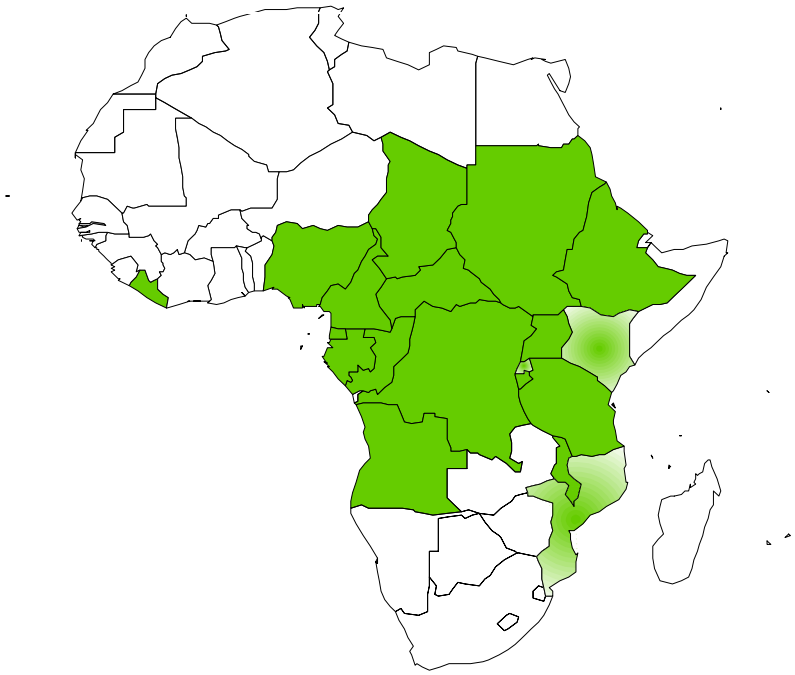
AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)



REPORT OF THE TWENTY-FIFTH SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE (TCC)

OUAGADOUGOU, 10-15 SEPTEMBER 2007

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ABBREVIATIONS

AAF	Assistant Administrative Finance Officer
AE	Adverse Events
APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
CBO	Community Based Organisation
CDD	Community-Directed Ivermectin distributor
CDI	Community Directed Intervention
CDTI	Community-Directed Treatment with Ivermectin
CSA	Committee of Sponsoring Agencies
CSM	Community Self Monitoring
DEC	Diethylcarbamazine
DRC	Democratic Republic of Congo
EMI	External Monetary Incentives
FLHF	Front Line Health Facility
GIS	Geographical Information System
HIPC	Heavily Indebted Poor Countries
HKI	Helen Keller International
HSAM	Health Education Sensitization Advocacy Mobilization
HQ	Headquarters
HW	Health worker
ICTC	International Coalition for Trachoma Control
IEC	Information, Education, Communication
ITI	International Trachoma Initiative
IVM	Ivermectin
JAF	Joint Action Forum
LF	Lymphatic Filariasis
LGA	Local Government Area
LOCT	LGA Onchocerciasis Control Team
MDP	Mectizan® Donation Program
MOH	Ministry of Health
MSST	Motion Sensitivity Screening Test
NGDO	Non-Governmental Development Organization
NOCP	National Onchocerciasis Control Programme
NOTF	National Onchocerciasis Task Force

NTD	Neglected Tropical Diseases
PAB	Plan of Action and Budget
PHC	Primary Health Care
PLERM	Probable Loa Encephalopathy Related to Mectizan®
PRSP	Poverty Reduction Strategic Papers
SAE	Severe Adverse Event
SCI	Schistosomiasis Control Initiative
SHM	Stake Holder Meeting
SIZ	Special Intervention Zones
SNEL	Societé National d'Electricité
SSI	Sight Savers International
SPSS	Statistical Package for Social Sciences
SSI	Sight Savers International
TCC	Technical Consultative Committee (of APOC)
TDR	UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
USAID	United States Agency for International Development
UTG	Ultimate Treatment Goal
VAS	Vitamin A Supplementation
WHO AFRO	Regional Office of the WHO Africa Region
WHO/NTD	Neglected Tropical Diseases - department within WHO cluster of communicable diseases (WHO/NTD)
WR	WHO Country Representative

1. Opening

1. The twenty-fifth session of the Technical Consultative Committee (TCC) of the African Programme for Onchocerciasis Control (APOC) was held from 10-15 September 2007 at the headquarters of APOC in Ouagadougou, Burkina Faso. It was opened by Prof. A. Abiose, Chair of TCC, who welcomed participants to Ouagadougou.

