REPORT OF THE SIXTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC)
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Provisional agenda item 6

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Erratum

Table under point 5 on page 21 (english version)

GABON: First year budget recommended, please read 137,500 dollars US and not 108,000 dollars US; hence the total should read 1,365,466 dollars US and not 1,335,966 dollars US.
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1. OPENING

1.1 Opening remarks

The meeting was opened by Dr David Heymann, Executive Director of the Communicable Diseases Cluster, who welcomed participants to Geneva on behalf of the Director-General. After a brief introduction of the new changes in WHO, Dr Heymann concluded that APOC fulfils many of the new DG’s objectives for the Organization: alleviating poverty, being firmly established into the UN system, enjoying a dynamic partnership with industries and being highly decentralized in its operation. He reminded participants that the planned debate on Health Sector Reform during this session was important not only to APOC but to WHO at large and was looking forward to its conclusions and recommendations.

1.2 Update on the 79th and 80th sessions of the CSA

Dr Thylefors of WHO/PBD and CSA member, briefed the Committee on issues relevant to the TCC and discussed at the above meetings. These include:

(i) CSA concerns over the sustainability of APOC-funded CDTI projects, especially in relation to the largely over-estimated (and therefore non-sustainable) financial support requests to APOC that are still coming from many NOTFs. TCC, while commending the remarkable scrutiny with which APOC management has revised budgets for approved projects so far, considers it imperative that more advocacy and assistance be provided to NOTFs in the design and implementation of CDTI projects likely to be sustained beyond the period of external funding.

(ii) Joint visits to member countries by APOC partners: these visits were welcomed and encouraged by CSA. However, given that various “overseeing” mechanisms for country visits were being planned, e.g. independent monitoring, financial monitoring, internal and external auditing, mid-term and final evaluation, it was suggested that these be seen primarily as a partnership development exercise and a support mechanism to projects, and not as a substitute to any of the above. To the extent possible, and whenever possible, participation in such visits should be extended to all APOC partners.

(iii) The involvement of local NGDOs in APOC operations: CSA requested the NGDO Group for ivermectin distribution to determine criteria for acceptance of national/local NGDOs for consideration by CSA and APOC.

1.3 Report of the 12th meeting of the NGDO Coordination Group for Ivermectin Distribution

Dr D. Etya’alé, the NGDO Coordinator, gave a report of the 12th meeting of the NGDO Coordination Group held in Haywards Heath, UK, on 29 - 30 July, 1998. Activities carried out by the Group and its Coordinator since the 11th meeting (March 1998) are summarized below.

1.3.1 Workshop on Community-Directed Treatment with Ivermectin, Nairobi, Kenya

The last of these introductory workshops, the Nairobi workshop, brought together 57 participants from Ethiopia, Kenya, Liberia, Mozambique, Southern Sudan, the NGDO community and the World Bank. The main objectives of the workshop, the same as in the previous ones, were to
clearly present the APOC programme philosophy, mandate and strategy to the participants, seek their advice and collaboration on ways to establish sustainable CDTI in their respective countries and work out a timetable of priority activities for each country. Also, like in previous workshops, the facilitating team was drawn from both APOC management and the NGDO Group, another practical and concrete way of building partnership. The workshop, however, was unique in that, except for Southern Sudan, all the participating countries were newcomers to both mass ivermectin treatment and APOC CDTI strategy and operations, and most were yet to provide definite answers to questions regarding the distribution and magnitude of onchocerciasis.

The following urgent needs were identified at the workshop: i) plan and/or complete REMO - Ethiopia, Kenya, Liberia and Mozambique; ii) identify suitable partner NGDOs and establish National Onchocerciasis Task Force (NOTFs) and, depending on REMO results, iii) develop National Plans and Project Proposals for submission early next year (1999).

1.3.2. **Fifth session of the Technical Consultative Committee (TCC5)**

The NGDO Coordinator was the main rapporteur of the 5th session of the Technical Consultative Committee (TCC) which was held in Ouagadougou on 30 March - 2 April 1998, during which TCC received and reviewed two progress reports from Uganda and Malawi on CDTI Projects funded by APOC, one National Plan and 13 Community-Directed Treatment with Ivermectin (CDTI) Project Proposals from Equatorial Guinea, Nigeria, Uganda and Tanzania; and one Vector elimination Project Proposal from Equatorial Guinea. Of these, three CDTI Project Proposals did not meet TCC’s requirements and were rejected for re-submission.

1.3.3. **Sixteenth In-House Ivermectin Committee meeting**

Held in Geneva on 7 May 1998, under the chairmanship of Dr Eric Ottesen, CTD/FIL, the meeting made a comprehensive review of current and potential future usage of ivermectin. This included on-going TDR research using ivermectin, namely on the economic impact of onchocerciasis skin disease, ways to optimize community-directed treatment of onchocerciasis and lymphatic filariasis, and report their effectiveness; a summary of all the studies (16) using ivermectin alone or in combination with albendazole or DEC for lymphatic filariasis; and discussions on the availability of ivermectin for diseases other than onchocerciasis, particularly for lymphatic filariasis.

The issue of the future of the In-House Ivermectin Committee was also discussed, given the already well established safety of ivermectin administration as currently being carried out in control programmes in Africa and Latin America. It was agreed that the Committee would be maintained but function henceforth on an ad-hoc basis, to address specific needs or unresolved issues, such as those related to the safety of combination drug treatment involving ivermectin, albendazole and DEC, or the safety of ivermectin use during pregnancy.

1.3.4. **Mectizan® Expert Committee (MEC) Meeting**

This first MEC session for 1998 was held in Atlanta on 28 - 29 May 1998. Matters discussed included an update on CTD/TDR clinical trials with ivermectin, a special presentation on the prevalence, distribution and control perspectives of Lymphatic Filariasis in Africa, a special report on ivermectin treatment in Nyankunde, Eastern DRC (ex-Zaire), and issues related to Mectizan® procurement, delivery and safety, in APOC and OCP countries. Concern over the latter stemmed from recent news of tablet loss, resurgence and increase in drug pilferage in some countries, all this in the
context of the ongoing transition from 6mg to 3mg tablets and the necessary, but delicate, integration of Mectizan® procurement and delivery into some of the existing systems (e.g., central stores). Solutions envisaged included a quicker circulation of relevant information among all concerned, a better coordination of both investigative and corrective actions required, and stepping-up advocacy to the highest health authorities in endemic countries.

Conclusions and Recommendations of the 12th NGDO meeting relevant to TCC included:

(i) Preliminary figures obtained from members of the Group indicating that during the first semester of 1998 NGDO-supported ivermectin treatments have been as follows: 8.2 million in APOC countries, 0.7 million in OCP countries, and 0.1 million in OEP countries. It is estimated that by the end of 1998 these figures will be 16.5, 1.3 and 0.36 respectively.

(ii) The renewed request made to all members (including Mectizan® Donation Program) to provide more accurate figures of the overall financial value of their input into onchocerciasis control programmes in APOC countries, in order to demonstrate its importance at JAF4. Current figures, estimated at around US $ 6 million, represent the single largest contribution to the support of ivermectin treatment in APOC countries and could still be an underestimation of the Group’s real input.

(iii) The renewed request by the Group to be better informed by TDR on onchocerciasis operational research issues. In order to promote closer association between the work supported by the Group and that of TDR, it was agreed that the NGDO Coordinator would circulate the TDR Task Force annual workplan to all members, and the Director of OCP and acting Director of APOC would approach TDR to renew the request for representation from the NGDO Group in the appropriate Task Force(s) as had been past practice.

(iv) The concern that TCC and JAF reports may not be receiving wide and timely circulation, especially in the field, and the recommendation that APOC Management send several copies to the National Coordinator for distribution to all NOTF members.

(v) The great concern over the recent losses of Mectizan in the field and the recommendation that every effort be made to minimize future losses. The Group welcomed the steps already taken by OCP/APOC to address this problem, the draft inventory management questionnaire prepared by Africare, and proposals for criteria and conditions concerning the consignment of Mectizan prepared by MDP. Members of the Group also agreed to request their field personnel to ensure that the security and accountability of Mectizan at all levels is properly addressed within the NOTF. A working group was set up to ensure that these matters are followed-up.

(vi) The need to further clarify the modalities of future roles and involvement of the Group in the transfer of responsibilities to OCP countries up to closure of OCP and beyond. The Group therefore requested OCP Management to facilitate contacts at country level, and in relation to the proposed Centre for Integrated Disease Surveillance and Control to support the sub-region.

