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
Eleventh session
Paris (France), 6-9 December 2005

Item 4 of the Provisional Agenda

REPORT OF THE TENTH SESSION OF THE JOINT ACTION FORUM
JOINT ACTION FORUM
AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

Tenth session, Kinshasa, Democratic Republic of Congo
7-9 December 2004

REPORT

CONTENT

A. OPENING OF THE MEETING ................................................................. 1
B. ELECTION OF OFFICERS ........................................................................ 1
C. ADOPTION OF THE AGENDA .................................................................. 2
D. REFLECTIONS OF THE COMMITTEE OF SPONSORING AGENCIES .......... 2
E. PROGRESS REPORT OF THE WORLD HEALTH ORGANIZATION .......... 3
F. REPORT OF THE TECHNICAL CONSULTATIVE COMMITTEE ............... 4
G. THE NON-GOVERNMENTAL DEVELOPMENT ORGANIZATIONS COORDINATION GROUP FOR ONCHOCERCIASIS CONTROL INCLUDING SUPPORT OF THE GROUP TO APOC ACTIVITIES .......................................................... 5
H. COUNTRY REPORTS ............................................................................... 6
I. CONSIDERATION OF NATIONAL PLANS AND PROJECT PROPOSALS .... 7
J. OPERATIONAL RESEARCH AND MACROFIL ...................................... 7
K. SUSTAINABILITY OF CDTI .................................................................... 8
L. ADDITIONAL HEALTH INTERVENTIONS USING CDTI AS A VEHICLE .... 10
M. PHASE II STUDIES ON THE LONG-TERM IMPACT ASSESSMENT OF APOC OPERATIONS .............................................................................. 10
N. AUDIT REPORT ...................................................................................... 11
O. PLAN OF ACTION AND BUDGET FOR 2005 ......................................... 11
P. FINANCING OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL ................................................................. 11
Q. TERMS OF REFERENCE FOR THE EXTERNAL EVALUATION OF APOC FOR THE PERIOD 2001-2004 ................................................................. 12
R. INFORMATION ON THE ACTIVITIES IN THE SPECIAL INTERVENTION ZONES (SIZ) OF THE EX-OCP, IN THE COUNTRIES/AREAS OF THE EX-OCP OUTSIDE THE SIZ, AND ON THE MULTIDISEASE SURVEILLANCE CENTRE ................................................. 12
S. OTHER MATTERS .................................................................................. 14
T. DATE AND VENUE OF THE ELEVENTH SESSION .............................. 14
U. CLOSURE OF THE TENTH SESSION ..................................................... 14
A. OPENING OF THE MEETING

1. At the invitation of the Government of the Democratic Republic of Congo (DRC), the tenth session of the Joint Action Forum (JAF) was held at the Grand Hotel of Kinshasa from 7 to 9 December 2004. The session was attended by representatives of the donor countries and institutions, participating countries, Non-Governmental Development Organizations (NGDOs), the World Health Organization (WHO) and the APOC Management. The list of participants is attached as Annex 1.

2. The meeting was opened by His Excellency, Mr Arthur ZAHIDI NGOMA, Vice President of the Democratic Republic of Congo in charge of the Commission on Social and Cultural Affairs. His opening remarks were preceded by statements of the Director-General of WHO, read aloud by Dr Claude Henri Vignes, representing the Legal Counsel of WHO; of the chair of the ninth session of JAF, represented by Mr Stephen RANDALL, Chargé d'Affaires of the Embassy of Canada to DRC; and of Dr Azodoga Sékétéli, Director of APOC. All four speakers essentially outlined the remarkable achievements of the Programme to date; hailed the merits of the Community-directed Treatment with Ivermectin (CDTI) strategy and the opportunities it provided for integration; and stressed the need for countries to allocate more resources to CDTI activities in order to ensure sustainability. The statements of the various speakers mentioned above are attached as Annex 2.

3. In his remarks, Dr Sékétéli warned that not all projects would have received the required minimum of five years funding from APOC Trust Fund by the year 2010 as some projects had still not yet started. It would be necessary therefore to make arrangements with the donors to authorize that the APOC Trust Fund for Phase II and the Phasing out period be maintained beyond 2010 to finance such CDTI projects within the budget limits of US$79 million forecasted for the period.

4. Dr Sékétéli informed the Forum of changes in the leadership at the Regional Office of WHO for Africa. Dr Ebrahim M. Samba, the current Regional Director's mandate would be ending at the end of January 2005 and he would be succeeded by Dr Luis Gomes Sambo who was elected at the fifty-fourth session of the Regional Committee in September 2004. Before ending his statement, Dr Sékétéli announced his retirement at the end of September 2005 as Director of APOC.

5. The working session was opened by Ms Catherine Bérard of the Canadian International Development Agency (CIDA) on behalf of Mr Paul Hunt, chair of JAF9.

B. ELECTION OF OFFICERS

6. The Democratic Republic of Congo was unanimously elected to the chair of JAF10 held by Her Excellency, Dr Anastasie MOLEKO MOLIWA, Minister of Health of DRC; and France as vice-chair, held by Dr Christian BAILLY, Coordinator of the Cellule Inter-Régionale d'Epidémiologie (CIRE), Rennes, France.
C. ADOPTION OF THE AGENDA

7. The provisional agenda attached as Annex 3 was adopted without any modifications.

D. REFLECTIONS OF THE COMMITTEE OF SPONSORING AGENCIES

8. In his presentation of the reflections of the Committee of Sponsoring Agencies (CSA), Mr Bruce Benton, chair of the Committee, focused on the achievements of APOC over the last twelve months and outlined the main activities planned for the coming year.

9. In referring to an information document entitled "Defeating Riverblindness: Thirty Years of Success in Africa", Mr Benton highlighted the considerable attention given to scaling up onchocerciasis control in Africa over the years.

10. Mr Benton also informed the Forum that an APOC Donors' Conference was held in June 2004 at the World Bank Headquarters in Washington. Donors at the Conference recognized the unique opportunity presented by the Community-Directed Treatment (ComDT) approach to broaden the scope of the formal health systems to reach neglected, poor populations particularly in remote areas. They emphasized that the success of APOC would be determined by the sustainability of CDTI and acknowledged the importance of APOC-supported operational research on sustainability. Donors also pledged not to abandon APOC before the end of its operations in 2010 and would consider supplemental contributions to promote integration of other health interventions such as Vitamin A supplementation, reproductive health, lymphatic filariasis and schistosomiasis into CDTI.

11. The strong financial management of APOC was also recognized by donors at the Conference. It was reported that the financing shortfall for APOC had been reduced by 50% to US$13 million over the past 18 months.

12. The Forum was informed of the cases of Severe Adverse Events (SAEs) which included 19 deaths recorded in the Bas Congo and Tshopo regions in DRC after treatment with ivermectin; and the joint actions taken by the various partners to manage those cases, and steps put in place to prevent future cases.

13. Mr Benton reminded the Forum that the external evaluation of APOC and the mid-term review of the activities of the Special Intervention Zones (SIZ) of the ex-OCP countries would be undertaken during 2005.

14. Furthermore, the World Bank and WHO were jointly planning to convene a Ministerial-level meeting in early 2006 which would bring together all eleven ex-OCP countries and the donors who supported the Programme. The purpose of the meeting would be to consider what action to take in the light of the findings of the mid-term review of the ex-OCP countries, in order to ensure a successful lasting closure of OCP activities in those countries.

15. The Forum acknowledged a report on the meeting held in October 2004 in Ouagadougou to review progress of the Multidisease Surveillance Center (MDSC). It was noted that the Center would initially focus on the surveillance of onchocerciasis and meningitis and progressively scale up to include other diseases. The governance structure had been established although the
stakeholders still had to assess what action needed to be taken in order to get the Center fully operational as soon as possible. See also paragraphs 106.

16. Before ending his presentation, Mr Benton informed the Forum of changes in the leadership of the Onchocerciasis Coordination Unit at the World Bank as he had recently retired as Manager of the Unit. Mr Benton reassured JAF that his successors, Dr Ousmane Bangoura and Dr Alexandre Abrantes would continue to provide high level support to onchocerciasis control activities from the World Bank.

E. PROGRESS REPORT OF THE WORLD HEALTH ORGANIZATION

17. Vector elimination activities continued in the four foci of the Programme in Itwara (Uganda), Mpamba-Nkusi (Uganda), Tukuyu (Tanzania) and Bioko (Equatorial Guinea). In the Itwara focus which had been vector-free for the past 7 years, activities had been limited to entomological surveillance. In 2003, large-scale ground larviciding campaigns started in the remaining foci with promising results. Whereas the second and last larviciding campaign had been carried out in the Mpamba-Nkusi focus in 2004 that in the Tukuyu and Bioko foci it would be done in 2005.

18. Having conducted the Rapid Epidemiological Mapping of Onchocerciasis (REMO) in all the APOC countries it was concluded that in 2004, the population at risk of contracting onchocerciasis was more than 87 million people (87 660 697), compared to 50 million, the figure used in the Programme Document. Likewise, the infected population was now estimated at 36.6 million people instead of 15 million, the estimated figure in 1995.

19. 73 CDTI projects, out of 106 approved (i.e. 69%), were now being implemented. Delays in implementation had mainly been due to: (i) the lapse of time necessary for the completion of the validation of RAPLOA; (ii) conflict/civil strife; and (iii) measures relating to risk management in the use of the APOC Trust Fund at the country level.

20. RAPLOA had been completed in Angola, Congo and Ethiopia, while it was ongoing in DRC, and scheduled for early 2005 in Sudan and the East, South and Littoral Provinces of Cameroon. The tool was now available for use in all APOC countries.

21. Capacity-building activities continued with the training of over 150,000 Community-directed Distributors (CDDs) and about 16,000 Health Workers at the end of 2003. More than 1000 nationals had also been trained in various activities including monitoring, evaluation, data management, REMO, RAPLOA and article-writing.

22. Over 33 million people were treated in 2003 in 68 841 communities with a mean therapeutic coverage of 66%.

23. APOC Management also undertook missions to over 13 countries to support them in the implementation of their CDTI projects.

24. A second round of the long-term impact assessment studies was being undertaken in 13 sites in 8 countries. The studies focussed on the dermatological, ophtalmological and
entomological impact of APOC operations on, as well as the socio demographic changes in the beneficiary communities (see also paragraph 82).

25. Remarkable results were achieved with the integration of some health interventions such as Vitamin A Supplementation (VAS), lymphatic filariasis (LF), schistosomiasis and Primary Eye Care (PEC) into 22 CDTI projects in 8 countries. It was planned to increase the number of projects integrating VAS into CDTI in four countries as from 2005. It was hoped that this integration would be progressively scaled up to other health interventions in all APOC countries.

26. Sixteen (16) out of 19 countries received APOC financial support during the year. There had also been an improvement in the financial management and reporting on the use of the APOC Trust Fund at the project level.

27. The great challenges APOC Programme is facing are i) upscaling integration of other interventions into CDTI, ii) maintaining compliance in healthy persons, iii) filling funding gap to support 117 approved projects, iv) launching 33 newly approved projects, v) preventing and managing severe adverse events (SAEs) following ivermectin treatment in areas where onchocerciasis and Loiiasis are co-endemic, vi) increasing and sustaining government financial commitment to onchocerciasis control activities, vii) involving additional NGDO partners in projects in conflict areas.

***

28. The Forum congratulated APOC Management for the impressive results achieved.

29. In response to concerns raised about the use of the Trust Fund beyond 2010 to allow the full 5 years of financing for projects whose implementation may have been delayed for various reasons, APOC Management assured the Forum that any potential extension would only extend the time in which disbursements could be made from the Trust Fund and would not increase the budget required beyond the current forecast. It was suggested that APOC Management should draw up a list of those projects which were expected to be funded beyond 2010 for the consideration of donors.

30. Countries expressed some concern about the new estimated population at risk of contracting onchocerciasis which, they feared, might continue to change beyond the end of APOC operations in 2010. APOC Management reassured JAF that, since REMO had now been conducted in all countries, the current estimations were very unlikely to change.

31. The Forum stressed the need for countries to allocate more resources to the health sector and to ensure that onchocerciasis was included in the national budgeting process.

F. REPORT OF THE TECHNICAL CONSULTATIVE COMMITTEE

32. Professor Ekanem Braide, Chair of the Technical Consultative Committee (TCC) of APOC, reported on the main activities of the Committee during 2004.

33. Prof Braide informed the Forum that TCC reviewed 54 annual technical reports, accepted 42 and rejected 12 of them. TCC also reviewed 7 new CDTI project proposals from Angola,
Burundi, Cameroon and DRC; recommended 5 projects for approval and rejected 2 which were to be revised and resubmitted to the Committee for reconsideration.

34. TCC was concerned about the few number of operational research proposals submitted to the Committee. Only 7 proposals were reviewed by TCC during 2004 of which 2 were recommended to APOC Management for approval. In addition, the Committee reviewed several guidelines and a new reporting format for technical reports.

35. TCC discussed and advised on a number of operational and managerial issues including (i) vector elimination activities; (ii) integration of VAS into CDTI activities; preliminary findings of the cost per treatment study and the report on a predictive model to assess the long-term impact of onchocerciasis control in Africa through drug distribution programmes.

