizan; timely sending of financial returns, and advocacy with APOC for timely provision of project funds that is quick and safe (WHO)"."

128. The Lunda Sul project is the oldest project in Angola located in the north of the country. The project was approved by APOC in 2002 but started distribution in 2005. The population at risk in hyper and meso-endemic zone is 251,125 distributed in 252 communities. Confusion exists regarding the total population of the project area: 491,000 inhabitants reported in the project description paragraph and 522,875 inhabitants in the paragraph dealing with the estimated population in 2010.
129. Regarding the other CDTI activities, performances are still low:
   (i) Only 12% of health workers were involved in CDTI;
   (ii) Out of 540 CDDs, 12 are females, i.e., 2% and 1 female CDD/community;
   (iii) The geographic coverage reached 100% only once in 2009 with a therapeutic coverage of 60%; that is the highest since the MDA started in 2005.

130. Since 2008, disbursed funds are from APOC only, the government and the NGO never disbursed the budgets allocated to CDTI. In 2011, out of the $45,359 disbursed, $9,967 were used. In fact, World Vision, the NGO that used to support the project stopped this support in 2009. It should be noted that the Independent Participatory Monitoring after Year 1 was not implemented and that the mid-year evaluation of sustainability was not carried out.

Recommendations to improve the project:
   (i) Address the lack of IEC tools in local languages for sensitization;
   (ii) Provide information on the impact on sensitization of municipal authorities of Cacolo and Saurimo;
   (iii) Initiate CSM and SHM;
   (iv) Order Mectizan timely, at least four months prior to distribution date;
   (v) Please, provide a report on the impact of steps identified in this report.

Recommendation to APOC:
   (i) Enhance technical support to this project, taking into account the fact that it never had an effective MDA (100% and at least 70% of therapeutic coverage).

Recommendation to MDP:
   (i) Consider ordering per project instead of a national order with a copy sent to the national coordination.

131. TCC accepted the report.

Lunda Sul CDTI Project 8th year annual technical report

132. All approximations considered related to translation, the report is unworthy of an eight-year programme, especially since it is a reformulation. Too many gaps and inaccuracies (confusion with 2010 which leads to doubt regarding the reality of treatment in 2011), and evidences of misunderstandings of some questions of the matrix. Data of treatment coverage are unacceptable at this stage of the programme. They extend a jolting series of poor results more or less mediocre where no positive change is foreseeable. Fortunately the focus (not delineated) is meso-endemic, but with only half of the eligible population treated, even achieving control may seem a long way off. It seems that all CDTI activities are to be started again but this is impossible without outside help setting stringent performance requirements.

Recommendations:
   (i) Take note of the report as it is, and classify it, and end this disability race, and resume normal assessment pace;
   (ii) Get the 2012 report as soon as possible and extractominatory recommendations on each failed point of the CDTI from the last two reports (three if expected to wait for the end of 2013);
   (iii) Convey these recommendations in a firm, precise and imperative manner to the Angolan NOCP and project coordination;
   (iv) Require that future reports (2012-2013) be written by the Coordinator;
(v) Review closely the risk of cross-border contamination of this focus with the DRC as well as Angolan contiguous foci;
(vi) Seek external financial support diligently.

133. **TCC rejected the report.**

**CONGO**

*CONGO CDTI 12th year annual technical report*

134. The report is well written. Adequate responses were provided to the TCC's recommendations. The refusal and absentee rate is high, notably in Brazzaville urban area (Makélékélé, MFilou and the Bas Congo). There is strong involvement of district sub prefects and community leaders. Women are more and more empowered in the CDTI. CDTI is integrated in the activities of other programmes: pooling material resources, intervention of some CDDS in other programmes. The national NTD control plan was developed. The geographic coverage is 100% and the therapeutic coverage > 80% since 2009.

**Recommendations:**

135. Explain why:
   (i) the number of health workers has decreased at the level of project area,
   (ii) CSM was not implemented in 2012,
   (iii) the delay of APOC funding,
   (iv) DOLF research.

**Recommendations to improve the project:**

(i) Train a larger number of CDDs to reduce their workload that is currently 1CDD/330 inhabitants;
(ii) Take some steps so that the supervision of FLHF is effective and reinforced;
(iii) Continue advocacy with the Government for timely disbursement of funds;
(iv) Take necessary steps to address the issue of materials, which is an increasingly crucial issue.

136. **TCC accepted the report.**

*Congo Extension CDTI Project 9th year annual technical report*

137. This 9th year project continues to evolve in good conditions. The report is well written. Responses were provided to the recommendations of the last TCC. The geographic coverage is always 100%. The therapeutic coverage that dropped from 84% (in 2010) to 77% (in 2011), due to the outbreaks of measles and polio is rising again (81%).

138. Regarding CDDs, the ratio is 1DC for 112 people; the number of female CDDs has declined (41% in 2011 and 36% in 2012). Table 1 shows a lack of health personnel involved in CDTI in the district of Divenie with the highest target communities (21/22) and most population to be treated. This situation, if proven true, would constitute a threat to the sustainability of the project. While in 2011 the financial contribution of the Government was highly appreciated, the TCC regrets that this effort did
not continue in 2012. However, efforts of communities to support the motivation of CDDs continue. The sustainability plan has not yet been implemented.

139. This project suffers from a lack of equipment. The efforts of co-implementation with the FL and STH continue.

**Recommendations:**
(i) TCC would like to have more information on the health staff actually involved in CDTI in the district of Divérié;
(ii) Advocacy efforts to recruit more women CDDs should be kept, may be by involving more opinion leaders;
(iii) The CSM sessions should be implemented;
(iv) TCC wishes the financial participation of the government be effective and properly maintained.

**Recommendation to APOC Management:**
(i) Continue efforts to help the project whose funds were not released in 2012.

140. **TCC accepted the report**

**DEMOCRATIC REPUBLIC OF CONGO**

*Bandundu CDTI Project 10th year annual technical report.*

141. Responses provided to the 5 recommendations made by TCC are satisfactory except those related to CSM and HSM that should be implemented.

**Report related:**
(i) The endorsers’ names are there but the signatures are missing;
(ii) The report is well written;
(iii) The executive summary is concise, complete, and coherent regarding the data in the report;
(iv) The number of expired tablets dropped from 83970 in 2011 to 0 in 2012 without any justification;
(v) The number of persons does not match between pages 9, 28, 29;
(vi) CSM and SHM data are identical to those of 2011;
(vii) Table 13a, b, and c do not include the 2012 budget and expenditures.

**Project related:**
(i) Women’s participation in CDTI activities is still low;
(ii) The workload is burdensome because 1CDD for 203 persons;
(iii) The number of refusals (2510) and absentees (3194) is seriously declining compared with 2011 (refusals: 14 728; absentees: 24826);
(iv) The geographic coverage is 100%;
(v) The average therapeutic coverage is 99 (100% everywhere except in Lusanga with 95%);
(vi) The number of communities with therapeutic coverage <80% is still high (155);
(vii) APOC funds were disbursed late.
Recommendations:
(i) Provide explanation relating to lack of expired tablets in 2012, CSM and SHM data, tables 13a, b, c data;
(ii) Improve more women's participation in CDTI activities;
(iii) Train a maximum of CDDs to reduce the workload;
(iv) continue sensitization to reduce the number of communities where the therapeutic coverage is < 80%;
(v) Continue sensitization/advocacy to increase the Government financial contribution
(vi) Write a research proposal.

142. **TCC accepted the report.**

**Bas Congo CDTI Project 8th year annual technical report**

143. The recommendations (ten) of TCC35 were all taken into account (report and activities) with effect, except advocacy with government authorities and external NGDOs. This project strangely covers a great distance (from urban area of the city of Kinshasa to the rural area of Bas-Congo). Depending on health areas, treatment rounds are actually 5 to 8 years; specific communities such as "stone breakers" of the Kinsuka area are not considered as such, but they come on a daily basis from different suburbs of the Megacity of Kinshasa. The geographic coverage is 100%; the therapeutic coverage is 74%. The report is true and tables are often supplemented by vague comments, but rather systematic and full of information. However no reference to cross-border actions shared with the Republic of Congo, and comparing the coverages with the data of epidemiological evaluations.

144. The data seem to be reliable although the writer speaks of incomplete data reporting. The unknown is the sequence of annual treatment by district, knowing that the project has suffered from numerous interruptions for reasons of force majeure whose magnitude and impact are unknown. A summary table would be useful. The project's weaknesses are listed. Without government, APOC or outside support, the hope for improvement prospects in the short term is very little. The coordinator believes in an NTD programme, but it does not look at it as a prospect or as a project built on realities.

**TCC Recommendations:**
(i) APOC to enhance the support to this project directly or indirectly, project whose focus is complex and difficult to separate from each bank of the river in the two Congos;
(ii) APOC Management to continue its efforts to ensure that the teams involved in this focus of the Congo River manage to work effectively together (those of Kinshasa and Bas-Congo, and those of the two banks of the river).

145. **TCC accepted the report.**

**Equateur Kiri CDTI Project 8th year annual technical report**

146. The Equateur-Kiri CDTI project was in its 8th year of funding in 2012 but in its 7th year implementation with a total population at risk of 1,236,869 distributed in 1,621 villages located in a meso and hyper-endemic region.

147. This 2012 report is basically made up of « cut and paste » compared to that of the year before, which is understandable. However, there are many inconsistencies. Figures in tables 4 and 5 do not match with those provided in the executive summary. The text that follows which explains table 10 for Mectizan inventory is not consistent.
148. However, the project reached a geographic coverage of 100% and a therapeutic coverage of 79%. The geographic coverage has been constantly 100% for the last 5 years and the therapeutic coverage has been about 80% for the last 4 years. This is an adequate performance.

