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Acronyms

AfDB  African Development Bank
APOC  Africa Programme for Onchocerciasis Control
CAR   Central African Republic
CDDs  Community Directed Distributors
CDI   Community Directed Intervention
CDTI  Community Directed Treatment with Ivermectin
CSA   Committee of Sponsoring Agencies
DALYs Disability Adjusted Life Years
DRC   Democratic Republic of the Congo
ECCAS Economic Community of Central African States
ECOWAS Economic Community of West African States
FLHF  Front Line Health Facility
JAF   Joint Action Forum
LF    Lymphatic Filariasis
MDA   Mass Drug Administration
MDGs  Millennium Development Goals
MDP   Mectizan Donation Programme
MoH   Ministry of Health
MDSC  Multi-Disease Surveillance Centre
NGDO  Non-Governmental Development Organisation
NTDs  Neglected Tropical Diseases
OCP   Onchocerciasis Control Programme
PAB   Plan of Action and Budget
SAEs  Serious Adverse Events
SIZ   Special Intervention Zones
SSI   Sight Savers International
STH   Soil-Transmitted Helminths
TCC   Technical Consultative Committee
TDR   Special Programme for Research and Training in Tropical Diseases
USAID United States Agency for International Development
WAHO  West Africa Health Organization
WHO   World Health Organization
Opening of meeting

1. The Fifteenth Session of the Joint Action Forum (JAF) of the African Programme for Onchocerciasis Control (APOC) was hosted by the African Development Bank (AfDB), from 8 – 10 December 2009 in Tunis, Tunisia. The meeting was attended by Honourable Ministers and Deputy Ministers, Permanent Secretaries and Directors of Public Health and Disease Control of 23 APOC and former OCP countries, 21 representatives of the donor community, WHO Geneva, WHO/AFRO, the West African Health Organization (WAHO), the Economic Community of Central African States (ECCAS), Non-Governmental Development Organizations (NGDOs), the Meztizan Donation Programme, Merck & Co. Inc., Pfizer Pharmaceuticals, Research Institutions, Directors and Coordinators of National Onchocerciasis Control Programmes and Representatives of the Statutory Bodies of APOC. A complete list of participants is attached as Annex 1.

2. JAF thanked the Government of Tunisia for the warm hospitality, and the AfDB for hosting JAF 15.

3. On behalf of Dr Donald Kaberuka, President AfDB - Dr Ilunga, head of the Health Sector AfDB, welcomed JAF participants to Tunis. He acknowledged APOC's position as a model of strong partnership which includes governments, donors and civil society. APOC has indeed shown a lot of success in Africa, caring for over 50 million people at risk of onchocerciasis.

4. Dr Ok Pannenborg, World Bank, introduced a tribute to Dr Robert McNamara, former President of the World Bank, who passed away in 2009. During his tenure at the Bank, Dr McNamara played a pivotal role in initiating the onchocerciasis control programme. A memorial tribute film was shown to JAF, in which the President of the World Bank reiterated its commitment to APOC until the closure of the programme.

5. Dr Uche Amazigo, APOC Director, expressed her sincere gratitude to Dr Donald Kaberuka, President AfDB, for hosting, for the first time, the governing body of this truly unique partnership – engaged in the complex fight against river blindness in Africa. Forty one years ago, in 1968, the first ever meeting to discuss the search for scientific tools to control the untold human suffering and economic devastation of river blindness was hosted by WHO in Tunis. By fate, the 15th session of the governing body is being hosted by the AfDB in the same city where it all began. APOC is a regional programme with strong ownership by African countries, therefore the strong support given by the AfDB to APOC symbolises the great importance President Kaberuka attaches to the role of health in the economic development in Africa.

6. Remarkably, seven of the nine major donors have been with the campaign continuously over three decades. Dr Amazigo reiterated APOC's gratitude to the donors and to traditional NGDOs whose continued commitment and confidence in the programme has now brought us to a stage at which countries can show evidence that elimination of river blindness in Africa is being accomplished. APOC partners have put in place a community-driven strategy and a huge cumulative grassroots workforce of over half a million trained community selected drug distributors in 15 countries who are addressing the control of onchocerciasis and other diseases of poverty. A critical requirement is the continued commitment of the donor community, NGDOs and in particular the governments.

7. Two musical artists Amity Meria from Burkina Faso and Upendo Kilahiro from Tanzania gave tribute through songs to the CDDs for their hard work under difficult conditions in the communities.

8. Dr Stephen Mallinga, Minister of Health Uganda, and outgoing Chair of JAF 14, highlighted the Programmes key achievements in 2008 and 2009. Despite the prevailing conflict situation in some countries, APOC management and the National Onchocerciasis Task Forces successfully expanded the search for new and untreated onchocerciasis endemic villages through disease mapping and refinement in Burundi, Cameroon, CAR, Sudan and Ghana. In 2008, almost 57 million persons in 120,000
communities were treated using CDI. Sixteen projects were evaluated of which twelve performed well. During 2008-2009, 418,000 CDDs and 39,000 health workers were trained and re-trained by CDTI projects, representing an increase of 18% for CDDs and 6% for health workers compared to 2007 figures. In addressing the issue of gender mainstreaming, 15 candidates, of whom 12 are female, were selected in 2009 to receive APOC-supported scholarships for Masters degree studies at public health institutions and Universities in Africa.

9. Other key activities and accomplishments in 2008-9 included: epidemiological evaluations in Nigeria, Chad, Uganda and Tanzania - with positive results showing good decline of the epidemiological parameters; APOC’s support in organising ministerial meetings on cross-border issues related to onchocerciasis and other disease surveillance and control in West and Central Africa in line with a recommendation of JAF14.

10. Dr Luis Gomes Sambo, Regional Director WHO/AFRO, highlighted in his statement the effectiveness of APOC’s CDTI strategy, which has proved effective in promoting primary health care through the control of onchocerciasis. The burden of disease, including other NTDs, constitutes a major obstacle to human development in the African Region. Ministers of Health and WHO jointly agree that health system strengthening, based on a primary health care approach, is the right response to cope with current public health problems. This requires strengthening local capacities to deliver quality health care and empowering communities to participate in decisions concerning their own health and development. The community-directed intervention strategy (CDI) pioneered by APOC has the potential to promote primary health care, having also facilitated the delivery of integrated packages of interventions by the communities, for the communities. Dr Sambo called upon Governments to increase their commitment in terms of funding, disease surveillance, cross-border collaboration, and in the creation of Centres of Excellence. This will strengthen the regional capacity for research to generate evidence for decision-making by governments in the areas of epidemiological surveillance, public health, and quality control of drugs and food. Dr Sambo informed JAF that, with respect to this, a project document was being finalised and would be discussed with the Economic Community of West African States (ECOWAS) Member-States and development partners with the aim of transforming the current Multi-Disease Surveillance Centre (MDSC) in Ouagadougou into a Centre of Excellence for Disease Control.

11. Dr Donald Kaberuka, President AfDB and host of JAF 15, officially opened the meeting. In his remarks he commended APOC’s CDTI strategy which is based on the mobilisation of members of the communities concerned and the participation of local NGOs. These key elements are crucial to the sustainability and consolidation of activities. The AfDB has been supporting onchocerciasis control since the operation was launched in 1975. Recognising the crucial nature of this last phase of the APOC programme, AfDB approved in July 2008, funding to the tune of US $23 million to strengthen the project’s achievements and to finalise the disengagement process and the devolution of activities to countries. In addition, thanks to this funding, gender issues will be better addressed, particularly in terms of improved services for women, given that this is a core element for sustaining such activities. Moreover, Dr Kaberuka highlighted that AfDB’s strategic approach to regional integration is in line with that of APOC – a programme which is a good model of an integrated regional approach, connecting various regional bodies in West, East and Central Africa. Lastly, Dr Kaberuka reiterated AfDB’s commitment to continue supporting the programme according to their signed agreement.

Election of officers

12. JAF elected the Government of the Republic of Cameroon, in the person of Mr André Mama Fouda, Minister of Health, as Chair of JAF 15, and the Government of the Republic of Tanzania as Vice Chair, in the person of Professor David Mwakyusa, Minister of Health, Tanzania. The African Development Bank, as host of the meeting, was elected as Executive Chair for JAF 15. JAF thanked the outgoing Chair, Dr Stephen Mallinga, Minister of Health Uganda, for his leadership as Chair of JAF 14.
13. In his acceptance speech, Mr André Mama Fouda, thanked APOC for its financial and technical support to Cameroon. He thanked donors and partners for their support in the fight against onchocerciasis and called for additional support to eliminate the disease as a public health problem.

14. Professor David Mwakyusa, Vice-chair JAF, congratulated the new chair. He then requested that APOC management reports on the implementation of the decisions of the previous JAF.

Special Presentation: The development of partnerships

15. Professor Allen Foster, President of CBM, gave a presentation on the history of onchocerciasis control which emphasized that the partnership between donors, NGDOs, APOC and countries is key to the success achieved to date. This partnership needs to be sustained and expanded to achieve the new objectives of co-implementation for NTDs and elimination of transmission of onchocerciasis.

16. JAF thanked Professor Foster for his visionary presentation.

Address by a community leader from Chad

17. Mr Pircolossou, a community leader and former onchocerciasis patient from Chad, addressed JAF and thanked partners, including Merck and other pharmaceutical companies for providing drug donations to the African people. He also thanked APOC for improving the health status of the African population. Good health is a basic human right and an important factor in the attainment of happiness, which is deserved by all Africans. Mr Pircolossou explained that within his communities people are convinced that treatment with ivermectin is the best way to ensure that people have access to health care services, and acknowledged the support of the Ministries of Health (MoH), APOC, donors and the NGOs. Mr Pircolossou concluded by calling upon other institutions to follow the leadership of the AfDB in acknowledging the suffering of Africans.

Adoption of agenda

18. The provisional agenda appended as Annex 2 was adopted without any amendments.

Reflections of the Committee of Sponsoring Agencies (CSA)

19. The reflections of the Committee of Sponsoring Agencies (CSA) were presented by Dr Chris Mwikisa, Chairman of the Committee. CSA recognised that the long-term commitment and sustained political will of National Governments and the steadfast support of donors and NGDOs to river blindness control continues to be recognised as one of the most significant major public health and development successes in Africa. Of the 20 APOC partners today, many have been with the programme for 2 or 3 decades. Since 1995, the equivalent of more than $1 billion has been invested, and the excellent use of funds by the programme has allowed for the development of high levels of partner confidence in APOC. APOC, a programme ‘for Africans, by Africans’, with a return on investment of 16%-20%, today remains one of the most successful and largest public health programmes in the world.

20. Dr Mwikisa informed JAF that 2009 had been a year of important growth and innovative developments for APOC. Over 56 million people from over 120,000 communities in Africa were treated with Ivermectin with an average coverage of 70%. Furthermore, APOC made significant contributions towards strengthening national health systems and primary health care through capacity building of community and front-line health facility staff and provision of equipment. Training or re-training of 420,327 CDDs and 39,727 health workers from all levels was accomplished by CDTI projects. A curriculum on CDI was also launched for teaching the strategy in medical and nursing schools in 18 universities of 11 countries in sub-Saharan Africa. Other CSA activities during 2009
were the development of a supplementary addendum to the strategic plan of action 2008-2015 and the finalisation of donor agreements.

21. In his concluding remarks, Dr Mwikisa stressed that APOC has a robust infrastructure that can be put to use in addressing the severe suffering caused by NTDs, and that many other partners have shown interest in moving in this direction in terms of financial support or implementation - while African governments have indicated the importance of addressing NTDs. It is therefore the view of CSA that as APOC maintains focus on its onchocerciasis mandate, bridges should be built to reach out to other partners to see how the agenda of NTDs can be moved forward in support of countries. CSA commended APOC management for the excellent work they continue to perform and the partners for their continued investment in APOC - it is through this collaboration that APOC's successes and achievements in the countries have been possible. Finally, acknowledgement was made of the ownership and leadership taken by governments to ensure that after APOC's exit, the achievements will be sustained.

**WHO progress report**

22. APOC Management presented JAF with an overview of key activities carried out by the programme in 2009, such as CDTI; strengthening health systems; co-implementation of CDTI with other health interventions and elimination of onchocerciasis transmission. In collaboration with the MDSC, APOC countries and 6 ex-OCP countries undertook a number of capacity building activities, including the training of staff in mapping CDTI and entomology, during 2008-2009. In the same reporting period, four ex-OCP countries also received both financial support and training in mapping, entomology, epidemiology, administration, finance and management of CDTI, as a means of building their capacity. As a result, major improvements were observed, especially in Cote d'Ivoire. Additionally, 18 African Faculties of Medicine, Schools of Nursing and School of Public Health approved the inclusion of the CDI strategy in their curricula. APOC management informed JAF that the programme had provided funding in 2009 for Masters degree level training to 15 individuals, 12 of whom are female, thus addressing the gender mainstreaming aspect brought up the JAF during the 14th session.