36. Finally, Prof Braide indicated that TCC was involved in providing technical support to some projects by assisting in, or monitoring the implementation of their sustainability plans and providing training.

37. JAF noted the report on TCC activities and thanked Prof Braide for a comprehensive presentation.

G. THE NON-GOVERNMENTAL DEVELOPMENT ORGANIZATIONS COORDINATION GROUP FOR ONCHOCERCIASIS CONTROL INCLUDING SUPPORT OF THE GROUP TO APOC ACTIVITIES

38. The report of the NGDO Coordination Group was presented by Dr Tony Ukety and Dr Adrian Hopkins, the Coordinator and the Chairman respectively of the Group. They summarized the Group's activities under four main points: (i) technical and managerial support, (ii) integration, (iii) research and (iv) financial support to CDTI activities.

39. NGDO partners continued to provide technical and managerial support to the CDTI projects. The Group was able to treat about 40 million people in 2003 across all the onchocerciasis-endemic countries covered by APOC, OEPA and ex-OCP. The Group also continued to promote integration of other health interventions into CDTI activities such as VAS, comprehensive eye care, Lymphatic filariasis, malaria, schistosomiasis and trachoma.

40. The Mectizan Donation Program (MDP) funded research on Loa loa in Cameroon in view of better managing and preventing SAEs. The Carter Center was also funding research on the elimination of onchocerciasis in the Americas.

41. The total financial contribution of the NDGO Group to onchocerciasis control activities in 2004 amounted to $9,563,833. In addition, the Group informed the Forum that Merck & Co. Inc had pledged an amount of US$1 million, to be paid over a period of five years, to the NGDOs in Africa working in the area of onchocerciasis control and a similar amount to the NGDOs in the Americas.

42. The Forum expressed great appreciation to the NGDO Coordination Group for its continuous support to onchocerciasis control activities, and to Merck & Co. Inc., which, in addition
to providing ivermectin free of charge, had pledged financial support to the NGDOs in Africa and the Americas working on onchocerciasis control.

H. COUNTRY REPORTS

43. Presentations were made by Uganda, Tanzania, Cameroon, Ethiopia, Congo, DRC, Burundi, Liberia, Sudan and CAR on their CDTI project activities.

44. Whereas CDTI was yet to begin in Burundi, most of the countries reported that CDTI was successfully integrated into other health activities in their countries. For instance, CDTI had been integrated with activities for the control of schistosomiasis and soil helminth in Uganda, and in Tanzania, the integration of CDTI with vitamin A supplementation (VAS), and the control of LF and Trachoma are underway.

45. The Forum was informed that governments were contributing financially to CDTI activities although, it was noted that in some countries the financial contribution was relatively small and the release of the pledged amounts was often delayed.

46. The Forum also noted that conflict in countries such as Congo, CAR, Liberia and Sudan had hampered successful implementation of CDTI in those countries

47. JAF was also informed that:
   i. A study on the impact of the cost-sharing experience in Congo Brazzaville was ongoing and the results would be reported at JAF11 in December 2005;
   ii. Some studies had been done on "nodding disease" but its cause appeared to be inconclusive. Countries where the disease was present were requested to forward research proposals to TCC for review and consideration of the need for further research by TDR or other research institutions;
   iii. Severe Adverse Events (SAEs) occurred, causing 19 deaths in Bas-Congo and Tshopo in DRC, following treatment with ivermectin. However, the cases had been satisfactorily managed and the training of health workers in the management of SAEs had been reinforced.

48. Countries expressed their gratitude for the financial and technical support they received from APOC Management and the NGDO partners, and appealed to donors to continue their support to APOC.

* * *

49. The Forum congratulated the countries on their achievements and noted the difficulties and challenges countries encountered in the implementation of CDTI.

50. The Forum, once again, stressed that participating countries needed to allocate more resources to health, and particularly, to onchocerciasis control activities. In this regard, it was agreed that:
i. Countries should specify the nature of government contributions (cash or in-kind, salaries, capital equipment, infrastructure and recurrent cost);

ii. Countries should indicate, over a minimum of 3 years, the trend of government contributions (whether they were increasing or decreasing);

iii. APOC Management should collate and make available to the External Evaluation Team information on government contributions to enable the Team easily make a comparative assessment of the contributions during the evaluation;

iv. Countries be encouraged to adopt an integrated budgeting system such as those reported by Uganda and Tanzania; i.e. including onchocerciasis in the national budgeting process.

I. CONSIDERATION OF NATIONAL PLANS AND PROJECT PROPOSALS

51. The Forum was informed by Dr Mounkàila Noma that, by the end of 2003, a total of 107 projects had been approved by APOC Management, out of which 63 were being implemented and 11 new projects were to begin implementation. An amount of US$10 359 466 was being requested to fund the implementation of the total of 74 projects in 2005.

52. The Forum endorsed the prior approval by APOC Management of the continuation of the 63 ongoing projects as well as the implementation of the 11 new national plans and project proposals recommended by TCC. JAF also ratified the corresponding budget of US$10,359,466 requested for the implementation of the 74 projects described above.

J. OPERATIONAL RESEARCH AND MACROFIL

53. Dr Hans Remme presented an update on operational research activities. RAPLOA validation studies had been undertaken in DRC and Congo. The validity of the method had been confirmed and RAPLOA was now being widely used by APOC for mapping Loa loa.

54. The multi-country study on Community-directed interventions (CDI) had been launched in 5 APOC countries, covering a total of 45 health districts. The Forum expressed considerable interest in the study and noted its significance for the future of integrated disease control in Africa. The Forum looked forward to the first results of the study which would become available by mid 2005.

55. JAF was informed, and noted with gratitude, that the Bill & Melinda Gates Foundation had agreed to fund for about $2 million, the proposed studies on the feasibility of local elimination of transmission with ivermectin treatment alone. The studies would start in January 2005.

56. Dr Janis Lazdins gave an update on MACROFIL activities. He informed the Forum that the development of a macrofilaricide remained a high priority. However, the development of moxidectin, the potential macrofilaricide for use in the treatment of onchocerciasis, had been suspended due to a safety concern with one of the veterinarian products containing moxidectin.
Further development activities were to be pursued if the concerns were cleared at a hearing of the US Food and Drug Administration (FDA) scheduled for 31 January 2005.

57. Dr Lazdins reported that the DEC patch was being re-tested for improved efficacy before its mass use. The cost of the patch was expected to be less than $0.10.

58. The Forum noted with satisfaction that clinical studies had demonstrated the safety and efficacy of the combined administration of albendazole, ivermectin and praziquantel. This finding was operationally significant for the integration of the treatment of onchocerciasis, lymphatic filariasis and other helminths.

***

59. In response to questions relating to research on integration of disease control activities, the Forum was reassured of the close collaboration between TDR, APOC Management and the WHO neglected diseases department.

60. JAF also acknowledged and endorsed other ongoing drug development and research activities. The Forum finally underscored the need to create and sustain basic and clinical research capacity in developing countries and encouraged APOC to continue providing support to research activities.

K. SUSTAINABILITY OF CDTI

61. Dr Uche Amazigo recalled the conclusions of the special meeting on sustainability held in February 2004 and further analysis of the data showed that three of the nine process indicators are critical for the sustainability of CDTI projects. The three indicators are: (i) training and HSAM (Health Education, Sensitization, Advocacy & Mobilization); (ii) Mectizan supply and distribution; (iii) monitoring and supervision.

62. The findings of the evaluations show that the community was an important operational level for sustainability of ivermectin treatment; and that CDTI was quite strong at the community level but rather weak at the Front Line Health Facility (FLHF) level of the formal health system.

63. In order to promote sustainability of all CDTI projects, APOC Management envisaged to: (i) reinforce advocacy, targeting senior health managers and policy makers; (ii) continue monitoring implementation of sustainability plans, particularly training and HSAM; and (iii) ensure that onchocerciasis was included in the Poverty Reduction Strategy Papers (PRSPs) of the countries.

64. The findings of the evaluation also show that 71% of communities provided financial support to CDDs and some governments (districts) were providing support for CDTI activities.

65. Out of 41 CDTI projects evaluated between 2002 and 2004, 78% were judged to be making progress towards sustainability. For those projects judged as not making progress towards sustainability, it was contemplated what additional support needed to be given to them in order to improve their performance.
66. The meeting recommended, among others, that all CDTI projects should be evaluated in their 3rd year and only those projects that had operational problems should be re-evaluated in their 5th year. However, those CDTI projects, which for some reason, had not been evaluated in their 3rd year should be evaluated in their 5th year. In any case, all projects evaluated in their 3rd year were required to submit a 5-year sustainability plan to APOC Management.

67. The Forum was also informed that a number of tools and guidelines had been finalized for evaluating and monitoring sustainability of CDTI activities.

68. The Forum endorsed the new definition of sustainability which now reads as follows: "CDTI activities in an area are sustainable when they continue to function effectively for the foreseeable future, with high treatment coverage, integrated into available health care services, with strong community ownership, using resources mobilized by the community and the government".

69. A report was given on the monitoring of implementation of sustainability plans of four CDTI projects in Tanzania, Uganda and Nigeria which had received five years of financial support from APOC. Three of the projects in Nigeria and Uganda did not receive any APOC funding after the fifth year and for almost 2 years prior to the monitoring visit. Nevertheless, CDTI activities continued in all four projects. Also, the projects, in particular, the Phase I CDTI project in Uganda received increased financial contributions from the Districts/LGAs.

70. In the Tanga CDTI project in Tanzania, LF had been integrated into CDTI and it was being planned to integrate VAS into CDTI in 2005.

71. In Uganda, there was clear evidence of effective integration of CDTI with other health activities at all levels of the national health system. At the same time, both geographical and therapeutic coverage remained as high as before. Planning and budgeting for CDTI activities had improved and a commendable financial contribution from the district had been recorded.

72. It was however noted in all three countries the main challenges facing the implementation of sustainability plans were: (i) insufficient involvement of the FLHF in CDTI activities; (ii) inefficient reporting and feedback from communities; and (iii) the late release of government funds in some cases, particularly, in Nigeria.

73. Sustainability of CDTI, in general, faced a number of challenges, including: (i) development of CDTI sustainability plans; (ii) retention of CDDs; (iii) strengthening the role of FLHFs; (iv) provision by countries of adequate government funding for essential field activities.

74. The importance of identifying risk factors early in a project life cycle in order to predict eventual sustainability issues was stressed by JAF. However, the Forum was reassured that consideration of risk was a systematic process when TCC considered new proposals.

75. In conclusion, the Forum noted that:

   i. there was a need to continue monitoring the implementation of sustainability plans of CDTI projects especially during the post-APOC era;
to enhance the sustainability of CDTI projects, it was important to strengthen the health systems and empower the FLHF level;

including onchocerciasis in the essential health package would ensure a sustainable government financial contribution, and could also be a step towards strengthening the FLHF in the health system.

L. ADDITIONAL HEALTH INTERVENTIONS USING CDTI AS A VEHICLE

76. From the presentation of country experiences of Uganda, Nigeria and Cameroon, JAF recognized the opportunities and synergies of integrating other health interventions with CDTI such as VAS and possibly reproductive health.

77. JAF was informed that a proposal was being submitted by the Micronutrient Initiative (MI) to APOC Management for pilot studies on the integration of VAS and CDTI in four countries. The growing partnership between MI and APOC was greatly encouraged by the Forum.

78. While the advantages of integration had been broadly acknowledged, it was also noted that integration entailed securing additional resources, particularly, adequately trained human resources. In this regard, the concern posed by "brain drain" was sufficiently addressed. Integration also required expanding partnerships and increasing coordination (planning; timing of distribution).

79. Other critical challenges of integration included: (i) mapping of disease distribution; (ii) government priorities regarding integration of health interventions; (iii) limitations in the mandates of NGDOs, (iv) funding of core CDTI activities and weak health systems. Training, monitoring and supervision, and retaining CDDs (incentives, risk of overloading) were also highlighted.

80. JAF was reminded that the APOC Trust Fund could only be used to finance pilot studies on integration.

81. It was suggested that donors could be attracted to share the cost of integrated programs if countries could first prioritize their activities for integration, and identify sources of funding of those activities. In other words, each country should have a concrete plan for integration.

M. PHASE II STUDIES ON THE LONG-TERM IMPACT ASSESSMENT OF APOC OPERATIONS

82. JAF was informed that the findings of Phase II studies of the long-term impact assessment of APOC operations would be reported at JAF11 (refer also to paragraph 24). The Forum stressed the importance of making these results available to participating countries and other partners and the need to publish the results as soon as possible. The results of Phase I would be submitted for publication in scientific journals by May 2005.
83. In socioeconomic terms, World Bank studies suggest that APOC operations had a rate of return of 17%. This rate of return may be even higher if the additional benefits of integrating other health interventions into CDTI activities were taken into consideration.

N. AUDIT REPORT

84. The report of the External Auditor on the accounts, receipts and expenditures of APOC was submitted to JAF. In the absence of any observations, JAF noted the report confirming the correctness of the financial accounts of the Programme.

O. PLAN OF ACTION AND BUDGET FOR 2005

85. The Forum approved the APOC Plan of Action for 2005 of APOC and the corresponding budget in the amount of US$13,544,000.