149. Regarding the inventory, the number of tablets used in 2012 per treatment is 2.48 tablets/treatment. A large number of tablets are lost, that is 14,267 lost tablets, which is less than the loss noted the previous year. However, the management of tablets should be improved, despite efforts made from the 29,340 tablets lost. It should be noted that the project has launched CSM and SHM in 8% and 6% of the villages. This effort should be encouraged.

**Recommendation to improve the report:**

(i) Review tables 4, 5, and 10 and make sure the entire calculation are accurate;
(ii) Review table 13 as well.
(iii) Calculate and interpret the proportion of villages with less than 80% therapeutic coverage and put it as an appendix to table 7 of treatments.
(iv) Check and correct inconsistencies due to cut/paste.

**Recommendation to improve the project:**

(i) Continue improving Mectizan management;
(ii) Conduct effective advocacy with partners to replace the obsolete vehicle and motorbikes (1 vehicle out of 2 and 9 motorbikes out of 10 are obsolete);
(iii) Continue advocacy so that to include CDTI activities in PHC budget and report the results;
(iv) Expand CSM and SHM to all the villages of the project.

150. **TCC accepted the report.**

*Kasai CDTI Project 12th year annual technical report*

151. Excellent report, very complete in the statement of activities and their results. Each result is followed by a reflection, an analysis or a suggestion for improvement. These results are remarkable in view of the exceptional size of the focus for which one wonders what administrative or epidemiological logic is behind.

**Recommendations to improve the project:**

(i) Take stock of loiasis and map the hydrographic network in the presentation,
(ii) Clarify the difference in the number of CDDs in tables 4 and 5,
(iii) Trace the history of annual treatments by geographical or epidemiological units,
(iv) Explain why there is a huge stock of Mectizan and what is to be done with it,
(v) Look for foreign funding in addition to the fundings from APOC and CBM.

**Recommendations to APOC:**

(i) Get the MoH engage in the integration of CDTI in the PMA and the DRC/NTD programme;
(ii) Activate cross-border dialogue with Angola if this is not already the case;
(iii) Correlate CDTI reported results and the project history with the results of epidemiological studies carried out by APOC Management by associating the coordinator.

152. **TCC accepted the report and congratulated the Project Coordinator for an excellent report and a very good achievement.**
Katanga Sud CDTI Project 7th year annual technical report

153. This is the 2012 report of the Katanga Sud CDTI project in the DRC in its seventh year of APOC funding. The project includes 1,061 communities with a population of 685,835 at risk. This is a project without NGO partners who had experienced situations of insecurity in two of the seven districts. Project performances for the year 2012 were:

(i) Positive impact of advocacy with political and administrative authorities;
(ii) A total of 6,240 CDDs with 1 female CDD for 3 male CDDs and a ratio of 1CDD/109 inhabitants;
(iii) Geographic coverage of 100% and 80% of therapeutic coverage with only 26% of villages that have less than 80% of TC;
(iv) These coverage have been reached the last 4 years of the programme;
(v) Treatment cost was $ 0.04 / treatment and CDDs were supported by the population with in-kind donations (bag of beans, etc.).

154. Unfortunately, though CDTI is included in the provincial development plan, there is no provincial funding. Also, no community self-monitoring or stakeholders meetings were initiated. The project was commended for the 4 years of good performances with the following recommendations:

Recommendation to improve the Report:
(i) Table 5 is confusing with wrong calculation of the totals in the last 3 columns;
(ii) Check the consistencies of figures used in the report. Two figures reporting the number of people treated 548,008 and 549,088 in tables 7 and 9.

Recommendation to improve the Project:
(i) Continue advocacy with the authorities for full integration of CDTI;
(ii) Carry out advocacy with APOC for the replacement of the unique vehicle and other equipment that are obsolete;
(iii) Continue good performances at the level of coverage;
(iv) Provide information on other NTDs mostly after finalizing the lymphatic filariasis and schistosomiasis mapping in 2012.

155. **TCC accepted the report.**

Mongala CDTI Project 8th year annual technical report

156. *This* report is fairly comprehensive, despite some shortcomings, lack of analysis and evaluation of the situations at the level of therapeutic coverage; but things not said appear in the executive summary. Whatever reasons, the project seems to be experiencing working to the limit of its capacity. It has never achieved in any area the minima of executives and the authority is weak. CDD’s training is very inadequate and inappropriate, sensitization activities, monitoring, mentoring, supervision do not meet the needs, and CDD motivation is fragile. The project is experiencing difficulties in advancing women’s participation. All of these weaknesses are identified. The government financial contribution is zero; integration does not seem effective or solid and external funding is in a very marked regression. If a rescue does not intervene quickly, it is to be feared that the situation should deteriorate and that the elimination should become an out of reach goal. This rescue can only result from a reinforcement of financial support to a revitalization plan that can be based on the report of sustainability if its study confirms its adequacy.
Recommendations to APOC:

(i) Accelerate the review of the sustainability report;
(ii) Provide funding for essential components of CDTI at the minimum level required.

Recommendations to the NOTF/DRC:

157. For the sake of the project and APOC advocacy support:

(i) Make a special effort to obtain from the central and provincial government a minimum financial support for the project;
(ii) Intensify or launch the advocacy toward external sources of financial support.

TCC accepted the report.

Sankuru CDTI Project 9th year annual technical report

158. TCC recommendations were taken into account and responses provided are satisfactory. The summary is concise and coherent with activity timelines.

Report related:

(i) Provide explanation of table 1a that indicates that 100% of health workers of the area are involved in CDTI;
(ii) Shorten the number of points referred to in « strengths and weaknesses » (pages 58 and 59) to a few key points.

Project related:

159. The project has a fairly good performance: geographic coverage of 100% and constantly increasing therapeutic coverage 2008 (75%), 2009 (81%), 2010 (82%), and 2011 (83.2%). TCC expresses its concern because the equipment provided by APOC is basically written off. TCC stresses the necessity to have other partners because the entire 2012 budget was provided by APOC as APOC will someday exit. TCC is satisfied by the fact that CSM and SHM are implemented in all the areas, as opposed to some older projects that have not yet launched these activities.

TCC urges the project to:

(i) Continue advocacy so that the authorities’ verbal pledge should be translated into actions (namely, financial support);
(ii) Continue sensitization to get communities take care of their CDDS, which will reduce the number of CDD attritions;
(iii) Take necessary steps to develop the sustainability plan and implement it;
(iv) Initiate the training of persons able to manage SAEs as soon as possible, taking into account the potential movements of populations from loiasis area;
(v) Finalize the operational research being developed.

160. TCC accepted the report.
Rutsuru-Goma CDTI Project 7th year annual technical report

161. This is a report of a 7th year funding by APOC covering the 2012 activities. This is one of the projects of North Kivu in the DRC in an area of insecurity due to rebellions. The project covers 636 communities with a population of 606,916 people at risk. The project performances are:

(i) 1,096 CDDs retrained with 1 female CDD/2 male CDDs and a very high CDD/population ratio of 1CDD/554 inhabitants;
(ii) The geographic coverage is 84.3%. There has never been 100% geographic coverage since 7 years and treatment was not provided in 2008;
(iii) The therapeutic coverage is 72.2% and has been about 74% these last 4 years;
(iv) Treatment cost is $0.05 with 2.5 tablets used for each treatment;
(v) The project did not initiate CSM or SHM.

Recommendation to improve the report:
(i) Explain why some of nurses have not been briefed about CDTI;
(ii) Check the figures and calculation: the geographic coverage is 84.3% and not 82.3%;
(iii) The column of SAEs of table 7 corresponds to severe events and not to minor adverse events. Check the definition of SAEs;
(iv) Clearly state the issue of CDD incentives and suggest ways to address it.

Recommendation to improve project:
(i) Improve CDD/ population ratio to 1CDD/100 people and select the annual goals consequently;
(ii) Surveys on communities having a therapeutic coverage (TC) < 80% because 73% (465 out of 636) of communities treated have <80% of TC;
(iii) Find ways to reduce absentee rates that are high, 36,061;
(iv) Conduct CSM and SHMs.

162. TCC accepted the report.

Tshuapa CDTI Project 8th year annual technical report

163. The report is well written. Appropriate responses were provided to TCC recommendations. Areas needing improvement:

(i) Who conducted the census in 2012?
(ii) Section mobilization, sensitization, and health education on page 20 has been ignored,
(iii) Review the calculation of tables 5 and 7,
(iv) CSM and SHM are missing in table 6,
(v) Fill in tables 13a and c,
(vi) P 46: “disbursement of APOC Trust Fund is always late”.

164. The number of refusals and mostly that of the absentee is particularly high. The number of lost and remaining tablets is high. CDDs’ workload is very burdensome. CDTI is integrated in the activities of other programmes: pooling of material resources, intervention of some CDDs in other programmes. The geographic coverage has been 100% since 2010 and the therapeutic coverage varies between 75% and 79% during the same period.

Recommendations:
(i) Provide explanation to points indicated above;
(ii) Fill in tables 5, 7, and 13a, c;
(iii) Continue sensitization to reduce the number of absentees;
(iv) Implement CDTI in timely period;
(v) Train a larger number of CDDs to reduce their workload that is currently 1CDD/501 inhabitants;
(vi) Continue community sensitization for providing incentives to CDDs;
(vii) Continue advocacy with the Government for timely disbursement of funds;
(viii) Take necessary steps to address the issue of the equipment that is completely obsolete.

165. **TCC accepted the report.**

_Tshopo CDTI Project 9th year annual technical report_

166. All TCC recommendations have been taken into account and the responses provided are satisfactory. However, the expected treatment in the health areas of Bafwagbogbo and Opienge will be administered in 2013.

