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

JOINT ACTION FORUM
Office of the Chairman

PROVISIONAL AGENDA ITEM 6

REPORT OF THE FOURTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC)

World Health Organization
AFRICAN PROGRAMME
FOR
ONCHOCERCIASIS CONTROL
(APOC)

REPORT OF THE FOURTH SESSION OF THE
TECHNICAL CONSULTATIVE COMMITTEE (TCC)

Ouagadougou, 22 - 25 September 1997
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPENING</strong></td>
<td>1</td>
</tr>
<tr>
<td>1.1 Opening remarks and adoption of the agenda</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Update on the 73rd and 74th sessions of the CSA</td>
<td>1</td>
</tr>
<tr>
<td>1.3 Follow-up of the recommendations of the 3rd TCC</td>
<td>1</td>
</tr>
<tr>
<td>1.4 Report of the 10th Meeting of the NGDO Coordination Group for Ivermectin Distribution</td>
<td>2</td>
</tr>
<tr>
<td>1.4.1 Workshops on Community-Directed Treatment with Ivermectin (CDTI):</td>
<td>2</td>
</tr>
<tr>
<td>1.4.2 Mectizan® Expert Committee/Mectizan® Donation Program meeting</td>
<td>3</td>
</tr>
<tr>
<td>1.4.3 The Conclusions and Recommendations of the 10th NGDO meeting</td>
<td>3</td>
</tr>
<tr>
<td>1.5 Report from TDR</td>
<td>3</td>
</tr>
<tr>
<td>1.5.1 Update on the Task Force on ComDT of Lymphatic Filariasis and Onchocerciasis</td>
<td>3</td>
</tr>
<tr>
<td>1.5.2 The Multi-Country Studies of ComDT in Onchocerciasis and Lymphatic Filariasis</td>
<td>4</td>
</tr>
<tr>
<td>1.5.3 Current Status of REMO in APOC countries</td>
<td>4</td>
</tr>
<tr>
<td><strong>REVIEW OF NATIONAL PLANS AND PROJECT PROPOSALS</strong></td>
<td>6</td>
</tr>
<tr>
<td>2.1 Cameroon</td>
<td>6</td>
</tr>
<tr>
<td>2.1.1 Cameroon National Plan</td>
<td>6</td>
</tr>
<tr>
<td>2.1.2 The Adamaua Province Project Proposal</td>
<td>6</td>
</tr>
<tr>
<td>2.1.3 The Centre 3 Project Proposal</td>
<td>7</td>
</tr>
<tr>
<td>2.1.4 The North Province Project Proposal</td>
<td>8</td>
</tr>
<tr>
<td>2.1.5 The Littoral II Project Proposal</td>
<td>9</td>
</tr>
<tr>
<td>2.1.6 South West Province CDTI Project Proposal</td>
<td>10</td>
</tr>
<tr>
<td>2.1.7 Proposal for NOTF Secretariat Support</td>
<td>10</td>
</tr>
<tr>
<td>2.2 Central African Republic</td>
<td>11</td>
</tr>
<tr>
<td>2.2.1 National Plan and Project Proposal</td>
<td>11</td>
</tr>
<tr>
<td>2.3 Chad</td>
<td>12</td>
</tr>
<tr>
<td>2.3.1 The Chad National Plan And Project Proposal</td>
<td>12</td>
</tr>
<tr>
<td>2.4 Nigeria</td>
<td>12</td>
</tr>
<tr>
<td>2.4.1 Adamawa State Project Proposal</td>
<td>12</td>
</tr>
<tr>
<td>2.4.2 The Benue State Project Proposal</td>
<td>13</td>
</tr>
<tr>
<td>2.4.3 The Borno State Project Proposal</td>
<td>14</td>
</tr>
<tr>
<td>2.4.4 The Federal Capital Territory (FCT) Project Proposal</td>
<td>15</td>
</tr>
<tr>
<td>2.4.5 The Niger State Project Proposal</td>
<td>15</td>
</tr>
<tr>
<td>2.4.6 The Osun State Project Proposal</td>
<td>16</td>
</tr>
<tr>
<td>2.4.7 The Oyo State Project Proposal</td>
<td>17</td>
</tr>
<tr>
<td>2.4.8 The Plateau State Project Proposal</td>
<td>17</td>
</tr>
<tr>
<td>2.4.9 Proposal for the support of NOTF Zonal Offices</td>
<td>18</td>
</tr>
<tr>
<td>2.5 Uganda</td>
<td>18</td>
</tr>
<tr>
<td>2.5.1 Uganda Phase II Project Proposal</td>
<td>18</td>
</tr>
<tr>
<td>2.6 Tanzania</td>
<td>19</td>
</tr>
<tr>
<td>2.6.1 The Tukuyu Proposal For Vector Elimination</td>
<td>19</td>
</tr>
<tr>
<td>2.7 Matters arising from the review of National Plans and Project Proposals</td>
<td>20</td>
</tr>
<tr>
<td>2.7.1 Completion/Updataing of REMO results in APOC countries</td>
<td>20</td>
</tr>
<tr>
<td>2.7.2 Support to NOTF Headquarters to supervise CDTI Projects</td>
<td>20</td>
</tr>
<tr>
<td>2.7.3 APOC Trust Fund support for NGDO administrative overheads</td>
<td>21</td>
</tr>
<tr>
<td><strong>OTHER MATTERS</strong></td>
<td>22</td>
</tr>
<tr>
<td>3.1 Evaluation, Monitoring and Reporting of APOC projects</td>
<td>22</td>
</tr>
<tr>
<td>3.2 Epidemiological, social and economic impact assessment of APOC operations</td>
<td>22</td>
</tr>
<tr>
<td>3.3 NGDO Chairperson attendance at the TCC sessions</td>
<td>23</td>
</tr>
</tbody>
</table>
4. Conclusions and Recommendations ............................................................ 23
4.1.1 Cameroon .................................................................................................... 24
4.1.2 Central African Republic ............................................................................ 24
4.1.3 Chad ............................................................................................................... 24
4.1.4 Nigeria .......................................................................................................... 24
4.1.5 Uganda ......................................................................................................... 24
4.1.6 Tanzania ...................................................................................................... 24

ANNEX 1: LIST OF PARTICIPANTS .................................................................... 25
1. OPENING

1.1 Opening remarks and adoption of the agenda

The meeting was opened by Dr K. Yankum Dadzie, Director a.i. APOC, who welcomed members to this fourth session of the Technical Consultative Committee (TCC) (see list of participants in Annex 1), and wished them fruitful deliberations in the face of an ever increasing number of Project Proposal submissions and delicate issues such as the request to APOC to support non-governmental development organizations (NGDOs) overhead cost.

Professor O. Kale was re-elected as the TCC Chairman and the provisional agenda was formally adopted with amendments.

1.2 Update on the 73rd and 74th sessions of the CSA

Mr Bruce Benton, Chairman of the Committee of Sponsoring Agencies (CSA), updated the TCC on the two sessions of the CSA held since the last TCC meeting and on other related recent developments. The following issues were of particular relevance to the TCC:

(i) the need to set up as soon as possible a separate group to work on issues related to sustainability. These, the TCC was reminded were central to the both the CSA and the Donor community.

(ii) the decision at the 74th session of the CSA to set up an ad hoc committee to urgently look into the issue of NGDO overhead cost support, with the view to address a clearly recognized need by some members of the NGDO group, but not at the expense of field operations

(iii) the World Bank/TDR work on socioeconomic importance of onchocerciasis skin disease will be presented to the forthcoming Donor Conference (20 - 22 October, 1997).

(iv) at the Donor Conference, a presentation is expected from Uganda on CDTI Project, the importance of which cannot be overemphasized. This will be the first exposure of the Donors to what is already happening on the ground, especially at the community level.