86. The Forum requested that the proportion of the recurrent cost actually attributed to country project operations should be clearly distinguished in future Plans of Action.

P. FINANCING OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

87. The donor financing requirements for APOC operations remained at a total of US$135 million, of which US$56 million for Phase I, had been fully funded.

88. Of the US$79 million required for Phase II and the Phasing-out Period, US$66 million had been lined up. The financing gap had been reduced by 50% over the past 18 months and now stood at US$13 million.

89. The Forum noted with pleasure the financial pledges made by donors. It also acknowledged with gratitude, the contributions of the NGDOs and the continued commitment of Merck & Co. Inc. to supply ivermectin free of charge for as long as needed for the treatment of onchocerciasis.

90. JAF noted that it might become necessary in the future to consider extending the APOC Trust Fund beyond 2010 to allow the full 5 years of financing of projects whose implementation may have been delayed for various reasons. It was understood that any potential extension would only extend the time in which disbursements could be made from the Trust Fund and would not increase the budget required beyond the current forecast.

91. JAF also observed that the presentation of the financing of the Programme did not reflect contributions from the NGDOs and the participating countries. The issue was to be considered further to see how future reports could reflect contributions from all APOC partners.
92. The Forum was informed that the APOC External Evaluation Team had now been constituted and would meet early in January or February 2005 to develop a work plan. The findings of the team would be reported at JAF11 in December 2005.

93. The Forum approved the Terms of Reference (TOR) for the APOC External Evaluation as presented to it in document JAF10.10.

R. INFORMATION ON THE ACTIVITIES IN THE SPECIAL INTERVENTION ZONES (SIZ) OF THE EX-OCP, IN THE COUNTRIES/AREAS OF THE EX-OCP OUTSIDE THE SIZ, AND ON THE MULTIDISEASE SURVEILLANCE CENTRE

94. JAF was informed that vector control activities were being conducted in the Oti tributaries and the upper Oueme river basins in Togo and Benin without major difficulties. The rotational scheme of the larvicides was being effectively applied, and the reinforced ivermectin distribution spirit was well understood and led to the identification and treatment of many additional villages and hamlets in the SIZ area.

95. As a result, biting rates have reduced significantly on the catching points in the river basin of the Oti tributaries, and at the same time, a downward trend in the transmission of the *Onchocerca volvulus* parasite is observed at all the 11 catching points. More importantly, the prevalence of microfilariae in the villages evaluated in Benin and Togo in 2004 has also reduced, as compared to the prevailing situation before the closure of OCP. Thus, the prevalence of microfilariae went down from over 30% (in 2000, in the case of Benin, and 2002 in the case of Togo) to less than 5% in several villages in 2004, except some villages in the Kara and Mo basins in Togo.

96. In Guinea, where only ivermectin distribution is carried out, the prevalence rate dropped from over 15%, before the end of 2002, to less than 5% in most of the villages. The data are yet to be validated. The therapeutic coverage rate has been about 80% over the past two years. Government financial contribution to these activities has been minimal thus far, with most of the funding coming from WHO/SIZ and NGDO partners.

97. Dr Yameogo mentioned also that, the entomological evaluation network in Sierra Leone started routine activities in April 2003. Transmission in the southern part of the country was found to be entirely caused by the forest species of the *Simulium*, whereas the savannah species accounted for 62% of the transmission in the northern of the Kaba River. The infectivity rate of flies was higher in the south (between 4% and 23%), while in the north it was between 0 and 8%. This data will be used as basis for assessing the impact of ivermectin on transmission in the country in the years to come. The epidemiological status as evaluated in the southern part of the country, is still a concern in that, gross prevalence is between 20 and 70%.

98. A report presented by the national team of Mali indicated that onchocerciasis activities were well integrated into the public health system; therapeutic coverage had remained over 80% and entomological surveillance activities indicated no incidence of transmission. These activities were regularly and fully funded directly from the national budget and through a strong NGDO partnership. However, the timely release of funds was reported to be a problem that needed to be
addressed. Of the total amount of US$111,106.30 budgeted in 2004, only US$69,726.27 was actually received.

99. In Guinea, government’s financial contribution had been minimal so far, with most of the funding coming from NGDO partners. Like in Mali, the release of the pledged funds was a problem in 2004.

100. JAF noted with pleasure the progress reports on onchocerciasis control activities in Guinea, Mali, Benin and Togo, but expressed great concern for the current epidemiological situation in Sierra Leone. A joint mission (SIZ management – Sight Savers International) will be going to Sierra Leone early 2005 to reassess the situation and feasibility of fully resuming CDTI activities.

101. JAF welcomed the possibility of the World Bank financing onchocerciasis and lymphatic filariasis activities in Sierra Leone together with other partners. The World Bank emphasized that such financing will be in addition to what it is already providing to a number of other health projects in the country.

102. The Forum commended the Special Intervention Team on the quite good results obtained so far and encouraged the partners to maintain their joint efforts in effectively controlling onchocerciasis in the SIZ.

103. The TORs for the mid-term review of the SIZ to be undertaken in 2005 were presented to the Forum. The review was estimated to cost US $132,000, but would increase to US $160,000 if the review were extended to the rest of the ex-OCP countries as was being envisaged. It was emphasized that particular attention should be paid to the case of Sierra Leone during the review evaluation.

104. The Forum acknowledged the capacity (expertise) left behind by ex-OCP and stressed the importance of maintaining and utilizing that capacity.

105. JAF was informed that the current balance of the budget for SIZ activities was only US$6.5 million.

106. JAF underscored the importance of the Multidisease Surveillance Centre (MDSC) in maintaining the surveillance of onchocerciasis in the region, thereby safeguarding the over US$600 million investment made in OCP.

107. The Forum stressed the need to establish or maintain strong collaborative links with national and other scientific institutions and reference laboratories. JAF also reiterated the importance of MDSC to have some autonomy in its operations, and to develop its activities gradually in accordance with the priorities of the beneficiary countries.

108. The Forum acknowledged the commitment of the World Bank to participate in the financing of the MDSC and strongly endorsed its plea to secure, as a matter of urgency, more donor support in order for the Centre to be fully functional as soon as possible.
109. On behalf of Mr James Wolfensohn, President of the World Bank, Mr Charles Pannenborg, Senior Advisor in the Africa Region at the World Bank, paid tribute to Mr Bruce Benton for his outstanding contribution to onchocerciasis control in Africa.

110. Dr Luis Gomes Sambo, the Regional Director-elect of WHO/AFRO, expressed his pleasure to be present at the session and pledged the continuous support of WHO to onchocerciasis control in Africa, and particularly, to APOC activities. In that regard, he announced that onchocerciasis would be an item of discussion on the agenda of the next Regional Committee meeting in 2005.

111. Dr Sambo deplored the onchocerciasis situation in Sierra Leone and assured the Forum that all would be done for control activities to resume in that country as soon as possible.

112. Dr Sambo ended by thanking all the partners for their efforts in supporting the MDSC.

T. DATE AND VENUE OF THE ELEVENTH SESSION

113. At the invitation of the Government of France, the eleventh session of JAF will be held in Paris from 6-9 December 2005.

U. CLOSURE OF THE TENTH SESSION

114. Participants expressed their sincere gratitude to the Government of the Democratic Republic of Congo for hosting this tenth session of JAF and for the warm hospitality they received during their stay in Kinshasa.

115. The chair paid a special tribute, and expressed the appreciation and gratitude of the participating countries, to Dr Ole Worm Christensen, a long-term voluntary consultant to OCP and APOC; and to Mr Bruce Benton, recently retired Manager of the Onchocerciasis Coordination Unit at the World Bank, for their dedication to onchocerciasis control in Africa. On behalf of Africa she wished them well for the future.

116. Dr Sambo thanked the Government of the Democratic Republic of Congo and particularly saluted the presence of His Excellency, the Vice President in charge of the Commission on Social Affairs, Mr Arthur ZAHIDI NGOMA, at the opening and at the closure of the session. This, he said, indicated the high level commitment of the Government of the Democratic Republic of Congo to onchocerciasis control activities in the country. Dr Sambo also thanked donors for their support and congratulated Dr Christensen and Mr Benton for their invaluable contribution to health in Africa. He reassured the Forum that onchocerciasis control will be among his priorities.

117. In their respective closing remarks, both the chair, Her Excellency, Dr Anastasie MOLEKO MOLIWA, Minister of Health of DRC, and His Excellency, the Vice President of DRC in charge of the Commission on Social Affairs, Mr Arthur ZAHIDI NGOMA, thanked all the partners for the honour given to DRC by holding this tenth session in Kinshasa. The Vice President echoed the commitment of the participating governments themselves as being a fundamental factor for the
sustainability of CDTI. He congratulated the Forum for the outcome of the session and wished participants a safe return to their homes.

118. The tenth session of the Joint Action Forum was declared closed by His Excellency, the Vice President in charge of the Commission on Social Affairs, Mr Arthur ZAHIDI NGOMA.
LIST OF PARTICIPANTS

Belgium

1. M. Pierre LEBRUN, Attaché/Chef de la Coopération a.i Belge, Ambassade de Belgique, Kinshasa, République Démocratique du Congo, Tel.: (243) 89 31 753, E-mail: diplobel.kinshasa.ci@ic.cd

2. Dr Urbain MENASE, Attaché de Santé, Coopération Belge, Ambassade de la Belgique à Kinshasa, République Démocratique du Congo, Tel.: 0893 1903, E-mail: diplobel.kinshasa.ci@ic.cd

Burundi

3. Dr Libère NDAYISENGA, Coordonnateur National du Programme National de lutte contre l’Onchocercose, B.P. 1820, Bujumbura, Burundi, Tel: 257 24 93 33, Fax: 257 22 91 96, E-mail: ndalibere@yahoo.com

Cameroon

4. Mr Hayatou ALIM, Secrétaire d’Etat à la Santé publique, Ministère de la Santé publique, B.P. 155 Yaoundé, Cameroun

5. Dr Marcelline NTEP, Coordonnateur National, Programme National de Lutte contre l’Onchocercose, Secrétaire Exécutif du GTNO, Ministère de la Santé publique s/c OMS BP 155, Yaoundé, Cameroun, Tel: (237) 222 69 10, Fax: (237) 222 69 10, E-mail: mangamar2001@yahoo.fr; sgoa@camnet.cm

6. Dr Amadou FOPA, Délégué Provincial de la Santé Publique de l’Ouest, B.P. 479, Bafoussam, Cameroun, Tel: (237) 344 14 17, Fax: (237) 344 25 64

Canada

7. Mr. Stephen RANDALL, Chargé d’Affaires, Ambassade du Canada, 19, Avenue Pumbu, Kinshasa Gombe, République Démocratique du Congo, Tel: 89 50 310, Fax: 88 41 277, E-mail: stephen.randall@international.gc.ca

8. Mlle Catherine BERARD, Agent de Développement, Programme Panafncain, Direction de l’Afrique et du Moyen Orient, Agence Canadienne de Développement International (ACDI), 200 Promenade du Portage, Gatineau, Québec, Canada K1A OG4, Tel: 1 819 994 4194, Fax: 819 997 5453, E-mail: catherine_berard@acdi-cida.gc.ca

9. Mr Luc ST-LAURENT, Coopération Canadienne, Agence Canadienne de Développement International (ACDI), 200 Promenade du Portage, Gatineau, Québec, Canada K1A OG4, Tel: 1 819 953 0140, E-mail: luc.st-laurent@international.gc.ca
Central African Republic

10. Dr Christophe NDOUA, Coordonnateur du Programme National de Lutte contre l'Onchocercose, B.P. 1777, Bangui, République Centrafricaine, Tel : 236 61 61 17, Fax : 236 61 01 37, E-mail : ndouachrist@yahoo.fr

Congo

11. Dr Damase BODZONGO, Directeur Général de la Santé, Président du GNTO, Direction Générale de la Santé, B.P. 78, Brazzaville, République du Congo, Tel : Cel : (242) 536 42 77, Bur : (242) 81 57 46, Fax : 242 81 04 81 42 77, E-mail : bodzongo_damase@yahoo.fr

12. Dr Charlotte GOKABA OKEMBA, Directrice de la Lutte contre la Maladie, Premier Vice-président du GTNO, Direction de la Lutte contre la Maladie, Ministère de la Santé et de la Population, B.P. 236, Brazzaville – Congo, Tel : 242 551 52 08, Fax : 242 81 04 81, E-mail : charokaka@yahoo.fr

13. Dr François MISSAMOU, Coordonnateur National, Médecin-chef du Programme National de Lutte contre l’Onchocercose, Direction de la Lutte contre la Maladie, B.P. 236 ou 1066, Brazzaville, Congo, Tel : +242 668 05 63, Fax : +242 81 04 81, E-mail : opc_congo@yahoo.fr

Democratic Republic of Congo

14. Dr Anastasie MOLEKO MOLIWA, Ministre de la Santé, Bd du 30 juin, N° 4310, B.P. 3088, Kinshasa 1 – Kinshasa/Gombe, République Démocratique du Congo - Tel : (243) 12 33 214/9919268, Fax : (243) 139 88 73, E-mail : cabsante-rdc@raganet.net