**Report related:**

(i) The report is well written, which justifies why it is reader-friendly. The summary is concise, coherent and full of information;
(ii) However, conflicting numbers exist: 1,167 health workers involved in CDTI on page 10, but the number is 1,357 in table 4; the therapeutic coverage is 71.7% in table 7 versus 74.3% in table 9;
(iii) The timelines are consistent and all the activities (mobilization, training, census, distribution, supervision) were well conducted according to the planned order;
(iv) CDTI is not initiated at Bafwagbogbo (p27 and p29) but CDTI results of this site are published on page 28.

**Project related:**

(i) CSM and SHM training for SAE management, data analysis and for reporting initiated at all levels;
(ii) Training on programme management at all levels except at the level of CDDs;
(iii) High number of refusals (61,095) and absentees (40,103);
(iv) Oncho budget line created in the MoPH;
(v) In 2012, geographic coverage of 100% everywhere except at Yalimbongo (80.7%), Opala (97.7%) and Badfawsende (98.4%). The geographic coverage shifted from 71.5% in 2009 to 88.10% in 2012;
(vi) In 2012, the average therapeutic coverage is 71.7% (minimum of 57.7% at Banalia and maximum of 86.8% at Basali). The therapeutic coverage in 2009 was 57.7%;
(vii) 962/2,318 communities have a therapeutic coverage <80% at their 9th year;
(viii) Adequate management of SAEs.

**Recommendations:**

167. **TCC urges the project to:**

(i) Harmonize the data on pages 27, 28, and 29;
(ii) Continue sensitization to reduce the number of refusals and absentees;
(iii) Implement CDTI in the remaining health areas;
(iv) Select treatment period in collaboration with communities but not during the rainy seasons;
(v) Closely supervise CDDs, mostly at the earliest stage of CDTI to address the issue of inadequate filling of registers for drug distribution;
(vi) Follow up the recommendations of sustainability evaluation.
168. **TCC accepted the report.**

**Ubangi-Nord CDTI Project 8th year annual technical report**

169. The 2012 CDTI activity report of the Ubangi Nord CDTI project which is at its 8th year implementation, covers 9 health areas or districts endemic for Onchocerciasis and loiasis. The population at risk is estimated at 784,987, living in 1,068 communities. For financial reasons, because APOC did not disburse the 2nd installment following dubious justifications, the project did not treat the Mobayi Mbongo health area and part of the Bili health area in 2012. The performance indicators are as follows:

(i) 4,257 CDDs trained or retrained. That corresponds to 1 female CDD for 9 male CDDs and 1CDD/185 inhabitants. Incentives for CDDs are a problem because community support to CDDS is missing.

(ii) Geographic coverage (GC) = 60%; all the districts have a GC of 100%, except Bili that was in its 1st treatment round in 2012.

(iii) Therapeutic coverage (TC) = 68% (468,038 people treated with $US 0.16 per treatment) 447 communities, i.e., 41% of the villages have a TC of at least 80%. A large number of people, i.e., 21,052 people were absent at the time of the distribution in 2012.

(iv) The project never reached the threshold of 100% GC but covered around 80%; the TC is about 70%.

(v) In total, 13 SAEs were described followed by an adequate management because no death occurred.

**Recommendation to improve the Report:**

(i) Check and harmonize the figures in the documents; therefore, review table 4b regarding number of CDDs (3,524 or 4,257 retrained CDDs);

(ii) Explain why 41% of the villages have a TC of less than 80%.

**Recommendation to improve the Project:**

(i) Conduct community self-monitoring and the stakeholders meetings systematically following each distribution campaign;

(ii) Intensify community sensitization and mobilization to contribute to motivating CDDS;

(iii) Improve women’s participation as CDDs that was 1 female/9 males in 2012;

(iv) The project is at its 8th year of funding. It is time to get to performances of 100% GC and at least 80% TC. Request assistance from NOCP and APOC;

(v) Train the project team on financial management to avoid the blocking of funding.

170. **TCC accepted the report.**

**Ubangi-Sud CDTI Project 8th year technical report**

171. Responses provided to the 7 recommendations of TCC are satisfactory. However, CSM and the research project, whose implementation is planned for 2013, need to be launched.

**Report related:**

(i) The report is well written;

(ii) The analytical summary is concise, complete, and coherent regarding the data in the report;

(iii) Tables 2, 4, and 5 should be checked and completed.
Project related:
(i) Women’s participation in CDTI activities is low, while they often play a galvanizing role;
(ii) The workload is overly burdensome because of 1CDD for 278 persons;
(iii) The geographic coverage is 100% everywhere except for Budjela (80%) and Boto (89%);
(iv) The therapeutic coverage is 75% (minimum: 69% in Gemena and maximum: 84% in Bominenge). Progress noted since 2006 and mostly from 2010;
(v) Number of communities with therapeutic coverage < 80% is 685, i.e., 58%;
(vi) Number of refusals (50389) and absentees (57817) is very high;
(vii) The transfer of APOC funds took place in June, which delayed the launching of the activities;
(viii) The Government contribution to ONCHO activities is low.

Recommendations
(i) Provide information at the level of each item of the report;
(ii) Review tables 2, 4, and 5;
(iii) Improve women’s participation in CDTI activities;
(iv) Implement CSM and SHM activities;
(v) Sensitize more to reduce the number of refusals and absentees;
(vi) Propose an operational research;
(vii) Develop a sustainability plan.

172. TCC accepted the report.

Uele CDTI Project 10th year technical report

173. The report is well written. Adequate responses were provided to the TCC’s recommendations. Areas needing improvement are:

(i) Complete data regarding training, supervision and mobilization in the summary.
(ii) No information related to the outcome of advocacy.
(iii) No indication regarding the number of tablets ordered table 14.
(iv) Clarify the status of the equipment approved by PAB 2012 and not yet received at the project level.
(v) Review the calculation of table 22.

174. The number of refusals and absentees is high. The CDDs’ workload is very burdensome. The lack of SAE is an asset. The CDTI activities are well integrated in PHC. The geographic coverage in 2012 is 100% everywhere except for Dengue (76%) and Ango (76%). The average therapeutic coverage was 68% in 2009, 80% in 2010 and 2011 but 77% only for 2012.

Recommendations:
(i) Provide explanation for areas indicated above;
(ii) Complete tables 14 and 22;
(iii) Continue sensitization to reduce the number of refusals and absentees;
(iv) Train a larger number of CDDs to reduce their workload that is currently 1CDD/459 inhabitants;
(v) Continue advocacy with the Government for the creation of an ONCHO budget line;
(vi) Supervise CDDS to ensure better filling of registers.
175. **TCC accepted the report.**

**LIBERIA**

*South East CDTI Project 7th year annual technical report (Resubmission)*

176. Overall this project seems to be doing well. Therapeutic coverage over the last four years ranged from 81% to 97%. The reported rate for 2012 is 84%.

**Recommendation to improve the report:**

(i) Re-check and correct data inconsistencies and gaps;
(ii) The information provided on the number of CDDs trained (3165) in the executive summary is not consistent with the corresponding information (3215) in table 5;
(iii) The data provided in the current updated version of the report suggests an increase in the number of communities (856 to 913) when compared with the version reviewed during the March 2013 TCC session. Even though the number of communities increased, the total population decreased (483870 as stated in previous report compared to 479795 as stated in current version of the 2012 report). The reasons for this trend are not clear;
(iv) Calculate UTG – table 2- the total population and UTG are the same, this denotes the use of wrong denominator;
(v) Table 4- Number of CDDs no dot adds up;
(vi) Table 5- 3215 CDDS trained yet only 2504 CDDs are active. What happened to the other 700 trained?
(vii) Complete Table 8- 828 SAEs and 374 serous cases. But table 8 was not filled. This is a serious omission and must be addressed;
(viii) Complete section 4 - The project is in its 7th year. No indication was given regarding evaluation activities that have taken place over the seven year period.

**Recommendations to improve project:**

177. APOC to pay close attention to this project because of the integrity of the data which is doubtful.

178. **TCC accepted the report.**

*North West CDTI Project 11th year annual technical report (Resubmission)*

179. This is a well-written report of a well-managed project. Complete treatment data for 2012 has been reflected in the report. The project is commended for the effort to treat endemic communities identified after the geographic coverage survey carried out in 2012. The media awareness effort on NTD is a good effort by the project and need to be sustained.
Recommendations to improve report:
(i) Recalculate the UTG because the current UTG as reflected in table 2 is the total population;
(ii) Reflect the contribution of the government for field activities which was said to be the highest in 2012 in table 13a;
(iii) Reflect the contribution of Liverpool school of Tropical medicine and MAP on table 13 a;
(iv) Provide more information on Severe Adverse Effect reflected in table 7 as the report indicated that 2265 had SAEs and 455 were referred to the hospital.

Recommendations to improve the project:
(i) Intensify effort to achieve 100% geographic coverage.
(ii) Improve on advocacy to the donors to ensure early release of funds for early commencement of activities.
(iii) Sustain mass media campaign for improved treatment compliance especially in the urban areas.

180. *TCC accepted the report.*

SOUTH SUDAN

*East Bahr El Ghazal CDTI Project 8th year annual technical report*

181. This is a solid report of a project with serious deficits due to resource constraints and regional context. The project covers a population of 550,325 across 8 CDTI counties. The project’s NGDO partner is CBM. Geographical coverage is very low at 71%, reflected in therapeutic coverage which is only 54%. The report provides sufficient background to illustrate the serious constraints that determine the project’s weak performance.