2. Prof. Abiose acknowledged Dr. Mary Alleman's numerous contributions over the years as a member of the TCC. Dr. Alleman has moved on from MDP to another job. Prof Abiose welcomed Dr. Yao Sodahlon who will now represent MDP in the TCC.

3. The TCC Chair also informed members about a working group that had been constituted by APOC Management to discuss the recent Lancet publication by Osei *et al*. on the topic of potential emergence of adult worms not responding to ivermectin as expected (Osei-Atweneboana MY, Eng JKL, Boakye D, *et al*. Prevalence and intensity of Onchocerca *volvulus* infection and efficacy of ivermectin in endemic communities in Ghana: a two-phase epidemiological study. Lancet 369, 2021-2029, 2007). The group, which includes two co-authors of the paper, Professors Gyapong and Boakye, will make a presentation of its discussions and a proposal for follow up studies during this TCC session.

4. Professor Abiose further called upon TCC members to begin reflection on the devolution of the review of annual technical reports of some of the CDTI projects to countries.

5. The Director of APOC, Dr Uche Amazigo, welcomed participants to Ouagadougou. The renewed discussion on the efficacy of ivermectin is one of the issues that have put APOC once again into the limelight. The TCC will be asked for guidance on an action plan produced by the working group to obtain further information that may allow assessment of data reported from Ghana. Guidance will also be sought from the TCC on how CDTI can be optimally used to strengthen the health systems of the onchocerciasis endemic countries.

6. Dr. Barryson, OTD/AFRO, reported on Dr M. Chan, WHO Director General's address to the Regional Committee for Africa in Brazzaville, which highlighted the CDTI strategy as in line with the principle of promotion of primary health care, and the importance of managing overlapping neglected tropical diseases (NTDs) in an integrated way. The WHO/AFRO Regional Director's speech at the past Regional Programme Management (RPM) also stressed NTDs among the priorities of the African Region. Before the end of 2007 an external evaluation of the models of integrated NTDs control in the fast track countries will be conducted. The results will help advice WHO and Donors on the most effective way to structure its support to countries.

7. Dr. Barryson stressed on TCC's important role of advising APOC management and WHO on integration of other health interventions into CDTI; and on how to address the issues that have arisen as a result of the publication of the article by Osei *et al*., whereby skin microfilaria level increase faster than expected post ivermectin treatment in study subjects in Ghana. He also stressed that systems for monitoring antihelminthic drug efficacy must be developed.

8. On behalf of Dr Baba Moussa, the WR Burkina Faso, Dr Sostène Zombré welcomed participants. He underscored the importance of looking for solutions especially in the context of the risk of emerging resistance to ivermectin; the need to discover new drugs which are as good as ivermectin and finally solutions for the integration of the fight

against other diseases using the CDTI strategy. He complimented the TCC on its track record of objective, fact driven discussions and recommendations and encouraged TCC to continue this way in, of addressing the challenges faced by APOC faces and which have to be seen in the context of strategies for poverty reduction.

9. The list of participants is provided in Annex 1.

2. Adoption of the agenda

10. The agenda was considered and adopted with the following changes:

(i) Agenda item 12 was moved to be part of agenda item 21;

(ii) Agenda item 21 will be discussed in conjunction with agenda item 15;

(iii) Agenda item 13 to be discussed on Friday under agenda item 21.