(vii) The concern by the Group over the administrative burden on field personnel to provide a variety of reports, and the agreement to ask them to provide a complete inventory of all reports presently required of them, for consideration at the next meeting. In addition, the Group recommended that the TCC propose minimum reporting requirements for APOC and that MDP to do the same.
The request by the Group that feedback be provided on the proposed independent monitoring missions to assess progress towards CDTI due to take place shortly in Sudan, Nigeria and Uganda, so that lessons learned may be applied also to routine monitoring.

A number of administrative issues which are impeding the smooth running of the programmes in Uganda and Nigeria and which were brought to members’ attention, and the recommendation that these be followed-up. Those issues which were general and could not be resolved at NOTF level could then be put in writing to APOC management, with a copy to the Coordinator for follow-up.

The recommendation that the excellent presentation made by Jeff Watson of CBM, Nigeria on the involvement of a local NGO in ivermectin distribution be further developed to include guidelines on the eligibility of local NGOs for inclusion in APOC, and finalized by a working group for inclusion at the 4th session of the Joint Action Forum (JAF4). A representative of the local NGO concerned, MITHOSATH, Nigeria, will be encouraged to attend the JAF.

The recommendation by the Group that SSI and HKI obtain information of any NGOs known to be working in the onchocerciasis affected areas of Mozambique, and that HKI consider hosting a briefing meeting in-country of those NGOs who might be interested in starting distribution programmes.

1.4  **Follow-up on the recommendations of the 5th session of the Technical Consultative Committee (TCC5)**

Dr A. Sékétéli, Programme Manager APOC, updated the TCC on actions taken in relation to the recommendations of the TCC5, as well as on the current status of APOC operations.

1.4.1. **Status of approved National Plans and Project Proposals for 1998**

For the 1998 budget, a total of twenty-six Letters of Agreement have been prepared by APOC Management. This represents a firm commitment of US $5,212,346 to be paid from the APOC TRUST FUND. On average, budget revision by the APOC Management of the 26 approved proposals has resulted in a 34.1% reduction. This could indicate that the budgets of most Project proposals submitted to APOC are still greatly inflated.

1.4.2. **Malawi CDTI project**

Participatory monitoring conducted by a team from the World Bank in 10 communities in the Project area confirmed that CDTI activities in Thyolo and Mwanza had been greatly delayed and that the Project administrative and financial management needed urgent strengthening. In particular, the Project could not afford to run without an accountant much longer, and a new one needed to be appointed by the Malawi Government as a matter of priority. The budget for Year 2 of the Project had been revised as requested by the TCC, by APOC Management, in consultation with the NOTF.

1.4.3. **Uganda Vector elimination projects**

As requested by TCC5, a revision of the original proposal for the vector elimination in Itwara focus and a review of a proposal for further feasibility studies in the Mpamba-Nkusi focus were carried out by APOC Management, in close consultation with the NOTF Uganda. Professor Molyneux and the
Chairman of the TCC. The resulting total budget of US $134,477 is a significant saving from the original approved US $162,821 for Itwara focus alone. Accordingly, the Letters of Agreement have been signed and funds will be released for activities to start in September (1998) for both Itwara and Mpamba-Nkusi foci.

1.4.4. Tanzania vector elimination Project (Tukuyu focus)

The NOTF Tanzania has finally communicated to APOC Management the completed list of all Tanzanian Vector elimination team members, and provision has even been made for an external consultant. As a result of these positive developments, the Letter of Agreement has been prepared and signed, and field activities related to vector elimination in Tukuyu focus are expected to start shortly.

1.4.5 Updating and use of REMO results

A workshop was organized in Nigeria on 6-10 June 1998, to address concern expressed by the TCC in its previous sessions (see TCC5 report, section 4.5.1.) regarding updating and use of REMO results in some countries. The main objective of the workshop was to review with NOTF (Nigeria) partners the current REMO map of Nigeria, to integrate additional independently validated REMO data into the GIS, to analyze the data and refine the map where possible in order to reduce "yellow" areas and, more importantly, to secure an official approval and recognition of the map by the NOTF, which was achieved for most endemic areas except for a few where further review and validation was deemed necessary by the workshop. A similar workshop is being planned for Cameroon.

1.4.6 Current status of impact assessment activities

Further to the approval by the CSA of the timeline of impact assessment activities for 1998 through 1999 (see TCC5 Report, section 5.2), a workshop was organized in Douala, Cameroon, from 3-16 May 1998, by APOC Management and the two Coordinators of this important Project, Professor E. Braide and Dr M. Boussinesq. Other participants (25 in all), included facilitators and the four teams of scientists that had been previously identified. Each team consisted of a dermatologist, an ophthalmologist, an entomologist and a social scientist.

The Douala workshop was preparatory to all subsequent activities on impact assessment and its main objectives were to allow all team members, coordinators and facilitators to know and interact with each other, but more importantly to:

(i) review and revise existing protocols, prepare a new protocol for socioeconomic study and finalize them;

(ii) undergo relevant trainings, carry out a pilot (field) exercise, and prepare a time plan for carrying out the studies in selected sites within APOC area of operation.

The first round of studies, aimed at collecting baseline data, have been completed in some sites and still ongoing in others due to delays in starting operations in the latter. As a result, a second workshop for the analysis of data, initially planned for September 1998, will convene at a later date (early 1999).
2. TECHNICAL AND FINANCIAL REVIEW OF FIRST YEAR PROGRESS REPORTS OF APOC-FUNDED PROJECTS

2.1 Nigeria

2.1.1 Cross River State 1st Year progress report and 2nd Year budget proposal

Support of this project by APOC Trust Fund was initiated in July 1997. The four LGAs viz: Akampa, Boki, Ikum and Obanliku that were originally selected for the first treatment cycle became five following the splitting of Ikum LGA into two, Ikum and Itung. Alongside these APOC-supported LGAs, nine others are also distributing with UNICEF support. The number of people treated in the project area was 133,870 (January - June 1997) and 116,562 (January - June 1998) making a total of 250,432 people treated in the first year. Given that no report was available for Itung LGA this figure is probably less than what was actually achieved.

Activities carried out during the first year of the Project were adequately reported. These included advocacy community mobilization and H/E, intersectorial links with local NGOs and other government sectors, cross-border collaboration, training, monitoring and supervision, cross validation and refinement of REMO data carried out by Professor Nwoke with funding from UNICEF.

Regrettably, the tables of coverage, people treated, population and eligible population are very confusing and cannot be used to compare yearly coverage, due to different denominators. The same applies to the other summary tables on monitoring, training etc.

The strengths of this first year Project implementation can be summarized as follows:

- the high acceptance of Mectizan in the Project area;
- the fact that selection of CDDs was generally done by the community: where the community leader’s opinion dominated, resulting in biased selection, there were problems of ineffective CDDs;
- the intersectorial links established with local NGOs and other government sectors was a very interesting and innovative move and could certainly lead to some measure of sustainability;
- the cross-border “community initiated ivermectin treatments” was also a remarkable achievement, given the current tension existing between Cameroon and Nigeria governments. Six communities in Cameroon were thus treated.

With respect to constraints, the main two identified were the weak PHC infrastructure in the Project area and the late disbursement of APOC funds to the Project sites, both of which were considered a hindrance to CDTI implementation.

Based on this first year experience of the Project, the following recommendations were made with the view to strengthen future implementation of the Project:

(i) NOTF should enhance and sustain advocacy at all levels of policy makers.

(ii) APOC should create a forum of NOTFs for interaction on trans-border cooperation.

(iii) NOTF should streamline the procedures for disbursement of APOC funds to Project sites.
TCC after review, considered that overall, this was a well written report with some interesting observations and recommended its approval as well as that of the 2nd year funding of the project, after appropriate revisions to its proposed budget.

Note: Cross River State Extension Proposal

Alongside the first year progress report, TCC also reviewed a proposal for the extension of the existing Project from the current 5 LGAs to a total of 15 LGAs. The additional LGAs thus being added comprise 71 health districts, 818 communities, with a total population of about 0.5 million persons.

TCC considered that despite the fact that this proposal had been submitted separately, it was actually an amendment of the original proposal approved for funding in 1997 and was recommended for approval as such. APOC Management must ensure, however, that the following requirements are met before funds for Year 2 are released to the project:

(i) The NOTF must submit the proposal with a full 5-year projection and a complete 5-year budget (beginning with 1997).

(ii) The resubmitted revised 5-year budget should reflect the budget approved for the first year and refer to the new revised budget approved for the second year. The current second year budget submitted by the NOTF amounts to US$ 223,220.