23. Concerning co-implementation, since the endorsement of CDTI as a platform for co-implementation by the WHO Regional Committee during a meeting in 2007, APOC has doubled financial and technical input to countries for key CDTI activities. Subsequently, there was an increase in the number of people treated through CDTI, which reached 57.6 million in 2008. Among these, multiple interventions were provided to 37 million people for malaria management, Vitamin A supplementation and control of other NTDs. It was noted that major efforts were being made by countries, in collaboration with other partners, to diversify and improve health services through co-implementation using the CDI strategy. Lastly, progress was made in the mapping of onchocerciasis and from 1997-2009, more than 11,600 villages were surveyed in 19 countries and 3,562 villages were surveyed using RAPLOA in 8 countries.

24. Following the presentation, JAF commended APOC management and countries for the progress made during the reporting period, with respect to increased treatment coverage; successful co-implementation of activities using the CDI strategy; and the shift from control to elimination of transmission of infection where feasible. JAF requested that APOC management reports on the implementation of decisions of the previous JAF during future JAF sessions.

**Statements by Ministers of Health**

25. Statements were given to JAF by Ministers of Health of the following APOC and ex-OCP countries:
a) **Burkina Faso**: Onchocerciasis is no longer a public health problem and has been controlled in 85 sentinel villages situated in the river basins. However, in 2007/8 some villages had prevalences above tolerable levels, thus it was deemed necessary to conduct research in these villages to assess the situation. During 2009, entomological surveillance was carried out in 10 sentinel villages and samples were sent for laboratory analysis. In terms of the financing of onchocerciasis activities, CFA 26 million was spent in 2009, 65% of which was paid by the government budget.

b) **Burundi**: Additional financial technical support is needed in this post-conflict country, in which over 1,400 million people (17% of the population) are at risk of onchocerciasis, in five out of the seventeen provinces. Currently, the three CDTI projects in the country achieve a geographical coverage of 100% and therapeutic coverage of 60%, although there are efforts to increase therapeutic coverage to 90%. Furthermore, there is a gradual increase in the health budget in order to improve health indicators linked to the MDGs.

c) **Cameroon**: Blindness is a serious public health problem in Cameroon and onchocerciasis is endemic throughout the country. In 2009, the number of CDDs was increased to 25,000, and this resulted in an increase in treatment figures. The country has developed plans for NTD control for the period 2007-2011, and is in the process of drawing up its exit plan for onchocerciasis control. Following the recommendations of JAF 14, Cameroon organised a sub-regional cross-border Ministerial meeting in October 2009. During the current reporting period, several cases of SAEs were observed following treatment with doxycycline and APOC provided financial support for monitoring SAEs in the Littoral project area. Mapping is underway for NTD control to be implemented in 2010, and the country called upon development partners to support the planned co-implementation of integrated health interventions.

d) **Central African Republic (CAR)**: Onchocerciasis is endemic to 10 out of the 16 prefectures of CAR, putting 2 million (almost 50%) of the country's population at risk. Itching and skin problems caused people to abandon agricultural land, resulting in serious socio-economic consequences for a country with a weak economy. The Government has renewed its commitment to onchocerciasis control and has been training CDDs and health workers as well as providing staff for effective implementation of the CDTI strategy. The country's sustainability and exit plans have just been finalised and will require financial support up to 2015. CAR has developed a strategic plan for integrated control of NTDs as well as a 3 year Plan of Action with support from WHO.

e) **Chad**: CDTI implementation has been ongoing since 1998 and encouraging results have been achieved. More than 19,072 health workers and 13,000 CDDs have been trained and are now working in 3,000 villages, achieving geographical and therapeutic coverages of 100 and 80% respectively. CDTI has been integrated into the primary care health system and CFA 50 million has been approved by the government for onchocerciasis control activities. These activities currently include: treatment impact assessments, development of a plan for integrated mapping of NTDs by 2010, development of a full system of surveillance and the organisation of a second sub-regional Ministerial cross-border meeting in N'djamena in 2010. A plea was made to all partners for financial support for these activities.

f) **Cote d'Ivoire**: Onchocerciasis is endemic throughout Cote d'Ivoire. Control activities increased in 2009 with more people being trained or retrained. Among these, 59 doctors, 331 health workers, and 7,038 CDDs were trained or retrained and ivermectin was distributed to 3,519 communities in 50 health districts. Epidemiological and entomological evaluations are currently in progress. Mobilisation of partners to support these activities and strengthen capacity is in progress. Cote d'Ivoire is conscious of its role in the programme for elimination of onchocerciasis and has contributed US $590,000, including equipment. A National programme for control of LF, STH and schistosomiasis will be implemented with CDTI and will require operational research and continued international support.

g) **Equatorial Guinea**: Onchocerciasis control is progressing despite some challenges, and encouraging data has shown that elimination of the vector, *Simulium yakense*, has been achieved in Bioko. From 2005 to the present, no blackfly has been found on that island despite many surveys – the
vector is totally absent. This is a very important scientific milestone for donor countries and institutions fighting the scourge of river blindness. CDTI will continue to be used to free carriers of the parasite in the population and entomological monitoring will also continue. The political commitment of the Government will ensure continued financing of onchocerciasis control in the country.

h) Guinea: Twenty-four out of the country’s thirty-three districts are affected by onchocerciasis, with more than 20,000 people at risk. Between 2000 and 2008, a cumulative total of 14,000 CDDs treated 2 million people in 8,000 villages using CDTI. The country also held cross-border meetings with neighbouring countries in 2009. Lastly, the partners were requested to provide both financial and technical support in order to strengthen surveillance activities.

i) Guinea Bissau: The AfDB was thanked for covering travel expenses for the delegate of Guinea Bissau to JAF 15. Efforts were being made to improve both geographical and therapeutic coverages, including the training of 63 trainers in 2009, who will in turn train 1000 CDDs. A request was made to APOC to provide teaching materials in Portuguese.

j) Ghana: The devolved Onchocerciasis control programme in Ghana is aimed at sustaining the gains of OCP, preventing recrudescence, eliminating the disease in 'black Spot' areas and extending onchocerciasis control to the endemic communities in the forest belt of the country. A draft 5 year strategic plan on NTDs has been developed, covering onchocerciasis, LF, schistosomiasis, STH and Trachoma. In 2008, geographic and therapeutic coverages were 97.8% and 72.2% respectively and 718,985 people from 1,283 communities received bi-annual treatments with ivermectin. Epidemiological surveys conducted in 2007 in these communities showed significant decreases in the prevalence of infection.

k). Liberia: The country is committed to the implementation of the poverty reduction strategy, including the global effort to fight onchocerciasis. Treatment and geographical coverages were 70% and just below 60% respectively in the three CDTI projects. Liberia has decided to conduct integrated mapping of NTDs and the country is working on a Plan of Action for a programme for integrated NTD control with CDTI. Given the range of challenges in Liberia, which include CDDs incentive requests, inaccessibility and transportation, a plea was made to APOC to increase financial and technical support to the country. The government remains committed to providing financial support, and in 2009 provided US $20,000 for CDTI activities and $20,000 for cross-border activities.

l) Niger: Onchocerciasis is no longer a major public health problem in Niger due to the activities of OCP. The prevalence of the disease which had been 60-70% at the beginning of the programme, with 5% blindness in 1976, is now almost zero. The Government of Niger provided a budget line for the National Onchocerciasis Programme to reinforce community participation to reduce the risk of recrudescence, as for example, from the development of a new dam at Kanadjé. It is also necessary to use efficient methods to deal with the disease. Integration of onchocerciasis and LF control is taking place, enabling 971,676 people in an area of co-endemicity to be treated in 2009.

m) Mali: Onchocerciasis is no longer a public health problem nor does it undermine social development in Mali, however prevalence is still high in some affected communities. Whilst transmission has now been reduced, there is an urgent need to consolidate efforts in order to prevent recrudescence. Surveillance and monitoring activities also need to be intensified. Currently, CDTI is reaching 3500 villages with a therapeutic coverage of 80%.

n) Nigeria: Ongoing efforts to control onchocerciasis supported by APOC are yielding positive results in Nigeria. An annual treatment coverage of over 65% has been maintained for the last 6 years, although the country is yet to achieve 100% geographical coverage. An exit strategy plan has been developed, however, a major constraint remains due to inadequate government contributions for the implementation of CDTI activities at the State level. An appeal was made to development partners to channel aid towards Nigeria’s health needs.
o) Sudan: CDTI was launched in 1998, and recently there has been a shift in the mandate of the national programme from control to elimination, in the northern area only. It is anticipated that elimination of onchocerciasis will be possible in the northern area by 2015. Gender representation remains an important element in Sudan, therefore materials that are relevant to women and children have been developed. In terms of capacity building, the programme aims to increase the number of supervisors and volunteers by 35%, by the end of 2010.

In the southern part of Sudan, the importance of controlling onchocerciasis in order to lessen the socio-economic burden is stipulated in Chapter 6 of the Southern Sudan Health policy. A strategic integrated NTD control Plan 2008-2011 is in place, targeting: onchocerciasis, LF, STH, schistosomiasis and Trachoma - using CDTI as a delivery mechanism. In 2008, 2,029,828 people were treated, achieving a therapeutic coverage of 39.1% and geographic coverage of 70%. A total of 4,771 CDDs and 474 health workers were trained. For the first time, onchocerciasis activities will be included in the MoH 2010 budget. JAF was informed that a Multi-NTDs stakeholders meeting will be held in February 2010.

p) Tanzania: In line with the development of a five year country plan for integrated NTD control, an NTD Coordinator post was established under the Ministry of Health and Social Welfare, to support co-implementation activities. The country also received financial support of US $703,958 from USAID through APOC, for phase one co-implementation of Mass Drug Administration (MDA) for five NTDs, namely onchocerciasis, LF, trachoma, schistosomiasis and STH. Tanzania is committed to fighting onchocerciasis and in the financial years 2008 and 2009, the government allocated US $121,529 and US $174,818 respectively.

q) Uganda: Onchocerciasis is endemic in 29 out of the 81 Districts, and about 1.5 million people are affected by the disease. Uganda is dedicated to eliminating onchocerciasis and has adopted a multi-pronged programme using targeted vector control and elimination with semi-annual ivermectin treatment. REMO has been completed in 30 villages in 2 post-conflict regions of Northern Uganda and data have been submitted to APOC. With the elimination campaign launched in 2007, there is an urgent need to address the current challenge of cross-border transmission from DRC and Sudan, if Uganda is to achieve its elimination objectives. Thus, an appeal was made to APOC to provide training to technicians from DRC.

26. Following the statements, JAF thanked the Ministers of Health for the updates given regarding the status of onchocerciasis control activities within countries. Given the shift in the programme’s focus from control to elimination of transmission where feasible, JAF welcomed the increase in governments’ financial contributions as well as their commitment to strengthening national onchocerciasis field and management teams. Furthermore, JAF urged Ministers of Health to explore ways of further increasing government financial allocations for the control of onchocerciasis and other NTDs. The Forum stressed the need for country ownership of CDTI activities as a prerequisite for sustained control.

27. It was also noted that the increased momentum for co-implementation of NTD control highlighted by countries provides an opportunity for an increased role of CDI. In that light, the Forum suggested that APOC explore ways to package and bring to the attention of the Global Fund, the lessons learned from the CDTI mechanism and its subsequent achievements. Potentially, this provides an opportunity to scale up co-implementation using the CDI strategy for the control of NTDs and of malaria.

Treatment coverage: presentation by representatives of countries

28. Data on treatment coverage from 15 APOC countries between 2004 and 2008 were reported showing that, overall, geographical coverage increased from 83,404 communities in 2004 to 120,367 in 2008, whilst therapeutic coverage increased from 37.8 million in 2004 to 56.7 million treatments in 2008. Both geographical and therapeutic coverage were good in all stable countries except for
Equatorial Guinea, in which some urban areas were not treated in 2008. All other stable countries exceeded 65% therapeutic coverage. Two countries, Chad and Malawi had treatment coverages above 82%.

29. Among the post-conflict countries, geographical coverage remained at 100% in Chad and Burundi, and showed significant improvement in Angola and Sudan, but CAR, DRC and Liberia, require further effort. Chad and Burundi also exceeded the 65% target for therapeutic coverage whilst five other post-conflict countries (CAR, Sudan, Angola, Liberia and DRC) were below this threshold. Despite the problems faced by post-conflict countries, 60% of them achieved a therapeutic coverage above 65%.