INFORMATION

3. Matters arising from 116th and 117th CSA session

11. Dr Amazigo reported on the 116th session of the CSA. Among key issues discussed were recommendations of JAF 12, in particular the extension of APOC to 2015; re-enforcement of integration of CDTI into national health systems; promotion of co-implementation of ivermectin treatment and other health interventions; expansion of the scope of APOC to include some ex-OCP countries and additional objectives. APOC needs to address the following challenges:

(i) Motivate countries to increase their commitment to fund CDTI from domestic sources/regular sources/PRSP/HIPC;

(ii) Scale up and maintain coverage in post conflict countries;

(iii) Devolve APOC activities, including some TCC activities, to the countries;

(iv) Strengthen country capacity to take over more of APOC and TCC activities.

12. The 116th CSA further:

(i) asked TCC to provide guidance on how to promote and implement integration;

(ii) recommended that the additional technical support provided to Tchad, Angola and DRC also be provided to Southern Sudan and CAR;

(iii) congratulated NOTF/DRC and APOC Management for the actions taken in collaboration with SNEL/DRC at the INGA site in DRC to reduce the nuisance that *Simulium* constitutes for the population;

(iv) reviewed and approved the amendment to the Memorandum of Understanding to allow APOC extension. The World Bank will forward the amendment to donors for consideration.

13. The 117th CSA session which was held in Paris, focused on discussions of the draft Exit Strategy for APOC 2008-2015. CSA provided guidance on all critical issues and objectives in particular the repositioning of APOC for strengthening the capacity of countries to take over its functions, prepare for data review and take decisions on when to stop ivermectin treatment.

14. Other issues discussed by the 117th CSA included:

(i) APOC's plan to build a data base of all CDTI communities;
(ii) The study on fly movement between Nigeria and Benin;
(iii) The special initiative on social mobilisation activities and training of CDDs;
(iv) Collaboration with the Erasmus University of Rotterdam on the Health impact assessment of APOC operations;
(v) The part the Regional Director (RD) and Director General (DG) played in order to increase the profile of APOC activities in the countries was well acknowledged.

15. The 117th CSA:

(i) Asked TCC for guidance on an action plan to better understand the data gathered in Ghana and published by Osei *et al*. CSA is very concerned about the negative publicity which followed the publication and its effect on donor attitudes and funding;

(ii) Recommended that in the future countries report not only on planned budget, but also on funds released for CDTI activities, including salaries of staff;

(iii) Agreed to the Memorandum of Understanding between AFRO/RD and African Development Bank that will allow ADB to continue to support APOC/CDTI activities financially.

4. NGDO: Recommendations from the 30th meeting of the NGDO Coordination Group for Onchocerciasis Control

16. The second joint meeting of the NGDO Coordination Group for Onchocerciasis Control, the NGDO LF Network and International Coalition for Trachoma Control (ICTC) was hosted by APOC and held in Ouagadougou from 6-9 September 2007. Participants included the Liverpool LF Support Centre, Merck&Co as well as WHO/NTDGeneva, WHO/AFRO and WHO/APOC. Observers included ITI, SCI, Representatives of MoH of Burkina Faso, Ghana, Mali, Niger and Uganda. The group recommended (for a complete list see Annex 2):

(i) Immediate development of integrated mapping tools for NTDs together with monitoring and evaluation by WHO;

(ii) Improved planning and coordination with ALL stakeholders. New NTD initiatives should be built into existing health programmes;

(iii) All countries with two or more NTDs should develop integrated control plans as a first step to securing necessary resources to implement comprehensive control programmes;

(iv) National programmes need to ensure that their needs and priorities, not donor wishes, drive activities;

(v) Community involvement is critical for successful and sustainable control programmes;

(vi) Continued commitment to ensure that drug and non-drug based components of control efforts get integrated into NTD control programmes.

(vii) Exit strategies should be identified and methods developed and implemented for measuring impact of NTD control activities.