(v) there is still a funding gap of US $ 20 million (i.e., 30%) of the US $ 70,000 needed for the first phase of APOC. It is essential to continue to impress upon the Donors that this unique global partnership, complex though it may be, can work.

(vi) between the two CSA meetings there was the statue unveiling ceremony at the World Bank Headquarters in Washington, during which all those present signed the declaration of intent for River Blindness.

1.3. Follow-up of the recommendations of the 3rd TCC

Dr A. Sékétéli, Programme Manager APOC informed the Group that the following actions had been taken since the last TCC session:

(i) all the budget corrections of the approved Project Proposals had been made as requested. As expected there was a big difference between what was requested and what was finally approved;
(ii) the use and importance of REMO maps in National Plans and Project Proposals have been emphasized during the various CDTI workshops organized since last April; more REMO maps have been produced and have been made available to Participating Countries, even though this is not yet fully reflected in the proposals received so far;

(iii) the evaluation form has been revised and further amended, with additional input from representatives of Participating Countries during the CDTI workshops; this revised version will be presented to the TCC at the present session;

(iv) a monitoring field visit with three consultants (one from the World Bank) is being planned by the Management to assess the implementation of the first APOC funded CDTI; a monitoring form to be used is being submitted to the committee for review.

(v) the impact assessment document has been further reviewed by another ad hoc committee, in keeping with the suggestions made at TCC3; a decision needs to be taken on the nature of the assessments, implementation tools required as well as the role, if any, of the two senior Scientists that had been already identified and contacted by APOC and approved by the TCC during its third session.

1.4 Report of the 10th Meeting of the NGDO Coordination Group for Ivermectin Distribution

A report of the 10th meeting of the NGDO Group for Ivermectin Distribution held on 19 - 20 September 1997 was given by the NGDO Coordinator. Activities of the Group and its Coordinator centred around the following:

1.4.1 Workshops on Community-Directed Treatment with Ivermectin (CDTI):

Three CDTI workshops were organized in Enugu, Nigeria (21 - 26 April 1997), in Ouagadougou (23 - 28 June 1997) and Khartoum (1 - 6 September 1997).

The CDTI workshop held in Enugu brought together 68 participants from Nigeria, Malawi, Uganda and Tanzania. The Ouagadougou workshop saw the attendance of 65 participants from Cameroon, Central African Republic (CAR), Chad, the Democratic Republic of Congo (former Zaïre), Equatorial Guinea and Gabon, many of which were about to submit their first Project proposals to APOC. Due to the very special circumstances of the Sudan, a separate workshop was held in Khartoum only for Sudanese and more specifically for those participants coming from the Government of Sudan (GOS) controlled areas1.

In all three workshops, participants were representatives of the Ministry of Health (MOH), their partners NGDOs, and other UN agencies, all key players in onchocerciasis control in their respective countries. The main objectives of the workshops were:

(i) to promote a clearer and common understanding of APOC/CDTI philosophy, strategy and expectations;

(ii) to agree on ways to ensure a speedy, effective and uniform implementation of CDTI in all Participating Countries, in a way that reflects the regional nature of APOC, while accommodating the specificity of each Participating Country;

---

1 A second workshop for participants from Operation Lifeline Sudan (OLS) areas is planned for October 1997.
1.4.2 **Mectizan® Expert Committee/Mectizan® Donation Program meeting** (Atlanta, 1 - 2 May 1996).

Besides the usual drug application review, discussions focused on the availability of the new 3mg Mectizan® tablets and problems related to transition from the 6mg to the 3mg tablets as well as the new 500 tablets packaging format of the latter. It was learned that though the new 3mg tablets might be ready for shipping by summer 1997, introduction of the new tablets in endemic countries will be progressive until the existing large stock of 6mg tablets is exhausted. Other matters discussed included updates on adverse reactions following Mectizan® treatment, ongoing clinical trials on Mectizan® for lymphatic filariasis and future directions, a special report on the use of Mectizan on the very young, and special events related to the tenth anniversary of the Mectizan® Donation Program.

1.4.3 **The Conclusions and Recommendations of the 10th NGDO meeting** included: i) the urgent need to review and update the current terms of reference of the Group and prepare a new Mission Statement that is consistent with today's onchocerciasis control in APOC countries; ii) the request by the Group to the CSA through the TCC that relevant NGDO overhead costs be recognized as allowable costs; iii) the need for the World Bank/NGDO ad-hoc committee on sustainability to continue their work and the request to the World Bank to consider employing a consultant, to work closely with the ad-hoc committee, and put together all relevant information on sustainability as applicable to APOC, and to formulate policy and programme recommendations; iv) the need for the Africare/Chadian experience on cost recovery in ivermectin distribution to be adequately documented and reported at the next NGDO meeting, and v) the need to implement wisely and flexibly the new recommendation from Merck to include pregnant women in mass treatment.

1.5 **Report from TDR**

This report consisted of an update to the Committee of the new TDR/Task Force on Community-Directed Treatment (ComDT) of lymphatic filariasis and onchocerciasis, a presentation of the new multi-country study of Community-Directed Treatment (ComDT) on onchocerciasis and lymphatic filariasis, and an update on REMO.

1.5.1 **Update on the Task Force on ComDT of Lymphatic Filariasis and Onchocerciasis**

The Manager of the TDR/Task force on ComDT Operational Research, Dr Hans Remme, reported on its activities and outlined its future plans. The Committee was informed that the new Task Force was seeking to provide answers to the basic questions of why, where and especially how to establish effective and sustainable drug delivery for onchocerciasis and lymphatic filariasis for which effective drugs are already available. This, the Task Force proposes to do by:

(i) documenting the burden of lymphatic filariasis and onchocerciasis and developing new approaches and materials for effective advocacy. In the case of onchocerciasis, a recently completed World Bank/TDR study on the economic impact of onchocercal skin disease (OSD) has already shown that the labour input of OSD cases is lower, their health expenditure higher, and the risk of children to drop out of school is higher if parent has OSD.

(ii) developing rapid methods of mapping the geographical distribution of lymphatic filariasis. A protocol development multi-country workshop has been conducted and field testing is under way in Asia and Africa.
evaluating and improving sustainability of Community-Directed Treatment with Ivermectin (see next section);

(iv) developing effective and sustainable large-scale treatment methods for lymphatic filariasis that are directed by endemic communities themselves and initiated and supported by the health services or other partners.

1.5.2 The Multi-Country Studies of ComDT in Onchocerciasis and Lymphatic Filariasis

Two such studies are being planned, one on onchocerciasis in Africa, and one on lymphatic filariasis in Africa and Asia. The studies will facilitate the integration of ComDT in the health system, encourage effective partnership between endemic communities and the health services. Both studies will be conducted in two phases.

(i) **In the Multi-Country study of ComDT in Onchocerciasis**, Phase I will consist of a study of communities, health services and their interaction, and the development of intervention that encourage the involvement of health services, while Phase II will compare cost-effectiveness of ComDT with and without additional interventions, and develop basic set of predictors of sustainability for routine operational use.

(ii) **In the Multi-Country study of ComDT in lymphatic filariasis**, Phase I will study communities health services and their interaction and develop a system of ComDT which includes the health services at the level of implementation, and Phase II will compare cost-effectiveness and predicted sustainability of ComDT versus mass-treatment by health services.