Recommendations to improve the Project:

182. While TCC understands the difficult situation in the project area, certain key issues require urgent attention:

(i) Please address the reasons for the low levels of health staff engagement in CDTI.
(ii) Lack of census data is problematic as the quality of the substitute source is unclear.
(iii) Lack of sensitization of and mobilization needs to be addressed, also with a view to the inclusion of women in CDTI.
(iv) Please address the prerequisites for conducting CSM and SHM.
(v) Training is a precondition for progress. Under current conditions, the ATO may be “realistic” but a contingency plan should be presented
(vi) It is obvious that the project context determines problematic coverage rates.
(vii) TCC kindly requests more detailed information about the reasons for the delayed CDTI re-launch and any assistance needs as well as any other issues relating to the implementation of the sustainability plan.

Recommendations to APOC Management:

183. APOC/HQ and SSOTF should follow up on the various problems of the project and develop a joint action plan to address the project’s serious problems, including a way forward to enable CSM and SHM as well as to move towards integration.

184. *TCC accepted the report.*
185. The project is on the downward slide as demonstrated by drop in geographic coverage and therapeutic coverage. Project funding has significantly reduced, with the NGDO partner not providing any financial support in the reporting year. This has significantly constrained project operations. Most equipment, including project vehicle, are non-functional. Project staff cannot be expected to deliver project outputs under these conditions. Following the project re-launch, we hope to get better results.

**Recommendations to project:**

(i) The deteriorating financial support needs to be addressed urgently including approaching other interested NGDOs to join in and provide additional support;

(ii) There is an urgent need to repair or replace equipment, including project vehicle, as this is constraining project operations;

(iii) Aim to train all health staff in the project area in CDTI;

(iv) Work towards increasing geographic coverage and therapeutic coverage to the acceptable target coverage rates;

(v) Minimize the number of drugs remaining and consider returning the remaining drugs to the county health stores rather than leaving them at the FLHF.

**Recommendations to APOC:**

(i) There is need to complete REMO refinement and better define geographical area of the project and population to be reached;

(ii) The issue of deteriorating financial support needs to be addressed urgently including SSOTF/APOC approaching other interested NGDOs to join in and provide additional support.

186. **TCC accepted the report.**

**Upper Nile CDTI Project 7th year annual technical report**

187. This report is well written, however, the issues of embezzlement of funds by a government employee interfered with the implementation of the project in three sites, an issue that is currently being addressed by the country.

**Recommendation to improve the report:**

(i) Correct table 7: it is reported that all the communities in Longichuk, Maaban and Maiwut achieved over 80% coverage yet there was no treatment;

(ii) Assess and include the existing opportunities for the project (e.g. the re-launch of CDTI provides an opportunity for the project to refine its implementation processes).

**Recommendations to improve project:**

(i) It is imperative that efforts are made to conduct a census in the project sites. The current figures are based on estimates that may be outdated;

(ii) Increase the proportion of health staff involved in CDTI activities from the current 15.2%. This would require setting training targets (there were no targets set for the reporting period);

(iii) Training for CSM and SHM should be undertaken because this would be a critical measure of community sensitization and mobilization.

**Recommendations To APOC:**

(i) Access remains a key challenge for this project. The vehicle and 4 motorcycles supplied by APOC are non-functional. There is a need to find mechanisms to support the implementation team to ensure that drug supplies are transferred to the communities in good time. This would also facilitate supervision.
188.  **TCC accepted the report.**

*West Bahr El Ghazal CDTI Project 7th year annual technical report*

189. The report is concise and it has been noted that the long-standing request for 3 separate CDTI projects instead of having one huge one has been granted.

**Recommendations to improve report:**

(i) Provide clear reason why drug balance is high;
(ii) Correct the number of CDDs trained which was 7217 in table 4 and 5477 in table 5;
(iii) Reflect the findings of the sustainability evaluation in the report and actions carried out to address its recommendations.

**Recommendations to improve the project:**

(i) Ensure that the purpose of separating the project from one huge to three projects is achieved which are for better programme management and supervision;
(ii) Train more CDDs and retrain Health workers;
(iii) Improve community participation through CSM and SHM;
(iv) Ensure that the use of media which started some years back is sustained;
(v) Increase and maintain high geographic and therapeutic coverage.

**Recommendation to APOC:**

190. APOC to consider replacing capital equipment for this project and ensure early release of fund.

191. **TCC accepted the report.**

*West Equatoria CDTI Project 8th year annual technical report*

192. This is an acceptable report of a project with considerable deficits due to resource constraints and other contextual factors. The Executive Summary is concise and instructive as well as consistent with data in the report. There is sufficient background information to reflect some of the project’s challenges. The project’s problems are persistent and require attention. The quality of the report is fine and sufficiently detailed, given the difficult background and condition of the programme.

**Recommendations to improve the project:**

193. TCC understands the difficult situation in the project area. Yet certain key issues require urgent attention:

(i) Please address the reasons for the low levels of health staff engagement in CDTI;
(ii) Lack of census data is problematic as the quality of the substitute source is unclear;
(iii) Low levels of sensitization of and mobilization need to be addressed, also with a view to the inclusion of women in CDTI;
(iv) Please address the prerequisites for conducting CSM and SHM;
(v) Training is a precondition for progress. Under current conditions, the ATO may be “realistic” (as postulated previously by TCC) but a contingency plan;
(vi) It is obvious that the project context determines problematic coverage rates;
(vii) TCC kindly requests to be informed in detail about the reasons for the delayed CDTI re-launch and proposals.
Recommendations to APOC Management:

194. APOC/HQ and SSOTF should follow up and develop a joint action plan to address the project’s serious problems.

195. *TCC accepted the report.*

**TANZANIA**

*Kilosa CDTI Project 10th year annual technical report*

196. The report is well written and reflects commitment of programme managers to CDTI. There seems to be a lot to learn from this project if their lesson on CSM and SHM is well documented. The project clearly indicated their expectation from the various partners, which is quite commendable. However Kilosa project seems to be having some missing report, which may require further clarification.

**Recommendations on the report:**

(i) Provide updated total population of the project. The population indicated in the report is the same for 2010;

(ii) Provide more information on sub village and how that affects your total number of communities;

(iii) Provide update on the missing reports in the sub villages, the year it occurred and effort to resolve the issue;

(iv) Provide correct estimate of UTG.

**Recommendations for the project:**

(i) Train health personnel involved in CDTI activities using the basket fund opportunity and integrated NTD intervention;

(ii) Train more CDDs to reduce CDD: Community member ratio;

(iii) Sustain advocacy for district support of CDTI and NTD intervention;

(iv) Achieve and sustain 100% geographic coverage and 84% therapeutic coverage.

**Recommendations for APOC management**

(i) Clarify whether Year 5 sustainability plan was conducted and whether the report has been shared with the project team.

197. *TCC accepted the report.*

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

198. This is an acceptable report although the team should sustain 100% geographic coverage. The fact that 14 villages in Morogoro Rural were not treated in 2012 is an issue of concern, given that this is an 8th year report.

**Recommendation to improve the report:**

(i) Correct the figures in table 4 on the total number of CDDs (males 600 + 634 = 1234 but the figure provided is 1271 while for females 653 + 646 = 1299 but the figure provided is 1262). Ultimately it is not clear which is the correct position in the implementing communities;
(ii) Ensure that the information for 2012 in table 9 is consistent with the information in the other tables (for instance the total number of villages treated is 1052 yet table 7 reports that 1045 communities were treated);

(iii) Table 10 indicates that there were no drugs in stock yet the 2011 report indicated that 617,972 drugs remained). The team should explain how these drugs were used. The team should explain what happened to these drugs since for this reporting year more than 700,000 drugs are reported to have remained;

(iv) Include information on the outcomes of internal monitoring (section 4.1.1. – 3) have been consistently blank.

**Recommendation to improve the project:**

(i) Ensure that all communities are covered during treatment. It is not clear why 14 villages in Morogoro Rural did not receive treatment in the current report period.

(ii) Address the reasons for refusals, which include people who have no signs and symptoms refusing to take treatment and the persistent association of Ivermectin with contraception.

(iii) Address the 63% of the villages (669) currently not achieving the 80% therapeutic coverage.

**Recommendations for APOC:**

199. Transport is a key challenge because the only vehicle and the 4 motorbikes are non-functional. The same situation prevailed in 2011 and APOC management was asked to respond to this need. It is not clear whether the equipment has been replaced.

200. **TCC accepted the report with minor changes to be made by the project team.**

**Ruvuma CDTI Project 13th year annual technical report**

201. The reviewers of 2011 were concerned with the seriousness given by the project team on reporting to APOC. The same issues prevail in this report. The lack of response on the issues raised in view of Ludewa and the continued under-performance of this district casts aspersions as to the integrity of the report.

**Recommendation to improve the report:**

(i) Correct the inconsistencies between the executive summary and the body of the report.

(ii) Correct information on Ludewa in table 2;

(iii) The number of CDDs trained - 3,477 is higher than the total number of CDDs in place – 2,636 but there is no explanation given. The same discrepancies were noted in the 2011 report;

(iv) Report on reasons for and outcomes of advocacy and monitoring and evaluation activities as required;

(v) Re-examine table 7 on the reported 21 SAEs in Ludewa and the high number of absentees;

(vi) Figures in table 10 on drugs do not add up.

**Recommendation to improve the project:**

(i) Pay attention to Ludewa, which has low coverage, a high number of absentees, and poor reporting;
The programme team should explain how the desktop and printer disappeared and the outcome of the report to the police on the stolen laptop.