2.1.2. Kaduna State 1st Year progress report and 2nd Year budget proposal

The Kaduna Project was approved in April 1997, but funding was available only in October the same year. Ivermectin distribution in the Project area in the framework of APOC activities, began in February 1998. In 1997, prior to APOC funding, 285,642 people had received treatment in 16 LGAs. The main achievements of the Project since its launching are as follows:

Five LGAs were selected for the change to CDTI in the reporting period:

- 111,915 persons were treated with a coverage of 80%;
- 10 SOCT personnel were trained in CDTI;
- 114 LOCT personnel were trained (81% of objective);
- 2,147 CDDs were trained (155% of objective).

In all the 805 communities involved in CDTI activities, 805 (100%) CDDs were selected by the communities themselves. Although CDTI had been initiated in the entire Project area only 435/805 communities had been treated at the time of reporting. Though this could easily be inferred, there was no clear indication in the report that treatments were still ongoing. There were, however, some inconsistencies. For instance, 435/805 communities were reported to have received treatment. In the same report it was mentioned that 622/805 villages collected ivermectin from the nearest health centre, 579/805 contributed in cash or kind.

Several constraints of interest were mentioned in the report, each with a potential to impact negatively the success of the project: the unreliable supply and the scarcity of fuel in the area, the perception of APOC as a rich programme and the resulting attitude of Project personnel vis-à-vis its operations, and the increased workload of health workers.
The financial review of this project could not be done because of insufficient information available in the report on both the first year of activities and the proposed budget for the second year.

TCC recommended the approval of the first year progress report of this project as well as the proposed implementation plan for the second year. Further release of funds to the project, however, should be deferred until the following conditions have been met:

(i) APOC Management should obtain clarification on the inconsistencies in treatment figures and other related data;

(ii) a full and satisfactory financial report must be completed and sent to APOC Management;

(iii) fuller explanations of treatment objectives and budget line items should be given to APOC Management. The current second year budget submitted by the NOTF amounts to US$91,475.

2.1.3. Kogi State 1st Year progress report and proposal for project expansion (Year 2 - 5)

This report is for a Project approved in April 1997 to treat only five of the 21 LGAs in Kogi State. TCC noted that during this session it was to review a ‘new’ proposal from Kogi to expand CDTI treatment strategies into the remaining 16 LGAs. TCC decided that the current Kogi project (this first year report) and the ‘new’ proposal had to be viewed as the same project (i.e. not as two separate five-year proposals but rather as an amendment to the currently approved project).

TCC noted the marked increase in treatments provided in Kogi State in 1997 (511,074 treatments in 16 LGAs compared to 213,959 treatments in 1996), most of these supported by SSI/MOH. It was also noted that there were apparent delays in APOC-supported treatment activities due to late arrival of funds: forty-seven thousand treatments were reported for one of the APOC funded LGAs in 1997, but no treatment data for the other four supported LGAs were available. An earlier report submitted to APOC this year (1998) showed 126,014 treatments in APOC-supported areas of Kogi State.

TCC noted progress made in advocacy efforts, including radio and TV usage. The high achievements in training (5 times the number of CDDs trained over the original plan) suggested better planning was needed to set more realistic training goals for the second year. TCC wondered about the differences between SSI posters and NOTF posters for health education activities, given the understanding that all materials were being standardized by NOCP in Nigeria.

**Budget:** APOC was asked to support 67% of the Year 2 budget of $131,822. That Year 2 budget was the same budget put forward in the ‘new’ proposal (expansion amendment). There was a mismatch in the amount requested of APOC in the summary table ($131,822) and the detailed budget ($129,000) and formatting problems with various budget lines. The budget could have better reflected expenditures for CDD training, and its justification could have gained in clarity and strength, had it been more detailed, providing reasons for the assumptions for the calculations. TCC questioned the need for purchase of additional capital equipment in Year 2 (four-wheel drive vehicles, computer) and noted that the Year 2 cost of this Project was as a result much higher than most second year budgets of APOC supported Projects. TCC also questioned the high costs of technical assistance (TA) and noted the difference in the proposed TA here and in a sister Project proposal from Kwara State. TCC requested APOC management to obtain clarification on all the above and adjust the budget accordingly.
Provided clarification is obtained as suggested above, and the budget is revised to the satisfaction of APOC Management (this would include a revised Year 2 budget and a detailed budget for Year 2 - 5 for the expanded project), TCC recommended the approval of the 1st Year progress report and the proposed project expansion. The requested Year 2 budget is US$ 131,822.

2.1.4. Taraba State 1st Year progress report and 2nd Year budget proposal

The TCC commended the Nigerian Ministry of Health, CBM, and MITOSATH for carrying-out and implementing a well devised CDTI programme from 1 July 1997 to 30 June 1998, and encouraged the “Taraba partners” to continue to keep up this excellent work. The thorough and organized Year 1 report could act as a model for other CDTI Projects. It succinctly describes the background information, fully completes the requisite tables for implementation of CDTI, training, mobilization and education and general achievements, and includes a comprehensive overview of the Project’s strengths and weaknesses.

Several issues, however, needed some clarification. Two LGAs (Takum and Ussa) did not receive treatment due to a “Communal Crisis”. The TCC would like the NOTF to provide information as to the chances of these issues being resolved in the near future. If not, what other strategies were being planned to provide Mectizan® to the affected communities in these LGAs? Also what was the reason for lower MOH involvement in mobilization efforts in Yorro, Ardo-Kola, Sardauna and Zing?

Encouraged by the excellent results in Year 1 and the thoughtfully planned Year 2 budget, the TCC recommended the approval for Year 2 activities, after the following budget-related concerns/issues have been adequately addressed to the satisfaction of APOC Management:

(i) The Year 2 budget US$ 165,025 is decreased for activities such as training and education while it is increased for travel and capital equipment. The former activities directly promote sustainability while the later do not. The necessity of the vehicle is clear, given the former NGDO vehicle was removed from the project site. This expenditure, however, should not replace justifiable training activities simply to meet a pre-determined budget. If the expenses for training and education are integral to the project’s long-term success and sustainability it is valid to support them as well.

(ii) TCC requests further justification for the $4000 expense for the procurement and storage of Mectizan®.

(iii) The need for 10 full-time (SOCT) and 90 full-time (LOCT) staff for a Project that is supposed to be fully integrated to the existing health care system requires further justification.

(iv) Travel makes up approximately 40% of the Year 2 budget. Though this is justified by the need for advocacy, (re)training, supervision, monitoring and evaluation, in a very difficult terrain, its long-term sustainability cannot be guaranteed. Therefore, the NOTF should consider how each trip to the field can bolster local capacity and reduce the need for this expensive travel. The TCC looks forward to seeing a reduction in travel costs as the Project evolves.
2.1.5. **Nigerian NOTF/HQ’s 1st Year progress report and 2nd Year budget proposal**

This report consisted of three main parts: a report of NOTF HQ activities during the first year of APOC Trust fund support, a proposed budget for year 2, and minutes of the last NOTF meeting.

a) **NOTF HQ activities of during Year 1**

Activities reported here related to the NOTF HQ’s role in:

- the procurement of capital equipment supplies and IEC materials,
- the procurement, storage and delivery of Mectizan®,
- the convening of meetings/workshops for review of project proposals before final submission to APOC, for standardization of IEC materials, and for the training of NOTF HQ core administrative staff.
- the monitoring of and advocacy to APOC funded projects, and nationwide sensitization and mobilization in favour of CDTI.