1.5.3 Current Status of REMO in APOC countries

Information on the current status of REMO and future activities planned/required for the various Participating Countries was presented by the Biostatistician/Epidemiologist of APOC and is summarized below.
<table>
<thead>
<tr>
<th>Country</th>
<th>Current status of REMO and GIS</th>
<th>Future activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Nigeria</strong></td>
<td>REMO completed and data entered in GIS</td>
<td>Further refinement of the initial maps needed. National teams to complete the maps validate data from other sources or further REMO.</td>
</tr>
<tr>
<td><strong>2. Cameroon</strong></td>
<td>REMO completed and data entered in GIS</td>
<td>Community-directed treatment with ivermectin areas to be defined on the map by the national team.</td>
</tr>
<tr>
<td><strong>3. Uganda</strong></td>
<td>REMO completed and data entered in GIS</td>
<td>Original REMO plans to be completed. (September or October 1997). Community-directed treatment with ivermectin areas to be defined on the map by the national team.</td>
</tr>
<tr>
<td><strong>4. Tanzania</strong></td>
<td>REMO is on-going. Available data entered in GIS</td>
<td>REMO to be completed in East and where feasible. Further refinement of the initial map needed.</td>
</tr>
<tr>
<td><strong>5. Sudan</strong></td>
<td>REMO completed for North and West and available data entered in GIS</td>
<td>On-going REMO data entry and refinement of the map.</td>
</tr>
<tr>
<td><strong>6. CAR</strong></td>
<td>Historical REMO data entered in GIS</td>
<td>National team to refine the community directed treatment areas. REMO to be completed when social conditions improve.</td>
</tr>
<tr>
<td><strong>7. Ethiopia</strong></td>
<td>REMO completed and data entered in GIS</td>
<td>Further refinement needed for the regions of Lekoumou, Niali and Kouilou. Activities postponed due to civil unrest.</td>
</tr>
<tr>
<td><strong>8. Congo</strong></td>
<td>No progress. REMO completed and data entered in GIS for the regions of Lekoumou, Niali and Kouilou. However the coverage is not sufficient to determine treatment areas.</td>
<td>REMO to be completed in phases according to original REMO plan.</td>
</tr>
<tr>
<td><strong>9. Gabon</strong></td>
<td>Historical data entered in GIS</td>
<td>Further REMO required.</td>
</tr>
<tr>
<td><strong>10. Mozambique</strong></td>
<td>On-going REMO field work. Presence of onchocerciasis confirmed</td>
<td></td>
</tr>
<tr>
<td><strong>11. Malawi</strong></td>
<td>REMO completed and data entered in GIS</td>
<td>Minor refinement of the map.</td>
</tr>
<tr>
<td><strong>12. Chad</strong></td>
<td>Historical REMO data entered in GIS</td>
<td>Validation of REMO needed. REMO to be conducted in the Province of Salamat.</td>
</tr>
<tr>
<td><strong>13. R.D. of Congo (ex Zaire)</strong></td>
<td>Most activities delayed due to civil unrest. REMO partially completed in Kasai, on going in two other regions</td>
<td>REMO to be completed in phases according to original REMO plan.</td>
</tr>
</tbody>
</table>
2. REVIEW OF NATIONAL PLANS AND PROJECT PROPOSALS

2.1. Cameroon

2.1.1. Cameroon National Plan

Sixty-five per cent of the population of Cameroon (13 millions) live in areas that are endemic for onchocerciasis. Both blinding and skin diseases exist in the country and in many parts co-infection with loa loa exists. Cross-border infection exists with Chad and CAR in the East and with Nigeria in the West.

The National Plan main objective is to establish nationwide annual distribution of ivermectin to all eligible persons within the framework of the “Reoriented Primary Health Care System”, the hallmarks of which are cost recovery and community participation. The programme will be developed in 4 phases, with the last Project Proposals to be submitted to APOC by the year 2000.

Mass treatment with ivermectin distribution was initiated in 1991 and to date nearly 600,000 cases have been treated. The following NGDOs are members of the Cameroon NOTF: IEF, HKI, SSI, BAHAI, GLOBAL 2000.

TCC considered that the document provides a good background of the country in relation to the onchocerciasis problem. It gives a good account of the Primary Health Care strategy within the Ministry of Health. However, TCC noted that the main mode of delivery of ivermectin envisaged in Cameroon is a pseudo-mobile system, that has a poor record, as against the Community-Directed (ComDT) mode that APOC has adopted as being more cost effective and more likely to result in a much greater coverage. The Committee expressed reservation that community-directed treatment with ivermectin will be implemented only in a few remote communities in the target areas. All proposals need to be closely, and specially monitored. Furthermore, the Cameroon NOTF should be inform that the concession on the mode of delivery would be closely linked to and assessed on the basis of adequate and efficient coverage of distribution of ivermectin to the eligible population. The following aspects need to be elaborated further:

(i) The procurement procedures: the document advocates for multiple entry points as a way to facilitate speedy delivery of the drug to endemic communities throughout the country. This needs to be agreed upon by the Mectizan Donation Program.

(ii) The proposed cost sharing should clearly state how exemptions for the poor are included to ensure equity in accessing ivermectin.

(iii) Strategies for dealing with cross-border problems should be outlined.

(iv) The budget should be rationalized and further reduced, in keeping with TCC guidelines.

TCC recommended that the Cameroon National Plan be accepted after the above concerns have been worked out between the APOC Management and NOTF Cameroon.

2.1.2. The Adamaoua Province Project Proposal

This Project seeks to establish CDTI in the health districts of Meiganga, Banyo and Tignere of the Adamaoua province and is a partnership between MOH and International Eye Foundation (IEF). The proposed Project is an extension of the current Sight First/IEF programme which is a 5 year programme (1996-2001).
The original Sight First /IEF Project area was divided into 2 after the first year due to the large area, poor or non-existent roads and difficulties in reaching the affected communities. Each include the following districts:

(i) **Sight First:** Ngaoundere, Djohan, Tibati
(ii) **APOC:** Banyo, Tignere, Meiganga

REMO data is almost complete although refinements are still needed in some areas. All three districts consist of meso and hyperendemic communities. The total target population is estimated at 190,000.

Despite the policy of the MOH in Cameroon, this Project will attempt to carry out a form of CDTI in which the method and place of distribution will be decided on by the community health committees, and the cost recovery and its use will be decided by the community. Health workers will work with the communities in areas where reorientation is complete; community health committees will be set up in the areas where there is not yet reorientation. That way CDTI will help initiate PHC.

The proposed Operational Research plans to look at socio-cultural factors affecting participation, compliance, coverage, etc.

The proposed budget summary show yearly decrease in the cost per person treated, the amount being $0.4 by the fifth year.

TCC considered that this is a good proposal that seeks to implement CDTI in a difficult area and recommended its approval with the following amendments:

(i) The discrepancies noted in the figures in all the various tables need to be clarified.

(ii) Annual targets for coverage may need to be set and some evaluation of coverage after the first year of the Project implementation may be required.

(iii) The budget should be reviewed in keeping with APOC guidelines and to the satisfaction of APOC Management. In particular, it should reflect a cumulative cost per person treated over 5 years to APOC of not more than $2.

2.1.3. **The Centre 3 Project Proposal**

This Project seeks to establish CDTI in 8 health districts, many of which are still going through the “reorientation” process of their PHC. The total population at risk consists of 380,000 people, living in 755 endemic communities (306 hyper and 449 mesoendemic). The population targeted for treatment is 274,000.

As is the case with other Cameroon Project proposals, ivermectin distribution will be integrated into existing PHC System, wherever this is already “reoriented” and functional. Elsewhere, CDTI will be used to initiate the reorientation of PHC.

The proposed budget show a decrease overtime. The cost per person treated is US $1.3 by the fifth year.

TCC considers that overall this is a good proposal with a strong commitment by the Government to integrate into PHC, the potential strength of cost recovery and good operational research ideas. The cautious start of the Project in Year 1 (37,000 people targeted for treatment in the first year) may be
justified given the coexistence of loa-loa infection in the area. There are however outstanding budget related issues that need to be addressed. These include the following:

(i) The request for 2 new vehicles from APOC
(ii) The request for 48 motorcycles in Year 1
(iii) The number of workshops/per diems
(iv) The per diem level of supervision

TCC recommended that this Project be accepted for APOC Trust Fund support, provided the above issues are addressed to the satisfaction of APOC Management.