202. **TCC rejected the report.**

*Tunduru CDTI Project 8th year annual technical report*

203. Well written report. The project has maintained 100% geographic coverage since inception and achieved 85% therapeutic coverage in 2012. Successful co-implementation of activities in CDTI, LF, Schistosomiasis, STH, malaria, nutrition, trachoma and Cataract surgery is commendable. The project enjoys dependable funding at District level. This and non-monetary incentives provided to CDDs by communities will continue to impact positively on CDD attrition.

**Recommendation to improve the report:**

(i) Resolve conflicting information on SAEs (Table 7) and 0 (Table 8).

**Recommendation to improve the project:**

(i) Address past TCC recommendations.
(ii) Use media n HSAM.
(iii) Produce and use IEC materials.
(iv) Conduct SHM and CSM in all communities.
(v) Conduct operational research on refusals and absenteeism and utilize results in addressing the problem.

204. **TCC accepted the report.**

TECHNICAL REVIEW COMMITTEES REPORTS: Agenda item 16

CAMEROON

*Cameroon Technical Review Committee: Report of the 9th meeting (TRC9)*

205. The ninth session of the Technical Review Committee (TRC9) of Cameroon was held in the conference hall of the WHO Country Office in Yaoundé on 20th and 21st August 2013. The meeting was attended by participants from the Ministry of Public Health, Onchocerciasis Non-Governmental Development Organizations (International Eye Foundation, Sightsavers and reviewers), the WHO Country Office, the Faculty of Medicine and Biomedical Sciences of the University of Yaoundé.

I. **OBJECTIVES:**

A. General Objective:

206. Make any useful comments to improve the Cameroon CDTI Projects’ reports and submitted operational research proposals.

B. Specific objectives:

(i) Review the 2012 Annual Technical Reports of CDTI projects in the South and Northwest, which should be sent to APOC TCC.
(ii) Consider the three operational research proposals.
(iii) Discuss and adopt the reviewers' decisions in the plenary session.
(iv) Write the report of the ninth session of the TRC.

II. PROGRESS OF THE SESSION:

(i) Follow up of TRC8 recommendations:
(ii) TCC 36 recommendations:
(iii) Review of the operational research proposals.

Topic 1: "Factors limiting community participation in CDTI: the case of Monatele and NTUI".

207. Following the reviewer's opinion, it was recommended that corrections be made and that the topic be merged with the 3rd project.

Topic 2: "The determinants of refusal and absenteeism from Community directed treatment with ivermectin (CDTI) in the Western Region, Cameroon in 2014."

(i) Merge with the two other proposals. However, due to the investigator's refusal, supported by one of the reviewers who felt that for reasons of intellectual property, the investigator should not be forced to merge their proposal with the other two, the project was accepted subject to the proposed amendments.

(ii) The project was accepted subject to the comments made by the reviewer.

Topic 3: «Community Strategies for the ownership and sustainability of the CDTI approach among the populations of rural Cameroon.»

208. The project was deemed admissible. It should, however, be merged with Topic 1: "Factors limiting community participation in CDTI: the case of Monatele and NTUI", considering similar issues raised.

Review of the 2012 Annual Technical Reports of CDTI projects

South CDTI Project.

209. It was recommended that emphasis be on education instead of focusing on alcoholism and isolation to justify the high number of refusals. It was noted that the report does not mention the functionality of existing equipment and is only confined to listing them.

210. The report was accepted. However, some corrections were made in the executive summary regarding the information relating to the contributions from different partners.

Nord West TIDC Project

211. It would be advisable to include in the executive summary information about the contributions of different partners. The reviewer suggests that the Project focus on the comments in the tables, which in itself does not provide sufficient information on the problems and solutions proposed.

212. The report was accepted subject to the proposed corrections.
III. GENERAL RECOMMENDATIONS:

To the NOTF Secretariat:

(i) Have a directory of research projects already carried out or under implementation, to avoid submitting the same issues in the future.
(ii) Make research priorities available to researchers and research institutions.
(iii) Develop an implementation plan of the recommendations of research projects.
(iv) Ensure that research projects are supported by institutions and not by individuals.
(v) Encourage investigators of research proposals 1 and 3 to merge them into one, given the fact that they address the same issue; the reviewed and corrected protocol is to be provided to the NOTF in three days.
(vi) Share with all stakeholders the results of research projects carried out.
(vii) Return the reviewing guides to the CDTI projects (RDPH and ROC).
(viii) Get closer to local communities to discuss support to be provided to the Programme in the context of decentralization.
(ix) Debate the concept of community supervisors during the next monthly meeting.

To South and Northwest CDTI projects:

(i) Correct the reports following the proposed amendments and send them to the NOTF Secretariat within three days.

To all the projects:

(i) Highlight the level of functionality of the equipment, their matching with the needs and clarify their location (regional level, HD, or health area) in the ATR;
(ii) Highlight the different partners and their contributions in the executive summary of the ATRs.

TCC comments:

213. TCC noted the report, thanked the TRC of Cameroon and made the following recommendations:

(i) SAEs should be reported early for their management on time;
(ii) Articles on loa loa should be published as there is a lot of experience gained in the management of SAEs. For that purpose, NOCP/Cameroon should contact MDP for the data;
(iii) APOC should train the new accountants appointed by the Ministry of Health in the framework of the devolution of activities. This will speed up the production of financial reports which are late.

MALAWI

Malawi Technical Review Committee: Report of the 1st meeting (TRC1)

214. In order to enhance sustainability and ownership of Onchocerciasis control programmes by countries and at the same time, reduce the workload on TCC and APOC Management, TCC recommended that countries with more than 7 years of implementation set up a Technical Review Committee (TRC) to perform functions similar to those performed by TCC.

215. Based on this, the APOC Director requested the Minister of Health to form a Malawi TRC and be composed of six members with the following Terms of Reference (TOR):
(i) Review Technical Reports for Community Directed Treatment with Ivermectin (CDTI) projects in Malawi and make recommendations for improvement of reports and projects.
(ii) Advise the National Onchocerciasis Task Force (NOTF) and APOC Management on technical issues and measures to sustain and improve CDTI implementation in Malawi.
(iii) Review proposals for operational research on CDTI projects in Malawi before submission to APOC for funding.
(iv) To report the TRC’s work in TCC sessions

Following the request, a six member committee was instituted in 2011. After the committee was instituted, with technical and financial support from APOC, the Malawi TRC underwent an orientation by Prof Braide (Nigeria TRC Chairperson) in February, 2012.

Objective of the meeting

216. The first Malawi TRC meeting was convened to review 2012 Technical Annual Reports for the Thyolo/Mwanza and Extension Projects.

Official Opening

217. The meeting commenced with opening prayer offered by Dr Likaka. In his opening remarks, the Chairperson, Dr Kathyola, indicated that he was pleased that members were present to do the task delegated by TCC. He requested them to do thorough work so that TCC is not disappointed. He indicated that onchocerciasis is one of the blinding diseases, but fortunately Malawi oncho is not the blinding type. He commended Malawi for the significant efforts to control the disease through Mass Drug Administration (MDA) with Ivermectin in the endemic districts. He also observed the positive impact of the oncho control programme on other health programmes which are now also using the CDTI structure to reach as many people as possible with interventions and commodities. He finally requested the members’ dedication to the work before them and a fruitful review.

Review of Reports and consolidation of reviews by project

218. A total of 2 Technical Annual Reports from 2 CDTI projects were reviewed. The reports were shared among committee members with three members reviewing one report. The three reviewers harmonized their findings/comments and the summaries/recommendations agreed upon (as per attached documents). Reports of reviews were presented and discussed after which the committee arrived at decisions on acceptance or rejection of each technical report.

Summary of reviews

Thyolo/Mwanza CDTI Project

Reviewers’ assessment and conclusions

219. The report is well written. The project is performing well with good coverage, adequate funding by Government, and commendable achievement in integration. It has achieved a high level of stakeholder and community involvement and consistently achieved treatment targets. Participation of Health Surveillance Assistants in supervision is impressive and male to female CDD ratio is ideal. The project exhibits high potential for sustainability as the districts are including onchocerciasis activities in their District Implementation Plans (DIPs) and funds are allocated and released. All this together with the readiness of the government to integrate CDTI into PHC suggests that Onchocerciasis control and
management is sustainable in Malawi. The fact that Malawi is moving towards elimination is testament to the good work by all involved and to the leadership by the National Coordinator.

220. However, high numbers of absentees and refusals pose serious challenges that will affect coverage, effectiveness and sustainability if not checked.

221. TRC accepted the report with the following recommendations and suggestions for improving reporting and project implementation

Report related:

(i) Outcomes of advocacy activities should be explicitly stated.
(ii) Executive summary should contain information on critical project achievements and activities.
(iii) Specific actions taken as a response to TRC/TCC recommendations should be adequately explained.
(iv) There is need to do more analysis of the cumulative data and results so that the project shows learning from all the years of operation – there is insufficient focus on trends such that one does not get the impression that this is a report on a 16-year old project.

Project related:

(i) If the project is going to break through the seeming barrier of 82%-83% Therapeutic Coverage, it may have to conduct operational research to better understand and hence address absenteeism and refusals.
(ii) The whole area of Community Self-Monitoring needs to be revisited in the context of the Malawi primary health care delivery system – need to avoid setting up parallel systems while capitalizing on the principle of community participation and integration in monitoring.

Extension CDTI Project

Reviewers’ assessment and conclusions

222. The report is well written. The project is performing well though the coverage has stagnated at 82% since 2006. It is also enjoying adequate funding from Government and it has high numbers of trained staff. Integration with other programmes is working very well. Male to female CDD ratio is ideal at 1 to 1.5. However, high numbers of absentees and refusals pose serious problem that will affect coverage and sustainability if not checked.