TCC regretted that although all the above were part of the coordinating functions of the NOTF HQ, the report, which was essentially administrative in nature, did not sufficiently highlight the uniqueness of this office in supporting, facilitating, and strengthening the implementation of individual CDTI projects. Similarly, though there was a mention in the report of the "tremendous help provided by the Zonal offices both to the projects and the NOCP HQ", few details were provided on what that help actually entailed. More generally the report was fairly silent on the specific roles played by the two structures in the support of the projects. Also missing in the report were future plans for the re-submission of project proposals that had been rejected by the TCC, especially those from high priority areas like Benue State.

b) **Minutes of the 12th NOTF meeting held in Makurdi, Benue State, on 5th May, 1998**

This meeting brought together all APOC partners in Nigeria and was attended by Dr A. Sékétéli, Programme Manager, APOC, and Dr J. Baptiste Roungou, WHO/AFRO. Besides the usual reporting of and discussions on ongoing activities throughout the country, the meeting provided the opportunity for APOC Management to clarify on numerous issues related to APOC operations in general, and its financial and administrative procedures in particular. The important role of the WR office in that respect was reemphasized and a much closer collaboration on the part of all partners encouraged.

c) **NOTF HQ Proposed budget for Year 2**

The total budget requested for Year 2 was US $494,434, of which $263,354 (i.e., 53.3%) was requested to APOC. Of that total budget, $185,204 were requested for personnel costs ($61,904 to APOC), and $78,860 for travel ($64,300 to APOC). Overall and compared to the 5 year budget submitted the previous year, this proposed budget for Year 2 represented at least a twofold increase on that of Year 2 in the original NOTF proposal approved by TCC in 1997. This could only be partly explained on the fact that this time, zonal offices needs had also been included in the proposed budget. However, the way the entire proposed budget was constructed made it difficult to determine the relative parts apportioned either to the NOTF/HQ or to the zonal offices. Furthermore, as no mention was made of the previous request for the Zonal financial support that was turned down at the last session (see TCC5 report, section 4.2.9), it was not clear to the TCC whether Zonal functions were now being absorbed by the NOTF/HQ. This, TCC warned, would only reinforce the verticality of the programme.
and could not be supported. Accordingly TCC requested APOC Management to insist on a more transparent budget, and obtain all needed clarification on the relative costs of the NOTF/HQ and Zonal offices in the proposed budget. Other issues needing to be addressed before the release of funds included the following:

(i) The WR office in Nigeria was currently supporting 4 out of the 6 zonal offices in Nigeria. For the sake of integration and cost effectiveness, this support should be taken into account in the request for APOC support to the Zonal offices.

(ii) In addition to the need for more transparency regarding HQ and Zonal costs, many budget line items need to be reviewed. For instance under Travel, there are separate requests for air travel, public transport, accommodation, per diem for travel, travel allowances. Also, the number of units used for the costing of these items varies depending on whether expenses are to be met by the Federal Ministry of Health (FMOH) or APOC. Other such discrepancies exist and are not adequately justified.

(iii) TCC concern over the proposed budget related not only to the fact that it was unacceptably high, in spite of clear advice given to the NOTF in that respect during the Makurdi meeting by APOC Management, but also to the unlikelihood of it being sustained at the end of APOC support. TCC wished to reiterate its commitment to supporting the essential coordinating and facilitating functions of NOTF Nigeria central and middle structures, however not at the expense of programme sustainability. The committee therefore requested APOC Management to revise the proposed budget in keeping with the above comments, and insisted that NOTF Nigeria clearly demonstrate its commitment to sustainability in all subsequent budget submissions.

(iv) Given that the needs of both the NOTF/HQ and Zonal offices will be catered for in the revised budget no other "zonal" proposal will be expected from NOTF Nigeria.

Provided the proposed budget is revised as discussed above, and provided APOC Management is satisfied with the detailed financial reporting of first year activities (see section 6.1 of this report), TCC recommended the approval of the first year Progress report and second year budget of the Nigeria NOTF/HQ.

2.2 Sudan

2.2.1 Report on HQ support to Sudan CDTI projects, 1st Year Progress report of the Northern Sector Project and 2nd Year Proposal for HQ and Northern Sector support

No separate report was available for the Sudan NOTF/HQ activities. It was clear, however, from the budget request that in addition to its administrative and overall coordinating role, the HQ was closely involved in ivermectin distribution among the displaced people around Khartoum (1.2 million) and the Sundus focus in East Sudan. This was confirmed by APOC Management, who informed the Committee that far more had been achieved by the NOTF/HQ and in the northern sector Project area than was reflected in the progress report submitted to the TCC. Furthermore, a large amount had been paid for capital items by APOC Management, but details on these had not yet been forwarded to the Project. All these activities, the committee was informed, took place against a backdrop of ongoing severe famine in many endemic areas of the country, where people needed food more than Mectizan®.
The fact that many objectives, e.g. training workshops, training of CDDs, community mobilization, etc. were reached and even surpassed was a remarkable achievement.

With respect to the proposed 2nd budgets for the above (US$ 96,600 for HQ and 97,461 for Northern Sector CDTI Project), TCC requested the review, or further clarification, of the following:

(i) The very high cost of Project personnel costs (¼ APOC budget).

(ii) The high costs for air travel: this may be justified in view of the prevailing war situation and the need for coordination of the two projects, north and south, between Khartoum and Nairobi. However, every effort should be made to ensure that these are kept as low as is reasonable and fully justified.

(iii) No explanation was provided on a small request for funds for operational research.

Notwithstanding the above, TCC recommended the support of the NOTF/HQ and Northern Sector Project for their second year, subject to the review by APOC management of the proposed budget as discussed above. Also, given the "pilot" nature of the Sudan Projects, it was recommended that another report, outlining all the achievements during this first year be produced and sent to APOC Management.

2.3 Tanzania

2.3.1 Tanzania NOTF/HQ progress report

This report was reviewed and it was considered that it did not fulfil expectation in the context of format and detail. The HQ office function was to ensure the effective implementation of APOC-supported Projects in Tanzania. To date, CSA upon recommendation by TCC, had approved three Projects (Mahenge and Ruvuma CDTI Projects and Tukuyu vector elimination Project). In order to facilitate implementation of the Mahenge Project, IMA funds had been loaned in advance of APOC funds arriving. However, the NGDO staff member arrived only in January and previously APOC had agreed to a contribution from APOC funds to this NGDO coordination, in the form of technical assistance.

The report of the HQ activities was not regarded as adequate and should be resubmitted in accordance with the guidelines provided by APOC Management, with a greater attention to detail. Whilst funds had been received in March 1998, there was no reference to the progress made in developing CDTI in eligible areas or to the progress in implementation of the Tukuyu vector elimination project. Whilst a list of HQ office furniture was provided and the constraints outlined (delay in arrival of funds, heavy rain, KAP delay in the production of IEC material etc.) the Committee was concerned that the issue above together with the low coverage achieved (see Mahenge focus report) needed more detailed explanation and that the HQ responsibility, i.e. NOTF, for project management did not address the key issues.

The Committee advised that APOC Management requests resubmission of the report which should address the issues above. TCC also requested clarification of the status of the agreement regarding the NGDO staff member and re-emphasized that the contribution should be time limited and consonant with the policy of diminishing technical assistance contribution to HQ office support as defined at TCC3 (see TCC3 report, section 2.4.5). The second year budget levels were acceptable (except for TA contribution and high audit work). The total second Year budget submitted by the NOTF amounts to US$ 92,193.
2.3.2 Mahenge first Year Progress Report and 2nd Year budget Proposal

The technical report of this Project was not accepted in its present form and should be resubmitted for the following reasons:

(i) The report was sketchy, brief and lacking in essential technical information that could have helped the Committee assess Project performance and progress.

(ii) The activities performed were not quantified, e.g. number of health education and training sessions held, number of CDDs trained, etc, during the reporting period.

(iii) It was not clear whether the Project was still on the CBIT phase or was already being reoriented towards CDTI. Moreover, there was not any clear indication as to whether the treatments carried out so far with their attendant low coverage (28% in Mahenge, 22% in Kilombe) were effectively done by CDDs as recommended, under APOC CDTI strategy.

(iv) No justification was given for the proposed second year budget amounting to US$ 107,507. Similarly, based on available information in the report, the request for another vehicle could not be justified.

The NOTF of Tanzania was encouraged to use in future the reporting forms prepared by APOC Management.

3. SUMMARY OF 2ND YEAR BUDGETS CONDITIONALLY RECOMMENDED BY THE TCC FOR APPROVAL AND FUNDING IN 1998

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PROJECT</th>
<th>TRUST FUND (BUDGET) US$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Year 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>approved</td>
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<tr>
<td>NIGERIA</td>
<td>Cross River State</td>
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<td>Kaduna State</td>
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<td>TANZANIA</td>
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<td>Mahenge focus</td>
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<td>TOTAL</td>
<td>9 Projects (6 CDTI + 3 HQ)</td>
<td>1,749,677</td>
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</tbody>
</table>

* Budget to be revised (down scaled) according to TCC recommendations
4. REVIEW OF NATIONAL PLANS AND PROJECT PROPOSALS

4.1 Democratic Republic of Congo

4.1.1 National Plan and HQ Support Project proposal

Though REMO is yet to be completed throughout the country, available existing data indicate that onchocerciasis is a major public health problem in the Democratic Republic of Congo, with an estimated 18,750,000 people at risk of the disease and 5,250 million infected. The disease was first described in 1903 and consists of nine main foci. Both the blinding and the severe skin disease forms exist in the country. In addition, nuisance from insect bites is a major concern in foci such as the Inga where biting rates in excess of 13,000 have been recorded.