15. Dr Elodie NDELA BULISI, Conseillère, Ministère de la Santé, République Démocratique du Congo, Tel : (243) 89 29 951

16. Dr Constantin MIAKA-MIA-BILENGE, Secrétaire Général à la Santé, Ministère de la Santé, Boulevard du 30 juin, Kinshasa, République Démocratique du Congo, Tel : (243) 99 04 294, E-mail : tshimbodi@yahoo.fr

17. Dr Mwanas Jean TSHISUAKA, Directeur de cabinet du Ministre de la Santé, Ministère de la Santé, Kinshasa, République Démocratique du Congo, Tel : (243) 99 31 635, E-mail : tshpsda@yahoo.fr

18. Dr Kalema WELO, Conseiller du Ministre de la Santé, Ministère de la Santé, Kinshasa, République Démocratique du Congo, Tel : (243) 98 47 49 62, E-mail : welokalber@yahoo.fr

19. M. Jacques BITIKA, Directeur de Cabinet adjoint, Ministère de la santé, Kinshasa, République Démocratique du Congo

20. M. Clément LUFUA, Chef du Protocole du Ministre de la santé, Ministère de la santé, Kinshasa, République Démocratique du Congo, Tel : (243) 9914280
21. Dr Marie-France KIABILUA SUNDAYA, Conseillère en matière de santé infantile et épidémie, Ministère de la Santé, Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Tel : (243) 081 52 62 237, E-mail : mfkibilua@yahoo.fr

22. Dr. Marcel Kupu MUKENGEShayAI, Directeur du Programme, Programme National de Lutte contre l’Onchocercose (PNLO), Boulevard du 30 Juin, no. 36, Kinshasa 1, République Démocratique du Congo, Tel : +243 99 47138, Fax : +243 12 33247, E-mail : pnlo_rdc@yahoo.fr et mukupa@yahoo.fr

23. M. Damase BANTUANGA, Membre du Groupe de Travail National de Lutte contre l’Onchocercose, Boulevard du 3 Juin, Salongo Sud, Tel : (243) 0815094941

24. Dr. Floribert AKOTSHI DOWO OYEMA, Directeur Adjoint du Programme National de Lutte contre l’Onchocercose, Avenue de la Justice No 36, Commune de la Gombe, Kinshasa, République Démocratique du Congo, Tel : +243 98 58 23 18, Fax : (243) 98 58 23 18, E-mail : akotshidf@yahoo.fr

25. Dr Opetha LOKADI, Directeur des Soins de Santé Primaires, Direction des Soins de Santé Primaires, 36, Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Tel : (243) 99 39 283, E-mail : plokadi@yahoo.fr

26. Dr Bajay TCHUMA, Project Manager, Catholic Relief Services, 3531, av. Colonel Lukusa, Kinshasa-Gombe, République Démocratique du Congo, Tel : (243) 81 88 46 792, E-mail : btchumah@crscongo.org; dr_bajay@yahoo.fr

27. Prof. David LUBEJI KAYEMBE, Ophtalmologiste/Membre de GTNO, Chef d’équipe 4, Études d’Impact des Opérations APOC, Cliniques Universitaires, B.P. 123, Kinshasa, République Démocratique du Congo, Tel : (243) 98 58 23 18, Fax : (243) 98 58 23 18, E-mail : prof_davidkayembe@yahoo.fr

28. Dr Simon MBETE, Président de Zone de Kinshasa I, Lions Club International, District 409, Building Flamboyant, Kinshasa, République Démocratique du Congo, Tel : (243) 89 12 663

29. Dr Ondjo SHULUNGU, Membre de GTNO/SNEL, 184, Avenue Pétunias, Commune de Limite, Kinshasa, République Démocratique du Congo, Tel : 081 700 5472, E-mail : roshul2003@yahoo.fr

30. Dr Bill William CLEMMER, Représentant SANRU/IMA, 75 Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Fax : (243) 993 9774, E-mail : clemma@sanru.org

31. M. Jean Jose NSALA LOMANGA, Directeur à la Recherche Scientifique, Membre du GTNO, Commune de Kinshasa Gombe, Kinshasa, République Démocratique du Congo, Tel : (243) 08 15 29 58 73, Fax : (243) 993 9774, E-mail : lomnsal@yahoo.fr

32. Prof. Dimomfu LAPIKA, Membre de GTNO, Député, Université de Kinshasa, B.P.836, Kinshasa XI, République Démocratique du Congo, Tel : (243) 99 08 093, E-mail : lapikadi@yahoo.fr
33. Mr David LAW, Administrateur du PNLO/Christoffel Blindenmission (CBM), 36, Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Tel: (243) 081 880 1974, E-mail: dlaw@rdc.maf.net

34. Mr Kalundalunda NGOLASHANGA, Administrative Assistant, PNLO, 36, Avenue de la Justice, Kinshasa Gombe, République Démocratique du Congo, Tel: (243) 99 99 814, E-mail: agcelestinngola@hotmail.com

35. Mr Mulut Jean TANKWEY, Chef, Direction Administrative et Financière, PNLO, 17, Avenue de la Justice, Kinshasa Gombe, République Démocratique du Congo, Tel: 081511 6382, E-mail: j-mulut@yahoo.fr

36. Dr Kapuku Didier BAKAJIKA, Data Manager, PNLO, Avenue de la Justice No 36, Commune de la Gombe, Programme National de Lutte contre l’Onchocercose (PNLO), Boulevard du 30 Juin, no. 36, Kinshasa 1, République Démocratique du Congo, Tel: +243 98 80 82 84, E-mail: dbakajika@yahoo.fr or dbakajika@hotmail.com

37. Dr Virgile Madua KIKAYA, Superviseur, TIDC Bas Congo, 36, Avenue de la Justice, Kinshasa Gombe Kinshasa, République Démocratique du Congo, Tel: (243) 0815113760, E-mail: virgilkikaya@hotmail.com

38. Dr Zawadi Antoinette BIFUKO, Chargée de la Lutte anti-vectorielle au PNLO, 36, Avenue de la Justice, Kinshasa/Gombe, Kinshasa, République Démocratique du Congo, Fax: 0814 52 6575, E-mail: antabifuko@yahoo.fr

39. Dr Longo Parfait YOKA, Superviseur Programme National de Lutte contre l’Onchocercose, 36, Avenue de la Justice, Kinshasa Gombe, République Démocratique du Congo, Tel: 0810386120, E-mail: yokalongo@yahoo.fr

40. Dr Mukiar Gabin Blaise TEMOR, Superviseur, PNLO, Avenue de la Justice, No 36, Gombe Kinshasa, République Démocratique du Congo, Tel: 9949 397, E-mail: gabatemor@yahoo.fr

41. Dr Justin Kabasele KANDE, Direction d’Etudes et Planification, Ministère de la santé, CAC L 88, 39, Avenue de la justice Kinshasa/Gombe, République Démocratique du Congo, Tel: (243) 081511 1552, E-mail: kandekj@yahoo.fr

42. Dr Mankiew Emile MAKWANGA, Directeur du Programme National Santé oculaire et Vision, PNSOV, CFOAC – Hôpital Saint Joseph, Kinshasa, Commune de Limite, Kinshasa, République Démocratique du Congo, Tel: 9931 381, E-mail: cfoac@ic.cd, makwanga_emile@yahoo.fr

43. Dr Tedende Floribert TEPAGE, Coordonnateur du Projet TIDC Uélé, 36, Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Tel: 0810 00 1479, E-mail: floritepage@yahoo.fr
44. Dr Simuna KUYANGISA, Coordonnateur Projet Bandundu, Mission Protestante Moanza, Province Bandundu, Kinshasa, République Démocratique du Congo, Tel: 98 534 103, E-mail : zsr_moanza@rdc-mof.net

45. Dr Boenga Beligo LIKWELA, Coordonnateur Projet Tshopo/PO, Inspection Médicale, Province Orientale, Kisangani République Démocratique du Congo, Tel: (243) 98 60 24 31 / 081 200 32 58, E-mail : lkwelabb@hotmail.com

46. Dr Jean-Paul TAMBEWA MANGALA, Coordonnateur Projet TIDC Bas-Congo, Projet TIDC Bas-Congo-Kinshasa Inga/Matadi, République Démocratique du Congo, Tel: (243) 081 077 91 60, E-mail: iptambwe@yahoo.fr

47. Dr Pierre César EDUMBADUMBA, Coordonnateur Projet TIDC Mongala, Bâtiment Santé, République Démocratique du Congo, Tel: (243) 0815081179

48. Dr Théo Barabutu BONG’U, Coordonnateur Projet Nord Ubangi, Gbadolité, République Démocratique du Congo, Tel: 00243 081 810 1278, E-mail: alwuou@yahoo.fr

49. Mr Esumbu Simon BOLONDA, Coordonnateur du Projet Equateur Kiri, PNLO, 36, Avenue de la Justice, Kinshasa, République Démocratique du Congo, Tel: (243) 0815009024, E-mail: elisembuyu@yahoo.fr

50. Dr Galaxy NGALAMULUME, Coordonnateur du Projet TIDC Katenga Nord, PNLO, 36, Avenue de la Justice, Kinshasa/Gombe, République Démocratique du Congo, Tel: (243) 08168 60 426, E-mail: rogergalaxy@yahoo.fr

51. Mme Elise MBUYU MBAYO, BCECO, Assistante/Chargée du Renforcement des Capacités, Avenue des Oasis No 17/378, Camp Livulu, Commune Lemba, Kinshasa, République Démocratique du Congo, Tel: (243) 98 86 32 88, E-mail : elisembuyu@yahoo.fr

52. Dr Adrien LOKA WONGA WOTSHO, Coordonnateur Projet TIDC Sankuru, Kasai-Oriental – District Sankuru, Lodja, Mission Catholique, Avenue de la Resellery No 8, République Démocratique du Congo, Tel: (243) 0816251600, E-mail: alwuou@yahoo.fr

53. Dr Euphrasie KIBOKO-FATUMA, Conseillère au Collège Social Culturel, Présidence, Palais de la Nation, Tel: (243) 9844 9904, E-mail: kibfatume@yahoo.fr

54. M. Polydor SANGWA, Protocole d’Etat et membre du Comité d’Organisation, Ministère des Affaires Etrangères, Kinshasa, République Démocratique du Congo, Tel: (243) 98137207

55. Prof. D. TSHOMBA HONDO, Professeur de Pathologie Infectieuse et Parasitaire, Ecole de la Santé Publique, Université de Lubumbashi, Kinshasa, République Démocratique du Congo, Tel: (243) 081 3331043, E-mail: profishombahondo@yahoo.fr

56. M. Venant TSHIELA, Secrétaire-Caissier, Projet TIDC Bas Congo, Kinshasa, Pool de Kinshasa, République Démocratique du Congo, Tél: (243) 0815170782, E-mail: venant64@hotmail.com
57. Mlle Stephanie BINAMA, Secrétaire, Avenue de la Justice No 36, Commune de la Gombe, Kinshasa, République Démocratique du Congo, Tél : (243) 98600296, E-mail : binanasteph@yahoo.fr

58. Mme Nicole MPUNGA, Secrétaire, PNLO, Avenue de la Justice No 36, Commune de la Gombe, Programme National de Lutte contre l’Onchocercose (PNLO), Boulevard du 30 Juin, no. 36, Kinshasa 1, République Démocratique du Congo, Tél : (243) 9999 507, E-mail : nicolempungu@yahoo.fr

**Ethiopia**

59. Dr Seifu Solomon ALEMARYEHU, Head, Disease Prevention and Control Department, Chairman of NOTF, Ministry of Health, P.O. Box 6238, Addis Ababa, Ethiopia, Tel: +251 1 15 96 82, Fax: +251 1 51 93 66, E-mail: alemayehuss@yahoo.com

60. Dr Jima Wayessa DADDI, National Onchocerciasis Coordinator, Ministry of Health, P.O. Box 1234, Addis Ababa, Ethiopia, Tel: +251 9 405722, Fax: +251 1 52 70 33, E-mail: malaria@telecom.net.et ; daadhij@yahoo.com

61. Mr Batiso Gabore ESSAY, Regional Onchocerciasis Coordinator, SNNP Regional Health Bureau, Awassa, Ethiopia, Tel: +251 6 207306, Fax: +251 6 205955, E-mail: batissoe@yahoo.co.uk

**France**

62. Dr Christian BAILLY, Coordonnateur CIRE, Cellule Inter-Régionale d’Épidémiologie Ouest, Expert pour la délégation française, 20 rue d’Isly – CS 84224 – 35042 Rennes Cedex, France, Tel : 02 99 35 29 60, Fax : 02 99 35 29 61 E-mail : christian.bailly@sante.gouv.fr

**Kuwait**

63. Dr Abdul Ridha BAHMAN, Agricultural Advisor, Kuwait Fund for Arab Economic Development, P.O. Box 2921 SAFAT 13030, KUWAIT, Tel: 965 2999186, Fax: 965 2999190, E-mail: bahman@kuwait_fund.org

**Liberia**

64. Dr Humphrey TUDAE-TORBOH, National Coordinator, NOTF, Liberia, Ministry of Health and Social Welfare, Monrovia, Liberia, Tel: (231) 512 898/551941, Fax: (231) 226 888, E-mail: oncholiberia2003@hotmail.com, htudae-turboh@yahoo.com