30. Progress with co-implementation of health interventions for other NTDs alongside CDTI was presented to JAF. Ivermectin treatments were distributed to 120,367 communities in 2008 and 87.2% of these (104,974) benefitted from additional health interventions. Of the total of 56,716,070 people treated in 2008, 37,507,494 persons from 104,974 communities were provided with health interventions/services for 11 diseases ranging from malaria control to primary eye care. Details of numbers of communities and people treated were given for each disease. Although data was incomplete for some countries, the available data showed that a total of 268,718 CDDs were involved in co-implementation, of whom 21.2% were female. The percentage of females varied considerably from country to country (range 2.5% to 72%).

**Government Contributions**

31. In both 2008 and 2009, overall government contributions to support CDTI activities, equipment and salaries amounted to US $25,543,341 and US $26,645,576 respectively. Out of this amount, US $784,919 was invested in health education, sensitisation, advocacy and mobilisation in 2008; a total budget of US $661,739 was allocated for these activities in 2009. It was noted that NOTFs advocated for sustainable financing and that the 2009 disbursed funds had been distributed as follows: 37% towards sensitisation, 33% towards health education and 30% towards advocacy. Evidently, sustainable financing of CDTI makes it possible to control or eliminate onchocerciasis in Africa and makes the control of other health interventions possible at low cost.

32. Following the presentation, JAF noted that government financial contributions indicate increasing support to onchocerciasis control, especially in the context of NTD control budget lines. JAF requested that, in future meetings, a complete picture of all sources of support for implementation of CDTI is provided, including from governments, NGOs, APOC and other potential donors. This will facilitate estimation of total programme costs and help identify current and potential future funding gaps as APOC implements its exit strategy. As CDTI is increasingly integrated into health systems for co-implementation, it should be noted that it becomes more difficult to breakdown costs by individual diseases.

**Report of the Technical Consultative Committee (TCC)**

33. Professor Adenike Abiose, Chair TCC, presented reports of the last two TCC meetings which were held in March and September 2009. TCC noted APOC’s achievements in continuing collaboration with NGDO, and other disease control partners in co-implementation activities. TCC endorsed these actions, however, they advised that co-implementation should take place using the CDTI platform to ensure that onchocerciasis control is not compromised. APOC was commended for its committed leadership and was urged to continue its support to countries to enable them to move from control to elimination of transmission where feasible. TCC commended Nigeria and Cameroon for setting up Technical Review Committees. During 2009, TCC continued to provide guidance to APOC on strategic, technical and research issues, the review of annual technical reports and country visits by TCC members to support CDTI. On technical issues, the report of the Informal Consultation on the Elimination of Onchocerciasis where feasible was received by TCC. TCC commended Uganda on their elimination efforts and encouraged APOC to provide Uganda with the necessary support and
information. With regard to research activities, TCC received updates on the moxidectin trial and expressed concern that the completion of the trial was less likely to occur before APOC's exit in 2015. An update was also received by TCC on the rapid assessment of Loa loa (RAPLOA) carried out in 7 APOC countries. Lastly, TCC approved 4 out of 7 research proposals received in 2009, three of which were from Cote d'Ivoire, which submitted for the very first time.

Sub-regional Ministerial meeting on cross-border collaboration

34. In response to the call of JAF14 to strengthen cross-border collaboration, a meeting was held in Ouagadougou from 29 September to 1 October 2009 for West African countries. The meeting was attended by more than 100 participants, 5 of whom were Ministers of Health, including 12 delegations (Benin, Burkina Faso, Cote d'Ivoire, Ghana, Guinea, Guinea Bissau, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo). The main objectives of the meeting were as follows; to review progress achieved thus far on integrated surveillance activities in 13 countries; and to strengthen collaboration both among and within countries. During the meeting, 20 diseases were identified for surveillance, including onchocerciasis, other NTDs and endemic diseases such as meningitis and polio. Some challenges were also identified, including; the absence of a framework for consultation and information-sharing across borders - surveillance activities were unable to cover all areas especially at borders; limited numbers of qualified personnel, laboratories, funds and limited community participation despite efforts being made. Following the meeting, documents were prepared aimed at building institutional capacity for cross-border epidemiological surveillance and control. It was also decided that national funds be provided within countries for cross-border activities. A key outcome of the meeting was an agreement to request WAHO to submit recommendations of the meeting to ECOWAS to allow for budget strengthening. The countries agreed to hold an annual meeting on surveillance.

35. A second cross-border meeting was held in Cameroon from 12-14 October 2009, was attended by Angola, Cameroon, Equatorial Guinea, CAR, Congo, DRC, Chad, representatives from WHO, APOC, and development partners. Specific objectives were to present the NTD situation in the region as a first step in strengthening and building strategies to increase cross-border NTD control activities, and to increase surveillance of polio. The following key challenges were highlighted; absence of sub-regional consultation on NTDs, and insufficient epidemiological surveillance information. The meeting’s outcomes included the development of plans for integrated mapping of NTDs, some of which are already underway in some countries. Recommendations were also made to establish the sub-regional level epidemiological disease status; and to strengthen and harmonise strategies for onchocerciasis and NTD control.

36. Following the presentations, JAF agreed that there was a continuing need for cross-border collaboration for NTD control, especially for onchocerciasis, and that this need will continue post-APOC. The Forum therefore encouraged Ministers of Health to continue engaging in sub-regional meetings to improve disease control outcomes. Furthermore, JAF recognised the importance for APOC to maintain a lead role in establishing sustainable sub-regional cooperation, which will be essential even after the closure of the programme.

Status of onchocerciasis transmission in Africa

37. At the closure of SIZ in December 2009, APOC made technical help available to these countries. Currently CDTI, using one annual treatment, achieves geographic and therapeutic coverages of 100% and 80-85% respectively; treating 10 million people in ex-SIZ countries in 2008. The activities carried out are CDTI, epidemiological evaluations and co-implementation of control of onchocerciasis with that of other NTDs. Overall, the geographical coverage was 100% in stable countries, however, in post-conflict countries geographical coverage was lower, for example - Guinea (80%), Cote d'Ivoire (20%), Guinea Bissau (50%). In most cases CDTI activities had been halted in these post-conflict countries, although ivermectin distribution has now resumed.
38. With regards to ex-OCP countries, epidemiological evaluations undertaken in seven countries, showed that all the sentinel villages had infection rates of 5% or below. Whilst, between 2004-2007 an upsurge in prevalence was observed in three communities in Ghana, prevalence has now declined. Currently, epidemiological activities are underway in Mali, Senegal, Guinea Bissau, Benin and Niger. Results from Togo, Ghana and Cote d’Ivoire were unsatisfactory, because of continuous transmission in these areas, for which reason, APOC had provided increased support. Co-implementation is also being conducted in some ex-OCP countries. In conclusion, the entomological situation is satisfactory in most ex-OCP countries, for which indicators have been kept below 5%. This is important in order to prevent recrudescence.

Elimination of onchocerciasis transmission in Africa, where feasible

39. Dr Hans Remme, presented the report of an Informal Consultation on Elimination of Onchocerciasis Transmission in Africa, and the results of evaluation studies undertaken in 2009, that indicated that elimination of onchocerciasis transmission and halting of ivermectin treatment without recrudescence could be a realistic target, at least in some parts of Africa. Scientific evidence from selected foci in Senegal and Mali, was published in an international Journal in July 2009, showing that elimination of onchocerciasis control using ivermectin alone is feasible.

40. Following the presentation, JAF noted with satisfaction that the Informal Consultation had been held at APOC HQ and was pleased to receive the report of this meeting. JAF endorsed APOC’s efforts to evaluate progress towards elimination in its’ CDTI projects and encouraged continuation of these efforts in the coming years. JAF also encouraged APOC to investigate alternative strategies to accelerate progress towards elimination of transmission of infection in trouble-spots, for example by using multiple treatments per year or alternative interventions. Furthermore, as APOC moves from control to elimination where feasible, JAF endorsed further mapping to identify transmission zones and possible additional target areas for treatment. Lastly, JAF asked that APOC management address other recommendations made by the informal consultation.

Co-implementation in Tanzania

41. In 2007, Tanzania developed a five-year integrated NTD control plan, which has been implemented in 36 districts within five regions. APOC and USAID provided a total of US $703,958 to support phase one activities and an NTD Coordinator post was established at the Ministry of Health and Social Welfare (MoHSW), in order to support country-wide co-implementation activities. In 2009, therapeutic coverage with ivermectin and albendazole was greater than 80% and CDI proved an effective strategy for delivery of multiple health interventions. Challenges encountered during the MDA in 2009, included: the need to coordinate different approaches (school-based vs. CDI), human resource and managerial issues for combined multiple interventions, the need for increased financial resources and an unforeseen outbreak of cholera in one Region.

42. JAF decided that APOC should contribute financially and technically to country-led co-implementation efforts to control onchocerciasis and other NTDs using CDTI. JAF recognised the value of the CDTI strategy, for both ivermectin treatment and as a vehicle for delivery of other health interventions and commodities and for strengthening health systems. Therefore, JAF decided that APOC and its partners should ensure that CDI is embedded in national health systems to ensure sustainability of the strategy after ivermectin treatment stops and before APOC phases out. Integration of CDI into national health systems will strengthen them from the bottom up, and deliver improved primary health care at the community level.

43. Lastly, in order to allow for specific comparisons of the costs and benefits of controlling and eliminating onchocerciasis with the costs and benefits of co-implementation with other interventions, JAF decided that obtaining cost analysis data would be desirable in several respects, especially in comparing costs and benefits of multiple disease interventions using CDI. APOC and the World Bank should take the lead in exploring means of obtaining more accurate and specific data.
Statements by Partners

Pfizer

44. Following the recent acquisition of Wyeth by Pfizer Inc., Dr Pol Vandenbroucke, Vice President for Development of Emerging Markets of Pfizer, addressed JAF and confirmed the commitment of Pfizer to continue clinical development of moxidectin. He expressed Pfizer’s hope to prove the efficacy and safety of moxidectin as part of their efforts to make Africa river blindness free.

USAID

45. Increased involvement of USAID in NTD control, starting in 2006, followed recognition by the US Congress of the opportunity to focus on integrated NTD control as a means of achieving cost-effective increases in treatment coverage. The funding represents an unprecedented level of support for NTD control and an opportunity for expanding this programme. The five targeted diseases are; lymphatic filariasis, onchocerciasis, trachoma, soil-transmitted helminthiasis and schistosomiasis. USAID currently supports NTD control through co-implementation with CDTI in South Sudan, Burkina Faso, Democratic Republic of the Congo, Tanzania and Cameroon. USAID funding is intended to supplement or complement that of other donors; working with them to fill gaps that have been identified in order to increase treatment coverage. The present administration announced a new health initiative of which NTDs are a component. It is planned to expand the existing programme for which the US $15 million initially allocated for 2006-8 was subsequently increased to US $25 million in 2009. The amount to be allocated for 2010 has not been announced but may increase significantly.

A new strategy for NTD control is being developed in view of the increased funding, which will include integrated programmes and scaling up of the key elements of MDA, including mapping. Countries are requesting assistance from USAID for morbidity control and improved sanitation and these will be incorporated into the new strategy. In conclusion, this is an exciting time to build on existing achievements for NTD control. Steps to be taken include the development of costed NTD national plans, mapping of disease programmes and accurate forecasting to enable sufficient quantities of drugs to be made available for timely treatment of populations. The new administration is expected to push for elimination of lymphatic filariasis.

CIDA Canada

46. CIDA has supported onchocerciasis from the establishment of the Onchocerciasis Control Programme in 1974. Canadian aid is now focussing on the development of a new model for strengthening primary health care (PHC). In 2006, the Canadian Prime Minister announced an initiative for strengthening PHC in Africa, development of human resources, equity in delivery of services and research in public health and health systems. CDTI is considered to be a highly appropriate approach for pursuing this initiative.

World Bank

47. The World Bank has endorsed its approach for engaging in the health sector through health systems strengthening for which the Bank has a comparative advantage. The Bank continues to assist lower and middle income countries with control of malaria, HIV/AIDS, TB and onchocerciasis. The board of the Bank is shifting emphasis towards assisting in strengthening health care systems. In line with that new strategy, funds have been allocated, half of which are being provided for results-based funding, for which successful schemes have been initiated. The Bank is now looking to see how APOC can be oriented towards health systems strengthening. APOC is increasing its strength on the system side, especially with delivery systems where these are complementary to the overall health system. The APOC approach involves primary health care from the bottom up and this concept has energised the World Bank President, who is now enthusiastic to involve APOC in this area. There is now a need to develop a systems approach for NTD control and to formulate a longer-term strategy for APOC to implement NTD control at the community level.
Belgium

48. In order to address some of the gaps in the delivery of primary health care in Africa, we need to look at the potential of onchocerciasis control to provide a more general approach to the delivery of health services. To provide this requires a discussion on APOC positioning based on either a project or programmatic approach.