223. TRC accepted the report with the following recommendations and suggestions for improving reporting and project implementation

Report related:

224. The few areas that have no information should be filled in the subsequent reports. The causes of refusals should be dealt with through Behavioural Change Communications.

Project related:

(i) The program must strengthen Community Self-Monitoring (CSM) or look for alternative approaches to CSM based on country capacity and sustainability concerns.
(ii) The project should continue reducing communities not reaching 80% Therapeutic Coverage (TC).
(iii) The project must indicate some best practices and lessons learnt.
(iv) The program should undertake operational research on absenteeism and refusals.

Meeting Recommendations

225. Since the financial contribution of Local NGDOs such as Tea Association of Malawi is not reflected in the financial report, it was recommended that NOTF should liaise with such Local NGDOs to provide information on their cash contribution towards oncho control implementation activities.

226. In view of the fact that there is only one member of staff at NOTF Secretariat, the committee recommended that the DPHS should appoint a Deputy Coordinator to strengthen national level capacity.

227. The next TRC Meeting will be held in February, 2014

TCC comments

228. TCC commended the Malawi Onchocerciasis Control Programme for controlling the disease to a point of elimination.

229. It was noted that the level of integration of CDTI activities with other programmes and the overall health system is commendable and may serve as learning model on how to achieve integration. The fact that Malawi Government contributes more than 90% to CDTI activities is commendable.

NIGERIA

Nigeria Technical Review Committee: Report of the 11th meeting (TRC11)

230. Prof Braide presented a report of the 11th meeting of Technical Review Committee Nigeria held in Calabar within the period July 15 to 19, 2013. The committee reviewed and accepted a total of sixteen Technical Reports from Abia, Anambra, Cross River, Edo, Enugu, Gombe, Imo, Jigawa, Kaduna, Kebbi, Kogi, Ogun, Taraba, Ondo, Osun, and Oyo. An update on extent of implementation of TRC 10 recommendations was given by National Coordinator. Jigawa SOCT Coordinator presented (on invitation) status of implementation of CDTI in the State. TRC observed that Jigawa CDTI was doing well by reporting accurate coverage figures, effectively treating nomadic populations and mobilizing adequate funding from the State Government. On request by Cross River SOCT, the Committee paid advocacy visit to the Commissioner and Permanent Secretary, State Ministry of Health.

231. Zonal Coordinators for Zones (A,B,C, D) presented reports on supervisory activities in the zones and flagged out the following actions to be taken by the SOCTs:

(i) Take control of drug requisition discussed (Enugu State).
(ii) Improve on planning and record keeping (all projects...in Ondo State coverage. Recorded during check is lower than figures in Technical Report).
(iii) Ensure proper handing over by health officers and CDDs (all projects).
(iv) Ensure the proper handing over to the new zonal coordinator (Zone B).
(v) Focus monitoring exercises on poor performing LGAs and communities.
(vi) Address problem of poor programme implementation (all projects).
(vii) Improve capacity of State and LGA staff.
(viii) Resolve reported high population figures (Ekiti State).
(ix) Train CDDs in communities and not in health centres (Gombe State).
(x) Increase duration of training (all projects).
(xi) Produce and place more ICE materials in communities.
(xii) Maintain accurate drug inventory (Plateau State).
(xiii) Follow up on promises of support made by State and Local Governments.

232. TRC acknowledged that by effectively co-reviewing Technical reports in TRC and conducting supervisory visits, NOCP officials and Zonal Coordinators can now easily verify information provided in Technical Reports.

TRC made the following recommendations:

**APOC**

(i) Review section on sustainability plan in the technical reporting format to capture not only availability of sustainability plan but also availability of work plan and extent of implementation of these plans.

(ii) Sustainability and elimination issues should be taken into account in revision of the reporting format as well as assessment form, given the change in focus from control to elimination.

(iii) Provide support for revival and up scaling of CSM and SHM.

(iv) Nigeria’s NOCP should be informed of the reasons why Kaduna epidemiological results were dropped from the publication on prospects of onchocerciasis elimination in the African region.

**NOCP**

(i) The Director, Public Health, should officially inform the NGDO Coalition of the appointment of the current NTDs national coordinator (who is also NOCP Coordinator).

(ii) Zonal coordinators should request projects to share their annual plans with them, copying the national office, to enhance adequate supervision of project activities by NOCP HQ and zones.

(iii) The C-zone coordinator should send a formal letter to NOCP HQs on the issues in Zamfara State for further action if his attempts at resolving them do not yield the necessary results.

(iv) NOCP should distribute hard copies of bulletin on Onchocerciasis to Key policy makers.

(v) the B-zone coordinator should write officially to the Carter Centre for support in synchronizing treatment activities at the Ondo-Edo border communities.

(vi) State Review meetings (for presentation/review of LGA reports) and Zonal Review meetings (for presentation/review of State reports) should be held regularly as this will provide additional opportunity to identify and sieve out inaccurate information usually contained in Technical Reports.

**Projects**

(i) Implement past recommendations from the previous monitoring and evaluation.

(ii) Implement CSM and SHM.

(iii) Train and involve teachers, NYSC members, religious and traditional leaders to assist in project implementation.
(iv) Train and involve more front line health facility staff and CDDs.
(v) Intensify advocacy to State and LGAs for release of counterpart funding.
(vi) Improve on drug inventory management.

233. TRC 12 will hold within the period February 17-21, 2014 in Calabar, Nigeria.

234. TCC noted the report, commended Nigeria TRC and recommended that:

(i) Nigeria TRC should consider documenting process and key issues tracked and addressed by TRC.
(ii) Exchange project visits should be made by programme officials in order to share best practices.
(iii) NOCP Bulletin circulated to policy makers should contain information on status of project performance and counterpart funding.

UGANDA

Uganda Technical Review Committee: Report of the 4th meeting (TRC4)

235. The report of the Uganda 4th Technical Review Committee meeting, held from 21st – 23rd August 2013, was presented by the Chairperson, Dr. Edridah M. Tukahebwa. The report is a review of technical reports from 7 projects for 2012 implementation year.

236. The presentation included key issues identified in reports of 5 CDTI and 2 Vector Elimination projects. Apart from one projects, Phase V which is in its second year of implementation with therapeutic coverage of 58%, the rest had rates above 70%. Also presented was status of an earlier approved research proposal, whose funds were sent to the APOC account of Ministry of Health (MoH) but the funds have not been released by the MoH. Eight research topics were also identified by TRC and presented to TCC.

TRC Recommendations:

(i) NOCP should strengthen training of CDDs and data retrieval in all CDTI projects.
(ii) CDTI projects should strengthen pharmaco-vigilance to track, manage and promptly report side effects during CDTI implementation especially in NTD multi-endemic areas.
(iii) TCC should review the APOC reporting format to allow capturing of two treatment cycles.
(iv) NOCP and partners should strengthen Post Treatment Surveillance in all the foci where treatment has been halted.
(v) In future, APOC approved operational research should be sent through WHO country office.
(vi) MOH and partners including APOC should consider provision of adequate facilitation for TRC members during meetings.
(vii) MOH and partners including APOC should consider recognizing and/ or rewarding the Simulium vector elimination teams for tremendous achievements made.
237. TCC noted the report and made the following recommendations:

(i) Research funds: At the time of proposal submission, indicate who the supplier (PI) is and give details for funds transfer where the funds would be sent if approved.
(ii) The reporting format will be reviewed to allow for inclusion of second round of treatment.
(iii) The government should take up the recognition of vector elimination team before it is brought to international body.
(iv) For TRC members' facilitation during 4th meeting, APOC has requested WHO country office to avail to them the country UN rates for reference and they will respond accordingly.
(v) APOC has approved a vehicle for Uganda and this procurement is in progress.
(vi) Phase V: This project is in its second year of implementation and TRC should not review the report.
(vii) TCC was concerned about Uganda’s decision to halt treatment for onchocerciasis without involving TCC/APOC. It was recommended that the deliberations from Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) and National Certification Committee (NCC) should be forwarded to APOC subject to TCC review and decision.

238. TCC thanked the TRCs of Cameroon, Malawi, Nigeria and Uganda for their commitment and cooperation through their experiences in setting up of Technical Review Committees in the countries be documented and shared with others.

DATE AND PLACE OF THE THIRTY-EIGHTH AND THIRTY NINTH SESSIONS OF THE TCC: Agenda Item 18

239. The 38th session of the Technical Consultative Committee (TCC38) is scheduled for 10 to 14 March 2014 and the 39th session from 8 to 12 September 2014, both in Ouagadougou, Burkina Faso.

CLOSURE OF THE SESSION: Agenda item 20

240. In his closing remark, the Director of APOC, Dr Roungou thanked all the TCC members for their remarkable achievements. He was pleased to note that after 15 years of absence from TCC, he found the same commitment of members with a lot of improvement in TCC’s processing, like online reviews and decentralization of the session to the countries. He observed that above all TCC remained a science base committee and promised his availability to continue the fight for the Programme to remain always a scientific based one.

241. Dr Roungou thanked all the TRC members in the countries for their achievements, especially the Nigeria TRC which has done a remarkable work. He commended Prof Eka Braide, Chair of the TRC of Nigeria for training TRC members in other countries. He also thanked the various sub-committees of TCC for their commitments.