**Saudi Arabia**

65. Mr Hasan M. ALATTAS, Director General, Africa Projects Department, Saudi Fund for Development P.O. Box 1887, Riyadh 11441, Saudi Arabia, Tel: + 96614641928, Fax: + 96614647450, E-mail: hattas@email.com
66. Mr Saud A. ALFANTOUKH, Chief Internal Auditor, Controller General, Saudi Fund for Development, P.O. Box 1887, Riyadh 11441, Saudi Arabia, Tel: + 96614641928/96614640292, Fax: + 96614647450, E-mail: salfantoukh@yahoo.com

Sudan

67. Dr Peter Adwok OTTO, Minister of Health, Coordinating Council for Southern States, Juba, c/o Academy of Medical Sciences and Technology, Mobile: (249) 09 12 15 04 82, Fax: (249) 183 23 55 03, E-mail: sudanonocho@hotmail.com

68. Ms Malwal Aguer ALOKIER, Advisor on Women and Child Affairs, Coordinating Council for Southern States, Juba, c/o Academy of Medical Sciences and Technology, Federal Minister of Health, P.O. Box 12810, Khartoum, Sudan, E-mail: alokier2004@yahoo.com

69. Mr John Angol KORODIT, State Minister of Health, c/o Academy of Medical Sciences and Technology, Federal Minister of Health, P.O. Box 12810, Khartoum, Sudan, Tel: (249) 0912 133802/424942 – Fax : (249) 776775, E-mail: korodit@hotmail.com

70. Prof. Mamoun HOMEIDA, National Coordinator, National Onchocerciasis Control Programme, President of Academy of Medical Sciences and Technology, P.O. Box 12810, Khartoum, Sudan, Tel: (249) 183 22 47 62, Fax : (249) 183 22 47 99, E-mail: amst33@hotmail.com

71. Mr Osman Mohammed EL-FAKI, Councellor, Sudan Embassy, 24 Boulevard du 30 juin, 1er Niveau AFORIA, Kinshasa, Democratic Republic of Congo, Tel: 993 7396, E-mail: osmanmeljaki@hotmail.com

72. Mr Alhadi AL-JACK, Councellor, Sudan Embassy, Kinshasa, Democratic Republic of Congo, E-mail: alokier2004@yahoo.com

73. Dr Chor Malek TONG, Assistant National Coordinator, Senior Field Officer, NOCP, Academy of Medical Sciences & Technology, P.O. Box 12810, Khartoum, Sudan, Tel: +249 183 22 67 99, Fax: +249 183 23 55 03, E-mail: tong_schewitaak@hotmail.com

74. Ms Gai Kok SAF, NOCP Member, c/o Academy of Medical Sciences & Technology, P.O. Box 12810, Khartoum, Sudan, Tel: (249) 0918065251

75. Mrs Agnes LUKUDU, Ambassador, Sudan Embassy, Kinshasa, République Démocratique du Congo

76. Mr Khalid Hassan AL-NAEIM, Third Secretary, Sudan Embassy, Kinshasa, République Démocratique du Congo

Tanzania

77. Dr. Ali. A. MZIGE, Director Of Preventive Services, Ministry of Health, P.O. Box.9083, Dar-es-Salaam, Tanzania, Tel: 255 22 2123676/ 744 495 998- Fax: 255 22 2138060, E-mail: amzige@hotmail.com
78. Dr. Grace E.B. SAGUTI, National Onchocerciasis and Eye Care Control Programme Coordinator, Ministry of Health, P.O. Box 9083 Dar-es-Salaam, Tanzania, Tel: 255 22130009, Fax: 255 22130009, E-mail: nec_ocp@yahoo.com or gracejengo@yahoo.co.uk

Uganda

79. Dr. Alex KAMUGISHA, Minister of State for Primary Health Care, P.O. Box 7272, Kampala, Uganda, Tel: 256 34 08 79, Fax: 256 23 15 84, E-mail: a_kamugisha@hotmail.com

80. Dr. D.K.F. LWAMAF A, Commissioner for Health Service, National Disease, P.O. Box: 7272, Kampala, Uganda, Tel: (256) 41 25 96 66, Fax: 256 23 15 84, E-mail: lwamafa@hotmail.com; or chs-ndc@health.go.ug

81. Dr. R. NDYOMUGYENYI, National Coordinator, Onchocerciasis Control Programme, Vector Control Division, Ministry of Health, P.O. Box: 1661, Kampala, Uganda, Tel: (256) 41 34 8332, Fax: (256) 41 34 8339, E-mail: notfl(r)i_lrl.com

World Bank

82. Dr. Alexandre ABRANTES, Sector Manager, Human Development Department, The World Bank, 1818 H Street, N.W., Washington D.C. 20433 USA, Tel: +1 202 473 0056, Fax: +1 202 522 3157, E-mail: aabrantes@worldbank.org

83. Dr. Ousmane BANGOURA, Onchocerciasis Programme Coordinator, Human Development Department, The World Bank, 1818 H ST., N.W.; Washington, 20433, USA, Tel: 202 373 4004, Fax: 202 473 8216, E-mail: obangoura@worldbank.org

84. Mr. Bruce BENTON, Consultant, Human Development Department, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Tel: +1 202 473 5031, Fax: +1 202 522 3157, E-mail: bbenton@worldbank.org

85. Dr. Bernhard LIESE, Consultant, Human Development Department, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Tel: +1 (202) 458 4491, Fax: +1 (202) 522 3157, E-mail: bliese@worldbank.org

86. Dr. Charles PANNENBORG, Senior Adviser, Human Development (Health, Nutrition & Population), Africa Region (AFTHD) The World Bank, 1818 H Street, NW, MSN J10-1000, Washington, DC 20433, USA, Tel: 1 202-473-4415, E-mail: cpannenborg@worldbank.org

87. Dr. Khama ROGO, Lead Health Specialist, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, Tel: +1 202 473 6117, Fax: +1 202 473 3000, E-mail: krogo@worldbank.org

88. Mme Tshiya SUBAYI CUPPEN, Health Specialist, The World Bank, Cotonou, Bénin, Tel: (229) 30 5849/30 5897/30 1777, Fax: (229) 30 1744 - E-mail: tsubayi@worldbank.org
89. Dr Jesse BUMP, Consultant, Human Development Department, The World Bank, 1818 H Street, NW, Washington, DC 20433, USA, via Pietrapiana 9 Florence, Italy 50121, Tel: +39 333 186 5374, E-mail: jbumpp@worldbank.org

NON-GOVERNMENTAL DEVELOPMENT ORGANIZATIONS

Christoffel Blindenmission

90. Dr Adrian Hopkins, Medical advisor, CBM Regional Office, P.O. Box 58004, Nairobi, Kenya, Tel: 254 203751 651/735 717 655/ 993 1354, Fax: 254 20 3740 305, E-mail: ahopkins@cbmi-nbo.org; adriandhopkins@aol.com

Helen Keller Worldwide

91. Ms Nancy HASELOW, Director, Onchocerciasis Programs, Helen Keller Worldwide (HKI), B.P. 14227, Yaoundé, Cameroon, Tel: 237 770 9304, Fax: 237 221 0848, E-mail: nhaselow@hki.org

Lions Clubs International/Sight First

92. Mme Dominique COSTE, Président Commission LCIF/Sightfirst Afrique Central/Ocean Indien, BP 4794, Yaoundé, Cameroun, Tel: +237 220 50 07, Fax: +237 221 55 67, E-mail: sight.first@camnet.cm

Mectizan Donation Program

93. Dr Bjorn THYLEFORS, Director, Mectizan Donation Program, 750 Commerce Drive, Suite 400, Decatur, GA 30030, USA, Tel: +1 404 687 5616, Fax: 1 404 371 1138, E-mail: bthylefors@taskforce.org

94. Dr Mary ALLEMAN, Associate Director, Mectizan Donation Program, 750 Commerce Drive, Suite 400, Decatur, GA 30030, USA, Tel: 1 404 687 5633, Fax: 1 404 371 1138, E-mail: malleman@taskforce.org

Organisation pour la Prévention de la Cécité (OPC)

95. Dr Jean François CECON, Directeur des Programmes, Organisation pour la Prévention de la Cécité, 17 Villa d’Alésia, 75014 Paris, Tel: 33 1 44 12 41 97, Fax: 33 1 44 12 23 01, E-mail: jf.cecon@opc.asso.fr

96. Dr Roland RIZET, Représentant de l’OPC au Congo, Troisième Vice-Président du GTNO, B.P. 13089, Brazzaville, République du Congo, Tel : 242 660 68 08/ 551 58 49, Fax : 242 81 58 95/004724139544, E-mail: rolandrizet@hotmail.com, rolandrizet@yahoo.fr

Sight Savers International

97. Ms Catherine CROSS, Manager; International Programmes, Sight Savers International (SSI), Governor Hall, Bohnore Road, Haywards Heath, RH16 4BX, United Kingdom, Tel: +44 1444 44 6600- Fax: +44 1444 44 6677, E-mail: ccross@sightsavers.org
98. Mr Ronald GRAHAM, Regional Director, East Central and Southern Africa, Sight Savers International, P.O. Box 34690, 00100 GPO, Nairobi, Kenya, Tel: +254 20 60 69 70/60 12 04, Fax: +254 20 60 96 23, E-mail: rgraham@sightavers.or.ke

99. Mr Simon BUSH, Regional Director, West Africa, P.O. Box 18190, KIA Airport, Ghana, Tel: +233 21 77 42 10/78 47 02, Fax: +233 21 77 42 09, E-mail: sbush@sightsavers.org.gh

The Micronutrient Initiative

100. Dr Julia MOORMAN, Technical Coordinator, Africa Region, The Micronutrient Initiative, 95 Oxford Road, Rosebank, Johannesburg 2094, South Africa, Tel: 27 11 327 6292 / 3, Fax: 327 6286, E-mail: jmoorman@micronutrient.org.za

101. Mr Dominic SCHOFIELD, Manager - Partnership & Business Development, The Micronutrient Initiative, PO Box 56127, 250 Albert Street, Ottawa, Canada K1R 7Z1, Tel: +1 (613) 782-6830, Fax: +1 (613) 782-6838 - www.micronutrient.org, E-mail: dschofield@micronutrient.org

Mitosath

102. Mrs Francisca OLAMJU, Executive Director, MITOSATH, 6 Noad Avenue, Tekan Headquarters, Behind Central Bank, P.O. Box 205, Jos, Plateau State, Nigeria, Tel: 234 073 454044/73 080333, Fax: 234 073 450153 – Mobile: 080333 18085, E-mail: mitosath@hotmail.com; olan-riiufcr(mitosath.org or mitosath@skannet.com

WORLD HEALTH ORGANIZATION

WHO/HQ

103. Mr Claude Henri VIGNES, Office of the Legal Counsel, WHO, 20 Avenue Appia, CH1211 Geneva 27, Switzerland, Tel: 4122 791 2638, Fax: 4122 791 4158, E-mail: c/o jaggipoulsen@who.int

104. Dr Janis K. LAZDINS-HELDS, Coordinator a.i. Product research and Evaluation, TDR/WHO, 20, Avenue Appia, CH-1211 Geneva 27, Switzerland, Tel: 4122 791 3818, Fax: 4122 791 4774, E-mail: lazdinsj@who.int

105. Dr Hans REMME, Coordinator, Science Strategy and Knowledge (SSK), WHO/TDR, 20, Avenue Appia, CH-1211 Geneva 27, Switzerland, Tel: 4122 791 3818, Fax: 4122 791 4774, E-mail: remmej@who.int

106. Dr. Tony UKETY, NGDO Coordinator for Onchocerciasis Control, WHO, 20 Avenue Appia, 1211 Geneva 27, Switzerland, Tel: 4122 7911450, Fax: 4122 791 4772, E-mail: uketyt@who.int
107. Mr Abdulai DARIBI, AFRO/APOC Liaison Officer, WHO, 20, Avenue Appia, CH-1211 Geneva 27, Switzerland, Tel: 4122 791 3883, Fax: 4122 791 4190, E-mail: daribia@who.int

WHO/AFRO

108. Dr Luis Gomes SAMBO, Director, Programme Management, B.P. 6, Brazzaville, République du Congo, Tel: 47 241 39111, Fax: 47 241 39509, E-mail: sambol@afro.who.int

109. Dr Sam BUGRI, Director, ad Interim, Multi Disease Surveillance Centre, 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 38 18 3, Fax: 226 50 34 28 75, E-mail: bugris@oncho.oms.bf

110. Dr Paul-Samson Lusamba-DIKASSA, Regional Adviser, Communicable Disease Surveillance and Response, WHO/AFRO, P.O. Box BE 773 Belvedere, Harare, Zimbabwe, Tel: 47 241 38264, Fax: 47 241 38004, E-mail: lusambap@afro.who.int

WHO/KINSHASA

111. Dr Mosiana EKWANZALA, DPC, Organisation Mondiale de la Santé, Avenue des Cliniques No 42, Kinshasa, République Démocratique du Congo, Tel: 081700 6409, E-mail: ekwanzala@cd.afro.who.int

WHO/APOC

112. Dr Azodoga SEKETELI, Director, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 22 77, Fax: 226 50 34.30.42, E-mail: seketelia@oncho.oms.bf