2.1.4. The North Province Project Proposal

The Northern province is part of a larger "onchocerciasis belt" stretching from the Nigerian states of Adamawa and Taraba to the south-western and north-western parts of Chad and CAR respectively. According to current estimate based on a partially completed REMO, there are 215,000 persons at risk with 172,000 infected, out of a total population of about 1 million persons. 431 communities are targeted for treatment.

Mass treatment with ivermectin was initiated in 1992 through funding from the River Blindness Foundation. To date 68,333 persons have been treated at a total cost of $98,000. This proposal in which the MOH is in partnership with the Global 2000 River Blindness Foundation seeks to expand ivermectin treatment to a total population of 172,000. Cost per person treated by the fifth year in the proposed budget is US$1.0.

TCC considered the North Province proposal is well written, and the expansion of ivermectin in this severely affected area should be supported. However, TCC also considered that further clarification should be sought by APOC Management on the following concerns (issues):

(i) the organization of the Project is too top down
(ii) there needs to be real evidence of CDTI in a situation where pseudo mobile treatment exists
(iii) the specific roles of the nurses and the village health committee members in the context of the “Reoriented PHC system” and how this relates and/or affects ivermectin distribution should be clarified
(iv) the mechanisms put in place to ensure sustainability of this Project once APOC funding has ceased perhaps through utilization of revolving Fund generated by cost-recovery
(v) the role of funding to NGDO

TCC recommended the approval of the North Province Project Proposal with the above amendments.
2.1.5. The Littoral II Project Proposal

The Cameroon Littoral II CDTI proposal covers 4 health districts consisting of a total of 34 Health areas in which hitherto there has been limited ivermectin mass treatment. The Littoral province is among five of the ten provinces in Cameroon that is still going through the reorientation process of its PHC system (43% of PHC reoriented to date). Since ivermectin treatment is integrated in the PHC system of Cameroon, this will have a direct bearing in the way CDTI is going to be implemented in the proposed target area. The target population is 320,000 persons living in 520 communities (152 hyper and 368 mesoendemic).

The NGDO partner supporting the current proposed CDTI Project is the Baha’i Agency for Social Economic Development (BASED). In the proposed budget there is evidence of a yearly decrease in cost per treatment. By the fifth year this amount is US $ 0.3.

TCC considered that overall this is a well written proposal which seeks to initiate mass treatment in an area that has received little consideration so far. The particular strengths of the proposal include:

- close post-treatment supervision and observation for serious adverse reactions being planned;
- operational research on incidence of adverse reactions;
- commitment on the part of the government to implement PHC and integrate all health related activities;
- MOH share of the budget increasing over years, including cash,
- consideration given to the possibility of collaborating on site with another more experienced NGDO partner.

However, TCC requests APOC Management to review or seek further clarification on the following issues:

(i) the rationale for starting in Year 1 with mesoendemic instead of hyperendemic communities;
(ii) the mechanisms to be put in place to ensure that adherence to cost recovery principle will not adversely effect coverage;
(iii) the description of the proposed monitoring of the Project is weak and needs to be further elaborated, particularly in view of the somewhat limited experience of the NGDO partner;
(iv) health education materials must be comprehensive and should not be limited only to the use of leaflets and budgeted;
(v) more detailed information must be provided on the NGDO partner personnel that will help implement the Project;
(vi) it is not clear which customs charges are being claimed by Government for importing Mectizan.
TCC recommended the approval of this proposal provided that the above issues are resolved to the satisfaction of APOC Management.

2.1.6. South West Province CDTI Project Proposal

Eight health districts are targeted in this proposed Project, made up of 294 onchocerciasis hyper endemic and 56 mesoendemic communities, with an aggregate population of 505,314.

Most areas have been subjected to REMO survey, with some refinement still needed in a few areas. About 3500 have treatment with ivermectin from the Medical Research Station in Kumba in the past five years, in association with CBM, the Presbyterian Church, a Special Fund for Health and the WHO/TDR. Cost per person treated shows a decrease year by year from US $ 1.5 in year 1 to US $ 0.3 in the fifth year.

As mentioned earlier TCC noted that the main mode of delivery of ivermectin envisaged is a pseudo-mobile system, that has a poor record, as against the Community Directed (ComDT) mode that APOC has adopted as being more cost effective. The Committee expressed reservation that (ComDT) for ivermectin would only be implemented in a few remote communities in the target area. Along with other Cameroon Proposals the South West Province I Project Area Proposal was to be closely, and specially monitored.

The Committee noted with approval the intention to carry out operational research on:

- alternative cost recovery mechanism;
- identification of communities where loasis infection is endemic using a rapid assessment method, and;
- evaluation of different ivermectin distribution strategies and assessment of sustain ability indicators:

The proposed budget totalling $1,793,000, over a five-year period was considerably too high, particularly the first year budget of $678,000. Personnel cost needs to be trimmed substantially. Lunch allowances and per diems as presented are not sustainable and should be pruned as well. The four tier level of training earmarked for every year is superfluous and excessive. It should be reduced by at least 50% in the first year and thereafter kept to the barest minimum necessary.

Four 4-WD vehicles and 31 motorcycles cannot be justified, given the current status of the programme. APOC Management is authorized to carry out appropriate adjustment of the budget.

Notwithstanding the above, TCC considered the proposal was well prepared with clear objectives and adequate background information provided on the Project area. TCC therefore recommended that the proposal be funded on the basis of its observation and the budgetary adjustments indicated above.

2.1.7. Proposal for NOTF Secretariat Support

This is a proposal submitted with the Project proposals of Phase I of the National Plan of Cameroon. It seeks support for the NOTF Secretariat which will oversee and coordinate distribution activities throughout the country for at least the next 12 years.
TCC considered that the NOTF though well established does not seem to be fully operational, and many of its members are yet to be identified or recruited.

The budget is too high with double funding being requested under various headings for some line items. Personnel costs represent 60% of the total budget and consist essentially of salaries and allowances, many of which are not justified. Similarly the request of US$ 20,000 for “contingencies” seems abnormally high.

Sustainability of this secretariat beyond the 5 years of APOC is of special concern. The contribution of both the MOH and the partner NGDOs is negligible and APOC Trust Fund support remains the same throughout the 5 years. No mention is made to the possible role cost recovery could play in support of the secretariat.

Notwithstanding the above, TCC reckoned that there was a strong case for the support of a functional NOTF secretariat in Cameroon, given the crucial role it will play in ensuring effective distribution of ivermectin to all eligible persons in the country within the framework of the “Reoriented PHC system”. The following recommendations are therefore made to APOC Management.

(i) The budget must be reduced significantly, in particular, activities related to specific projects should not be included into the secretariat budget.

(ii) Any personnel related cost should be proportional to the time that is actually spent on onchocerciasis control activities.

(iii) Capital equipment must be in keeping with the actual needs of the secretariat.

2.2. Central African Republic

2.2.1 National Plan and Project Proposal

One and a half million people out of a total population of 2.68 million (1988 census) live in areas that are hyper and mesoendemic for onchocerciasis. This corresponds to 10 (out of 16) prefectures in the country. Cross border infection exists with Chad and Cameroon in the North West, the Democratic Republic of Congo in the South and the Sudan in the East.

The National Plan and the Project Proposal seek to establish nationwide CDTI integrated into PHC for a target population of 1,000,000., to reach at least 75% of the at risk population. Mass treatment with ivermectin was initiated in 1991 and expanded from 1993 through funding from CBM and RBF. About 400,000 people received treatment in 1996. In the proposed budget, the cost per person treated is US$ 0.2 by the fifth year.