DFID (UK)

49. In September 2009, the UK Government committed £50 million for NTD control. Some of these funds have been channelled through the Carter Center and some provided for procurement of drugs for control of schistosomiasis and STH.

Centre for Neglected Tropical Diseases (CNTD), Liverpool

50. Professor Moses Bockarie, the new Director of CNTD, announced the receipt of £10 million from DFID and GSK for activities related to NTD control. The Liverpool Centre for Neglected Tropical diseases now has a mandate beyond lymphatic filariasis and will expand its focus on training to support six countries and research laboratories for NTD surveillance. The Centre has made a call for fellowships and supports regional workshops for training and monitoring and evaluation. Support for operational research and integrated control based on the CDI strategy will also be increased.

Training of CDDs

51. The number of CDDs newly trained or re-trained increased from 147,202 in 2004 to 405,552 in 2008, of whom 277,679 were retrained and 127,843 newly trained. The number of health workers trained increased from 36,404 in 2007 to 39,556 in 2008 of whom 25,537 were retrained and 13,919 newly trained.

52. Following the presentation, it was noted that progress is being made with gender-mainstreaming within the APOC programme, particularly in the training and retraining of CDDs. Opportunities were identified for improving the reporting of such activities by disaggregating existing and future data, by gender. JAF urged APOC to continue mainstreaming gender throughout its activities and to report on this aspect at future JAF meetings.

53. The need for Information, Education and Communication (IEC) materials produced in national languages to facilitate and strengthen the work of country Programmes was discussed. To this end, JAF agreed that the APOC Trust Fund should be used to produce IEC documents in national working languages to satisfy specific country needs.

Outcome of the closed door sessions

54. Separate closed-door sessions of African Health Ministers, Donors and NGDOs were held with the following outcomes:

Statement by Ministers of Health

55. The closed session of Ministers discussed three agenda items: 1) Cross-border collaboration and setting up of a Ministerial sub-committee, 2) National ownership and financing CDTI projects and 3) Financial support to elimination of onchocerciasis transmission in areas where feasible. The Ministers’ made the following recommendations to JAF: (i) a sub-ministerial committee was not needed; rather, cross-border activities on onchocerciasis should be taken up by a technical committee that would meet and prepare a report for JAF and that report would be used to brief Ministers during closed sessions; (ii) that CDTI is a very useful and effective model strategy taking into consideration a
bottom up, grass-roots approach, and donors should continue to provide technical and financial support to strengthen capacity building and national ownership of CDTI projects; (iii) The Ministers reaffirmed their commitment to increase their budget and to the fight against onchocerciasis.

56. Following the statement of Ministers of Health, JAF approved all the recommendations from the Ministers, including the request for APOC to extend financing to all projects in Cameroon up to 2015.

Statement by NGDO Group

57. The closed session of the NGDO Group discussed the following issues: sustainability of the ivermectin programme, the responsibility of governments to address challenges related to the motivation and incentives for CDDs work; the challenge of maintaining the principles of CDTI where school-based treatments are also given; the need to develop integrated packages of training and the need to strengthen monitoring systems to ensure that CDDs appropriately apply the skills learnt.

58. Following the statement of the NGDO Group, JAF thanked the Group for their continued support to the communities and countries and urged Governments to address the issues related to incentives for CDDs.

Statement by Donors

59. Donors feel that national ownership is a necessity in order to ensure programme sustainability. Countries are encouraged to extend national ownership and to find means of assessing Health strengthening metrics. Yearly progress reports should be provided that are linked to specific targets and objectives.

60. Following the statement of donors, JAF decided that APOC should undergo a mid-term external evaluation of the programme in 2010. Lastly, JAF thanked the donors for their unwavering support and commitment to the programme

Health Impact Assessment of APOC operations

61. Professor, Dik Habbema from the Department of Public Health, Erasmus MC, University Medical Centre Rotterdam, the Netherlands, presented an update of the health impact of APOC to JAF, including calculations on the burden of the disease in Disability Adjusted Life Years (DALYs). In 2008, the geographical coverage of APOC programmes increased by 1.4% to 82.2% from 2007 figures. However, a slight decline was observed with the therapeutic coverage which fell from 62.5% in 2007 to 61.2% in 2008. Based on simulated trends in prevalence of infection and disease, the number of prevented disease cases in APOC countries in 2009 were: Infection - 24 million, Itch – 12,000 and Low vision or blindness – 400,000. The loss of more than 1 million DALYs was prevented by APOC in 2008.

62. Data on the funding of OCP/APOC and its impact were also presented. On average, the donor contribution to OCP/APOC is $30 million per year, and in 2008, just under $15 million (0.5% of total donor aid to health) was received by APOC from donors for onchocerciasis activities. During the same year, treatment cost was $0.25 per person. Erasmus and APOC activities for 2010 include; the revision of the ONCHOSIM software, which is now 20 years old; validation of model predictions against trends in epidemiological data, and the provision of HIA at project level. Additionally, an analysis of the synergistic effects of co-implementation of interventions, both in terms of costs and benefits, would be essential.
63. Dr Tony Ukety, Coordinator of the NGDO Coordination Group for Onchocerciasis Control, presented the annual report of the Group. During the year under review, the Group continued to provide managerial, technical, and financial support to APOC, ex-OCP countries and the Onchocerciasis Elimination Programme for the Americas (OEPA). Dr Ukety, informed JAF that in March 2009, the Malaria Consortium and the International Agency for the Prevention of Blindness (IAPB) joined the NGDO Group as ‘member’ and ‘associate member’ respectively, bringing the total number of NDGO ‘members’ to 15 and ‘associate members’ to 3. He also highlighted the outcome of an event of this Group which was held on 8-10 September 2009 in Accra, Ghana, in conjunction with the International Coalition for Trachoma Control (ICTC) and the Lymphatic Filariasis Non-Governmental Development Organizations Network (LF NGDO Network). The main outcome of this meeting was the establishment of the ‘Non-Governmental Development Organisations Neglected Tropical Diseases Network’ (NGDO NTD Network), and subsequently the nomination of Dr Adrian Hopkins, Director of the Mectizan Donation Program and Mr. Simon Bush, Director, African Alliances & Advocacy from Sightsavers International, as Chair and Vice-Chair respectively, of the Network on a two year term.

64. JAF received the report with thanks and commended the NGDO Coordination Group for Onchocerciasis Control for their continued support.

Update from the Multi-Disease Surveillance Centre (MDSC)

65. Professor Evariste Mutabaruka, acting Director, MDSC, informed JAF of the proposal to turn MDSC into a Centre of excellence that was discussed in July 2009 by ECOWAS Ministers. MDSC is collaborating with regional training centres in order to improve availability of qualified laboratory technicians and managers trained in modern diagnostic techniques and quality assurance systems. Such a regional disease surveillance system would provide a platform for policy harmonisation, cross-border collaboration, coordination of response to trans-boundary epidemics, capacity building, experience sharing and resource mobilisation. Professor Mutabaruka appealed to donors and partners for additional funding to enable the Centre to achieve its goals and objectives.

66. JAF noted the information provided and congratulated MDSC on this development.

Current research within APOC and TDR collaboration

67. Dr Annette Kuesel, from TDR, gave an update on the ongoing development of Moxidectin, which is being conducted in collaboration between WHO and Pfizer, USA. Phase two studies have now been completed in Ghana on 172 ivermectin naive subjects, and final data will be available in the second quarter of 2010. In Liberia, studies commenced in April 2009 and 156 subjects have been treated to date. In DRC, approval from the Ministry of Health was received in December 2009, which led to the initiation of the study in the same month. Dr Kuesel highlighted the importance of preventing delays in Phase three, which would otherwise cause a number of problems including: the advancement of CDTI into the study area; insufficient ivermectin-naive subjects for study; delays in decisions on moxidectin provision to Africa, and increased development costs. The next step for the project is to conduct community studies on about 40,000-80,000 subjects, in countries that are yet to be identified.

68. Other completed studies include; firstly, the examination of the effect of early treatment with albendazole and diethylcarbamazine on progression of LF (Brugia malayi) pathology in 3-15 yr old children. After, six 6-monthly treatments with 400 mg Albendazole plus 6 mg/kg Diethylcarbamazine, results from 94 subjects (children) showed cleared microfilaraemia in 100% (32/32) of subjects; relieved early lymphoedema in 75% (3/4); and reversed lymph vessel dilation in 89.6% (69/77). Secondly, a study on the effect of bimonthly treatment with albendazole on Loa loa microfilaraemia
conducted in Cameroon, showed that albendazole treatment does not decrease *Loa loa* microfilaraemia sufficiently. Lastly, was the development by TDR of a tool to monitor ivermectin efficacy.

69. Following the presentation, JAF noted that current data suggest that elimination of onchocerciasis where feasible using CDTI with annual distribution would take more than 10 years of continuous high treatment coverage. The possibility of twice-yearly ivermectin treatment expediting progress towards elimination compared with the standard single annual treatment was raised. Twice-yearly treatment may effect this sooner, but current studies have yet to provide scientific evidence to justify twice-yearly treatment as a better approach in APOC countries. Therefore, JAF urged APOC, TDR and TCC to determine if twice-yearly treatment hastens elimination and shows benefits over annual treatment in health impact and overall cost. Further studies on Moxidectin should be accelerated and results should be made available as early as possible.

Audit Report

70. The Forum took note of, and accepted, the Auditor’s report, read by the Legal Counsel of WHO.

Addendum to Plan of Action and Budget 2008 – 2015

71. During JAF 14, the Forum had noted that additional funding would be required by APOC for implementation of the expanded activities for the period 2010-2015, especially in consideration of the increased demands for co-implementation of NTD control with CDTI. APOC presented to JAF 15 an indicative supplementary addendum for the period 2012-2015. It was emphasised that this was an indicative budget and that following further consultation with partners, APOC management would submit a detailed document with a revised budget taking into account the needs of countries for 2012-2015 to be received by JAF, 30 days before JAF 16. The areas expected to be covered in next years’ submission include; strengthening health systems, moving towards elimination of onchocerciasis transmission where feasible, co-implementation of NTD control with CDTI, human resource development and management.

Plan of Action and Budget for 2010-2011

72. JAF approved the Plan of Action and Budget for 2010-2011 and the corresponding budget for the amount of US $57,415,000. It was reported that budgetary planning had shifted from annual to biennium budgets in accordance with the GSM system. The budget has increased, mainly due to up-scaling of activities in post-conflict countries, expanding co-implementation to 62 CDI projects, strengthening research on surveillance markers, strengthening staffing, and strengthening of health systems.

73. Following the presentations of the audit report, addendum to the PAB and the financing of APOC, the following points were raised during the plenary discussion:

(i) The issue of cross-border activities in all sub-regions was discussed as was the equitable distribution of funds across countries and regions. APOC management reminded JAF that cross-border issues are part of the strategic plan (page 9) in which it is stated that APOC will promote and co-finance Ministerial and cross-border meetings and this was done in 2009. Distribution of funds to countries is based on needs; funding to post-conflict countries and central Africa has therefore increased, whilst ex-OCP countries do not receive disproportionate funding but receive what is essential to maintain the benefits achieved by OCP.
Concern was expressed that there may still be under-budgeting, given the move towards elimination of transmission where feasible and the need for improved diagnostic tools and additional operational research. The need for clearer concepts for post-treatment surveillance was noted. It was also recognised that the CDTI/CDI strategy has been a highly significant development for health system strengthening, however, where health systems are weak parallel systems may be set up and FLHF need some support.

The clear goals of the PAB were commended but the percentage (17%) for administrative costs was questioned. APOC management explained that this had previously been between 10-15%, but had risen largely because of the need to increase support to the 7 post-conflict countries. In these countries, following recommendations of TCC and with CSA approval, APOC provided experienced field people as Technical Advisers to work with their Ministries of Health and NOTFs. Furthermore, country visits by TCC members, recruitment of consultants and increased staffing at APOC HQs had increased costs. Additionally, APOC is recruiting epidemiologists, a health system specialist and a person to take responsibility for co-implementation. An additional point of discussion was the possible advantage for APOC to move from a project to a programmatic approach that might ease the administrative burden and fit better into National plans for co-implementation. This could also allow APOC to concentrate more on organisational tasks and M&E.