17. The NGDO group discussed the two recent publications in the Lancet and PLoS Neglected Tropical Diseases (Bourguinat C, Pion SDS, Kamgno J, et al. Genetic Selection of Low Fertile Onchocerca volvulus by Ivermectin treatment, PLoS Neglected Tropical Diseases, Vol. 1, e72 page 1-11, 2007). A Press Release by the NGDO group declaring their confidence in the value of continued CDTI is being prepared.

5. Follow up to recommendations of 24th TCC session

18. All recommendations from TCC 24 that required APOC action have either been initiated or completed by APOC Management (for a complete list see Annex 3):

STRATEGIC AND TECHNICAL ISSUES

6. Prevalence and intensity of *O. volvulus* infection and efficacy of ivermectin in endemic communities in Ghana: a two-phase epidemiological study

19. Dr. D. Boakye presented the study conducted by Awadzi *et. al*. and published in 2004 which formed the background of the study in Ghana published by Osei *et all* in the Lancet (Awadzi K, Boakye DA, Edwards G, *et al.*: An investigation of persistent microfilaridemias despite multiple treatments with ivermectin, in two onchocerciasis-endemic foci in Ghana. Ann. Trop Med. Parasitol. 98, 231-249., 2004; Awadzi K, Attah SK, Addy ET, *et al.*: Thirty-month follow-up of sub-optimal responders to multiple treatments with ivermectin in two onchocerciasis-endemic foci in Ghana. Ann Trop Med Parasitol 98, 359-370, 2004). The Awadzi study concluded that the presence of subjects with persistent significant microfilaridermia (>10 mf/snip after 9 or more treatments with ivermectin (IVM)) is due to macrofilaria in these subjects which are less sensitive to the reproduction delaying effect of ivermectin. The Awadzi paper described these subjects as 'atypical responders'.

20. Dr. D. Boakye presented the major results of the Osei *et al.* study, which was conducted in Ghana in 20 communities with long term IVM treatment and a therapeutic coverage of at least 55% in the five years preceding the study. Some of the villages belong to the Special Intervention Zone (SIZ). Subjects were randomly selected and their treatment history verified through local treatment records and interviews. Skin snips were taken before IVM treatment, and 30, 90 and 180 days post treatment. Skin mf levels 30 days after treatment were virtually 0 in all subjects. In 4 communities, skin mf levels 180 days post treatment were much higher than in the other communities. The authors concluded that these data indicate that 'ivermectin is still effective as a microfilaricide after almost 19 years of MDA'. However, the data also suggest that 'resistant adult parasite populations which are not responding as expected to ivermectin are emerging'.

21. Nodules were obtained from the individuals in this study and the results of the histopathological evaluations will be published at a later date.

22. Dr. Remme summarized the discussions and recommendations of the small working group put together by APOC (see paragraph). The working group agreed that there are two potentials, not necessarily mutually exclusive, explanations for the data: (1) selection of macrofilaria which start reproduction earlier than the majority, and (2) local transmission which has resulted in a new generation of young, and thus more productive macrofilaria. The working group had focused on potential explanation (2) since explanation (1) will be discussed within the WHO/AFRO/NTD/TDR organized meeting on monitoring anti-helminthic resistance in Washington in October/November 2007. The information from the Asubende data base support the hypothesis that younger worms have

a higher microfilaria production after IVM treatment than older worms, which may include earlier resumption of microfilaria production. Since infection will occur across villages, the geographic and therapeutic treatment coverage in the whole area around the study villages is relevant to determine the potential of new infections among residents of the study villages. The 'control village' in the Lancet paper study had received no ivermectin treatment at all and a Sight Savers International (SSI) survey suggests that there are several villages with very poor, if any treatment coverage. The working group recommended that more data is required on the treatment coverage in the geographic area of the study villages. The working group also recommended that TCC defines at which point loss of efficacy of IVM would render IVM useless as a tool for effective onchocerciasis control.