113. Dr Ole W. CHRISTENSEN, WHO/ APOC consultant, Poppelhuset, Jespervej 274, DK – 3480 Fredensborg, Denmark, Tel : +45 48 24 88 68 ; Fax : 48 23 28 68; e-mail : owc@mail.dk

114. Dr Eleuther Tarimo, Consultant, Medical Doctor, c/o WHO/Tanzania, P.O. Box 9292, Dar-es-Salaam, Tanzania, Tel: (255) 22 2775891, E-mail: eleuther@ud.co.tz

115. Dr Laurent YAMEOGO, Coordinator, African Programme for Onchocerciasis Control (APOC) 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34.29.53, Fax: 226 50 34 28 75, E-mail: yameogol@oncho.oms.bf

116. Dr Uche AMAZIGO, Chief, Sustainable Drug Distribution Unit, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34.29.53, Fax: 226 50 34 28 75, E-mail: amazigouv@oncho.oms.bf

117. Dr Mounkaïla NOMA, Chief, Epidemiology and vector Elimination Unit, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34.29.53, Fax: 226 50 34 28 75, E-mail: nomam@oncho.oms.bf
118. M. Koffi AGBLEWONU, Budget and Finance Officer, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: agblewonu@oncho.oms.bf

119. M. Yaovi AHOLOU, Administrative Officer, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: aholouy@oncho.oms.bf

120. Mrs Agnes DRABO, Secretary, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: drab@oncho.oncho.bf

121. Ms Jeanne LAWSON, Secretary, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: lawsonj@oncho.oncho.bf

122. Mr ODAME-BAMFO Samuel, Translator, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: bamfosa@oncho.oms.bf

123. Mrs Edith KABORE, Secretary, Administrative Assistant in charge of meetings, African Programme for Onchocerciasis Control (APOC), 01 BP 549, Ouagadougou 01, Burkina Faso, Tel: 226 50 34 28 75, Fax: 226 50 34 28 75, E-mail: kaborc@oncho.oms.bf

EX-OFFICIO PARTICIPANTS

124. Dr Bernard PHILIPPON, Chargé de mission Santé, Institut de Recherche pour le Développement (IRD), 213 Rue Lafayette, 75480- Paris-Cedex10, France, Tel /Fax: 33 1 40 44 94 04; E-mail : abphilippon@yahoo.fr ; philippon@ird.fr

125. Dr Michel BOUSSINESQ, Directeur de Recherche, Membre du CCT d’APOC, Membre du Mectizan Expert Committee, Institut de Recherche pour le Développement (IRD) – Département Sociétés et Santé, 213 Rue Lafayette, 75480- Paris-Cedex10, France, Tel : 33 1 42 49 38 15 Fax: (33) 1 42 49 38 15, E-mail: boussinesq@ird.fr

TCC

126. Prof Ekanem BRAIDE, Chair TCC, Vice Chancellor, Cross River University of Technology, P.M.B. 3679, Calabar, Nigeria, Tel: 234 80 33 41 68 42, E-mail: ekanem_b@hotmail.com

INTERPRETERS

127. Mr. Christian STENERSEN, Interprète, Les Rossanets, F-01170 Segny, Gex, France, Tel: 33 4 50 41 78 80, E-mail : stenersens@wanadoo.fr

128. Ms. Geneviève CLEMENT, Interprète, 80, rue de Meyrin, F-01210 Ferney-Voltaire, France, Tel: 33 4 50 40 76 50
Mme Isabelle POLNEAU, Interprète, 08 B.P. 1517, Abidjan 08, Côte d'Ivoire, Tel : (225) 05 94 43 07, Fax : (225) 20 86 63, E-mail :

Mme Safiatou BARRY, Interprète, 09 B.P. 526 Ouagadougou 09, Burkina Faso, Tel: (226) 50 37 12 22 – Cell: (226) 70 21 41 14, E-mail: safibar@fasonet.bf

**Observers**

**Denmark**

131. Dr. Erling M. PEDERSEN, DANIDA Temporary Advisor, Danish Bilharziasis Laboratory, Jaegersborg Alle 1D DK-2920, Charlottenlund, Denmark, Tel: +45 77327763 (direct) + 45 77 32 77 32 (Swiss Board), Fax: +45 77327733, E-mail: emp@bilharziasis.dk

**Guinea**

132. Mr Roger T. LAMA, Entomologiste national, Programme de Lutte contre l’Onchocercose et la Cécité, Ministère de la Santé, B.P. 585, Conakry, Guinée, Tel: 224 11 29 69 78, E-mail: rogerlama2002@yahoo.fr

**Mali**

133. Dr Mamadou Oumar TRAORE, Coordonnateur National du Programme de lutte contre l’Onchocercose, Direction Nationale de la Santé, BP : 233, Bamako, Mali, Tel : 223 222 64 97 – Tel/Portable : 223 671 1766, Fax : 223 222 36 74, E-mail: traoremot@yahoo.fr

134. M. Moussa SOW, Entomologiste National, Programme National de Lutte contre l’Onchocercose (PNLO), Direction Nationale de la Santé, BP : 233 Bamako, Mali, Tel : 223 222 64 97, Fax : 223 222 36 74, E-mail: sow_moussa@caramail.com

**United Front Against River Blindness**

135. Dr Daniel SHUNGU, Chief Executive Officer, 13 Carnation Place, Lawrenceville, New Jersey 08648, USA, Tel: 609 771 3674 – Tel/Portable: 609 954 3398, E-mail: dlshungui@aol.com

**Coopération Italienne**

136. Dr Andrea CADELANO, Coordinateur de la Coopération Italienne, Avenue de la Mongala, 8, Kinshasa/Gombe, République Démocratique du Congo, Tel: (249) 0818804302 /0818846106 /08 13 55 77 22, Fax: (243) 9975360, E-mail: ambitalyc@ic.ed

**Coopération Canadienne**

137. Mme Marie-Jeanne BOKOKO, Expert Santé à l’UAP, 17, Rue Pumbu, Kinshasa/Gombe, République Démocratique du Congo, Tel: (243) 081 50 25 667 / 999 55 21, E-mail: mjeanne.bokoko@uaprdc.org
Mr President of the Democratic Republic of Congo,
The Vice Presidents of the Democratic Republic of Congo,
Representatives of constituent bodies,
The Minister of Health,
Excellencies,
Dr Seketeli, Director of APOC,
Representatives of bilateral and multilateral agencies,
Representatives of the donor community,
Distinguished guests,
Ladies and Gentlemen,

On behalf of the Government of Canada and on my own behalf, I would like to welcome you and to thank the Government and people of the Democratic Republic of Congo for the warm hospitality extended to all participants in this meeting since their arrival in Kinshasa.

Since the ninth session of the Joint Action Forum (JAF) at Gatineau in December 2003 under the chairmanship of Mr Paul Hunt, the Programme has made remarkable progress. I am therefore very honoured to underscore the main achievements in 2004:

1. DISEASE MAPPING

Refinement of the Rapid Epidemiological Mapping of Onchocerciasis (REMO) was undertaken in Angola, Burundi, Ethiopia and Tanzania and from the recent refinement exercises a total of 111 Community-Directed Treatment with Ivermectin (CDTI) projects have been forecasted for the Programme. Out of these, 106 have already been approved.

In order to prepare adequately for the management of Serious Adverse Events, APOC management has facilitated the mapping of the co-endemicity of loaisis and river blindness in the high-risk zones of DRC, Angola, Cameroon and the Republic of Congo.

2. PROJECT IMPLEMENTATION

In 2004, 84 projects were implemented compared to 76 in 2003. According to the data for 2003 a total of 33,206,849 persons in 68,841 communities were treated as compared to 28,574,000 in 60,024 communities in the previous year.
3. EVALUATION FOR THE SUSTAINABILITY OF CDTI

Since the last session of JAF, 7 projects in their third or fifth year of implementation have been evaluated for sustainability of CDTI. In addition, a Special Meeting on sustainability was held in February 2004 to streamline a number of issues as suggested by JAF9. The meeting re-defined sustainability; assessed progress made so far in this important subject; reviewed indicators, guidelines and instruments for evaluating CDTI projects for sustainability; developed criteria for reviewing sustainability plans; and designed a tool for monitoring the implementation of sustainability plans. In addition, 8 articles on the sustainability of CDTI have been written. They are currently being edited and will be published soon.

The tool for monitoring the implementation of sustainability plans has been pre-tested in Tanzania, and fact-finding missions were conducted in Uganda and Nigeria. The tool is being finalized for use by National Onchocerciasis Task Forces (NOTFs).

4. CAPACTY-BUILDING AND COUNTRY SUPPORT MISSIONS

Several missions were undertaken throughout the year for various reasons. These missions involved APOC staff, Technical Consultative Committee (TCC) members, Temporary advisers and NOTF members. Some of the objectives of these activities were to provide technical advice to NOTFs, capacity-building, post-conflict assessment, REMO refinement, consultation with national authorities and vector elimination. As such, teams were sent to Angola, Burundi Cameroon, CAR, Chad, DRC, Equatorial Guinea, South Sudan, Tanzania and Uganda.

5. IMPACT ASSESSMENT

The activities of the second round of Impact Assessment of APOC operations have been launched and the data to show scientific evidence of the efforts of the Programme will be ready for the next JAF session.

6. VECTOR ELIMINATION

Ground larviciding in Tukuyu (Tanzania) and Mpamba Nkusi (Uganda) are continuing while aerial spraying is being used in Bioko (Equatorial Guinea). Surveillance results in Uganda show that there is no sign of re-infestation seven years after the last ground larviciding exercise.

7. TCC ACHIEVEMENTS

I would like to thank the Technical Consultative Committee for reviewing 7 project proposals, 59 annual technical reports and 7 operational research proposals. This Committee has also been instrumental in addressing technical matters such as progress in MACROFIL, independent participatory monitoring, vector elimination, financial management, impact assessment of APOC operations and the use of the CDTI network and resources for other additional health interventions. We note with satisfaction the commissioning of a study to assess the cost of ivermectin treatment in Cameroon, Nigeria and Uganda. The results of this study will be presented to our next JAF session.
8. INTEGRATION

Fellow participants, I am pleased to associate myself with the CDTI strategy which has become a popular vehicle for delivering basic health service to the poor. In the absence of functional health care delivery, the Community-Directed Distributors (CDDs) and health workers who are trained in CDTI are aptly used to serve the needy populations by identifying cataract cases; distributing Vitamin A capsules, anti-malarial drugs, praziquantel, condoms and Insecticide Treated Nets; mobilizing people for immunization and primary eye care (PEC); and rehabilitation of the blind. We are definitely getting more for APOC investments!

To date, more than 30,000 CDDs have been trained in the provision of 4 other health interventions in 21 districts of Uganda; about 38,000 CDDs have been trained on the distribution of Vitamin A, 39,600 CDDs trained in Primary Eye Care, more than 11,000 trained in distributing praziquantel, 9,800 trained in distributing albendazole, and over 39,000 CDDs participating in Primary Eye care service delivery in Nigeria. Currently more precise data is being collected from Cameroon and Uganda so we encourage all other NOTFs to do likewise.

9. OTHER ACTIVITIES

In the year behind us, APOC Management continued to support the conduct of statutory meetings comprised of 2 TCC and 3 Committee of Sponsoring Agencies meetings and the JAF10 which started today; participated in funds mobilization activities such as the Donors' Conference in Washington last June; and as a way of strengthening partnership took part in the two MEC/Albendazole Coordination meetings, the two Non-Governmental Development Organization meetings, the meetings of the Special Intervention Zones and the Shanghai Conference on scaling up poverty reduction.

Other activities undertaken include participation in the Meeting on the Implementation of Home Management of Malaria, the integration meetings of the Bill and Melinda Gates Foundation, and the filming in Ghana and Togo so as to produce a documentary on river blindness, among others.

THE CHALLENGES:

➢ To date, the population at risk of contracting river blindness stands at 87.6 million and is projected to be over 107 million in 2010. This gives an Ultimate Treatment Goal for the year 2010 of about 90 million people. If we continue our relentless effort against river blindness, close to 90 million will therefore be receiving Mectizan treatment every year against this devastating scourge;

➢ Needless to say there is a funding gap of US$13 million that needs to be bridged so as to establish sustainable CDTI systems thereby controlling this devastating disease as a public health concern;

➢ More advocacy for support to CDTI remains a critical necessity in order to solicit for greater commitment among policy-makers at all levels of governments so that they become focal players in CDTI. In view of the need for compliance to long-term treatment with
ivermectin, it is imperative for these stakeholders to fully understand and take charge of their responsibility;

- Let us use the important lessons learnt such as simplicity, efficiency, cost-effectiveness, empowerment of communities and integration that we have learnt from implementing CDTI to replicate health service delivery to the underserved populations of Africa.

As a member of the Joint Action Forum, Canada would like to underscore the importance of this partnership in onchocerciasis control. Our joint efforts have yield impressive results. This long-dated collaboration precisely falls within the new scope of development as stipulates in the Monterrey Consensus. We can count on an admirable team that brings together the African Governments, the donor community, the multilateral agencies, the Non-Governmental Organizations, the scientific community, private sector and, of course, the affected communities themselves. This association where each member of the team plays a remarkable role is the very basis of the success of APOC.