Efforts to control the disease in the past have included aerial spraying of DDT around Leopoldville (Kinshasa) in 1940-49, the Inga dam (1967-1975) and two years aerial spraying of temephos in the Lusambo area from 1975. More recently, mass distribution of ivermectin has taken place on a limited scale in various parts of the country.

TCC, after review, considered that this was a well-documented plan with useful information on the country's education system, economy, mineral resources and industries. The country's health system structure and functionality was equally well-described.

Detailed information was provided on the current level of onchocerciasis in the country and the main objectives of the national plan were clearly outlined. These were:

- to eliminate onchocerciasis as a public health problem throughout the country;
- to complete and finalize REMO;
- to implement CDTI in all eligible areas.

The proposed strategy for onchocerciasis control, CDTI, was well-described and its integration into PHC well-discussed.

It was indicated in the plan that the actual implementation of the proposed National Plan will be carried out in five phases and a timeline for all the main activities was provided.

The budget of the HQ Support showed a clear trend of APOC contribution diminishing over the years. However, the overall budget remained quite high, especially with respect to running costs. Likewise, the costs of technical assistance was high and capital costs even included items such as office furniture. Also, there was a multiplicity of closely-related administrative posts requiring APOC funding, which role and contribution to the success of the project was unclear and poorly justified. In general, justification for this fairly high budget was rather weak.

Notwithstanding the above comments, TCC recommended the approval of this otherwise well-documented National Plan and the HQ Support proposal. The budget of the HQ Support, however, needed to be revised by APOC Management, especially with respect to personal and capital costs, as discussed above.
4.1.2 The Kasai CDTI Project Proposal

This Project seeks to establish CDTI in a vast (324 043 sq km²), poorly accessible area of central Democratic Republic of Congo (DRC) where some limited mass ivermectin distribution has taken place in the past. An estimated 10 million people live in the Kasai, of which about 3.5 million will be targeted for CDTI.

TCC, after review, considered that this was a well-documented project proposal providing detailed implementation plans and treatment objectives for each year. Accordingly, future monitoring and evaluation of this project should be fairly straightforward. However, like its accompanying National Plan, the proposed budget is not adequately justified even though it must be said the unit cost of treatment in this project is the lowest observed so far ($0.36 in Year 1, down to $0.01 in Year 5!).

TCC, therefore, recommended that the Kasai project proposal be approved for funding and its budget be revised with respect to both capital and running costs, as discussed above.

4.2 Gabon

4.2.1 National Plan

This is a well-organized plan and generally well written, containing all the relevant information on background, country’s geography, economy, health system, onchocerciasis situation (except for its precise distribution) and the proposed objectives and strategies for its control. REMO is not completed yet, but there appear to be six foci of onchocerciasis where prevalence is 10-88%. There are three zones where cross-border control will be an issue. Vector control is mentioned, but no details are given. Similarly, it is simply mentioned that cost-recovery will be introduced in the project area and later integrated in the national PHC system. With respect to the actual distribution strategy, the fact that Loaisis is so prevalent in onchocerciasis areas seems to have led to a strategy of “strict medical treatment” for the first round of treatment, with progressive integration into the community over two years.

As only about 3,700 people were treated in 1997, this means that the majority of the 168,500 people to be treated in the first year will be receiving their first treatment. A key question to be answered by the NOTF is whether the Loaisis issue justifies the vertical/mobile team approach during the first two years of the project? TCC considered that if the proposed strategy were allowed to be implemented, sustainability of the project will be difficult to attain by the 5th or even the 6th year. A more detailed description and justification of the first year of treatment and its attendant “strict medical supervision” is therefore required.

Budget: overall the total budget of $846,789 for 168,500 people over five years makes it one of the highest so far. Because 52.6% of this budget will be provided by the Gabon government, issues regarding government long-term financial commitment and “actual” contribution to the budget need to be addressed to the satisfaction of APOC Management.

Provided these and other issues mentioned above are adequately addressed, TCC recommends approval of this National Plan.
4.2.2 The Gabon CDTI Project Proposal

This project seeks to establish CDTI in six provinces of Gabon comprising 13 administrative divisions (départements) and 714 communities. The population targeted for treatment in the project area is quite stable and is estimated at 168,500 persons. Though there have been some experiences with community participation in the project area, ivermectin treatments in the past (since 1988) have been entirely vertical, based on mobile strategy and limited to no more than 3,000 persons.

Project objectives are the same as those of the National Plan, as discussed in the previous section. The proposed strategy for reaching these objectives, CDTI, is well-described. However, because of an infection with Loa-Loa in the project area, it is proposed that treatment in the first two years will be conducted under strict medical control. How this will be achieved is somewhat questionable, given that PHC is not functional in many parts of the project area. In that respect the proposed plans to use CDTI as an entry point for the development of PHC needs to be closely followed up. As mentioned in the previous section, 52.6% of the proposed budget will be provided by the Gabonese government. TCC, while commending this strong financial commitment, warned of its adverse consequences on the success and sustainability of the project if this did not materialize.

TCC recommended the approval for funding of the Gabon CDTI Project proposal and requested APOC Management to ensure that the government financial commitment will be effective, and CDTI is implemented right from the beginning of the Project. The proposed budget must be revised accordingly.

4.3 Nigeria

4.3.1 Edo & Delta States Project Proposal

TCC reviewed the proposal to the above States whose partners were GRBP and Lions Club. The population in both States is 4.7 million of which around one million required treatment in 21 LGAs, which had been identified as hyper/meso-endemic. Eight hundred and fifty-eight villages had been identified. Ivermectin distribution had commenced in 1993 and there had been a gradual and sustained increase in population treated by community based programmes to a figure of 948,000 in 1997. The project had already achieved a treatment unit cost of about US $0.12 and over the five years of operation this had been consistently falling.

The proposal was well written and included all the necessary information. Concerns expressed related to the possible problems of the transition process from community-based to community-directed treatment system and the strong hierarchical systems in the communities which may influence approach to selection of distributors. The proposal contained a relevant proposal for operational research on the role of women in CDTI which needed appropriate scrutiny.

TCC considered that overall the project should be funded but in a context which took into account the stages of CDTI intervention and the efficacy which the systems had already achieved. The request to APOC involved a significant increase in unit treatment costs. It was important to evaluate how far the project had moved towards sustainability and view the request in the light of TCC’s desire to see the project reach sustainability with minimal additional (APOC and other) resources. TCC also considered that towards the end of the project an evaluation be attempted as to the impact the 10 years’ treatment had had on onchocerciasis and its transmission.
TCC instructed APOC management to take into account the above recommendation in discussing the project budget with the NOTF and State authorities as the budget was not acceptable as presented.

4.3.2 Jigawa State Project Proposal

This is a project seeking to establish CDTI in eight meso- and hyper-endemic LGAs, out of the 27 in Jigawa State. The population targeted for CDTI is estimated at 135,000 and the proposed project is a continuation and expansion of an existing IDP which has been in operation since 1996, treating 36,708 and 37,802 persons in 1996 and 1997 respectively. It was not clear why Burji LGA, seemingly hyperendemic, was not included in the project.

The process of reorienting existing field staff, community leaders and members, as well as that of implementing CDTI in new territories within the Project area is comprehensively discussed in the proposal.

TCC recommends the approval for funding of the Jigawa State Project on the condition that the following issues are resolved to the satisfaction of APOC Management.

(i) An explanation of why the Local Government Area (LGA) of Burji, which has hyperendemic areas, is not included in the project.

(ii) The NOTF should provide APOC management with improved population data by LGA and community.

(iii) The number of Community Directed Distributors (CDDs) that will be trained varies throughout the document. This issue must be resolved and the NOTF must provide APOC Management with a clear number of the CDDs that will be trained and a justification supporting that need.

(iv) An explanation of why in Year 1 there is a total 9-fold increase in funds (from $26,200 to approximately $200,000) provided to the project but less than a 10% increase in the number of people targeted for treatment.

With respect to the proposed budget, in 1997, the cost per person treated was $0.69 ($26,200 ÷ 37,820). During the first year of this proposed Project the cost per person treated soars to $5.54 which is well above the recommended first year limit of $2. By year five the cost remains high at $0.80 per person treated, i.e. higher than the pre-APOC accomplishment of $0.69 and well above the target of $0.20. These high costs must be brought down to an acceptable level before APOC Management can release funds. Clarification is needed on the following budget issues:

(v) The number of Ministry Health staff on the Local Oncho Control Teams (LOCTs) varies from 4/LGA (page 32) to 10/LGA (page 51). This difference must be resolved.