The issue of APOC moving from control to elimination of onchocerciasis transmission where feasible was discussed. It was noted that this had financial implications and that because of the inadequate knowledge of the epidemiological heterogeneity throughout endemic countries it was important to be aware that elimination may not be feasible or cost effective in all areas. In relation to this, there is a need for improved diagnostics and surveillance.

APOC was commended for efforts towards gender mainstreaming and it was noted that AfDB is now working closely with APOC in this area; however, there is need for a mechanism to ensure that women are engaged in elimination of infection.

APOC management agreed to include in the budget the request to document “best practices” for Community-directed interventions.

The ability of NGOs to take over responsibility for supporting CDTI projects following APOC’s withdrawal of funds would depend upon their ability to raise funds and this could not be guaranteed.

Financing of the African Programme for Onchocerciasis Control (APOC)

Dr Ok Pannenberg introduced Dr Don Bundy, formerly a Professor at Oxford University, UK, who will be taking over as the World Bank’s Onchocerciasis coordinator following Dr Pannenberg’s retirement. It was noted that APOC is one of the largest partnerships in public health in terms of scope, financing and duration. The World Bank, as fiscal agents of APOC, would like the tenure of this role to be marked by transparency and will be indicating resource flows on its website along with financial forecasts and projections. A second characteristic is due diligence with respect to the fiscal aspect including costs and resource flows. APOC is one of the largest players in terms of regional activity in public health. Regarding its financial history, the cumulative costs of OCP and APOC since 1974 total US $1.1 billion. This shows that the scale of investment is now plateauing, which is a good thing as it indicates increased cost efficiency. In terms of total receipts, the resource flows of the first and second phases of APOC show a consistent upward trend. The earlier NGDO presentation showed that its contribution was US $5-6 million so the actual resources are at least 50% greater. It was stated previously that the contribution of Governments was US $25 million, which also makes the total substantially higher. As part of the APOC team, the Bank would like to consult with NGDOS about their contributions and move towards results-based financing according to the numbers of people treated. The maps showing the shrinking of onchocerciasis distribution produced by APOC and TDR are impressive, demonstrating how the investment in APOC is really translating into health improvements. The Strategic Plan and Budget of APOC is being used as the target for financing. JAF 14 had determined that we were 20% behind for this plan; this does not include NGDO or Government
expenditure. Expenditure in 2008 and 2009 is more or less on target and there is more to be disbursed in 2009. The Bank thanked the 20 donors for their patience in working through the funding mechanisms and for their contributions. Based on current pledges and receipts the programme is fully funded and has a cushion of funding for 8 years. Major new challenges that are not costed include the NTD agenda, activities in DRC and the need to respond to challenges of post-conflict countries. Based on the indicative budget of around US $60 million, forecasting shows that additional pledging that has been discussed with new donors comes to between $34-42 million, so there will still be a shortfall of $20 million but there are other donors that are likely to provide funding if NTDs and health system strengthening are among the goals.

75. In discussions it was suggested that for health system strengthening and new funding initiatives from USAID and DFID, it would be timely to have an independent evaluation of APOC.

Donor Pledges

76. The international donor community reaffirmed their commitment to onchocerciasis control in Africa, with new and additional pledges:

a) **Kuwait Fund**: The Kuwait Fund has been contributing to Onchocerciasis control since 1974 and will continue making contributions up to 2015. For the coming year the contribution is US $1.5 million.

b) **Kingdom of Saudi Arabia**: Saudi Arabia has supported OCP from the beginning and subsequently APOC, and will continue supporting the programme to the end with the sum of US $43 million. The Kingdom of Saudi Arabia supports the PAB for the coming year and pledges the sum of US $2 million for 2010-2015.

c) **DFID**: The United Kingdom has pledged £50 million for NTD control up to 2014 and will continue to support APOC. For the coming year DFID will give £500,000 for ongoing APOC activities.

d) **Canada - CIDA**: Canada will continue to finance APOC between 2009 and 2015. Canadian dollars $4.5 million have already been given in 2009 and $2.4 million will be disbursed in 2010.

e) **World Bank**: The World Bank is pleased with APOC proposals and in its capacity as donor rather than as fiscal agent will give US $2 million for 2009-2010 and will continue to do so for 2010-2011 in line with APOC’s mandate for CDTI and expanded mandate for NTD control.

f) **USAID**: This year USAID awarded a new grant with a ceiling of US $25 million for the period 2008-2015 and will provide $2 million to APOC in 2010. USAID noted the highly successful collaboration with APOC over the years.

g) **Merck & Co., Inc.**: At JAF13 Merck pledged US $25 million for the period 2008-2015 and for 2010 will contribute $3.125 million to the trust fund.

h) **NGDO Group**: The NGDOs do not support the APOC trust fund financially but reconfirmed their commitment at current levels. The group has grossly underestimated their contributions to APOC and this will be fully acknowledged at a later date.

i) **Belgium**: The contribution of Belgium for 2010-11 will be €400,000 per year.

j) **Netherlands**: Like Belgium, the Netherlands makes a multi-year contribution and has already given €2 million and will give the same amount of €2 million in 2010. After 2011 it is not likely that the Netherlands contribution will grow but the country will, nonetheless, continue to support APOC.
k) **African Development Bank:** The African Development Bank made a pledge in Brussels and that funding was approved for 2008-2015, and disbursement of funds had begun in 2008-9, and will continue as planned to the tune of 15 million units of account, which is approximately equal to US $23 million.

77. Following the pledges, APOC management on behalf of the beneficiary communities, expressed their profound appreciation for the donations and reassured the donor countries and institutions, of the programme’s commitment to the elimination of onchocerciasis in Africa.

**Other matters**

**Special tribute to champions of onchocerciasis control**

78. JAF acknowledged the dedicated contributions to APOC and onchocerciasis control in Africa made over many years by Dr Ok Pannenborg, World Bank, Dr Hans Remme, former WHO/TDR, Dr Claude-Henri Vignes, former WHO Legal Counsel and Professor Allan Foster, CBM.

**Date and place of JAF16**

79. At the kind invitation of the Federal Government of Nigeria, the 16th session of JAF will be held in Abuja, Nigeria. Dates will be communicated to JAF members in the coming months.

**Review of Final Communiqué**

80. The Final Communiqué was reviewed and adopted.

**Closure of the Fifteenth JAF Session**

81. In her closing remarks, Dr Amazigo, on behalf of the onchocerciasis affected communities, thanked the donors, governments and the NGDOs. She reiterated that APOC would undergo a mid-term external evaluation of the programme in 2010, as requested by the donors. Finally, Dr Amazigo thanked the AfDB, in particular Dr Ilunga for organising JAF15.

82. The chairman commended participants for the quality deliberations during JAF 15, and the development partners for their dedicated commitment to onchocerciasis control activities. He called upon fellow Ministers of Health to intensify advocacy activities and to consult with their respective heads of government, as a way of strengthening political will and commitment towards fighting onchocerciasis. Lastly, the Chair thanked the Government of Nigeria for extending the invitation to host JAF 16.
Annexes

Annex 1

African Programme for Onchocerciasis Control (APOC)
Programme africain de lutte contre l'onchocercose

JOINT ACTION FORUM
Office of the Chairman

JAF-FAC
FORUM D’ACTION COMMUNE
Bureau du Président

JOINT ACTION FORUM
Fifteenth session
Tunis, Tunisia, 8-10 December 2009

ORIGINAL: ENGLISH
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LIST OF PARTICIPANTS/LISTE DES PARTICIPANTS

APOC COUNTRIES/PAYS APOC

Burundi

01. Dr Emmanuel GIKORO, Ministre de la Santé Publique, B.P. 1820 Bujumbura, République du Burundi – Tel: (+257) 22229195 – Fax: (+257) 22229196– Email: egokoro2001@yahoo.fr

02. Dr Norbert BIRINTANYA, Directeur Général de la Santé Publique, Ministère de la Santé Publique, B.P. 1820, Bujumbura, République du Burundi – Tel: (+257) 777732134; (+257) 22242542 – Fax: (+257) 22229196 – Email : birintanya@yahoo.fr

03. Dr Onésime NDAYISHIMIYE, Coordonnateur National du Programme « Maladies Tropicales Négligées », Ministère de la Santé Publique, B.P. 3128, Bujumbura II, République du Burundi – Tel: (+257) 777735102 – Fax: (+257) 22229196 – Email: ndayones@yahoo.fr

04. Dr Didace MBARRIMBANYI, Coordonnateur National, Programme National de lutte contre l’Onchocercose, B.P. 1820, Bujumbura, Burundi - Tel: (+257) 22249333; (+257) 22249334 – Fax: (+257) 22229196 – Email: mbarididace@yahoo.fr; pnloburundi@yahoo.fr

Cameroon/Cameroun

05. Monsieur André MAMA FOUDA, Ministre de la Santé Publique, Yaoundé, Cameroun – Tel : (+237) 22 220-172 – Fax: (+237) 22 220-233- Email: andramama@yahoo.fr

06. Professeur Gervais ONDOBO ANDZE, Directeur de la Lutte contre la Maladie, Président du GTNO, Ministère de la Santé Publique, Yaoundé, Cameroun – Tel: (+237) 22 23 93 48 – (+237) ; L.D.: (+237) 22 23 33 84 – Cellulaire: (+237) 99 86 44 01 – Fax: (+237) 22 22 44 19 – Email: andzegervais@yahoo.fr

07. Dr Marcelline Dorothee Noël NTEP, Coordinateur du Programme National de lutte contre l’Onchocercose/ Secrétaire Exécutif du GTNO, Ministère de la Santé Publique, Yaoundé, Cameroun – Tel/fax: (237) 22 226-910 – Cellulaire: (+237) 99 81 08 01; (+237) 77 30 01 60 – Email: sgoa@camnet.cm; mangamar2001@yahoo.fr
Democratic Republic/Рépublique Centrafricaine

08. M. André NALKE DOROGO, Ministre de la Santé Publique, de la Population et de la Lutte contre le Sida, B.P. 883, Bangui, République centrafricaine – Tel: (+236) 21 61 47 29 (direct) et (+236) 75 505417 – Fax: (+236) 21 61 27 49 – Email: analkedorogo@yahoo.fr

09. Dr Bénoin KEMATA, Coordonnateur National du Programme National de Lutte contre l'Onchocercose, Ministère de la Santé Publique, de la Population et de la Lutte contre le SIDA, B.P. 1772, Bangui, République centrafricaine, Tél: (+236) 70 40 26 01; (+236) 72 77 46 75; s/c WR (+236) 21 61 01 37 - Email: bkemata@yahoo.fr

Chad/ Tchad

10. Dr NGOMBAYE DJAIBE, Ministre de la Santé Publique, B.P. 440, N'Djamena, République du Tchad – Tel: (+235) 2515114- Fax: (+235) 6291637 - Email: djaibe_n@yahoo.fr

11. Dr Ndeikoundam NGANGRO MOSUREL, Directeur Général des Activités Sanitaires, Ministère de la Santé Publique, B.P. 440 N'Djamena, République du Tchad – Tel: (+235) 2 52 28 66 – Email: ndeikoundam@yahoo.fr

12. Mr. Hassane SALIM, Directeur de Cabinet du Ministre de la Santé Publique, B.P. 440, N'Djamena, République du Tchad – Tel : (+235) 6291637 – Email : hphas@yahoo.fr

13. Dr Dadjim BLAGUE, Directeur Système de Santé, Ministère de la Santé Publique, B.P. 440, N'Djamena – République du Tchad - Tel: (+235) 6348952 – Email: dadjimb@yahoo.fr

14. Dr Mahamat Saleh YOUNOUS, Secrétaire Général du Ministère de la Santé Publique, B.P. 440, N'Djamena, République du Tchad – Tel: (+235) 6293614 – Email: msyounouss@ yahoo.fr

15. Monsieur Lokemla NADJILAR, Coordonnateur National du Programme de Lutte contre l'Onchocercose (PNLO), B.P. 440 N'Djamena, République du Tchad – Tel (+235) 629 01 64; (+235) 913 38 96 – Fax: (+235) 252 48 38 – Email: nadjilar@yahoo.fr

16. Mr. Akouna Bénoit PIRCOLOSSOU, Chef de Canton, Bayaka, Region Tandjile, République du Tchad

Republic of Congo/Рépublique du Congo

17. Prof. OBENGUI, Directeur de l’Epidémiologie et de la Lutte contre la Maladie, Ministère de la Santé et de la Population, Direction de l’Epidémiologie et de la Lutte contre la Maladie, Brazzaville, République du Congo – Tel: (+242) 5563544; (+242) 4202580 – Email: docteur_obengui@yahoo.fr