TCC considered that the National Plan and the proposed CDTI Project have relevant data on demography, endemicity (mainly from REA data), health policy and structure. The proposed implementation of CDTI is well described, as well as some of the major constraints needing to be addressed along the way. Cross-border issues are adequately addressed. The budget is in keeping with APOC guidelines and reflects the lowering costs to APOC and treatment costs. The following issues need to be further clarified:

(i) 75% of the Fund provided by the NGDO are for paying salaries;

(ii) It is not clear why training is planned during the rainy season;
(iii) The time at which supervision of CDTI will take place needs to be further elaborated.

Notwithstanding the above, TCC accepts the National Plan of the Central African Republic and recommends the funding of its Project Proposal by APOC Trust Fund.

2.3. Chad

2.3.1 The Chad National Plan and Project Proposal

Onchocerciasis is a serious public health problem in Chad. The disease, mainly of the blinding type exists in 5 prefectures (Logone Oriental, Logone Occidental, Mayo Kebbi, Moyen Chari, Tandjile), with a prevalence ranging from 20 - 100%, a total population at risk of 2.7 millions and 870,000 persons infected. Two other prefectures, Salamat and Gaera are also likely to harbour the disease and there are plans in the current proposal to carry out REMO in these areas. Chad shares a common focus with Cameroon and CAR.

Though a National Programme had been in existence since 1991, mass treatment with ivermectin was actually initiated in 1993 by AFRICARE, through funding from the River Blindness Foundation, using essentially mobile strategy. To date 469,748 people have been treated.

The proposed Project is a partnership between MOH, AFRICARE and OPC and seeks to establish CDTI throughout all the eligible endemic communities in Chad. The proposed budget show a decrease in the cost per person treated; by the fifth year the cost is US $ 0.6/person/treatment.

TCC considered that overall this is a good and fairly well documented proposal, with a novel approach to cost recovery, with evidence of more community involvement and a recognition of sustainability. The proposal should be supported, provided the following issues are addressed to the satisfaction of APOC management:

(i) a detailed time line is provided in Annex F but no estimate of numbers of treatment is given;
(ii) there is no flow chart for Mectizan distribution;
(iii) there is no reference to earlier studies, namely the classic work of Buck et al;
(iv) there is no reference to or specifically;
(v) there is scant if any reference to KAP/IEC and no detail is given;
(vi) the budget must be reviewed in keeping with existing guidelines.

2.4. Nigeria

2.4.1. Adamawa State Project Proposal

The TCC commended the NOTF for the Adamawa State proposal, for effectively addressing the issues raised by TCC3 (see TCC3 report, section 2.1.1). The document is greatly improved in all major areas. In particular, the budget structure is clear and well presented. In fact, TCC considered that the budget format utilized in this proposal and the summary table on page 34 could serve as standard formats for future APOC Proposals. The Committee also noted the yearly decrease in the cost per person treated being US $ 0.3 by the fifth year. TCC therefore recommends the approval for funding.
of this proposal, in the condition that the following issues are resolved to the satisfaction of APOC Management:

(i) Given the importance of sustainability, and its relation to the utilization and strengthening of the Primary Health Care System, the discussions of this link must be improved. First, it is mentioned that only 10% - 20% of communities have access to Primary Health Care (PHC). Later when asked how CDTI will initiate or expand the PHC system, the response was that the question was not applicable. The applicability is obvious and must be understood and adequately explained.

(ii) The discussion of the previous programme is improved, however, it still requires strengthening. The Total Costs which include Global 2000's financial contributions should be reflected in the proposal. Also, further information is required on the nature of the Project that treated 332,850 people in 1996, contributors to this success and their strategies.

(iii) The operations research that will compare the GRASP health education methods to others seems interesting. It is necessary to further describe the other methods that are planned to be compared with the GRASP methodology.

(iv) NGDO Letter of Endorsement must be provided to APOC Management.

(v) With respect to the proposed budget, the following issues need to be further clarified:

- The 10% annual increase in personnel salary must be justified;
- Personnel cost calculations which include the 10% increase (see (I), above) are faulty in places, and must be corrected;
- The $2,000/yr. cost to APOC for the storage and transport of Mectizan must be justified;
- The fuel cost of $217,000 over the life of the Project seems high and should be reduced;
- Although a KAP survey is intended to be carried out, a budget for this is not included;
- the $2,500/yr. cost for Sub-Committee Special Assignments under other Expenses, needs justification;
- There are 12 vehicles included in the budget. However, only 3 receive maintenance.

2.4.2 The Benue State Project Proposal

TCC, after a thorough review of this proposal, considered that it cannot be recommended for funding in its current format. There are major issues which need to be addressed. In the proposal for resubmission the NOTF needs to address in priority the following:

(i) the target population should be clearly stated, with appropriate REMO maps provided, and the proposed coverage rate should be discussed;
the number of MOH personnel is too high for a CDTI, and quite unnecessary for the Project, especially in view of the fact that it has a bearing on the MOH contribution and overtime expenditure;

(iii) cross-state border infection with Taraba State has not been addressed;

(iv) the proposed budget is a cause for special concern:

- the total budget is too high and does not reduce by Year 5, this does not augur well for financial sustainability of the Project; the same is true with the budget for training and health education, even though it is suggested most of the training and health education would have taken place by Year 3;

- the travel budget, car and motorcycle repair and maintenance are all very high, with no justification provided for this;

- the section "other expenses" of the budget (with 16% of the request to APOC) is high and includes items/facilities covering a 10-year period for a 5-year budget request;

- the overtime expenditure does not seem necessary, neither is it justified satisfactorily.

2.4.3. The Borno State Project Proposal

The proposal covers 8 of the 21 LGAs in the State consisting of 25 districts. PHC exists in the proposed area but is only partly functional. The target population is 827,862 persons living in 902 communities (709 hyper and mesoendemic).

Mass treatment with ivermectin were initiated in 1993 by AFRICARE. To date 224,309 persons have been treated at a total cost of $205,979, of which 45% were contributed by the state.

This proposal, which is a resubmission seeks to establish and expand CDTI to a total population of 827,862. The cost per person treated is US $0.3 in the fifth year.

TCC considered this second version of the Borno proposal had adequately addressed the critical issues raised at TCC3 (see TCC3 report, section 2.1.2). The particular strengths of this proposal include the following:

- past experience of the partners in working in this highly endemic area;

- the relative low cost of treatment per person treated if adequate coverage is achieved;

- the proposed intention to introduce cost recovery, that will be decided by the community, as a means to sustain the Project;

- the strong commitment of the State to support ivermectin treatment, as is reflected in the existing IDP;

There are however some issues still needing clarification. These are:
(ii) PHC structure and functionality in the Project area: More information concerning the existing Primary Health Care Structure in the Project area must be provided, specifically with respect to the number of clinics and existing manpower.

(iii) Past History of Ivermectin Treatment in Project area: There is a poor account of what has occurred with respect to ivermectin distribution in the past. It is mentioned that 200,000 people were treated in 1996 for $30,000. If this is true, an explanation is necessary on how this was accomplished. If not, further information must be provided to enable APOC Management to have a more accurate picture of past activities.

(iv) Operational Research: The proposed operational research comparing programme and community directed ivermectin treatment has already been turned down by the TCC during the last submission (see TCC3 report, section 2.1.3, iv). If other research activities are to be proposed in the future phase, then another relevant topic needs to be selected.

(v) Health Education: A KAP survey is clearly needed, if appropriate additional educational materials are to be developed.

(vi) Budget:

   (a) Year 2-5 budget justifications are missing;

   (b) Many Year 1 budget details are either missing or incomplete:

   - LOCT Leader 700/yr x 11 = 77,000 should be 7,700; $50,000 for workers overtime was deemed excessive and unacceptable to the TCC;

   - APOC’s contribution of $3,600 to communications was missing in the detailed budget;

   - $15,000 for T-Shirts was deemed excessive.