(vi) It is quite difficult to determine the present situation in regard to the availability of functional vehicles and motorcycles. The vehicles that appear in the budget on page 53 are difficult to reconcile with those listed in the tables on pages 31, 34 and 38. TCC recommends that APOC Management work with the NOTF to determine the current vehicle situation need in the field, and responds to it as appropriate.
(vii) Explain why a typewriter costs the SMOH $1000 and the LGA $500.

4.3.3 Kwara State Project proposal

TCC found this proposal to be somewhat disorganized, short on detail and graphics, and containing many inconsistencies and illegible tables. 1997 treatment activities (page 7, sections 2.2 and 2.3) show different information of numbers of treated LGAs (9 vs 11), villages (275 vs 426) and persons (103,573 vs 121,432). No discussion of coverage nor coverage data is provided, yet the operations research proposal begins with the statement “Despite the long duration of the programme, treatment coverage and programme expansion have remained relatively low.” Coverage information needs to be shared with TCC to enhance the attractiveness of the proposal. Other key Project components concerned by these inconsistencies include the following:

(i) CDTI: Some items proposed do not seem to be in line with the CDTI philosophy (page 45). LOCT visits to communities for notification of arrival of drugs, and LOCT/SOCT supervision of distribution of drugs by SOCT/LOCT needs to be explained in the context of CDTI.

(ii) Training: Different figures are given for CDDs to be trained (page 12 ‘1600-1750 CDDs’ and page 13 ‘1426-2236 CDDs’). A table would be useful here. The justification section on training provides no additional information (page 50).

(iii) Budget: TCC appreciates submission of expenditures for the entire 5-year proposal. However, the budget justification could be more detailed and provide justification of the assumptions for the calculations. The summary budget page (58) is completely illegible.

(iv) Technical Assistance: The TCC questioned the sudden increase (by over 100%) of TA in Years 4 and 5 of the Project. Why are the TA figures in this proposal ($5,100/year) so dramatically different from those of the sister project in Kogi ($22,800/year)?

TCC considered that this proposal, coming from an area with the longest experience in ivermectin distribution in Nigeria, and with hyperendemic areas straddling the border with Benin, needed further strengthening, and could not be recommended for APOC support in its current format. The resubmitted proposal should particularly seek to adequately address the concerns discussed above.

4.3.4 Oyo State Project proposal

This Project proposal is a marked improvement on the previous two submissions and has taken into account most of the points raised in these two rejections.

Ivermectin distribution has been taking place in the Project area since 1992, and in 1997 a little over 200,000 persons were treated. The Project proposes to treat over 900,000 people in 1999 increasing to 1,300,000 in 2003.

The numbers of LGAs and the numbers to be treated are misreported in the proposal and need to be clarified.
The outline plan looked as if it had been copied from other Project proposals with a time chart showing distribution during rainy season ivermectin instead of dry season as indicated elsewhere in the document.

CDTI implementation in the Project area is well described and the community approach, health education, training, supervision and monitoring are adequately covered.

Primary Health Care is present in the State but not fully functional. The plans indicate integration of CDTI into PHC where it is functional and other strategies are planned where it is not functional.

The cross-border control of the disease is an important issue not fully addressed in the document as the adjacent focus in Benin corresponds to the Eastern border of OCP operations. Effective cross-border distribution could be the subject of several areas of operational research. None is planned in the project.

The following issues relate to the proposed budget and need to be further addressed:

(i) Personnel costs: Salaries of government staff are doubled through "technical assistance". This makes sustainability of the Project beyond the 5-year external support nearly impossible.

(ii) Training, travel and education line items are all excessive and like most budget items lines in this proposal, inadequately justified.

(iii) Prolonged government commitment is questioned in the budget justification despite the letter of support by the MOH is included. This must be clarified, as APOC must ensure that MOH commitment to support the Project will last beyond the 5-year duration of external funding.

TCC recommended the approval of this project proposal subject to the following conditions:

- the above budgetary related issues are adequately addressed and the budget revised accordingly;
- clarification is obtained on the LGAs to be included and the population to be treated;
- in view of the importance of this focus on the border with Benin and of the historical focus of Loa-loa, the TCC recommends that the NOTF seriously considers, in consultation with APOC Management and TDR, the possibility of conducting relevant operational research there.

4.4 Uganda Phase IV Project proposal

This is a proposal to establish CDTI in five districts in Uganda: Moyo, APAC, Gulu, Adjumani and Kibaale. The total population targeted for treatment in the Project area is estimated at 632,785 persons, living in 622 communities. Mass treatment with ivermectin in the Project area has been taking place since 1993. The proposed Project seeks to consolidate and expand ongoing activities, as well as reorient these to APOC CDTI strategy.
TCC, after review, considered that overall this was a well-written, technically sound proposal and recommended it for funding by APOC Trust Fund. The following issues however must be addressed to the satisfaction of APOC Management before any fund is released to the Project:

(i) In areas where there are no PHC, CDDs will be used as a core to provide other health services. This approach is acceptable, provided that the CDDs are not overloaded with work that divert or dilute their prime duty to distribute ivermectin. This is particularly crucial in the first years of the project.

(ii) The problems of cross-border fighting between factions in S.Sudan and N.Uganda and their effect on ivermectin distribution, the insecurity in Gulu and the negative impact of refugee movements and displacement in these areas should be addressed and catered for in the implementation process. Operational research addressing these issues is encouraged, as lessons learned here could be applied elsewhere.

The following issues relate to the proposed budget:

(iii) It is of concern that APOC contribution rises from 25% in the first year to 42% in the fifth year. This is a reversal of the recommended trend in APOC-supported projects, making the financial sustantiation of this project highly questionable after the fifth year.

(iv) The MOH and/or local district authorities should be encouraged to increase their contribution to the project, as a clear indication of their commitment.

(v) The requested amount, i.e. US $42 650 on supplies is high and requires readjustment and better justification.

(vi) Operating expenses at a level of US $52,025 are high and must be better justified.
5. **SUMMARY OF 1ST YEAR BUDGETS OF THE CDTI PROJECTS PROPOSALS RECOMMENDED BY TCC FOR APPROVAL WITH CONDITIONS AND TO BE FUNDED IN 1999**

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>PROJECT</th>
<th>TRUST FUND 1ST Year budget recommended for approval*</th>
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<tbody>
<tr>
<td>GABON</td>
<td>CDTI Project</td>
<td>137,500</td>
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<td>NIGERIA</td>
<td>Edo/Delta States CDTI Projects</td>
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<td>Jigawa State CDTI Project</td>
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<td>Oyo State CDTI Project</td>
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<td>RDC</td>
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<td>CDTI Project in the Kasai</td>
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<td>UGANDA</td>
<td>Moyo, Apac, Gulu, Adjumani &amp; Kibaale CDTI Project</td>
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<tr>
<td>TOTAL</td>
<td>7 Projects (6 CDTI, 1 HQ support)</td>
<td>1,365,466</td>
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</table>

* Budget to be revised (down scaled) according to TCC recommendations

6. **MATTERS ARISING FROM NATIONAL PLANS AND PROJECT PROPOSALS**

6.1 Technical and Financial reporting of APOC-funded Projects

Technical and financial reporting on the progress of APOC-funded Projects is likely to increase, given that an ever-growing number of Projects will be receiving APOC support. Review of this progress will only add to that of new Project proposals. In addition TCC, reckoned that financial information available to its members on funded Projects at the time of review while informative, may not always be sufficient to assess the "financial" soundness of the project, even when technically everything seems to be going well. **This was the case of many projects in Nigeria which were yet to satisfy the minimum financial reporting requirements of APOC Management.** TCC therefore agreed and recommended that no subsequent funding be released to a Project until both TCC and APOC Management are satisfied with both its technical and financial performance.
6.2 Guidelines for preparation of progress reports on NOTF/HQ support to Projects and Technical and Financial Performance of APOC-funded Projects

In order to simplify and harmonize the review of progress reports of APOC-funded projects, TCC recommended the systematic use of the guidelines by NOTFs in their production. Such guidelines already exist for reporting the technical performance of projects. They must now be completed to comprehensively cover the key financial aspects of the project as well.

With respect to all future reporting of NOTF/HQ support to projects and as a first step, TCC recommended these be structured along the lines suggested in Annex 2.