I would also like to highlight the important role played by the men and women of the affected communities. We should not forget to closely involve the youth in these communities in the planning process and distribution of ivermectin because ivermectin treatment will continue beyond the end of the Programme. At this moment when HIV/AIDS threatens a large number of activities and development programmes, we must ensure that future generations understand the need for vigilance and long-term follow-up.

Ladies and Gentlemen, we have learnt a lot from the success of onchocerciasis control. The APOC partnership and the autonomy which allows the affected communities to elaborate their own plans of action are real indications of success. However, we still need to ensure that the fruits of our years of efforts are well sustained. This sustainability undoubtedly rests in integration and ownership - integration into the existing health systems; and ownership by the participating governments who formally undertook, several years ago, to fight against onchocerciasis.

Mr President of the Republic, Ladies and Gentlemen, you will agree with me that if all the results I have brought to your attention here are an indication of real achievements, a lot remains to be accomplished. We need to consolidate these achievements particularly in the light of the multiple priorities we are currently faced with.

I thank you all and wish you fruitful deliberations.

Kinshasa, DRC, 7-9 December 2004

Thank you Mr Chairman,

First of all, I would like to thank the Government of the Democratic Republic of Congo for hosting this 10th session of the Joint Action Forum of the African Programme for Onchocerciasis Control (APOC) here in Kinshasa.

Excellencies, distinguished participants, ladies and gentlemen,

For the past 30 years, onchocerciasis control in Africa has brought scientists, the international development community, the African governments and the affected communities together in a unique partnership working to rid Africa of the public health and socioeconomic burden of this disabling disease.

Community-directed treatment with ivermectin (CDTI) has proven to be a successful method for delivering health care on a large-scale to remote communities.

In nine years of operations, APOC has approved 106 projects for CDTI implementation, of which 73 are being implemented. As a result, the Programme has been able to reach out to some 33.5 million people in 2003 alone. APOC aims to treat 90 million people per year by 2010.

To rid Africa of onchocerciasis, treatment with ivermectin needs to be sustained for a minimum of 15 to 20 years at high coverage and compliance rates. This sustainability will largely depend on the political will of the countries to provide the necessary resources for CDTI activities; but also, on the empowerment of communities and the commitment of governments to take responsibility for the implementation of CDTI activities.

The CDTI structure has been a new basis for promoting the integration of other health interventions such as Vitamin A supplementation, lymphatic filariasis and reproductive health. A number of studies are under way to determine how best to plan and implement integration at the community level in order to streamline synergies of the various field programmes to the maximum benefit of the affected communities.

When the successful Onchocerciasis Control Programme in West Africa (OCP) ended two years ago, the Multidisease Surveillance Centre (MDSC) was created to provide support to the former OCP countries in the surveillance of onchocerciasis as well as of other infectious diseases such as meningitis, tuberculosis, HIV/AIDS and malaria. Thanks to the combined efforts of the various partners, the governance structure of the MDSC has now been established and efforts are being made to mobilize and put in place the necessary resources for the Centre to be fully operational.

A mid-term review to assess the current situation of onchocerciasis in the former OCP countries will be taking place from June 2005, and the outcome will undoubtedly contribute significantly to
improving the surveillance of onchocerciasis; and enable an appropriate review of the surveillance infrastructure in the sub region. An external evaluation of APOC will also begin in the first quarter of 2005 and the results will be presented to you at the next JAF meeting in December 2005.

I wish to thank the donors for their support all these years and for pledging at a recent APOC Donors' Conference in Washington not to abandon the programme before the end of its operations in 2010.

I am grateful to Merck & Co. Inc. for its standing pledge to provide ivermectin for as long as needed for the control of onchocerciasis; and to the Non-Governmental Development Organizations who are actively involved in facilitating the distribution of the drug to the communities. Of course, the role of the participating countries, particularly, that of the communities themselves, is central to the success of APOC.

I express our gratitude to the World Bank for successfully coordinating the financing; and efficiently maintaining the Trust Fund of the programmes to ensure continuity of their operations. Mr Chairman, allow me to specifically congratulate Mr Bruce Benton, the Manager of the Onchocerciasis Coordination Unit at the World Bank whose personal devotion to the cause of onchocerciasis control has certainly played a significant role in the achievements of OCP and APOC. We need many more advocates like Mr Benton to see the neglected diseases enjoy similar international support.

I would also like to acknowledge the strong leadership that has always driven the success of onchocerciasis control activities. In this regard, I would particularly like to pay tribute to Dr Ebrahim M. Samba for his leadership as Director of OCP for 14 years; and for his support as the WHO Regional Director for Africa in the last 10 years. As Dr Samba retires at the end of January 2005, I do believe that his successor, Dr Luis Sambo, will continue to provide such strong support to APOC at all times and wherever it may be necessary.

Excellencies, distinguished participants, ladies and gentlemen,

I wish you success in your deliberations and thank you for your attention.
OPENING SPEECH BY HIS EXCELLENCY
THE VICE PRESIDENT OF THE DEMOCRATIC REPUBLIC OF CONGO
IN CHARGE OF THE NATIONAL SOCIAL AND CULTURAL COMMISSION
AT THE TENTH SESSION OF THE JOINT ACTION FORUM
Kinshasa, December 2004

Honourable Ministers of Health of APOC member countries;
Representatives of countries and donor organizations;
Distinguished guests;
Dear participants,

I am highly elated today in playing host to you here in Kinshasa for the three days of deliberations on the activities of onchocerciasis control in member countries of the African Programme for Onchocerciasis Control (APOC).

DRC is a vast country in the heart of Central Africa, and has great potential embedded in its underground soil, as well as animal and plant resources. The development of the country will contribute to the revamp of several other countries of the sub-region in particular, and Africa in general.

The most important of its resources is, of course, its population, which is estimated at 60 million. A population made up of youth in its majority, and which represents the major factor that could transform the great potential of the country into a development force.

Diseases that reduce on a large scale its creative capacities are currently decimating this population. Pandemics such as AIDS and malaria are the cause of thousands of deaths among the population, and other diseases like tuberculosis and trypanosomiasis, which, for a long time, were thought to be under control, are reappearing and causing havoc.

In addition to this, onchocerciasis, the African disease that is greatly affecting DRC, is pushing our people deeper into the abyss of poverty. Those who are ignorant of the disease may think it is of little importance, which is an error.

Onchocerciasis blinds, and particularly the populations in our country, who make up the granaries of our cities. The young adults, who were spared the other pandemics, find themselves burdens for the society, and the children who have the responsibility of leading them have already compromised their future. This sorry rampant image of a blind person led by a child with a stick in hand, symbolises so well the common destiny of these two individuals: The destiny of misery and poverty.

The good news for Africa is that, onchocerciasis is curable, and could be eliminated in the rather near future, if we have the will to work at it in harmony.

I would like to take this opportunity to express my gratitude to the countries, NGOs and international agencies, which provide, through the African Programme for Onchocerciasis Control
(APOC), the needed support for implementing onchocerciasis control-related activities under the mass community-directed treatment with ivermectin strategy in 19 member countries.

I would also like to thank the Director of APOC and his staff for their dynamism, foresightedness, flexibility and anticipation which they employed to assist the DRC in starting up in great fashion to ensure that in three years – between 2002 and 2004, we carried out large-scale REMO surveys, (mapping of onchocerciasis), and set up 18 CDTI projects.

I would also like to thank all partners for their active input in the process of implementing mass community-directed treatment with ivermectin in our country. Your participation in this forum is a source of joy and pride for the Congolese people, who are hosting you today.

I say a big “welcome” to you all, and wish you the best in your deliberations and stay here.

On this note, I declare open the 10th Joint Action Forum.

Thank you.
OPENING SPEECH BY THE DIRECTOR OF APOC, DR AZODOGA SEKETELI, 
AT THE TENTH JAF SESSION OF THE AFRICAN PROGRAMME FOR 
ONCHOCERCIASIS CONTROL

His Excellency, the Vice President of the Republic,
Honourable Ministers,
Honourable Chairperson of the 9th session of the Joint Action Forum,
Distinguished Guests and participants,
Ladies and gentlemen,

You would agree with me that this day, 7th December 2004, is a memorable day. We have in our midst, a Vice President, standing in for the President of the Republic, to grace the opening of one of the annual sessions of the governing bodies of the Onchocerciasis Programmes in Africa. This endemic disease has, in the quiet, caused havoc and desolation among the poorest of the poor of our continent.

Your Excellency, Vice President, your presence here today is proof of the political commitment of the highest authorities of your country to support the current effort geared towards eliminating onchocerciasis from our continent.

I am convinced that history, and especially that of the fight against onchocerciasis in Africa, will have on record that you were present here this morning of 7 December 2004. We are all full of praise for this, and thank you very sincerely.

Excellencies, ladies and gentlemen,

We have just heard the speeches by the outgoing chairperson of JAF, and the representative of the Director General of WHO, which gave an overview of achievements of the Programme, with special emphasis on the gains made since the last session in Gatineau (Canada) in December 2003.

I would not like to go into the details of these achievements, since they are going to be highlighted in presentations that will be discussed during the meeting. But, allow me to briefly recall three key stages of the progress made by APOC since its inception in December 1995.

Prior to this, let us recall the primary objective of the Programme which, substantially is "to set up in the entire geographical area of the Programme, an effective and sustainable community-directed ivermectin distribution system ... and later on leave the member countries and their communities to use the system to outreach, on an annual basis, and with adequate therapeutic coverage rates, all eligible populations, with a view to eliminating onchocerciasis, at the end of the day, as a public health problem, and an obstacle to social and economic development of the areas concerned ..."

Let us now see the three key stages of APOC’s move these past 9 years, towards the attainment of this objective:
1st Stage: Progress made in mapping, and its impact on determining the disease burden:

From the outset, the attainment of the first objective of APOC was to enable the countries and their communities to eventually protect 50 million at-risk persons, by treating on an annual basis 33 million people, out of an eligible population estimated at 42 million.

Thanks to the progress made in disease mapping, the total population at risk to be protected stands at an estimated 107 million persons. To ensure protection, there is the need to annually treat more than 66 million people, out of an eligible population of nearly 90 million.

These figures speak for themselves: The disease burden and the effort needed to fight it have doubled since the Programme was launched in 1995.

2nd stage: progress in developing and implementing community-directed treatment with ivermectin (CDTI) projects, following a more realistic appraisal of the disease burden and its distribution:

At its inception, the CDTI strategy, which was adopted to set up our sustainable ivermectin distribution system, was to lead to the implementation of a maximum of 40 CDTI projects, to eventually protect 50 million persons, who were initially estimated to be at risk. Today, our estimation of the number of CDTI projects to be implemented in order to eventually protect a population of 107 million at risk as mentioned earlier, could be put at 111, at the least.

The network that we will set up, especially at the peripheral level, and “beyond the end of the road”, will thus become more intricate and outreach more than 100,000 rural communities in 16 countries. These communities will have to own this CDTI process, in line with the Programme’s philosophy. This network will buttress health services in the countries, and serve as a vehicle for other public health activities.

3rd Stage: This stage brings us face to face with the Loa loa onchocerciasis co-endemicity, with the risks of Severe Adverse Events (SAE), linked with ivermectin treatment:

Thus, at the inception of the Programme in December 1995, we least expected that in our effort to set up a sustainable ivermectin distribution system, “Loa loa”, with its devastating SAEs, after ivermectin treatment, would intrude our progress. It therefore became necessary to undertake operational research to develop a rapid Loa loa mapping tool, with criteria for delineating SAE high-risk areas. This tool for the rapid epidemiological mapping of Loa loa in the onchocerciasis-endemic areas (RAPLOA) was validated only this year, 2004. It was also necessary to define the guidelines to follow for ivermectin distribution in the high-risk Loa loa/onchocerciasis co-endemic areas. These SAE call for caution during the distribution of the drug in the afore-mentioned areas, and is a factor that slows down the implementation of approved CDTI projects.

Excellencies, ladies and gentlemen,

As you might have noticed, the realities at hand are far beyond the projections we made at the outset. If we add to this excess burden the fact that, for majority of the areas concerned, we operate in rather unstable social and political environments, then it is easy to already predict that mathematically, we will not be able to meet the challenge of providing all the projects with the minimum of five years of APOC funding by 31 December 2010 when the Programme comes to an end. As a matter of fact, as at now, about 40 CDTI projects, of which about 30 are already
approved, are yet to be implemented. The last batch of these projects, from all indications, will be implemented towards the end of 2006.

It is comforting, however, to note that, owing to the rigorous management of risks relating to our expenditure, especially in conflict areas, to the increasingly visible support of the governments of APOC member countries and the communities themselves, and finally, thanks to the support of partner NGOs and Merck & Co. Inc., the budget of US$79 million earmarked for Phase II and the Phasing-out Period is, and will remain sufficient as APOC Trust Fund contribution, to take up the challenges and bring the Programme to a successful end. Therefore, when the time comes, for the reasons I put forth above, there will be need to ask you, generous donors of APOC, for your authorization to use, after 2010, the funds which would not have been committed by then, with the sole aim of completing what will be left to be done.

Meanwhile, I would like to reassure you, Excellencies, ladies and gentlemen that, by 2010 all will be done to ensure that the sustainable Mectizan distribution system, which we are to set up, will be more real and tangible than it is today, and that it will be the dream model of a tool that would strengthen our health systems and have a positive impact on disease control in general, on infant mortality, education and finally, on poverty alleviation in sub-Saharan Africa.