23. TCC discussed the results of the studies by Osei et. al. and Awadzi et. al. and made the following observations and recommendations:

(i) Effective onchocerciasis control depends on sustainable CDTI and sustained efficacy of IVM. The early repopulation shown by Awadzi et al. and now by Osei et al. should be seen as an indicator of the need to closely monitor treatment response to IVM across the onchocerciasis endemic areas;

(ii) Appropriate sites and methods/protocols need to be established for surveillance of the efficacy of CDTI. This should include capacity development and strengthening plans for all countries to prepare for post APOC activities;

(iii) Available databases should be evaluated for indication of presence of 'suboptimal responders' in the past, in particular earlier on in ivermectin treatment history, i.e. before ivermectin had the time to exert any selection pressure;

(iv) A protocol for dealing with any indication of increasing frequency of atypical response to ivermectin (including types of atypical responses not noted to date), needs to be defined. This protocol should include:

- ***definition of a threshold at which the onchocerciasis control strategy needs to be changed, e.g. through increasing the frequency of CDTI treatments,***
- ***requirements for surveillance sites and methods/protocols to determine when and where this threshold is being crossed,***
- ***How to deal with subjects harbouring macrofilaria with suboptimal response to ivermectin to reduce their contribution to the O. volvulus population.***

24. The TCC agreed on the following definition of ivermectin resistance that would constitute an operational problem for onchocerciasis control programmes:

(i) ***It is no longer possible to control onchocerciasis as a public health problem with annual ivermectin treatment (provisionally defined as maintained < 0.5 mf/snip) so that a new control strategy or new intervention tools are require;***

(ii) ***An operational problem would be indicated by increasing CMFL or failure to reduce CMFL below 0.5 mf/snip despite good treatment coverage;***

(iii) ***Early warning signs include reduced microfilaricidal effect and/or increased fecundity of the adult worm and/or potentially other 'atypical responses'.***

25. Dr. Lazdins gave an overview of MACROFIL supported research on ivermectin resistance and further studies recommended by three consultative meetings involving APOC, TDR, MDSC and MDP and relevant experts:

(i) Retrospective studies: Re-analysis of data from previous studies, trials, and surveillance with the purpose of defining;

- The early microfilaricidal response of ivermectin treatment;
- The dynamics of repopulation of microfilariae in the skin over a 12-month period after treatment with ivermectin;
- Where available, investigate the above parameters in the context of multiple rounds of treatment.

This analysis should consider:

- Geographic variation, prevalence of onchocerciasis in the specific geographic area, the initial skin microfilarial loads in the study population, and the number and frequency of rounds of treatment with ivermectin.

(ii) Prospective studies;

- Cross-sectional studies to measure the prevalence of the genetic changes and the "suboptimal" phenotype as a function of the number of rounds of ivermectin treatment. There should be multiple sites in multiple countries;
- Investigate genotype changes in microfilariae. One particular urgent case for the genotyping studies identified was Rio Corubal focus in Guinea-Bissau;
- Determine skin microfilarial loads at baseline and 1 week, 1 year (and if possible 3-6 months) after treatment with ivermectin in communities that have received different numbers of rounds of treatment with ivermectin;
- Longitudinal studies to measure the presence of genetic changes and "suboptimal" phenotype and its prevalence over time;
- Samples to be collected for genotype analysis in "ivermectin-naïve" populations and over time as mass treatment with ivermectin is established;
- Archiving of entomological material, with standardized storage procedures, from already identified sentinel sites in endemic countries for future analysis.

(iii) The participants at the consultative meetings (involving APOC, TDR, MDSC and MDP and relevant experts) agreed that they did not view studies of clinical indicators (disease manifestations) for identifying emergence of ivermectin resistance as feasible at this time.

- Mazzotti reactions monitoring was suggested as a non-invasive way of assessing re-emergence of significant levels of infection, since the frequency and severity of Mazzotti reactions correlate with the intensity of infection/amount of microfilaria.

26. Dr Lazdins went on to say that in the context of integrated preventative chemotherapy, the meeting on monitoring of antihelminthic resistance in Washington in October/November 2007 will:

(i) Review methods and tools available to monitor emergence of resistance,
(ii) Discuss operational plans for monitoring emergence of resistance,
(iii) Identify research needs.