242. Least but not the last, he thanked the interpreters for their availability and cooperation throughout the five-day session, an all the APOC colleagues for their commitment and dedicated work.
Annex 1. List of participants

37th SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE
Ouagadougou, 09-13 September 2013

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Annex 2: TCC37 Agenda

Opening
Adoption of the Agenda

Information

CSA: matters arising from the 140th and 141th sessions
TCC: follow-up of the key recommendations of the thirty-sixth session

Strategic and technical issues

Feasibility of elimination of Onchocerciasis infection and interruption of transmission:
(i) Elimination of Onchocerciasis with ivermectin in Africa
   a) Update on Epidemiological evaluations results: Chad, Equatorial Guinea, Ethiopia, Mali, Niger and Togo
   b) Delineation of treatment boundaries
   c) Concept Note on Elimination of onchocerciasis in all hypo-endemic areas by 2020
(ii) Entomological studies:
   a) Update on the delineation of transmission zones
   b) Update on black flies trapping and other studies related to Onchocerciasis

Revised Concept Note for the post 2015 period: TCC contribution to its finalization

Research on new control and surveillance tools by collaborating institutions:
(i) Update on Moxidectin and Target Product profile for drug for Onchocerciasis control via mass treatment
(ii) Update on the DEC patch test and Lohmann

Report on the last Mectizan Expert Committee Meeting
(i) “Filling the Gaps”: Operational Research for the NTDs, Bill and Melinda Gate Foundation funded NTD grant
(ii) Evaluation of the status of LF in areas with ivermectin distribution for Onchocerciasis, an operational research from the US Centers for Disease Control and Prevention

Protocol for the multi-country study on CSM
Protocol for Independent Monitoring of treatment coverage of CDTI Projects.
Remarks by Technical Advisors to APOC Management
Review of operational research

Management of APOC Trust Fund

Report on the financial management of APOC funded Projects

Reviews

Report on the review by the APOC Management of the financial content of 1st, 2nd, 3rd, 4th, 5th, 6th and 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th years projects progress reports as an introduction to their technical review

Review of New project proposals and 1st, 2nd, 3rd, 4th, 5th, 6th and 7th, 8th, 9th, 10th, 11th, 12th, 13th, 14th years annual technical reports of projects

Technical review Committee: Cameroon, Malawi, Nigeria and Uganda

Other matters

Date and place of the thirty-eight session of the TCC
Conclusions and recommendations of TCC37

Closure of the session
## Annex 3: Follow up of the key recommendations of the 37th Session of TCC

<table>
<thead>
<tr>
<th>Subject/Topic</th>
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<tbody>
<tr>
<td><strong>MATTERS ARISING FROM CSA 138TH AND 139TH SESSIONS AND JAF18</strong></td>
<td>TCC requested for the overall total amount of the 7.5% overhead cost for all the NGDOs and subsequently the amount required to reimburse the 12.5% overhead cost. The Director assured the Committee that the figures were being compiled and would be shared in the next TCC session</td>
<td>Estimate of overhead payments is based on allocations to CDTI which are not yet finalized for 2014. Will be made available for next session.</td>
</tr>
</tbody>
</table>
| **MATTERS ARISING FROM CSA 138TH AND 139TH SESSIONS AND JAF18** | The Committee encouraged APOC and CSA to devise means to motivate the MOHs to attend the JAF sessions. TCC was informed of the ongoing discussions at the CSA to visit countries as well as to mobilize more resources within the countries. | • The just ended RC session was used to talk to some ministers and request the support of the WHO Regional Director for Africa to support this advocacy.  
  * Country representatives at the expanded CSA session in July were sensitized and visits are planned to some countries by APOC Management.  
  • Proposals will be submitted to a few countries (Equatorial Guinea, Angola, DRC, Chad) to request their financial support to elimination in hypo-endemic areas |
<p>| <strong>NGDOs: MATTERS ARISING FROM THE NGDO/NTD NETWORK MEETING</strong> | The Committee encouraged APOC Management to quickly find a replacement for Dr Stephen Leak, who retired and was the Officer in charge of operational research | There was an arrangement to transfer someone from TDR but this was abandoned recently. The whole process is being re-launched therefore and the recruitment would be concluded by early next year |
| <strong>TCC: FOLLOW UP OF KEY RECOMMENDATIONS OF THE THIRTY-FIFTH SESSION</strong> | TCC suggested that the recommendations and follow up actions should be circulated to the Members prior to the TCC meeting to allow enough time for the Members to review the actions | This was not achieved but promise is made that it will be implemented for the future sessions |
| <strong>Elimination of Onchocerciasis with ivermectin in Africa / a) Revision of ivermectin treatment boundaries for the purpose of elimination-procedures and implementation plan for 2013-2014</strong> | TCC recommended accelerating the finalization of the mapping and the delineation work to include the at risk areas as soon as possible in the face of achieving elimination in at least 80% of the countries before 2025 | Mapping of hypoendemic zones is completed in Cameroon (Littoral and South regions), Burundi, partially done in Chad and will be conducted soon in Equatorial Guinea (mainland) and Cameroon (East and Centre regions). Planning in going on for the completion before end of first quarter of 2014 in Ethiopia and Nigeria and Mozambique. Entomological delineation is also |</p>
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<td>b) Evaluation of epidemiological trends towards elimination (phase 1A) - review of evaluation results for 2012 and plan for 2013</td>
<td>TCC discussed the disproportionately high nodule prevalence seen in CAR and asked APOC management to look into the details during the final analysis of the data. Following a comprehensive discussion on the impact of LF/oncho endemic overlay in achieving elimination, TCC proposed to have clear information on LF and to synchronize the information in the interest of elimination goal. The Committee reiterated that the feasibility of using nodule prevalence as a rapid assessment method to assess the decline in infection levels after ivermectin treatment should be considered. The committee was informed that the results of the final analysis of the nodule data that have been collected during the epidemiological evaluations over the last few years, and the relationship between the prevalence of nodules and the prevalence of MF after many years of ivermectin treatment will be presented in the next session.</td>
<td>Being boosted. Presentations will be made under agenda item 5. Will be done and presented at TCC38. This is work in progress between APOC and AFRO/NTD. This is work in progress that will be presented at TCC38.</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / a) Update on delineation of transmission zones</td>
<td>(i) The detailed cytotaxonomic analysis should not be done in the context of an academic exercise since it is time consuming but should be done in the context of determining possible migratory patterns and hence assist in the delineation of transmission zones. (ii) The utility of the exercise is indicated by the current results but it is important that discussions are held with members of the EVE unit of APOC such that sampling is done to improve the use of the data for decision making. (iii) It will also be important to examine molecular methods such as micro-satellite analysis for delineation of transmission zones.</td>
<td>The presentation under 5.(ii) a. will show how this recommendation has been taken into account. Discussions are held and a comprehensive approach is adopted as recommended. The approach is being discussed with different scientists samples in carnoy will be used to assess the efficacy of the micro-satellite method.</td>
</tr>
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<td>Elimination of Onchocerciasis with ivermectin in Africa /</td>
<td>The Committee recommended that the protocol be fine-tuned by making it simpler and practical to fit its purpose.</td>
<td>A protocol taking into account the observations/ recommendations of the TCC is prepared and will be...</td>
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<td>PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE</td>
<td>PATH to coordinate with APOC and WHO/TDR to ensure head-to-head evaluations are done with Ov16 and DEC patch, or at a minimum compatible study designs are used</td>
<td>presented under agenda item 10.</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / Elimination of O. volvulus infection: New diagnostics of PATH</td>
<td>(i) TCC commended the Joint Working Group for their work, however, TCC requested for clarity on how implementation and sustained coordination would be tackled, how to convert decisions into actions and what are the means of funding; (ii) TCC suggested to have a platform to make consensus and concerted decisions for elimination of both diseases; (iii) TCC recommended that LF-Oncho Joint Working Group created should become a link between RPRG and TCC, and that the decisions made by the Group be endorsed by TCC and RPRG. In addition TCC confirmed the membership of the JWG; (iv) The TCC did not find necessary for an MOU to be signed regarding the group establishment and operation. Rather, the group should establish guidelines for its operation reporting for both the TCC and RPRG about its activities and recommendations</td>
<td>Waiting for the release of DEC patch for implementation</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / COLLABORATION BETWEEN AFRO/NTD AND APOC</td>
<td>(i) TCC concurred with the conclusions and recommendations of the review committee; (ii) TCC stressed the need for publication of the results of the studies; (iii) TCC agreed with the CSA recommendation that TDR go ahead and identify donors, a manufacturer and a license holder; (iv) TCC noted the JAF's recommendation</td>
<td>Will be done for the revised version submitted by APOC Management</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / APOC AND TDR SUPPORTED RESEARCH / Update on moxidectin development</td>
<td>Details of the implementation will be provided during the presentation on agenda item 7 (i).</td>
<td></td>
</tr>
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**Subject/Topic:** PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE

**Action to be taken:** PATH to coordinate with APOC and WHO/TDR to ensure head-to-head evaluations are done with Ov16 and DEC patch, or at a minimum compatible study designs are used

**Status of implementation:** presented under agenda item 10.

**Subject/Topic:** Elimination of Onchocerciasis with ivermectin in Africa / Elimination of O. volvulus infection: New diagnostics of PATH

**Action to be taken:** (i) TCC commended the Joint Working Group for their work, however, TCC requested for clarity on how implementation and sustained coordination would be tackled, how to convert decisions into actions and what are the means of funding; (ii) TCC suggested to have a platform to make consensus and concerted decisions for elimination of both diseases; (iii) TCC recommended that LF-Oncho Joint Working Group created should become a link between RPRG and TCC, and that the decisions made by the Group be endorsed by TCC and RPRG. In addition TCC confirmed the membership of the JWG; (iv) The TCC did not find necessary for an MOU to be signed regarding the group establishment and operation. Rather, the group should establish guidelines for its operation reporting for both the TCC and RPRG about its activities and recommendations.