6.3 Support by APOC Trust Fund of existing well-run ivermectin Projects

In its previous three sessions, TCC has received for review proposals from Projects that have been running for a number of years. Though none of these was yet implementing CDTI, most were already using some form of Community-Based Distribution strategy for ivermectin, and a few were being run quite successfully, even achieving treatment unit costs of US $0.20 or even lower. TCC had therefore hoped that support requests from such Projects would be relatively lower, and that a much greater emphasis would be laid on the Project implementation in ways to consolidate and further sustain existing gains and achievements. Unfortunately, this has not been the case. What TCC has instead observed has been a significant increase in the annual cost of these proposed Projects (sometimes five-fold or more) under APOC support, with, in many cases, a unit cost per treatment that never returns to its pre-APOC level at the end of the 5-year funding period. This is a major cause for concern to the TCC, as this may suggest that sustainment of CDTI Projects is still a goal that many NOTFs still embrace only half-heartedly.

While recognizing that there is a real cost, even in existing Projects, to establish or reorient CDTI, TCC still considers that the current level of support requests from existing well-run ivermectin Projects remains unacceptably high. TCC reminds NOTFs that the main objective of APOC’s 5-year support to a Project is to help establish a self-sustaining ivermectin distribution system within that Project, and not simply to provide it with just another funding cycle. Accordingly, in the future, recommendation for approval of existing and well-run ivermectin projects requesting further support from APOC will be subject to these, clearly demonstrating how and in what specific areas that support would add, or further strengthen, existing gains or achievements.

6.4 Issues related to budgeting of proposed Projects

APOC Management reiterated its concern that nearly all proposed budgets submitted for review were grossly inflated (by 34% on average, see also previous section). This not only makes the cost of many proposed Projects unnecessarily high, but also suggests on the part of NOTFs little concern as to how these Projects will sustain themselves once all external support has ceased.

TCC requested that in the preparation and justification of proposed Project budgets, more consideration be given to the links between Project costs during and after APOC Trust Fund support. In that connection, given the importance of the last two years of the budget (Year 4 & 5) in helping assess the potential for the proposed Project to sustain itself, TCC recommended that all new proposals provide for review, a detailed 5-year budget as well as some indications as to how any “remaining cost” will be funded after APOC.
6.5 Operational research in APOC-funded Projects

TCC6 referred to TCC5 recommendations on Operational Research (OR) given in sections 5.4 (page 22) of the TCC5 Report. TCC reaffirmed that statement, with the following amendments and procedural clarifications for management:

(i) OR pre-proposals should be presented in either an initial APOC proposal or an annual or six monthly report. Each research idea should be presented in no more than one page, and should include brief statements of the problem, the objective of the research, the methodology, outcome variables to be measured, and cost (maximum of $10,000).

(ii) Reviewers of initial (successful) APOC proposals or of an ongoing Project reports would give their recommendations on research pre-proposals worthy of funding at full TCC meetings. TCC would decide on those research pre-proposals to be conditionally approved pending receipt of a detailed proposal and budget (see below). A local independent Principal Investigator (PI), apart from programme staff, may be requested by TCC in order to assure the best possible results with the least interference with Project execution.

(iii) In the Letter of Agreement sent to the Project by APOC Management, the amount conditionally approved for operational research will be allocated as an OR line in the Project budget. Conditions for release of funds will include receipt of detailed and acceptable information on: a) methodology; b) budget and justification; c) implementation plan/time line; d) principal investigator (PI).

(iv) The TCC chair may elect to name a subcommittee from among TCC membership as needed to review the full proposal and approve the release of OR funds allocated.

TCC hoped that this process would result in speedy execution of OR within the year of budget approval for the overall Projects without sacrifice of adequate scientific review or interference with APOC programmatic functions.

6.6 APOC Trust Fund support in areas without NGDO assistance

TCC was informed of the possibility that some priority areas needing urgent treatment are without NGDO assistance, and thus may not easily gain access to APOC Trust Fund support.

Given the possible legal implications regarding this important issue, and in the absence of clear guidelines in the Programme document, TCC requested the CSA to clarify and advise on how project proposals from such areas, if technically and managerially sound, could receive APOC support.

7. UPDATE ON TDR OPERATIONAL RESEARCH ISSUES RELATED TO APOC OPERATIONS

Dr Remme updated the TCC on the following operational research issues relevant to APOC operations.

- The effect of ivermectin on skin disease: clinical and psychological assessment of persons after their first round of treatment with ivermectin.
Indicators of RIM (rapid independent monitoring) CDTI projects: developing and validating a simple method which can be used to determine the coverage achieved by CDTI (community-directed treatment with ivermectin) Projects.

Impact assessment indicators for CDTI: this should enable the adapting of the ONCHOSIM model to predict among others, what levels of infestation should be considered acceptable at 5 years.

Implementation of CDTI: Phase I of this planned research programme is nearly completed (see below). Phase II will be an intervention phase, when the effect of an 'enhanced approach' to CDTI is measured by comparing communities where it is used to those which are still approached following the original CDTI package.

Research in all four areas was progressing satisfactorily. TCC will be kept informed as results become available. With respect to research activities related to the enhancing and accelerating of CDTI, the following additional information were provided:

7.1 Second multi-country study on community-directed treatment

Following the first large multi-country study that had shown community-directed treatment with ivermectin was feasible, and its adoption by APOC as its control strategy, TDR was requested to further evaluate the performance of Community Directed Treatment within the context of routine disease control, to identify optimal approaches with respect to sustainability, and to develop mechanisms in which the health services and other partners can effectively initiate Community Directed Treatment and provide the necessary support.

The main objective of this second multi-country study which is currently ongoing is to develop and test novel approaches to the introduction and implementation of Community Directed Treatment which facilitates its integration into the health system, encourage effective partnership between endemic communities and health services, and improve monitoring and reporting. The study sites are in Mali, Ghana, Togo, Nigeria (3 sites) and Uganda. The Mali and Togo sites are funded by OCP. The first phase of the study, which concerned itself with the characterization and current performance of communities and health services is nearly completed.

The extensive data set that has been generated during this first phase are still being analyzed. Preliminary findings, presented to the TCC by two principal investigators from Togo (Dr Pana) and Nigeria (Dr Brieger), and the discussions that followed, raised the following issues/concerns:

(i) ‘CDTI’ has become a catchphrase. Health workers are using the phrase to describe what they do, but in reality it is they (and not the communities) who are directing the programmes. Although health workers are basically happy with the idea of the community undertaking the distribution of ivermectin, they still feel that they should play a leading role in the process;

(ii) Communities are willing and able to put CDTI into practice (although they find the present record-keeping system too complicated). However, they would like more interaction with health workers, and more support from them;

(iii) The question of payment and/or recognition for village distributors is a common concern. On the other hand there are voluntary organizations in communities who are willing to be partners in putting CDTI into practice.
(iv) Although there is general agreement that CDTI has to be integrated into the health services, the concept ‘integration’ means different things to different people. Integration is difficult, and does not happen automatically. It has to be carefully thought through and implemented, using indicators to assess to what extent it is really happening.

(v) The ‘enhanced approach’ to CDTI is the same approach as before, with the following additions: feeding back research results to actors in the field, in the spirit of empowerment; organizing local stakeholder meetings to discuss support for CDTI; using a simplified reporting system.

(vi) There is a danger that CDTI might become the ‘new orthodoxy’, a rigid prescription which fails to adapt to local needs and realities and therefore becomes inequitable, ineffective and inefficient. An important lesson from health sector reform has been that there is no one ‘right answer.’

7.2 Method for Rapid Independent Monitoring (RIM) of CDTI Projects

A simple method has been developed for the independent monitoring of CDTI Projects and has been recently validated in Mali. The study showed a very close correlation between the treatment coverage reported through the rapid monitoring method and the treatment coverage according to individual treatment records. The TDR/ComDT/Task Force will decide whether the method is ready for transfer to control. The Task Force has funded seven exploratory studies of existing recording systems at community level and on generating new ideas for reporting of Community Directed Treatment.

8. APOC OPERATIONALIZATION IN THE CONTEXT OF ONGOING HEALTH SECTOR REFORMS IN AFRICA

In response to JAF4 request (see TCC5 report, section 5.3) a special forum was held during this current session on ongoing Health Sector Reforms in Africa, particularly as they relate to APOC operations and its objective to establish sustainable large-scale ivermectin treatments in all eligible endemic areas. Contributors to this important session included in addition to TCC members, representatives from all relevant divisions within WHO and external advisors. The full report of the forum has been produced, courtesy of Professor D. Prozesky, as a separate document to be submitted to JAF4 in Accra, Ghana, next December.