27. After Dr Lazdins's presentation, the Director of APOC said she will only issue a Press Statement on this subject after the basis has been provided by TCC and after approval has been received from the CSA.

28. Dr. Amazigo requested that results of research conducted with APOC funding be reported to APOC once they are available and that publications including these results be sent to APOC for comment prior to submission to a journal.

29. TCC recognizes that in view of the critical role of ivermectin for onchocerciasis control, OCP, APOC and TDR have been fully aware of the fact that onchocerciasis control's reliance on a single drug exposes the programmes to the risk of losing its achievements if resistance should emerge. Consequently, OCP, APOC and TDR have dedicated resources and expertise to address this potential risk. Since the mid 90's, TDR, the research arm of OCP and APOC, has supported research aimed at understanding the mechanism of action of ivermectin in *O. volvulus,* the identification of possible molecular markers of resistance, as well as clinical and epidemiological studies of the response of *O. volvulus* to ivermectin. This effort has engaged many researchers from Africa and industrialized countries and has resulted in many fundamental observations and potential leads for the development of a field-suitable tool for surveillance of emergence of resistance. Within this context, and in view of the recent Osei et. al. publication, TCC recommends:

(i) A comprehensive review of all data relating to the response of O. volvulus to ivermectin, possible emergence of resistance and potential indicators of selection should be generated. A subcommittee has been set up;

(ii) A statement by TCC regarding efficacy of ivermectin for control programmes was issued (see Annex 4);

(iii) The organizers of the Washington consultation on monitoring of helminth resistance should be requested to include scientists and onchocerciasis control programme managers from Africa in the meeting;

(iv) A meeting focusing on research on resistance of O. volvulus should be organized in one of the onchocerciasis endemic countries;

(v) The following studies to be conducted.

- ***A study to better understand the findings and the epidemiological/transmission context in areas in Ghana where the study of Osei et al. was conducted in conjunction with the Ghanaian authorities. This study should include collection of detailed treatment coverage data in all three areas in which the study villages were located, including small hamlets, followed by epidemiological surveys in selected locations to be decided upon based on the treatment coverage data. The data should be reviewed - if possible in March 2008 - by TCC for a decision on whether an entomological survey should be conducted.***

- ***A study to determine whether (1) individuals harbouring macrofilaria with a response to ivermectin similar to that seen in Ghanaian subjects exist in other countries and (2) whether there is a correlation between the existence of such macrofilaria and treatment history.This study should include sites in at least four countries of former OCP and APOC countries. Sites selection should be based on (a) availability of treatment records and baseline parasitological information and (b) requirement to have sites with different lengths of ivermectin treatment history. Sites with as few ivermectin treatments as is feasible (ideally no prior treatment) should be included. The protocol should follow that of the study in Ghana with microfilaria loads (mf/mg skin) being obtained at day 0, 30, 90 and 180 and nodules being excised for phenotyping (reproductive status) and genotyping (for all genetic changes found previously to possibly be correlated with ivermectin treatment history).***
- ***Literature review and analysis of available data, as well as the prospective (longitudinal and cross-sectional) studies previously recommended by the consultations held by APOC, TDR and MDP (see paragraph).***
- ***Genetic changes evaluated in cross-sectional and longitudinal studies should include all loci/genes for which the basic research conducted through the TDR Ivermectin Resistance Product Development Team (PDT) have indicated a possible correlation with treatment history and changes should be correlated wherever possible not only to treatment history but also to the phenotype of response to ivermectin.***
- ***Members of the Ivermectin Resistance PDT should assist TCC in advising and guiding the proposed studies.***

(vi) These studies should be carried out by MDSC and APOC in collaboration with local scientists and, where necessary, external scientists. These studies should be used to build capacity in endemic countries;

(vii) All studies should be conducted <u>as soon as possible</u> with the exact timing dependent on the type of study and the activities involved. It is necessary to develop the protocol and obtain Ethics Committee approval.