   - UNICEF’s budget, page 36 - section 9.2.2 stated that UNICEF support was $42,400 for Year 1 of the Project. This does not match with the Year 1 detailed budget of $94,000. An explanation is needed for this discrepancy.

(vii) General: more detailed treatment figures should be provided and the cost/treatment figures calculated and stated for the next proposal. The cost/person treated by Year 5 in the current proposal is $0.83, a figure higher than $0.20 acceptable to APOC.

In summary, the lack of proper target population figures, poor maps, incomplete history of the Project, lack of health material development strategy and several budget concerns as summarized, make it impossible for TCC4 to recommend support for this proposal to the CSA.

2.4.6. The Osun State Project Proposal

This proposal is an extension of an existing programme already treating 90,000 people, through funding from UNICEF, the MOH partner in the Project area since 1992.

The Project, which is a resubmission (see TCC3 report, section 2.1.5), seeks to establish CDTI in 10 LGAs and treat up to 623,000 by Year 5, with 226,000 targeted for treatment by Year 1.
2.4.4. The Federal Capital Territory (FCT) Project Proposal

The Federal Capital Territory of Nigeria was established in 1976 to provide a new capital for Nigeria. It comprises Abuja, the Capital city and the surrounding rural areas of some 500-600 settlements. The Federal Capital Territory of Nigeria is divided into six administrative areas (Local Government Councils), comprising 28 districts. The population is 300,000.

Mass treatment with ivermectin in the FCT has been in existence since 1995. To date, 95,653 have been treated at a total cost of $33,000. The proposed Project in the State is an extension/continuation of the current treatment programme and will include all the 6 Local Government Councils. The target population is 280,704 (200,250 hyper, 80,454 mesoendemic).

However, CDTI will be confined primarily in the areas outside the Capital city itself.

TCC considers that this is a good and well written proposal that should be recommended for funding with the following amendments:

(i) REMO for the LGA be completed within the first year of Project implementation;

(ii) The budget be reviewed (minor adjustments) in consultation with the NOTF and to the satisfaction of APOC Management.

2.4.5. The Niger State Project Proposal

TCC reiterated APOC’s commitment to develop a regional, comprehensive programme to control onchocerciasis in 19 African Countries include an equally strong commitment to manage the programme according to clearly defined technical, operational and financial guidelines (see TCC3 report, sections 2.1.1 & 2.1.3). In this context and after careful review, TCC considered that this proposal does not meet the criteria for funding. It should be re-submitted only after the issues outlined below have been adequately resolved. These include the following:

(i) Target Population: The target population figures only include hyperendemic communities. It is mentioned, however, that there are 300 mesoendemic communities in the 11 LGAs in question. The exact population figures do not seem to reflect the true numbers in the field. There is no attempt to break population figures down by LGAs. This is required for the next proposal unless a sound justification can be provided. It was not clear until page 32 which 11 LGAs were included in these proposals. Please provide an LGA map for next submission.
TCC considered that this Project Proposal had been improved upon quite significantly, and recommended it to be accepted for APOC Trust Fund support, in the condition that the following outstanding issues are addressed to the satisfaction of APOC management:

(i) That sufficient technical assistance for training and supervision is available for implementation of the Project.

(ii) That clarification is obtained regarding the endemicity and justification for why some communities are being treated and others not, in light of the existing treatment programme area.

(iii) That the budget undergoes major revision, particularly in regard to the requested first year expenditure on capital ($123,000), training ($76,000), travel ($55,000) and personnel ($59,000).

2.4.7. The Oyo State Project Proposal

TCC, after a review of the resubmitted proposal, considered it had not yet adequately addressed many outstanding issues, some of which had been pointed out already at the last TCC session (see TCC3 report, section 2.1.6.). It could not be recommended for funding at this stage, and needed further revision before resubmission. The revised proposal should seek to particularly address the following:

(i) **Endemic area:** Explanation of why the 10 LGAs have been chosen, others previously treated now omitted, and information on what population in each LGA has hyper- and meso- and hypoendemic disease.

(ii) **Coverage and supervision:** Explanation how the programme can expand from approximately 100,000 in 1996 to 400,000 in 1998, and continue to expand throughout the 5 years to 1,000,000 at year 5.

(iii) **Financial sustainability:** The MOH provides $50,000 in Year 1 and is expected to provide $300,000 in Year 5. Further clarification on the utilization of this fund is required. Is there a commitment by the MOH to pay salaries?

(iv) **Budget:** There is a high expenditure on training and mobilization ($211,000), travel ($141,000), capital items ($108,000) and operating expenses ($76,000). This needs major revision and more detailed justification.

2.4.8. The Plateau State Project Proposal

This proposal concerns two states, the new Plateau State and Nassarawa State (both formerly one state, Plateau State). The new Plateau State has 17 LGAs, 5 of which are hyper or mesoendemic, while Nassarawa has 13 LGAs, of which seven are hyper and mesoendemic. The two states have a combined population of 3,843,814.

Mass treatment with ivermectin in the two states was initiated in 1992, through funding from the River Blindness Foundation, which mission was handed over to the Carter Global 2000 Program in 1996. 564,731 persons were treated in 1996.

The proposed Project is an expansion and a reorientation of the current programme, to reach and provide treatment to a target population of 800,000 persons.
The proposed budget show a yearly decrease in the cost per person treated; $ 0.2 for the fifth year of the Project.

TCC considered that this is a good proposal that will be greatly helped by solid experience already on the ground. TCC recommends that this proposal be accepted for APOC Trust Fund support, when APOC management is satisfied that the following outstanding issues have been satisfactorily addressed:

(i) Technical Assistance for NGDO staff
(ii) Need for new vehicles
(iii) Operational research

2.4.9. **Proposal for the support of NOTF Zonal Offices.**

A request was made by the NOTF Nigeria, for the support of Zonal Offices. However, the document was lacking in detailed justification for the requested support from APOC Trust Fund. TCC nevertheless recognized the legitimacy of such a request, given the size of the country and the need for such mid-level coordination. TCC recommended that properly prepared proposal be submitted at the next session, with a budget showing evidence of yearly decrease of Project running costs, and a total budget not exceeding US $ 160,000 in the first year. In the meantime, and in order to ensure the optimal support/supervision of the already approved Nigerian CDTI projects, latitude was given to APOC Management to decide the level of financial support required by the Zonal Offices.

TCC reminded the Nigeria NOTF that the main role of the four NOCP Zonal Offices is to provide technical and managerial support to the State Onchocerciasis Programmes (SOCP), just as the SOCPs are to help guide and support LGAs level activities, which in turn should serve to support endemic communities in implementing CDTI at the grass-roots level. Thus, the Zonal Offices are to assist the national programme leadership in supervision, monitoring, and evaluating the implementation of programme activities in the respective states. As APOC assistance to the NOTF/NOCP begins, the four Zonal Offices are each challenged to help the approved projects in their zones to succeed, and to help the NOTF in ensuring consistently high quality in subsequent Project proposals submitted to the TCC.

2.5. **Uganda**

2.5.1. **Uganda Phase II Project Proposal**

This phase 2 of APOC-supported Project in Uganda will be carried out in the districts of Kabale (assisted by Global 2000 river Blindness Program), Busheny (assisted by Christoffel BlindenMission), Kabarole (GTZ), and Mbale (Global 2000 River Blindness Program). It is an expansion and reorientation of existing ivermectin distribution programmes in these districts. The total population targeted for CDTI in the Project area is close to 2 million.

The proposed budget shows a yearly decrease; the cost per person treated is $ 0.2 by the fifth year.

The TCC recommends with conditions the approval of this well written and presented proposal. The issues that need to be addressed before it can gain final approval include:
The TCC recommends the APOC Management not to release fund to this Project until all appropriate Letters of Endorsement from the NOTF & partner NGDO’s are submitted. The budget received and reviewed by the TCC from the NOTF will be considered as the official budget. If the NOTF wishes to submit another budget, it should be accompanied by NOTF Letter of Endorsement. In this case, the TCC must review and approve the amended budget before it is officially adopted by the APOC Management.