**Status of implementation:** Waiting for the release of DEC patch for implementation.

**Subject/Topic:** Elimination of Onchocerciasis with ivermectin in Africa / COLLABORATION BETWEEN AFRO/NTD AND APOC

**Action to be taken:** (i) TCC concurred with the conclusions and recommendations of the review committee; (ii) TCC stressed the need for publication of the results of the studies; (iii) TCC agreed with the CSA recommendation that TDR go ahead and identify donors, a manufacturer and a license holder; (iv) TCC noted the JAF's recommendation

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**Subject/Topic:** Elimination of Onchocerciasis with ivermectin in Africa / APOC AND TDR SUPPORTED RESEARCH / Update on moxidectin development

**Action to be taken:** Details of the implementation will be provided during the presentation on agenda item 7 (i).
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<td>Elimination of Onchocerciasis with ivermectin in Africa / APOC AND TDR SUPPORTED RESEARCH / Nodding syndrome in the North East of DRC</td>
<td>that TDR seek funding to allow completion of the development and TCC considered it as an important element for elimination of onchocerciasis.</td>
<td>Not yet done. Clarifications to be provided by Dr Kuesel</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / REPORT ON TCC AND APOC MANAGEMENT MISSION TO ETHIOPIA</td>
<td>TCC encouraged Dr. Mandro to prepare a research proposal for submission to APOC which TCC will review in September</td>
<td>APOC Management assisted Ethiopia to organize a partners’ meeting for the launching of the two new projects based on the strategy proposed by the country in their project proposals</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / REPORT ON THE MECTIZAN EXPERT COMMITTEE MEETING</td>
<td>TCC strongly felt that it is necessary to help the country at this critical moment to determine the implementation strategy as some partners are forcing to introduce twice-yearly treatment</td>
<td>Chair to decide and organize</td>
</tr>
<tr>
<td>Elimination of Onchocerciasis with ivermectin in Africa / REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA / CAMEROON a) Epidemiology of ocular attack of onchocerciasis in the forest areas of Cameroon</td>
<td>TCC requested the investigators to review the proposal taking into consideration their observations and send it back to APOC Management for review during the next TCC</td>
<td>Revised proposal not yet received</td>
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<td>Elimination of Onchocerciasis with ivermectin in Africa / REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA / CAMEROON a) Epidemiology of ocular attack of onchocerciasis in the</td>
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<td>forest areas of Cameroon</td>
<td>In conclusion, TCC recommends that the three protocols on Evaluation be combined into a single protocol with research questions put together</td>
<td>Revised proposal received and submitted for review by TCC.</td>
</tr>
<tr>
<td>REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA / b) Evaluation of onchocerciasis community directed treatment strategy in Cameroon c) Evaluation of the approach &quot;Community Distributor&quot; in onchocerciasis control in Cameroon d) Evaluation of health competencies of the populations in Cameroon regarding onchocerciasis</td>
<td>TCC recommends that the research team review the protocol, taking into account their observations and resubmit it to the next TCC. It is necessary for the team to be assisted by TCC members for the drafting of this protocol TCC recommends that APOC Management explore appropriate ways and means to set up a team in DRC for the drafting of operational research proposals</td>
<td>Revised proposal not yet received</td>
</tr>
<tr>
<td>REVIEW OF OPERATIONAL RESEARCH PROPOSALS INCLUDING THE RESEARCH ON THE IMPACT OF IVERMECTIN ON LOA LOA / DEMOCRATIC REPUBLIC OF THE CONGO (DRC) a) Study on the causes of poor women involvement as Community Directed Distributors in health areas of Western Kasai in Democratic Republic of Congo b) Study on the therapeutic coverage of CDTI in the mining health areas of Kamonia, Mutena and Kamuesha of the Kasaï CDTI project c) Study of the reliability of therapeutic coverage in the elimination context of Onchocerciasis in Democratic Republic of Congo</td>
<td>TCC requested APOC management to find a way to build capacity in drafting operational research proposals in DRC</td>
<td>Revised proposal not yet received</td>
</tr>
<tr>
<td>DESK REVIEW ON</td>
<td>The committee advised that CSM should</td>
<td>Newly launched projects' Managers</td>
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<tr>
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<tr>
<td>COMMUNITY SELF MONITORING (CSM)</td>
<td>be incorporated in new projects at the start, to become a culture within the projects. The committee also agreed that there is need to relook the CSM activity as a whole and review the concept</td>
<td>have been advised to include CSM at the start and a protocol for a multi-country study has been developed. A presentation will be made under agenda item 9.</td>
</tr>
<tr>
<td>SUSTAINABILITY EVALUATION IN THE CONTEXT OF MOVING FROM CONTROL TO ELIMINATION</td>
<td>Tools for sustainability evaluation should be revised to make them adaptable and the use of the strategy in a more focused way as there is need for supervision and monitoring methods to continue till the programme ends</td>
<td>A committee will be set up to guide/produce revised guide and tools.</td>
</tr>
<tr>
<td>PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE</td>
<td>The Committee recommended that the protocol be fine-tuned by making it simpler and practical to fit its purpose</td>
<td>A protocol taking into account the observations/recommendations of the TCC is prepared and will be presented under agenda item 10</td>
</tr>
<tr>
<td>REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS</td>
<td>(i)To undertake advocacy visit to traditional donors as well as expand donor umbrella by encouraging countries to become donors and approaching new donors (Arab states); (ii)To carry out high level advocacy visit to countries to mobilize resources internally needed for sustainability and activity implementation; (iii)To encourage governments to pay their contributions (financial tool being finalized by APOC for monitoring Government financial contributions); (iv)To encourage countries to raise resources by holding forums under the auspices of the MOH or MOF, engaging philanthropists, local firms and companies and good will ambassadors; (v)To repackage onchocerciasis elimination advocacy message as a solution to social and economic growth for the nation</td>
<td>Plan is prepared and discussions ongoing with the Fiscal Agent will address the concerns</td>
</tr>
<tr>
<td>ETHIOPIA Assosa CDTI Project proposal</td>
<td>(i)TCC recommends continued dialogue between the Country, APOC and the Carter Centre to explore possibilities for additional funding for the Assosa project; (ii)There is an urgent need for Ethiopia to take steps to revive the National Onchocerciasis Task force (NOTF) to provide the required leadership at central level; (iii)Present a realistic period in which to accomplish the various activities outlined. For instance, 3 weeks are allocated for KAP but it is not clear whether this includes the data processing, analysis and</td>
<td>Recommendations shared with the country and are being followed up by APOC focal person for Ethiopia</td>
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<td>Report production; (iv) Include perceptions towards the programme and the implementation process and towards voluntarism in the KAP; (v) Include the cost for the KAP in the budget for 2013; (vi) Factor in periodic evaluation activities and using existing baseline data as the benchmark</td>
<td></td>
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<tr>
<td>Contribution of TCC to a special issue of the African health monitor on APOC</td>
<td>TCC suggested the following topics for consideration: (i) Moxidectin as a potential drug for MDA in general; (ii) CDI in curriculum of nursing institutions and medical institutions - Capacity building, impact assessment – APOC service to institutions; (iii) The impact of the recommendations and guidelines of SAEs to tackle loa loa; (iv) The relationship between onchocerciasis and epilepsy; (v) Success story of government contributions from control to elimination of Onchocerciasis in the African continent; (vi) Companions in disease control: The contribution of African Philanthropists in onchocerciasis elimination in Africa</td>
<td>Contributors are being identified but it seems unrealistic to have it ready on time</td>
</tr>
<tr>
<td>b) Review of TCC duration</td>
<td>TCC requested APOC Management to reevaluate the matter according to the agenda items and make the final decision</td>
<td>Still under discussion</td>
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<td>TRC in DRC</td>
<td>TCC encouraged creating a TRC in DRC and requested the attendance of TCC members at the initial stage of the TRC</td>
<td>Waiting for the nomination of the TRC members promised by the ministry of health</td>
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| Feed back of the sub committee on Angola | 1. The group suggested the following actions: (i) To make a detailed documentation of all visits and attempts to visit the country, listing the major impediments for more positive outcomes; (ii) APOC management should take the necessary measures to urgently reinforce the technical support team in the country as a way to improve the country program and collaboration with the program management at the national and provincial levels; (iii) In view of the partners forthcoming visit to the country in June 2013 initiate | - Documentation of most visits was done in 2010 and will be updated;  
- Initiative to strengthen technical support to Angola was rejected by the immigration department;  
- The planned visit failed because the MOH proposed another period than the one agreed by the team members |
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<tr>
<th>Subject/Topic</th>
<th>Action to be taken</th>
<th>Status of implementation</th>
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<td>preliminary contacts with the Angolan authorities and other partners involved at the regional and global levels; (iv) High level advocacy group (APOC, WHO-AFRO-NTD, NGDOs) will try to meet with the Angolan Minister of Health during the upcoming World Health Assembly next May, in Geneva. In such a meeting, the minister will be explained about the importance of an improved engagement of the country with partners in implementing interventions for Oncho elimination. Mention will be made to the Memorandum of Understanding signed by the Ministers of Health of the African region during the Regional Committee meeting in Luanda in November 2012; (v) APOC management should make a formal approach to the Minister of Health of Angola with a letter addressing the issue.</td>
<td><em>It has not been possible to meet with the Angola Minister during the last World Health Assembly. Director/APOC may update us on any progress made during the just ended RC.</em></td>
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<td>Twice yearly treatment</td>
<td>TCC requested the subcommittee on alternative approaches to provide an update on the issue as soon as possible, based on scientific and technical evidence for TCC stand. The subcommittee should have consultation with APOC Management on how to come up with a strategy/plan or a concept paper that TCC will adopt. TCC also suggested that all members should provide suggestions to the subcommittee on matters related to twice yearly treatment.</td>
<td><em>The subcommittee members may need to report.</em></td>
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