Following are its main conclusions and recommendations

8.1 Onchocerciasis control has to become an integral part of the routine functioning of the health system. Officers should come to accept it as an integral part of their day-to-day work, like tuberculosis or leprosy. Practically speaking it should be included in the minimum package. District medical officers and district chairmen/ head of local government should be targeted in the advocacy that has to be undertaken to achieve this.

8.2 Communities should be seen as the lynchpin of whatever system of community-based directed treatment is to be used in a given situation - there is really no other option than partnership with them.

8.3 The health care system is a crucial partner in Community-Directed Treatment - the more effectively it functions (at all levels) the greater the likelihood that Community-Directed Treatment will succeed. A change of attitude/paradigm/culture/ relationship is needed though, on the part of many health workers, so that they become more attuned to partnership with the community, rather than insisting on owning the programme themselves.
8.4 The approach and methods that APOC is using are likely to enable it to contribute usefully to health sector reform on a wider scale: the partnership between the health service, NGDOs, the pharmaceutical industry and the community; tackling critical issues in the health service (like salary and motivation of health centre workers), and not glossing over them etc. This programme embodies many of the priorities outlined by the new Director-General of WHO.

8.5 One of the principal lessons of the health sector reform movement has been that diverse situations require diverse solutions. CDTI must not become the ‘new orthodoxy’ in ivermectin distribution - there must be flexibility and innovation in applying it.

8.6 Ivermectin must be distributed through the State system (in the long-run, as an ideal).

The following specific recommendations were also agreed upon:

8.7 Programmes of research need to be initiated/ intensified in APOC countries, in the following areas:

(i) The recurring costs of ivermectin distribution.
(ii) The role of health education in maintaining the programme.
(iii) The effect that institutional arrangements regarding fees have on coverage.
(iv) The nature and cost of activities at district and health centre level, which are critical for the success of CDTI.
(v) The financial situation of district and health centre level workers, and how this affects their motivation and willingness to become involved in CDTI.

8.8 It was accepted that strong support for APOC’s activities will be needed from WHO in the long run, in order to ensure that progress is sustained after 2007. The nature of this support needs to be clarified and an agreed process to achieve it set in motion.

9. CONCLUSIONS AND RECOMMENDATIONS OF THE 6TH SESSION OF THE TCC6

9.1. First Year Progress Report of APOC-funded CDTI Projects

9.1.1 Recommended for approval, after budget review by APOC Management

A. Nigeria

(i) Cross River State Project
(ii) Kaduna State Project
(iii) Kogi State Project
(iv) Taraba State Project
(v) NOTF HQ Support Project

B. Sudan

(i) Northern sector Project
(ii) NOTF HQ Support
9.1.2 To be resubmitted to the TCC

A. Tanzania

(i) Mahenge Project  
(ii) NOTF HQ Support

9.2. National Plans and Project Proposals

9.2.1 Recommended for APOC’s funding

Provided they are revised as suggested, and pending issues are clarified to the satisfaction of APOC Management, TCC recommends the approval for funding of the following:

A. Democratic Republic of Congo

(i) National Plan  
(ii) HQ Support Project proposal  
(iii) Kasai CDTI Project proposal

B. Gabon

(i) National Plan  
(ii) CDTI Project proposal

C. Nigeria

(i) Cross River State amended CDTI Project proposal  
(ii) Edo Delta States CDTI Project proposals  
(iii) Jigawa State CDTI Project proposal  
(iv) Kogi State amended CDTI Project proposal  
(v) Oyo State CDTI Project proposal

D. Uganda

(i) Phase IV CDTI Project proposal

9.2.2 To be resubmitted to the TCC

(i) Kwara State CDTI Project proposal

9.3. Matters arising from National Plans and Project proposals

9.3.1 Funding of subsequent years of APOC-approved projects

TCC agreed that funding of subsequent years of APOC-approved projects should be subject not only to their satisfactory technical review (by the TCC), but also to the satisfaction of APOC Management with respect to the financial returns from the NOTF (see section 6.1).
9.3.2 Guidelines for preparation of progress reports on NOTF/HQ support to projects and technical and financial performance of APOC funded projects

TCC recommended the systematic use of guidelines in the production of the above reports so as to simplify and harmonize their review (see section 6.2).

9.3.3 Support of APOC Trust Fund of existing well-run ivermectin projects

TCC recommended that proposals from existing well-run ivermectin distribution Projects requesting APOC Trust Fund support should clearly demonstrate why such support is needed, focusing on elements needing further strengthening with respect to sustainability (see section 6.3).

9.3.4 Operational research in APOC-funded projects

TCC has provided additional guidelines on the submission and review of operational research in APOC funded projects (see section 6.5)

9.4. APOC Operationalization in the Context of Ongoing Health Sector Reforms in Africa

The main conclusions and recommendations regarding this important topic are found in section 8 of this report.

10. DATE AND PLACE OF THE 7TH SESSION OF TCC

The seventh session of the TCC will take place in Ouagadougou, Burkina Faso, on 22-26 March, 1999.
LIST OF PARTICIPANTS

TCC MEMBERS:
- Dr T. Diarra, Bamako, Mali
- Dr S.E.O. Meredith, Atlanta, USA
- Professor M. Homeida, Khartoum, Sudan
- Dr A. Hopkins, Bossangoa, CAR
- Dr F. Richards, Atlanta, USA
- Professor O. Kale, Ibadan, Nigeria
- Dr J. Kassalow, New York, USA
- Dr P. Kilima, Dar-es-Salaam, Tanzania
- Professor D. Molyneux, Liverpool, United Kingdom

Advisers:
- Dr B. Brieger, Centers for Disease Control, Atlanta, USA
- Dr A. Pana, National Onchocerciasis Coordinator, Togo
- Professor D. Prozesky, Faculty of Medicine, Pretoria, South Africa
- Dr E. Tarimo, World Bank Consultant

Observers:
- Dr B. Kollo, Director of Community Health, Cameroon
- Dr H. Mwenesi, Research, Evaluation & Planning of Health Care & Social Development, Nairobi

World Bank:
- Ms Joyce Msuya, Health Specialist, Onchocerciasis Coordination Unit
- Dr P. Coyne, Tropical Medicine Consultant, Onchocerciasis Coordination Unit

WHO/APOC:
- Dr K.Y. Dadzie, Director a.i., Ouagadougou
- Dr (Mrs) U. Amazigo, Scientist
- Dr M. Noma, EBIS
- Dr A. Sékétéli, Programme Manager

WHO/AFRO:
- Dr J.-B. Roungou, OTD/AFRO

WHO/Geneva:
- Dr D. Heymann, (Executive Director, Communicable Diseases Cluster)
- Dr R. Henderson (Special Adviser to the Director-General)
- Dr D. Makuto, Director, ARA
- Dr B. Thylefors, Director, PBD
- Dr O.W. Christensen, OCP
- Dr D.E. Etyalé, NGDO Coordinator, PBL
- Dr Hans V. Hogerzeil, DAP
- Mr J.D. Kutzin, ARA
- Dr J. Lazdins, OCT
- Dr J.H.F. Remme, CTD/TDF
ANNEX 2

GUIDELINES FOR HQ SUPPORT REPORTING

The National Plan

Changes in National Plan during the reporting period
Review of project progress in management terms
- project timeliness on stream
- inter-project linkages
- new project proposals in preparation
- HQ perception and critical appraisal of project progress

Assessment of Treatment Coverage

Progress in assessment of endemicity and treatment coverage of priority areas
New information in relation to onchocerciasis epidemiology/control
REMO update
Meetings
Cross border issues

Sustainability

National office function
Central Government financial support for the programme
Mectizan Procurement, storage, and security
Management and training at different levels, progress and constraints
Preparations on post-APOC support activities and how office function will be sustained

Advocacy

Role of HQ in national advocacy for the programme
Special celebrations, events or announcements in support of Programme activities
Meetings
Newsletters, articles, TV programmes

Management of APOC supported projects

Capital purchases/status of equipment
Personnel changes within structures associated with APOC
Fund receipt/disbursement/reporting
Changes in Ministry of Health/NGDO on

- how it relates to APOC directly
- how it relates to potential outcomes of APOC activities in country, e.g. new programmes, new donor involvement, structural reforms, changes in organization of systems, opportunities for integration, policy changes etc.
Partnership in APOC supported project

Functioning of NOTF
Analysis of partnership function
Attempts to utilize local NGDOs
Links to WHO country office
Links to other UN agencies in country (UNICEF, UNDP, FAO, World Bank).

Any other relevant issues not covered by the above outline.