18. Dr François MISSAMOU, Coordonnateur National du Programme National de Lutte contre l’Onchocercose (PNLO), Ministère de la Santé et de la Population, Direction de l’Epidémiologie et de la Lutte contre la Maladie, BP 1066, Brazzaville, République du Congo – Tel: (+242) 52549 41; (+242) 6680563 – Email: opc_congo@yahoo.fr

Democratic Republic of the Congo/Рépublique Démocratique du Congo

19. Dr Fortunat TSHITOKA NTUMBA TUDIK, Superviseur National, Programme National de Lutte contre l’Onchocercose (PNLO), Ministère de la Santé Publique, Avenue de la Justice, n° 36, Kinshasa-Gombe, République Démocratique du Congo – Tel: (+243) 994 538 960; (243) 813395626 – Email: dfntumbacito@yahoo.fr
Equatorial Guinea/Guinée Equatoriale

20. Dr Anacleto SIMA NSUE, Directeur National, Programme Onchocercose et Autres Filarioses, Ministère de la Santé et du Bien-Etre Social, Malabo, Guinée Equatoriale – Tel: (240) 232620

21. Dr Rufino NGUEMA ANDEME, Technicien, Programme National de Lutte contre l’Onchocercose (PNLO), Ministère de la Santé et du Bien-Etre Social, Malabo, Guinée Equatoriale – Tel: (240) 270124 – Email: vanguemaandeme@yahoo.es

Liberia

22. Mrs. Helena KAMARA, Program Manager, National Eye Care Program, Ministry of Health & Social Welfare, Capitol By-pass, P.O. Box 10-9009, 1000 Monrovia 10, Liberia – Tel: (+231) – Email: hkama_wvl@yahoo.com

23. Mr Abraham W. NYENSWAH, Deputy Program Manager, Ministry of Health & Social Welfare, Capitol By-pass, P.O. Box 10-9009, 1000 Monrovia 10, Liberia – Tel: (+231) 6747602; (+231) 77025215 – Email: nynswah@yahoo.com

Malawi

24. Mr. Laston SITIMA, National Coordinator, CHSU, P/Bag 65, Lilongwe, Malawi – Tel: +265 1 750 896; + 265 888 303 446 – Fax: +265 1 753 308 – Email: laston-sitima2000@yahoo.com

25. Dr Lillian Matolase GONDWE CHUNDA, District Health Officer, Blantyre District Health Office Private Bag 66 Chichiri, Blantyre 3, Malawi - Tel: (+265) 995249724 - Fax (+265) 1 872551 - Email: lmchunda@gmail.com

Nigeria

26. Dr Michael ANIBUEZE, Director, Public Health, Federal Ministry of Health, New Federal Secretariat Complex, Shehu Shagari Way, P.O. Box 083, Garki, Maitama-Abuja, Nigeria – Tel: (+234) 8033139474 – Email: mikanibileze@live.com

27. Dr Emmanuel C. MERIBOLE, Technical Assistant to the Honourable Minister of Health, New Federal Secretariat Complex, Shehu Shagari Way, P.O. Box 083, Garki, Maitama-Abuja, Nigeria – Tel: (+234) 8023071624 – Email: meribole@yahoo.com

28. Mr. Chukwu OKORONKWO, Programme Officer, National Onchocerciasis Control Programme (NOCP), New Federal Secretariat Complex, Shehu Shagari Way, P.O. Box 083, Garki, Maitama-Abuja, Nigeria – Tel: (+234) 80336198945 – Email: chukoro_christ@yahoo.co.uk

29. Mr. Sulaiman AUDU, Protocol Officer, New Federal Secretariat Complex, Shehu Shagari Way, P.O. Box 083, Garki, Maitama-Abuja, Nigeria – Tel: (+234) 8036050451 – Email: kamishe2000@yahoo.com

Sudan/Soudan

30. Dr Tabita SHOKAI, Honourable Federal Minister of Health, Ministry of Health, Khartoum, Sudan – Tel: (+249) 183774381; (+249) 912309169 – Email: fmohshokai@yahoo.com
31. Dr Hashim Mohamed Osman KAMAL, Chairman of the NOTF, Director, Prevention of Blindness Administration, Federal Ministry of Health, Nile Avenue, P.O. Box 630, Khartoum, Sudan - Tel: (+249) 183741422 – Fax: (+249) 183741421 – Mobile: (249) 912309628 – Email: kamalbinawi@yahoo.com

32. Dr. Adil SULIEMAN MOHAMED, Federal Ministry of Health, Curative Medicine Department, Khartoum, Sudan – Tel: (+249) 912332880 – Email: rowahail.com

Southern Sudan/Sudan

33. Dr Nathan RIAK ATEM, Director General for Preventive Medicine, Ministry of Health, Government of Southern Sudan, Juba – Tel: (+249) 907710546 – Email: atemd@gmail.com

34. Dr Mounir Lugga, Director NTDs, Ministry of Health, Government of Southern Sudan, P.O. Box 88, Juba, South Sudan – Tel: (+249) 926590019 – Email: mounir_lado@yahoo.co.uk

35. Mr F. Bizuneh, NGDO Coordinator, CBM-Kenya, South Sudan - Tel: +254-725954977 – Fax: +254-0203751654 – Email: fbchane@yahoo.com

Tanzania/Tanzanie

36. Prof David H. MWAKYUSA (MP), Honourable Minister of Health and Social Welfare, Samora Avenue, P.O. Box 9083, Samora Avenue, Dar-es-Salaam, Tanzania – Tel: +255 22 2127192 – Fax: +255 22 2138060 – Email: dmwyakusa@moh.go.tz

37. Dr Donan William MMBANDO, Director for Preventive Services, Medical Doctor, Public Health Physician, Ministry of Health and Social Welfare, P.O. Box 9083, Samora Avenue, Dar-es-Salaam, Tanzania – Tel: 255 22 2120061-7 – Fax: +255 22 2138060 – Email: dwmmbando@hotmail.com

38. Dr Nkundwe G. MWAKYUSA, Program Coordinator, Ministry of Health and Social Welfare, P.O. Box 9083, Samora Avenue, Dar-es-Salaam, Tanzania – Tel: +255 22 2130025 – Fax: +255 22 2130009 – Email: tukku29@yahoo.com

39. Mr. Titus Aloyce MKAPA, Minister's Private Secretary, Ministry of Health & Social Welfare, Samora Avenue, P.O. Box 9083, Samora Avenue, Dar-es-Salaam, Tanzania – Tel: +255 22 2127192 – Fax: +255 22 2138060 – Email: tamkapa@yahoo.com

Uganda/Ouganda

40. Dr Stephen Oscar MALINGA, Honourable Minister of Health, Ministry of Health, P.O. Box 7272, Kampala, Uganda - Tel: (+256) 772404703 – Email: smallingal@yahoo.com

41. Dr Dennis Wilfred Kigambe LWAMAFA, Commissioner Health Services, Department of National Disease Control, Ministry of Health, P.O. Box 7272 Plot 6, Lourdel Road, Nakasero, Kampala, Uganda - Tel/Fax: (+256)414-259-666 - Fax: (+256)414-348-339 - Email: lwamafa@yahoo.co.uk; lwamafa@hotmail.com

42. Mr. Tom Luroni LAKWO, Senior Entomologist, National Onchocerciasis Control Programme (NOCP) Secretariat, Ministry of Health, 15 Bombo Road, P.O. Box 1661, Kampala, Uganda – Tel: (256) 414 348-332; Mobile: (256) 772-438-311 – Fax: (256) 414-348-339 – Email: lakwo2001@yahoo.com
OCP COUNTRIES/PAYS OCP

Burkina Faso

43. Dr Sylvestre Roger Marie TIENDREBEOGO, Directeur de la Lutte contre la Maladie, 03 B.P. 7009, Ouagadougou 03, République du Burkina Faso – Tel: (+226) 70 25 94 38 – Fax: (+226) 50 31 54 40 – Email: syltiend@hotmail.com

Côte d’Ivoire

44. Dr Rémi ALLAH KOUDIO, Ministre de la Santé et de l’Hygiène Publique, Ministère de la Santé et de l’Hygiène Publique B.P V4, Abidjan, République de Côte d’Ivoire –Tel: (225) 20 21 08 71 – Fax: (+225) 20 22 22 01 – Email: allahremi@yahoo.fr

45. Dr Marie Madeleine KOUAKOU IILLINGA, Directeur Coordonnateur du PNLC6, 25 B.P. 299, Abidjan 25, Cocody-Danga, République de Côte d’Ivoire – Tel: (+225) 07 08 38 03 – Fax: (+225) 22 44 37 83; (+225) 22 44 37 01 – Email: magdy_koua@yahoo.fr

46. Dr Pierre Gbayoro BRIKA, Directeur Coordonnateur Adjoint du PNLC6, Ministère de la Santé et de l’Hygiène Publique, 06 BP 7172 Abidjan 06, République de Côte d’Ivoire – Tel: (+225) 09 24 27 77 – Fax: (+225) 22 44 37 01 – Email: gbayoropierre@yahoo.fr

Ghana

47. Dr Joseph Akkesi AMANKWAH, Director, Public Health Division, Ministry of Health, P.O. Box M44, Ministries, Accra, Ghana – Tel: (+231) 21 68 08 92 – Email: joseph.amakwa@dhsmail.org jaamankwa@yahoo.com

Guinea/Guinée

48. Dr André GOEPOGUI, Coordonnateur National, Programme National de Lutte contre l’Onchocercose et la Cécité (PNLOC), Ministère de la Santé et de l’Hygiène Publique, BP 585, Conakry, République de Guinée - Tel: (+224) 60 29 31 59 – Email: agoep@yahoo.fr

Guinea-Bissau /Guinée Bissau

49. Dr Augusto Paulo DA SILVA, Secrétaire d’Etat de la Santé, Ministère de la Santé Publique, Av. Clinidade C.P. 1013 - 50, Guinée Bissau – Tel: (+245) 672 99 78 – Mobile: (+245) 663 30 27 – Email: augustopaulo.silva@gmail.com

50. Dr Ramalho Joao CORREIA, Directeur Régional de la Santé et Coordonnateur National Oncho, Ministère de la Santé, B.P. 50, Gabu, Guinée Bissau, Tel: (+245) 677 19 16 – Email: rantonia2006@yahoo.es

Mali

51. Dr Mamadou Oumar TRAORE, Coordonnateur du Programme National de Lutte contre l’Onchocercose, Direction Nationale de la Santé, B.P. 233, Bamako, République du Mali – Tel: (+223) 66 71 17 66; (+223) 20226497 – Email: traoremot@yahoo.fr
Dr Mallam Ekoye SAIDOU, Secrétaire Général, Ministère de la Santé Publique, BP 623 Niamey, République du Niger, Tel: (+227) 96 02 16 17 – Email: ekoye_saidou@yahoo.fr

Dr Adamou SALISSOU, Coordonnateur National, Programme National de Dévolution Onchocercose et Elimination de la Filariose Lymphatique (PNDOLF), BP 623, Niamey, République du Niger – Cellulaire: (+227) 96 96 03 76 – Fax: (+227) 20 35 03 46 – Email: sadamouba@yahoo.fr

Dr Santigie SESAY, Programme Manager, ONCHOA, ITDs Control Programmes, c/o New England Ville, Freetown, Sierra Leone – Tel: (+232) 76 60 4658 – Email: sannqmail.com

Dr Koffi Potochoziou KARABOU, Coordonnateur, Programme National de Lutte contre l’Onchocercose, BP 487 DRS/Kara, République Du Togo – (+228) 66 01 70; (+228) 66 00 35 – Cellulaire: (+228) 902 47 95 – Fax: (+228) 66 04 14 – Email: karaboup@yahoo.fr

Mr. Thomas HURLEY, Directeur, Département du Développement Humain (OSHD), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002, Tunisie - Tel: (+216) 71 10 20 46 – Email: t.hurley@afdb.org

Dr Tshinko Bongo ILUNGA, Chef de Division, Division Santé, Département du Développement Humain (OSHD.3), Banque Africaine de Développement, 13 Rue du Ghana, 1002, Tunis, Tunisie, Tel: (+216) 71 10 21 17, Email: t.ilunga@afdb.org

Mr. Mohamed Mohsen CHAKROUN, MD, MPH, Expert en Santé, (OSHD.3), Banque Africaine de Développement, Avenue Hedi Nouira, B.P. 323, 1002 Tunis Belvédère, Tunisie, Tel: (+216) 71 10 25 11, – Email: m.chakroun@afdb.org

Dr Maïmouna DIOP LY, Analyste Supérieure en Santé, BAD, Division de la Santé, OSHID.3, 13 Rue du Ghana, 1002, Tunis Belvédère, Tunisie - Tel: (+216) 71 10 34 35 - Email: m.diopy@afdb.org