Excellencies, ladies and gentlemen,

Allow me to exhaust your patience for a while, ten months away from my retirement to my native Togo, to praise the courage, selflessness, the high sense of duty and the urge to venture of all those, men and women, who strived and continue to strive in their various fields to successfully carry out the control of a disease, a fight through whose impact one sees a combat for a better life, and some kind of social justice.

From my remote native village, where I will, God willing, continue the fight through other missions, I will continue to think of you, partners and companions in struggle, and of these two Onchocerciasis Control Programmes in Africa, for which I had the privilege and singular honour of devoting 24 out of the 30 years I served at the World Health Organization.

I would simply like to say a big thank you to all of you!

Your Excellency, it is with great pleasure and honour that I am addressing you in conclusion, and by towing the line of my predecessors in asking you to, respectfully, extend to His Excellency the President of the Republic, and to the entire government, as well as to the able organizers of this tenth session of JAF, our deepest gratitude for the excellent work done under the most difficult conditions, which enabled us to meet here today in Kinshasa, such a warm and appeasing city, despite the reality of the difficulties that you live with.

May success crown this tenth JAF session, and may it be a befitting reward for the African people, who are victim to this scourge, i.e. onchocerciasis.

Thank you once again for your patience.
SPEECH BY APOC COUNTRIES’ REPRESENTATIVE AT JAF10, KINSHASA

Your Excellency the Vice President,
Excellency Madam Chair of the tenth session of JAF,
WHO Regional Director General elect,
Director of APOC,
Ladies and gentlemen,

On behalf of all participants at the tenth JAF session, I would like to thank and congratulate the organizers of this forum, which has brought together all stakeholders in onchocerciasis control.

Through the various papers and presentations that highlighted these past three days, we understood the progress made by the National Programmes, and also the difficulties they encounter in the implementation of CDTI, one of the challenges being prevention and management of Serious Adverse Events in loa loa/onchocerciasis co-endemic areas. We are convinced that the conclusions arrived at on this issue will enable us ensure that CDTI projects in this situation are given a leap forward.

Participants are full of praise for, and encourage the scientific progress in macrofilaricide research, hoping that the outcomes of the latter would be positive.

Putting in place sustainable CDTI projects in our various countries remains our objective, and the decisions and conclusions of this forum will contribute to building our capacities toward achieving this objective. Besides, we agree that CDTI is a potential vehicle for other health interventions.

The success of deliberations, and hence the outcomes we arrived at, are the resultant of the kind hospitality we enjoyed, as well as the quiet atmosphere in which the session took place. To this end, I would like, on behalf of all participants at this JAF10, extend our sincere gratitude to the Government and people of the DRC.

I take this singular opportunity to particularly thank, on behalf of participants at JAF10, all partners who, right from the inception of the Programme, showed their readiness to support the efforts of our countries. Their reaffirmed commitment at this forum reassures and encourages us to pursue with determination the fight that we are waging together toward the effective elimination of onchocerciasis, which is a public health problem and an impediment to development.

Last, but not the least, our gratitude goes to the APOC Management that has left no stone unturned in its effort to coordinate all these onchocerciasis control activities. We just heard at this forum that the Director of APOC, Dr Seketeli, will be retiring in 2005. It is the fervent wish of participants, however, that he attend the next JAF. We count on his availability.

Thank you and see you all at the JAF11 in Paris in December 2005.
AGENDA

A. Opening of the session
B. Election of the Officers
C. Adoption of the Agenda
D. Reflections of the Committee of Sponsoring Agencies
E. Progress report of the World Health Organization
F. Report of the Technical Consultative Committee (TCC)
G. Report of the NGDO Coordination Group for Onchocerciasis Control including the support of the Group to APOC activities
H. Country reports:
   (i) (Cameroon, Nigeria, Tanzania, CAR, Uganda, Malawi, Sudan, Equatorial Guinea, DRC, Liberia, Congo, Chad, Ethiopia, Burundi, Angola)
   (ii) (Gabon, Mozambique, Rwanda, Kenya)
I. Consideration of National Plans and Project proposals
J. Operational Research and MACROFIL
K. Sustainability of CDTI Projects
   (i) Outcome of the special meeting on sustainability
   (ii) Developing and monitoring the implementation of sustainability plans
L. Additional health interventions using CDTI as vehicle
M. Phase II studies of the long term impact assessment of APOC operations
N. Audit report
O. Plan of Action and Budget for 2005
P. Financing of the African Programme for Onchocerciasis Control (APOC)
   (i) Report of the World Bank
   (ii) Pledging of Donor contributions
Q. Terms of Reference for the External Evaluation of APOC for the period 2001-2004
R. Information on the activities in the Special Intervention Zones (SIZ) of the Ex-OCP, in the countries/areas of the ex-OCP outside the SIZ, and on the Multidisease Surveillance Centre (MDSC)

S. Other matters

(i) Date and place of the eleventh session
(ii) Consolidation of JAF10 conclusions and decisions and preparation of the final communiqué

T. Approval of the conclusions and decisions and adoption of the final communiqué

U. Closure of the tenth session
REFLECTIONS OF THE COMMITTEE OF SPONSORING AGENCIES (CSA) FOR THE TENTH SESSION OF THE JOINT ACTION FORUM OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

Excellencies, Ladies and Gentlemen:

It is an honor for me to present the Reflections of the Committee of Sponsoring Agencies of APOC. I would like first to express our gratitude to the Government of the Democratic Republic of the Congo for its kind hospitality in hosting this Tenth Session of the Joint Action Forum. It is most fitting that we are holding this important meeting in a country which has been seriously ravaged by onchocerciasis, but where the Program, despite a sometimes demanding environment, is also putting into place a solid foundation to address onchocerciasis and other health problems in some of the most remote areas in Africa here in Democratic Republic of Congo.

Over the past year considerable attention has been drawn to the successful scaling up of onchocerciasis control, begun by OCP in West Africa and extended to cover all endemic areas on the continent by APOC. APOC and the World Bank prepared and presented a case study on this unsurpassed achievement of scaling-up poverty alleviation through disease control at a major conference in Shanghai in May of this year. This remarkable story of scaling-up poverty alleviation is told in an information document for this meeting, entitled, “Defeating Riverblindness: Thirty Years of Success in Africa”. You, the international community, through a highly effective partnership, can take great pride in scaling-up a successful disease control effort from just a few countries in West Africa to cover an entire continent comprising 30 endemic countries and 150 million of Africa’s poorest citizens.

Under APOC alone, Program management has approved 117 projects in 16 countries, treating 40 million people in 80,000 communities in 2004. We need to add only five more projects in three countries to reach the Program’s ultimate target of 122 projects. The Program will now focus on expanding the implementation of these projects to treat 90 million people per annum by 2010, over a sustained period of time, well into time. This ultimate target is deemed sufficient to protect 107 million people at risk in the APOC countries alone, and, over time, to eliminate onchocerciasis throughout Africa.

The CSA is pleased to report that the APOC partnership held a successful Donors’ Conference at World Bank Headquarters in Washington this past June. Highlights included the following:

- A cumulative reduction of the financing shortfall for APOC by 50% over the past year down to a US$13 million gap;

- A pledge by the donors, not to abandon APOC before its closure in 2010 and to consider supplemental contributions, given the success of the Program in difficult areas and the opportunity to integrate other health interventions so as to broaden access to health services among neglected populations;
Recognition of the strong financial management of APOC;

- Emphasis that the success of APOC will ultimately be determined by the sustainability of Community Directed Treatment with Ivermectin and recognition of the important contributions of APOC-supported operational research on sustainability;

- Recognition of the unique opportunity presented by Community-Directed Treatment (ComDT) to broaden the scope of the formal health systems to reach neglected, poor populations, particularly in remote areas. Examples cited were the implementation of Vitamin A supplementation, reproductive health and control of lymphatic filariasis and schistosomiasis.

The CSA wishes to bring to the attention of the JAF that some serious adverse reactions have occurred when Mectizan has been delivered to populations where Loa-loa is hyper-endemic. These adverse reactions have been concentrated in parts of Cameroon and in the Bas Congo area of the Democratic Republic of Congo. In response, the Technical Consultative Committee and the Mectizan Expert Committee have developed guidelines for treatment of onchocerciasis where these two diseases overlap. These guidelines include:

- Assessing the endemicity of Loa-loa when considering the risk of delivering Mectizan;

- Education of the population to be treated, and appropriate training of all personnel involved in Mectizan distribution;

Ensuring that hospital facilities, including trained staff, medical supplies and equipment are nearby, to facilitate the management of any adverse reactions.

Following the reporting of several cases of Adverse Reactions, including several deaths, in the Bas Congo area of the Democratic Republic of Congo in late 2003, field investigations were conducted by the Ministry of Health with input from external advisors. Most recently, a joint APOC-Mectizan Donation Program mission was organized in July 2004 to investigate the origin of the Serious Adverse Reactions in the Bas Congo area. The report from that Expert mission has provided the basis for a plan of action to deal with these adverse reactions, allowing oncho treatment to go forward throughout most of the APOC area.

The CSA is organizing an external evaluation of APOC and a mid-term review of the activities of the Special Interventions Zones of the ex-OCP countries. The OCP Review would include assessing the effectiveness of the onchocerciasis surveillance systems in the ex-OCP countries. These two evaluations, for APOC and OCP, will be conducted in 2005 and should give the partnership insight as to what may be required to bring onchocerciasis control to a successful and lasting conclusion throughout Africa. These will be among the most important evaluations in the histories of OCP/APOC and will inform the partnership of any needed mid-course corrections.

Furthermore, the World Bank and WHO intend to convene a Ministerial-level meeting early in 2006, consisting of the 11 ex-OCP countries, and the donors who have supported OCP for more than a quarter century. The purpose of this meeting will be to consider what steps need to be taken in light of the OCP review exercise in the ex-OCP countries. This meeting might also
consider the locus of a mandate to ensure the successful and lasting closure of onchocerciasis control in the ex-OCP countries.

A meeting was organized in Ouagadougou, Burkina Faso, this past September, to discuss how to make the Multi-Disease Surveillance Center (MDSC) fully functional. It was agreed that the Center should initially focus on onchocerciasis and meningitis. Also, a governance structure was established. The ex-OCP stakeholders will need to assess what action to take to ensure that an active MDSC gets fully underway as soon as possible.

The CSA feels it is important to bring to your attention that there are a number of personnel changes that will affect the leadership of APOC, the SIZ activities in the ex-OCP countries, and the World Bank’s onchocerciasis supported activities. As you know, the Regional Director for Africa, Dr. Samba, will be retiring at the beginning of 2005. Dr. Sékétéli, Director of APOC, will be retiring in September 2005. While a replacement for him has not yet been chosen, it is our intention to work with WHO to ensure that a person be selected who is highly knowledgeable of the Program and embodies the same dynamism as Dr. Sékétéli.

I personally retired from the World Bank last week. My successors will be Dr. Alexandre Abrantes, Sector Manager for Human Development in West African, and Dr. Ousmane Bangoura, the new Onchocerciasis Coordinator in Dr. Abrantes’ Office. Both of these individuals are present at this JAF and I have the honor of introducing them. The World Bank will continue to strongly support APOC and activities in the ex-OCP countries. Arrangements have been made to ensure continuity and a seamless transition in the World Bank with respect to its future responsibilities for Onchocerciasis Control matters. Support for completing onchocerciasis control throughout Africa will also continue under the able leadership of Dr. Sambo, the newly nominated Regional Director for Africa, and Dr. Asamoah-Baah, the WHO Assistant Director-General for Communicable Diseases in Geneva.

In summary, Mme Chair, APOC is proving to be a highly successful program in rapidly scaling-up poverty alleviation in Africa. We are well on our way to eliminating the devastation of onchocerciasis as a major public-health problem and constraint to socioeconomic development throughout Africa. Donor support remains steadfast in moving the Program toward this objective. In addition, a new extensive effort is well underway to help ensure that national sustainability plans are put into place and that each project is achieving the required indicators to secure sustainability beyond the closure of APOC in 2010.

A plan of action to deal proactively with severe adverse reactions that are occurring in confined areas where Loa-loa and onchocerciasis overlap has been put in place to allow control of onchocerciasis through the delivery of Mectizan to continue in affected areas. The CSA has been impressed by the demonstrated potential of APOC’s method of delivery, ComDT, to extend the reach of the formal health system to address other important health problems. ComDT is making important inroads on poverty alleviation beyond onchocerciasis in remote areas where poverty is most intractable, and existing health systems are often extremely weak or non-existent. Hence, APOC is assisting in revolutionizing the delivery of primary health care by incorporating into the formal health system community empowerment and community-driven interventions by those with the most at stake-those directly affected by some of Africa’s most devastating and unyielding health problems.
Mme Chair, these remarks provide an overview of the major developments relating to APOC over the past year and set out issues, which the CSA feels are important for consideration at this watershed 10th session of the JAF. We hope that our introductory reflections will play a role in establishing a framework, as well as setting the tone, for your deliberations over the next three days. We are looking forward to a productive and substantive 10th Joint Action Forum here in Democratic Republic of Congo.

Thank you, Mme Chair, Excellencies, Ladies and Gentlemen.