The calculation of the target population to include 91% of the total population must be further justified.

The Letter of Endorsement from the partner NGDO must be in order.

The cost of treatment pre-APOC is $.038. This level of efficiency is not achieved again until the 4th year of this grant. This needs further explanation and justification.

The proposed operational research on transmission may duplicate studies undertaken by TDR. This must be further discussed with APOC Management. Once these issues are resolved, the TCC 4 recommends the approval of the Project.

2.6. Tanzania

2.6.1. The Tukuyu Proposal For Vector Elimination

TCC reviewed this proposal and an accompanying report provided following a feasibility study on vector elimination for the TDR Task Force on Tanzania foci. This proposal was reviewed in the context of the criteria which were required for a vector elimination Project. The focus must be isolated, there should be a local defined vector, the activity should be cost-effective and manageable, and provide a rapid return on investment by enhancing productivity and reducing the requirement for long term CDTI.

The Tukuyu focus was an area of 3000 km² on the Tanzania/Malawi border. Endemic onchocerciasis in Tukuyu was centred around 4 river systems draining south into Lake Malawi. The focus was believed to be isolated and transmission of *O. volvulus* by the *S. damnosum* Kiwiro form was at its peak in dry season June-November months. Maps of the river system provided dosing points and spraying of insecticide (temephos) to be used as provided in the report and accompanying document. Earlier studies of the area were referred to which provided information on biting rates, transmission potentials and distribution of the Kiwiro form, together with hydrology.

The TCC considered that whilst it was in favour of embarking on vector elimination in Tukuyu it required clarification of certain key questions raised in the report, some of which may have been addressed in the interim.

(i) Confirmation of the absence of the Kiwiro from the Songwe river

(ii) Susceptibility tests should be completed to confirm the susceptibility to temephos of the Kiwiro form of *S. damnosum*

(iii) Confirmation of the minimum duration of egg to pupae as more than or approximately 2 weeks

The Committee recommended that the Project should receive support to obtain information relevant to the control programme which were critical to the successful implementation of the programme. TCC recommended that provided the issues above were satisfactorily resolved, control
should commence in 1999. Detailed planning should commence in 1998 to anticipate commencement of field operations a year later than envisaged in the proposal.

TCC requested APOC Management to ascertain if, as indicated in the report, any information on the cytogenetics of the *S. damnosum* populations was available following the 1996 and 1997 dry seasons. TCC considered it appropriate to involve an experienced consultant to assist further susceptibility tests and preimaginal development duration.

The proposal and the feasibility report were well prepared and the proposal was recommended for support at a budget level for 1997 and 1998 activities as determined by APOC Management. The scheduling of activities according to the time lines in the proposal had been delayed and management flexibility was necessary to respond to managerial and technical information required by TCC and accepted by the proposers as necessary prerequisites for the commencement of operations.

### 2.7. Matters arising from the review of National Plans and Project Proposals

#### 2.7.1. Completion/Updating of REMO results in APOC countries

TCC was informed of the request from some participating countries (e.g., Nigeria), to review the distribution and endemcity of onchocerciasis where REMO results were conflicting with earlier historical data in any given area. TCC agreed to the principle of such a review, but insisted that this be done in the standardized and replicable way that has characterized the REMO methodology so far. The same would apply to the many areas still needing refinement of their REMO results in many countries.

#### 2.7.2. Support to NOTF Headquarters to supervise CDTI Projects

Discussions on this recurrent issue were facilitated by a document prepared by Mr D. Miller, CAM/OCP, following a request from the TCC at its third session to APOC Management, to propose some basis for providing support to NOTF headquarters to supervise CDTI Projects. If a rational formula could be agreed, then the TCC could concentrate on the principle of support of NOTF Headquarters, and leave the administrative details to APOC Management. TCC had suggested that a standard formula relating to the number of persons treated, or the number of projects supervised would perhaps be helpful.

Mr Miller’s presentation consisted of the following key points:

(i) It was in the interest of APOC that all NOTF offices had a certain minimum capacity to supervise field projects and to provide timely reports and to respond quickly to correspondence and inquiries.

(ii) The three NOTF Headquarters projects already supported, required funding of $160,125 (Nigeria), $157,815 (Sudan) and $150,817 (Tanzania). This was after rigorous screening in all three cases.

(iii) The list of items requested in these cases were very similar despite the widely differing situations. The basic hardware requirement has also been identified, even though it must be added, this related to fairly large countries: 2 FWD vehicles, 2 desktop computers, 2 laptop computers, peripherals and printers, 1 slide and 1 overhead projector, 1 photocopier and consumables. Thus, an average of $150,000 approx., seems to have emerged as the first year’s needs for APOC funding for an NOTF Headquarters.
The activities supported generally include training, IEC, field supervision, movement of ivermectin from the port of entry to the primary distribution points, liaison with the government as well as the keeping of accounts and providing office services.

In view of the above, it was proposed that TCC prescribes an upper limit of $160,000 for first year support to any NOTF Headquarters and requires APOC Management to pronounce on whether the items requested in any such proposal are appropriate in cost and quantity in relation to the number of persons to be treated and the amount or work to be done by the office. At a later date, with experience project implementation, similar guidelines could be laid down by the TCC for the subsequent years, in relation to the number of persons treated, or to a percentage of the non-capital expenditure of the previous year.

TCC agreed that a minimum and effective support by APOC Trust Fund to NOTF HQs was critical both to APOC and to the funded projects and their optimal implementation. TCC considered that the above suggestions contained useful elements that could help reach the decision for such a support. However, TCC reckoned that up till now, approval for HQ’s support has concerned only fairly large countries, the needs of which cannot be considered as standard for the rest of APOC countries. Furthermore, it is important that any request for NOTF HQ support do not include items that are likely to be included in the CDTI project’s budget, e.g., training, and that the budget for such a support show evidence of yearly decrease in the amount of running cost requested to APOC Trust Fund.

2.7.3 APOC Trust Fund support for NGDO administrative overheads

A concern had been expressed by some NGDOs that “overheads” associated with APOC project support be covered by APOC financing. This, it was reminded, had become of vital importance to some NGDOs, and was in keeping with the “Guiding principles regarding NGDO involvement in APOC” as written in the APOC Programme document, and which reads:

“Limits on administrative overheads for participating NGDOs will be fixed by the APOC Programme - through the TCC, Programme Management and the CSA”.

The CSA established at its last session (London, 17 and 18 July, 1997) an ad hoc committee2 to make recommendations regarding:

- APOC funding of NGDO administrative overheads and
- Direct costs which might qualify for direct funding

The ad hoc committee met on the 21 September 1997 and submitted their preliminary conclusions to the TCC the following day. The ad hoc committee document generated much debate, not least because according to the “Guidelines” document for Project Proposal developed by TCC1, out of country administrative overheads had been excluded for funding by the Trust Fund. At the end of lengthy and careful deliberations, TCC acknowledged that administrative overheads are a real cost to any organization running a field project. However, the committee insisted that if administrative overheads are included in the APOC Trust Fund budget, it is important that all members of the APOC partnership are in agreement and that there is transparency of the mechanisms and financial implications for the programme. TCC therefore made the following recommendations to the CSA:

2 The membership of the ad hoc Committee included: B. Benton, World Bank (Chair), Y. Dadzie, Director a.i., APOC, A. Seketeli, Manager, APOC, Catherine Cross, Chairperson, NGDO Group, J.H. Kyabaggu, NOTF Uganda, Daniel Etya’alé, Liaison, NGDO Group, J.B. Roungou, WHO/AFRO and O.W. Christensen (Rapporteur).
the overhead cost rate should be an agreed percentage, applied to the NGDO direct contribution on the approved budget for that year;

(ii) the overhead cost rate to be reimbursed should be kept to a minimum (e.g. maximum 10%), and the figure calculated according to options 2 or 3 in the CSA ad hoc Committee report;

(iii) any such formula should as far as possible give equal treatment to all NGDOs participating in APOC, although any NGDO may choose to waive its right to apply for overhead costs;

(iv) the mechanism for applying and agreeing upon allowable overheads to partners should be through the NOTF, although disbursement can be direct to the partner NGDO;

(v) in adopting any proposal for reimbursing agreed upon overheads it is strongly advised that the Memorandum of Understanding should not be amended;

(vi) in adopting any proposal for reimbursing agreed upon overheads, TCC considers it important that the budget allocated for field operations of APOC should not be compromised. The committee acknowledges that the NGDOs and World Bank are jointly committed to raise additional funds for field operations.