Mrs. May Ali BABIKER, Spécialiste en Genre, Département du Développement humain (OSHD.0), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002, Tunis, Tunisie – Tel: (+216) 71 10 33 66 – Email: m.babiker@afdb.org

Dr Nadine YONGUI ABIOLA, Consultant, Département du Développement humain (OSHD.3), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002, Tunis, Tunisie – Tel: (+216) 71 10 26 17 – Email: n.yonguimassok@afdb.org

Mrs. Shu Shu TEKLE HAIMANOT, Principal Health Analyst, Département du Développement humain (OSHD.0), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002, Tunis, Tunisie – Tel: (+216) 259 15084 – Email: s.tekle-haimanot@afdb.org
63. Mr. Walter MUCHENJE, Chief Health Analyst, Département du Développement humain (OSHD.0), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002, Tunis, Tunisie – Tel: (+216) 71 10 24 43 – Email: w.muchenge@afdb.org

64. Mr. Mohamed Mahdi YOSSOUF, Lead Health Analyst, Département du Développement humain (OSHD.0), Banque Africaine de Développement (BAD), 13 Rue du Ghana, 1002 Tunis Belvédère, Tunisie – Tel: (+216) – Email: m.youssouf@afdb.org

65. Mrs. Bineta BA DIAGNE, Chief Health Analyst, Département du Développement humain (OSHD.0), Banque Africaine de Développement (BAD), Avenue Hedi Nouira, BP 323, 1002 Tunis Belvédère, Tunisie – Tel: (+216) 71 10 23 06 – Email: baba-diagne@afdb.org

66. Dr Olayide FATOYINBO, Consultant, 58, Rue du Parc, LA-Soukra, Tunis, Tunisia – Tel: (+216) 25050662 – Email: olayidefatoyinbo@yahoo.co.uk

Belgium/Belgique

67. Dr Ignace RONSE, Expert Santé, Ministère de la Coopération Internationale, Karmelietenstraat, 15, 1000 Brussels, Belgium – Tel: 003225014379 – Email: Ignace.Ronse@diplobel.fed.be

Canada

68. Ms Nathalie GARON, Agent Principal de Développement, Agence Canadienne de Développement, 200, Promenade du Portage, Gatineau Québec, K1A 0G4, Canada - Tel: (+819) 994 7088 – Fax: (+819) 997 5453 – Email: nathalie.garon@acdi-cida.gc.ca

69. Dr Pierre-Claver BIGIRIMANA, Theme and Sector Specialists Division Geographic Programs Branch, CIDA, 200 Promenade du Portage, Gatineau (Québec), Canada K1A 0G4 – Tel: (+819) 953-2086 – Email: pierre_bigirimana@acdi-cida.gc.ca

France

70. Dr Christian TOSI, Médecin Conseiller Régional Secteur Santé, Ambassade de France, Rue Alfassa, Brazzaville, République du Congo – Tel: +002426275761 – Email: christian.tosi@diplomatie.gouv.fr; christiantosi@yahoo.fr

Kitasato Institute

71. Professor Satoshi OMURA, Ph.D., President Emeritus, The Kitasato Institute, Professor Emeritus Kitasato University, 3-3-12 Okamoto Setagaya_ku, Tokyo, Japan – Tel: (+81) 03-7415-3744 - Fax: (+81) 03 3415 3799 - Email: omuras@insti.kitasato-u.ac.jp

72. Prof. Andy CRUMP, Visiting Professor, Kitasato Institute/University, 2-7-11 Shibaura Minato-Ku Tokyo 108-0023, Japan – Tel: (+81) 3 3456-0448 – Email: crumpa@easynet.co.uk

Kuwait Fund for Arab Economic Development

73. Dr Abdul-Redha BAHMAN, Agricultural Advisor, Kuwait Fund for Arab Economic Development, P.O. Box 2921, Safat 13030, Kuwait - Tel: direct (+965) 22999186 Ext. (9186); (+965) 22 999 000 - Fax: (+965) 22 999 190 - Email: bahman@kuwait-fund.org

74. Mr. Ayad I.Y.H. AL-GHARABALLI, Assistant Regional Manager, Kuwait Fund for Arab Economic Development, P.O. Box 2921, Safat 13030, Kuwait - Tel: (+965) 22 999115 - Fax: (+965) 22 999 190/1 - Email: ayad@kuwait-fund.org
Merck and Co. Inc.

75. Mr. Kenneth M. GUSTAVSEN, Director, Access to Medicines, Merck & Co., Inc., One Merck Drive WS2A-56, P.O. Box 100, Whitehouse Station NJ 08889-0100, USA – Tel: (+908) 423 3088 Fax: (+908) 735 1839 – Email: ken_gustavsen@merck.com

Netherlands/Pays-Bas

76. Ms. Marja ESVELD, Senior Health Advisor, Social Development Department, Health and AIDS Division, Ministry of Foreign Affairs, P.O. Box 20061 2500 EB, Den Haag, The Netherlands – Tel: +31 70 3485304 – Fax: +31 70 3485366 – Email: marja.esveld@minbuza.nl

Saudi Arabia/Arabie Saoudite

77. H. E. Eng. Hasan ALATTAS, Director General, Technical Department, The Saudi Fund for Development, P.O. Box 1887, Riyadh 11441, Kingdom of Saudi Arabia – Tel: +966-1-2794100 – Fax: +966-1-4647450 – Email: abamaan@yahoo.com

78. Mr. Saud ALFANTOUKH, Director General, Control & Audit Department, The Saudi Fund for Development, P.O. Box 1887, Riyadh 11441, Kingdom of Saudi Arabia – Tel: +966-1-4640723 – Fax: +966-1-4647450 – Email: safantoukh@gmail.com

The World Bank/Banque Mondiale

79. Dr C. OK PANNENBORG, Senior Health Advisor for Africa, Africa Region Human Development Department, The World Bank, 1818 H Street NW, Washington DC 20433, USA – Tel: 202-473-4415 – Fax: 202-473-8216 – Email: Opannenborg@worldbank.org

80. Dr Donald A.P. BUNDY, Lead Specialist and APOC Coordinator, Africa Region Human Development Department, The World Bank, 1818 H Street NW, Washington DC 20433, USA – Tel: 202-473-3636 – Fax: 202-473-8216 – Email: dbundy@worldbank.org

81. Dr Andy TEMBON, African Region Human Development Department, The World Bank, 1818 H Street, NW, Washington DC 20433, USA – Tel: 202-458-4879 – Fax: 202-4738216, Email: atembon@worldbank.org

82. Mr. Alireza AZIMIPOUR, African Region Human Development Department, The World Bank, 1818 H Street NW, Washington DC 20433, USA – Tel: +202-458-2181 – Fax: +202-473-8216 – Email: aazimpour@worldbank.org

United States of America/Etats Unis d’Amérique

83. Ms. Angela WEAVER, Neglected Tropical Disease Advisor, U.S. Agency for International Development (USAID), GH/HIDN/ID, Room 3.07-27, 1300 Pennsylvania Avenue, NW, Washington, DC, 20523, USA – Tel: +1 202-712-5603 – Email: aweaver@usaid.gov

84. Dr Eric A. OTTESEN, Technical Director, RTI Intl. – NTD Control Program, 805 15th Street, N.W., Washington, DC 20005, USA – Tel: +1 404-275-0758 – Fax: +1 202-974-7892 – Email: eottesen@rti.org
NGDOs/ONGD

Carter Center

85. Dr Frank O. RICHARDS, Jr., Director, Malaria, River Blindness, Lymphatic Filariasis & Schistosomiasis Programs, The Carter Center, One Copenhill Avenue, 453 Freedom Parkway, Atlanta, GA 30307, USA – Tel: 770-488-4511 – Fax: 770-488-4521 – Email: frich01@emory.edu

86. Ms Nichole KRUSE, Chief Development Officer, Health Programs, the Carter Center, 453 Freedom Parkway, Atlanta, GA 30307, USA – Tel: 404 420 5132 – Fax: 404 688 1701 – Email: nkruse@emory.edu

CBM

87. Prof. Allen FOSTER, President, Christoffel-Blindenmission (CBM) e.V. Nibelungenstrasse 124, D-64625 Bensheim, Germany, Tel.(+49) 62 51 131-300, Fax: (+49) 62 51 131-309, Email: allen.foster@cbm.org; overseas@cbm.org

Centre for Neglected Tropical Diseases – Liverpool School of Tropical Medicine

88. Prof. Moses BOCKARIE, Director, Centre for Neglected Tropical Diseases (CNTD)/Liverpool School of Tropical Medicine (LSTM), Pembroke Place, Liverpool, L35QA, UK – Tel: 44 151 705 3343 – Email: mjb@liv.ac.uk

DFID (Global Alliance for Elimination of Lymphatic Filariasis - GAELF)

89. Prof. David H. MOLYNEUX, Centre for Neglected Tropical Diseases, Liverpool School of Tropical Medicine, Liverpool, United Kingdom – Tel: +44-151-705-3291; +44-7780-991-824 – Email: david.molyneux@liv.ac.uk

Helen Keller International (HKI)

90. Mr Chad MACARTHUR, Director of NTD Control, Helen Keller International (HKI), 532 Park Avenue South, 12th floor, New York City, NY 10010, USA – Tel. +1-212-532-0544 - Fax: +1-212-532-6014 - Email: emacarthur@hki.org

Institut de Recherche pour le Développement (IRD)

91. Dr Michel BOUSSINESQ, Institut de Recherche pour le Développement (IRD), UMR-145, 911 avenue Agropolis, BP 64501, 34394 Montpellier Cedex 5, France, Tel: +33 4 67416162 – Fax: +33 4 6741 63 30 -Email: boussinesq@ird.fr

Lions Clubs International Fondation (LCIF)

92. Mr. Karim BENGRAINE, Program Coordinator, 300 W. 22nd Street, Oak Brook, IL 60523, USA – Tel: +1-630-468-6825 – Fax: +1-630-706-9178 – Email: karim.bengraine@lionsclubs.org

Mectizan® Donation Program

93. Dr Adrian HOPKINS, Director, Mectizan Donation Program, 325 Swanton Way, Decatur, GA-30030, USA – Tel +1 404-371-1460 – Fax: +1 404-371-1138 – Email: ahopkins@taskforce.org

94. Dr Kisito OGOUSSAN, Associate Director (Onchocerciasis), Mectizan Donation Program, 325 Swanton Way, Decatur, GA-30030, USA – Tel +1 404-687-5633 – Fax: +1 404-371-1138 – Email: kogussan@taskforce.org
MITOSATH

95. Mrs. Francisca O. OLAMIJU, Executive Director, Mission to Save the Helpless (MITOSATH), 605 Hospital Place, Opposite Green Valley Suites, GRA, P.O. Box 205, Jos – Plateau State, Nigeria, Tel: (234) 73 464 792 - Mobile (234) 8033318085 - Email: mitosath@hotmail.com or olamijufo@mitosath.org

Organisation pour la Prévention de la Cécité (OPC)

75. Dr Bernard PHILIPPON, Chargé de Mission, Organisation pour la Prévention de la Cécité (OPC), 17 Villa d’Alesia, 75014 Paris, France – Tel: (0033) 01 44 12 41 90; Fax: (0033) 01 44 12 23 01 – Email: abphilippon@yahoo.fr; opc@opc.asso.fr

Sight Savers International (SSI)

76. Mr. Simon BUSH, Director of African Alliances and Advocacy, Sight Savers International (SSI), P.O. Box KIA 18190 Airport, Accra, Ghana – Tel: +233 21 774210 – Fax: +233 21 774209 – Email: sbush@sight savers.org

WHO/HQ/GENEVA-OMS/SIEGE/GENEVE

77. Dr Denis DAUMERIE, World Health Organization (WHO), 20 Avenue Appia, 1211 Geneva 27, Switzerland - (Direct) Tel: +41-22-791-2111 – Email: daumeried@who.int

78. Mr Claude-Henri VIGNES, Legal Adviser, Office of the Legal Counsel, c/o World Health Organization (WHO), 20 Avenue Appia, CH-1211, Geneva 27, Switzerland – Email: chvignes@bluewin.ch

79. Mr Gian Luca BURCI, Legal Counsel, Office of the Legal Counsel, World Health Organization (WHO), 20, Avenue Appia, CH-1211, Geneva 27, Switzerland, Tel: +41-22 791-4754, Fax: +41-22 791-4846, Email: burcig@who.int

80. Mr. Xavier DANAY, Legal Officer, Office of the Legal Counsel, World Health Organization (WHO), 20 Avenue Appia, CH-1211, Geneva 27, Switzerland – Tel: +41-22 791-1871 – Fax: +41-22 791-4846 – Email: daneyx@who.int

81. Dr Badara SAMB, Adviser to the Assistant Director-General, Health System and Services Cluster (HSS), World Health Organization (WHO), 20 Avenue Appia, CH-1211, Geneva 27, Switzerland Tel: 41 22 781 4452 – Fax: 41 22 791-4817 – Email: sambb@who.int

82. Dr Annette Christiane KUESEL, Scientist, TDR, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland, Tel: +41-22 791-1541 - Fax: +41-22 791-4774 - Email: kuesela@who.int

83. Dr Tony UKETY, NGDO Group Responsible Officer, World Health Organization (WHO), 20 Avenue Appia, 1211 Geneva 27, Switzerland - Tel: +41-22-791-1450 – Fax: +41-22-791-4772 - Email: uketyt@who.int

WHO/AFRO/OMS AFRO

84. Dr Luis Gomes SAMBO, Regional Director, World Health Organization Regional Office for Africa (WHO/AFRO), Cité du Djoué, BP 06, Brazzaville, Congo – Tel: +47 24 139 351 – Email: sambol@afro.who.int
85. Dr Chris MWIKISA, Director, Division in Health System Development, World Health Organization Regional Office for Africa (WHO/AFRO), Cité du Djoué, BP 06, Brazzaville, Congo - Tel: +47 24 139 388 – Email: mwikisac@afro.who.int

WHO/MDSC-OMS/MDSC

86. Prof. Evariste MUTABARUKA, Director a.i., Multi Diseases Surveillance Center (MDSC), Avenue Naba Zombré No 1473, 01 B.P. 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 70 20 02 63 - Fax: (+226) 50 34 28 75 – Email: mutabarukae@oncho.afro.who.int

WHO/SECRETARIAT-SECRETARIAT OMS

87. Dr Uche Veronica AMAZIGO, Director, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 22 77 – Fax: +(226) 50 34 48 00 - Email: amazigouv@oncho.afro.who.int

88. Dr Laurent YAMEOGO, Coordinator, Director’s Office, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 41 04 – Fax: (+226) 50 34 28 75 - Email: yameogol@oncho.afro.who.int

89. Dr Mounkaïla NOMA, Chief, Epidemiology and Vector Elimination Unit, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 29 53 – Fax: (+226) 50 34 28 75 - Email: nomami@oncho.afro.who.int

90. Mr Honorat Gustave ZOURE, Responsible, Biostatistics and Mapping, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box. 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 29 59 – Fax: (+226) 50 34 28 75 – Email: zoureh@oncho.afro.who.int

91. Dr Grace Fobi, COP/APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou, Burkina Faso, Tel: (+226) 50 34 29 53, Fax: (+226) 50 34 28 75, Email: fobig@oncho.afro.who.int

92. Mr. Koffi Benoît AGBLEWONU, Budget and Finance Officer, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 29 53 – Fax: (226) 50 34 28 75 - Email: agblewonuk@oncho.afro.who.int

93. Mrs. Patricia MENSAAH, Senior Administrative Assistant, Sustainable Drug Distribution Unit, APOC, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 29 53 – Fax: (+226) 50 34 28 75 - Email: mensahp@oncho.afro.who.int

94. Mrs. Ida SAVADOGO, Secretary, APOC, Avenue Naba Zombré No 1473, 01 P.O. Box 549, Ouagadougou 01, Burkina Faso - Tel: (+226) 50 34 29 60 – Fax: (+226) 50 34 28 75 – Email: yugbareli@oncho.afro.who.int

APOC TECHNICAL CONSULTATIVE COMMITTEE

95. Prof. Adenike ABIOSE, P.O. Box 29771, Secretariat Main Office, Ibadan, Oyo State, Nigeria - Tel: 234-8037865702 - Email: abiose@skannet.com
INTERPRETERS/INTERPRETES

96. Mr. Christian STENERSEN, 123 Les Rossanets, F-01170 Segny (France)-Tel: +33 45041 7880 - Email: christian.stenersen@orange.fr

97. Ms Geneviève CLEMENT, Le Parc du Jura, 42 avenue du Jura, F-01210 Ferney-Voltaire, France -Tel: +33 456820578 - Email: g.clement@club-internet.fr

98. Mme Safiétou BARRY, 09 B.P. 526 Ouagadougou 09, Burkina Faso - Tel: (+226) 50 46 02 82, Cellulaire (+226) 70 21 41 14; (+226) 78 03 64 55 - Email: barrysafietou@gmail.com

99. Mr. Victor IMBOUA-NIAVA, 3 Maple Crescent, DTD, Silver Bells 2, Regimanuel Estates, East Airport, Accra - Tel: (+233) 21811934 - Email: vimbouaniava@yahoo.com

100. Mme Anthea BLACKHURST GOMES DA SILVA, Conference/Interpreter, Rua Vasco da Gama, 21, Alto do Lagoal, 2760-119 Caxias, Portugal – Tel: +351 21442 63 00 - Email: artheablackhurst@mail.telepac.pt

101. Mrs. Montserrat CASANOVA, Conference Interpreter, Calle Itaca 44 ES-2822 Majadahonda, Madrid, Spain – Landline: +34-610 46 31 75 – Email: montserrat.casanova@yahoo.com

102. Mrs. Ruth CARRERAS, Conference Interpreter, Cami del Colomer, 3-9, 2B 08172 Sant Cugat del Valles, Barcelona, Spain – Mobile: +34 93 589 6397 – E-mail: rcarrerab@yahoo.com

103. Mrs. Sofia VARELA HALL, Conference Interpreter and Translator, Chef-Lieu, 74270 Contamine-Sarzin, France – Tel : +3363779987 – Email: sofiavarelahall@hotmail.com

104. Ms. Pamela Del Pilar VALDES RIVERA, Freelance Conference Interpreter, Rue Etienne-Dumont 3, 1204, Genève, Suisse - Tel: +41797825207 - Email: world_interpreting@yahoo.com

105. Mr. Mourad BOULARES, Interprète Conférencier, free-lance, 1 bis rue d’Amérique, La Marsa, Tunisie – Tel: (+216) 21 10 49 47; +0033 608003270 – Email: mouradboulares@hotmail.com

106. Professeur Michel KABORE (Traducteur) 01 B.P. 1444, Ouagadougou 01, Burkina Faso, Tel: (226) 50 36 13 83 – Cellulaire: (226) 70 27 05 96, Email: kaborem@cenatrin.bf

RAPPORTEURS

107. Dr Stephen LEAK, Technical Officer, Avenue Naba Zombré N° 1473, 01 Box 549, Ouagadougou, Burkina Faso, Tel: (+226) 50 34 29 53, Fax: (226) 50 34 28 75, Email: leaks@oneho.afro.int


109. Ms Juliet OCHIENGHS, Administrative Officer, World Health Organization (WHO), 20 Avenue Appia, 1211 Geneva 27, Switzerland - Tel: +41-22-791-12580 – Fax: +41-22-791-4772 - Email: ochienghsj@who.int
INVITED PARTNERS/PARTENAIRES INVITES

DANIDA/DBL-Centre for Health Research and Development

110. Dr Erling M. PEDERSEN, Senior Scientist, DBL - Centre for Health Research and Development, Faculty of Life Sciences, University of Copenhagen, Thorvaldsensve 57, 1871 Frederiksberg C, Denmark - Tel: +45 35 33 14 06 – Fax: +45 35 33 14 33 - Email: emp@life.ku.dk

ECCAS/CEEAC

111. Dr Gabriel MALONGA MOUELET, Médecin, Communauté Economique des États de l’Afrique Centrale (CEEAC/ECCAS), B.P. 2112, Libreville, République Gabonaise – Tel: +241-07-65.32.39 ; +241-06-23-78-99 – Fax: +241-44-47-32 – Email: gabrielmalonga@yahoo.fr

Pfizer

112. Mr. Pol VANDENBROUCKE, Vice president, Development - Emerging Markets, Pfizer, 235 East 42nd Street, New York, NY 10017, USA – Tel: +212-733-1114 – Fax: +641-441-6527 – Email: pol.vandenbroucke@pfizer.com

113. Mr. Nand KUMAR, Director, Access Programs for Developing Countries, Pfizer, 500 Arcola Road Collegeville PA 19426, U.S.A - Tel: +484-865-3351 – Fax: +484-865-6419 – Email: kumar38@pfizer.com

114. Mr. Ken SCHANBACHER, Associate Director, Project Management, Pfizer, 500 Arcola Road, Collegeville, 19426, USA – Tel: +484-865-2364 – Fax: +484-865-9197 – Email: schanb@pfizer.com

West African Health Organisation (WAHO)/Organisation Ouest Africaine de la Santé (OOAS)

115. Dr Placido Monteiro CARDOSO, Directeur Général, Organisation Ouest Africaine de la Santé (OOAS), 01 BP 153, Bobo-Dioulasso, Burkina Faso, Tel: (+226) 20 97 57 75 – Fax: (+226) 20 97 57 72 - Email: wahooas@fasonet.bf; placar2002@hotmail.fr

116. Dr Doulaye SACKO, Professionnel en charge du Programme Vision 2020, Organisation Ouest Africaine de la Santé (OOAS), 01 BP 153, Bobo-Dioulasso, Burkina Faso, Tel: (+226) 20 97 57 75 – Fax: 226 20 97 57 72 - Email: wahooas@fasonet.bf; wahooas@wahooas.org; bayesacko2000@yahoo.fr

117. Mr Salifou ZOUMA, Directeur de la Planification et de l’Assistance Technique, Organisation Ouest Africaine de la Santé (OOAS), 01 BP 153, Bobo-Dioulasso, Burkina Faso, Tel: (226) 20 97 57 75 – Fax: (+226) 20 97 57 72 - Email: wahooas@fasonet.bf; wahooas@wahooas.org; szouma@wahooas.org; yzsalifou@yahoo.fr

INVITED SPEAKERS/ORATEURS INVITES

118. Prof. Dik HABBEMA, Professor of Medical Decision Sciences, Department of Public Health, Erasmus MC, University Medical Center, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands – Tel: +31 10 7030049 – Email: j.d.f.habbema@erasmusmc.nl

119. Dr Hans F. REMME, 120 rue des Campanules 0120 Ornex, France -Tel: +33 64 545 74 04 – Email: hansremme@gmail.com
INVITED GUEST/ INVITE

120. Mrs. AMITY Meria, Directrice Casaïs Production, 09 BP 555, Ouagadougou 09, Burkina Faso – Tel: (00226) 50 45 77 53

121. Mrs. Upendo Amon KILAHIRO, Singer, P.O. Box 759, Dar-es-Salaam, United Republic of Tanzania – Tel: +255-757578114 – Email: upendokilahiro@hotmail.com
Annex 2

African Programme for Onchocerciasis Control (APOC)
Programme africain de lutte contre l'onchocercose

JOINT ACTION FORUM JAF-FAC FORUM D’ACTION COMMUNE Bureau du Président
Office of the Chairman

JOINT ACTION FORUM JAF15.2 Fifteenth session
Fifteenth session
Tunis (Tunisia), 8-10 December 2009 Revision 1

PROVISIONAL AGENDA

Opening
1. Opening of the session
2. Tribute to the late Mr R. McNamara
3. Election of Officers
4. Adoption of Agenda
5. Reflections of the Committee of Sponsoring Agencies

CDTI: Implementation/Monitoring/Evaluation/Surveillance
7. Country reports: treatment coverage, Governments and NGDOs’ financial contributions
8. Report of the Technical Consultative Committee (TCC)
9. Sub-regional meetings on cross-border collaboration: Special report by the Governments of Burkina Faso and Cameroon
10. Status of Onchocerciasis Control in former OCP countries
11. Elimination of Onchocerciasis transmission in Africa: recent evaluation studies and implications for shrinking the map

Strengthening health systems and Co-implementation
12. Co-implementation: Special report by the Governments of Tanzania and Democratic Republic of Congo
13. Capacity building of countries

Closed session
14. Closed session of Ministers of Health, donors and NGDOs

Research and Drug Development
15. Health Impact Assessment of APOC operations
16. Current research within APOC and TDR Collaboration

Partnership
17. Report of the NGDO Coordination Group for Onchocerciasis Control
18. Multi-Disease Surveillance Centre (MDSC)

Programme management and Finance
19. Audit report
20. Addendum to the Plan of Action and Budget 2008-2015
21. Plan of Action and Budget for 2010-2011
22. Financing of the African Programme for Onchocerciasis Control (APOC)
23. Pledging of Donor contributions

Final Communiqué and closure
24. Date and place of the sixteenth session
25. Final Communiqué
26. Closure of the fifteenth session

DIR/APOC/31.10.2009