As regards direct costs, TCC suggested that the following costs, if requested with sufficient justification will be considered by TCC and Management for APOC Trust Fund support: salaries for full-time project staff, fees for technical assistance, and travel costs for technical assistance. In this case, they should be included in the Project Proposal Budget from the NOTF.

3. OTHER MATTERS

3.1 Evaluation, Monitoring and Reporting of APOC projects

As a follow-up to the last session, and at the request of the TCC, revised versions of monitoring and evaluation forms were submitted to the TCC by APOC Management, for further review, after additional input from representatives of participating countries and their NGDO partners during the recent CDTI workshops. The revised forms included two monitoring forms: one for routine and one for independent project monitoring, and one form for annual evaluation. TCC reckoned that the forms had been simplified quite significantly and could now be field tested after minor amendments, before final approval.

3.2 Epidemiological, social and economic impact assessment of APOC operations

TCC, at its third session, had recommended that a new position paper be presented at the next TCC meeting. The document, TCC requested, should assess impact in all APOC countries Project sites, using fewer but relevant indicators of impact on skin and eye disease, the effect of ivermectin on transmission, indicators on quality of life and health of the population, indicators on ability to work and of school attendance.

On the basis of the above recommendations and following the inputs from other experts on the ad hoc committee's report, a group was convened which modified both the indicators and the methodology. In this regard, two protocols for the evaluation of epidemiological impact of APOC activities and Studies on the long-term impact of CDTI on transmission were produced and reviewed by TCC4.
The following conclusions relate to the evaluation of the epidemiological impact:

(i) Four teams will be formed to carry out the evaluation up to 22 sites in APOC countries. Each team will consist of one or two ophthalmologists, one or two dermatologists or clinicians, two assistants for the Wu-Jones machines, a coordinator and a local helper.

(ii) The professionals in each team will be trained for standardization of techniques and procedures shortly (no later than October 1997) for about 14 days. The venue for the workshop should allow easy access to both patients and materials, facilitate training and provide adequate administrative and secretarial support.

(iii) A pilot study will be organized as part of or following the training.

(iv) It may be necessary to include a social scientist in some of the sites to collect data on the community’s views and acceptance of the APOC activities while the possibility of conducting a more detailed social impact assessment study is being considered.

(v) It is suggested that following the baseline evaluations, the second assessment be done after five years and the third assessment after nine to ten years. Thought should be given to maintaining the structure and the skills of the members of the teams since the gap of 4 to 5 years between evaluations could create problems.

(vi) Detailed studies in Nigeria and Cameroon as originally planned are no longer feasible in the near future. In the new study with emphasis on ophthalmology and dermatology, the role of the two senior scientists previously selected for coordination of the projects needs further consideration and redefinition. In this regard, it was suggested they be informed by APOC Management accordingly. APOC Management will contact them in future when their services will be required.

With regard to the studies on the long term effect of CDTI on transmission, it was proposed that DNA assay on pools of blackflies to determine the level of infectivity be carried out. The baseline material could be handled by the laboratory at Bouaké and subsequently, after four and eight years laboratories in some APOC countries could take over. Appropriate training strategies will be developed during this time.

The economic indicators were not considered explicitly in the ad hoc Committee revised report. However, it was suggested that the information on the economic impact of control could be obtained by extrapolation from the results of the epidemiological evaluation and by using recent information on the relationship between disease burden and socioeconomic impact.

3.3. NGDO Chairperson attendance at the TCC sessions

A request was made to the TCC from the NGDO Group to allow the NGDO Chairperson to attend non-restricted deliberations of the TCC, to enable her to have a better understanding of the many matters that are initiated at the TCC and are further discussed at the CSA, to which she has now been invited to attend as well. TCC agreed to that request.

4. Conclusions and Recommendations

4.1. Provided they are revised as suggested and notwithstanding the comments and suggestions to APOC Management for follow-up action, TCC recommends the approval for funding of the following Projects Proposals.
4.1.1 Cameroon

(i) Adamaoua Province Project Proposal for CDTI
(ii) Centre-III Project Proposal for CDTI
(iii) Littoral II Project Proposal for CDTI
(iv) North Province Project Proposal for CDTI
(v) South West Province Project Proposal for CDTI
(vi) Proposal for NOTF Secretariat Support

4.1.2 Central African Republic

(i) CAR Project Proposal for CDTI

4.1.3 Chad

(i) Chad Project Proposal

4.1.4 Nigeria

(i) Adamawa State Project Proposal for CDTI
(ii) Borno State Project Proposal for CDTI
(iii) Federal Capital Territory (FCT) Project Proposal for CDTI
(iv) Osun State Project Proposal for CDTI
(v) Plateau State Project Proposal for CDTI

4.1.5 Uganda

(i) Uganda Phase II Project Proposal for CDTI

4.1.6 Tanzania

(i) Tukuyu Proposal for Vector Elimination

4.2 Recommendation of the completion/update of REMO results in APOC countries, see section 2.7.1

4.3 Recommendation on APOC Trust Fund support for NGDO administrative overheads, see section 2.7.3

4.4 Recommendation on impact assessment of APOC operations, see section 3.3.
ANNEX 1:  LIST OF PARTICIPANTS

TCC MEMBERS

1. Dr Rosa Befidi-Mengue, Yaoundé, Cameroon
2. Dr T. Diarra, Bamako, Mali
3. Dr A. Foster, London
4. Dr S.O. Meredith, Atlanta, USA
5. Prof. M. Homeida, Khartoum, Sudan
6. Dr D.R. Hopkins, Chicago, USA
7. Prof. O. Kale, Ibadan, Nigeria
8. Dr J. Kassalow, New York, USA
9. Dr P. Kilima, Dar-es-Salaam, Tanzania
10. Prof. D. Molyneux, Liverpool, United-Kingdom

WHO/GENEVA

11. Dr H. Remme, Geneva
12. Dr D.E. Etya’ale, NGDO Coordinator, Geneva

WHO/AFRO

13. Dr J.B. Roungou, OTD/AFRO

WHO/OCP/APOC

14. Dr K. Yankum Dadzie, APOC Director a.i., Ouagadougou
15. Dr (Mrs) U. Amazigo, Scientist/APOC
16. Dr B. Boatin, CPET, Ouagadougou
17. Dr Noma Mounkaila, EBIS/APOC
18. Dr Itondo, Ouagadougou
19. Mrs M.-P. Kaboré, DOC, Ouagadougou
20. M. D.E. Miller, CAM, Ouagadougou
21. Dr A. Sékétéli, APOC Programme Manager, Ouagadougou
22. Dr E.A. Soumbe, CBIS, Ouagadougou
23. Dr L. Yaméogo, COORD a.i., Ouagadougou

WORLD BANK

24. Mr B. Benton, World Bank, Washington, Chairman CSA
25. Dr Bernard Liese, World Bank, Washington

FAO

26. Dr Felix Moukoko N’doumbe

OTHER

27. Dr Kyabaggu, NOTF, Uganda (Observer)