7. Results of the study on external monetary incentives

30. Dr. Elizabeth El Hassan presented the results of an APOC-funded multi-country study on the extent and type of external monetary incentives (EMI) provided by different types of programmes in Cameroun, Nigeria, Ethiopia and Uganda. The research questions addressed in the study were:

(i) What are the policies of different health programmes relating to external monetary incentives for community volunteers?

(ii) What are the determinants of policies of different health programmes relating to external monetary incentives for community volunteers?

(iii) Where do the policies of different health programmes relating to external monetary incentives for community volunteers overlap at the implementation level?

31. The study concluded that:

(i) Use of community volunteers for service delivery is common;

(ii) There is limited guidance from government regarding EMI, with a few notable exceptions;

(iii) Most programmes have a policy/practice of giving external monetary incentives;

(iv) The two major reasons for giving EMI are to motivate volunteers and to facilitate service delivery;

(v) The main reason not to give EMI is to ensure sustainability. These policy-guiding assumptions appear to reflect programme managers' perceptions;

(vi) **Cash incentives are the most common types of external monetary incentives**. Transport allowances, stipends and per diems often represent a sizeable form of income, especially when compared to GDP per capita;

(vii) **The average monetary value of EMI varies per site** (US$ 20 to US$ 310 per volunteer per year) **and per health issue** (US$ 10 to US$ 290 per volunteer per year);

(viii) TB/Leprosy, Reproductive health, STI/HIV/AIDS, Malaria, Nutrition and Immunisation are the health issues providing the highest EMI. These also happen to be the issues receiving the largest donor funds;

(ix) Donors play a significant role in setting these EMI;

(x) Their role is mostly indirect, through the provision of funds;

(xi) Some donors influence policies more directly by actually convincing programme managers to have a certain policy or by making it a funding condition;

(xii) **Current geographical overlap is high**, with about 10 programmes using community volunteers overlapping per district/LGA. This number is likely to increase;

(xiii) The occurrence of sharing community volunteers among programmes is highly variable;

(xiv) Coordination and especially harmonisation are very limited.

32. The study team recommended APOC and onchocerciasis control programmes to:

(i) Formulate a general policy at the national level to guide the implementation of the widespread practice of giving EMI to community volunteers;

(ii) Develop a framework to coordinate and harmonise incentive policies and packages taking into account programme-specific needs, types of services required, time-frames and resources available;

(iii) Labels should be removed from incentive packages. If community volunteers are to be given EMI at all, these should be under a general health label;

(iv) Harmonize with the other sectors concerned (water, agriculture, environment) to achieve cost-effectiveness: If a programme is incurring costs for EMI, while it is using community volunteers who are also receiving EMI from other programmes, it would be more cost-effective to put resources into a common basket and give joint EMI.

33. APOC data shows that low performance was frequently observed in areas where incentives existed, while performance was high in areas without incentives. Thus, evaluating the impact of externally provided incentives (as opposed to community provided/decided upon incentives) on performance and thus ultimately sustainability of performance needs to be investigated. Evaluating factors that motivate volunteers to work WITHOUT incentives is necessary. This is planned within the new TDR strategy (for details see paragraph).

34. The data that APOC already has and the results of the research on incentives conducted and planned need to be made available in an effective manner to policy decision makers and donors to ensure coherent policies and implementation plans that are data driven.

8. Update on operational research

35. The update on CDI study concentrated on data from year two of the study which had to do with Health Systems expenditures. Health system expenditures for interventions delivered via CDTI was comparable to that of expenditures for the same interventions delivered in the traditional way. Since coverage was higher when the interventions were delivered via CDTI, the costs/subject reached or cost/intervention delivered is lower. Thus, delivery of the health interventions tested in the study is more cost effective through CDTI.

36. When to stop ivermectin treatment: Study update is now in the Second Phase in which ivermectin treatment is being stopped in some test villages in Senegal (River Gambia), at the Senegal/ Mali border (River Bakoye) and in Mali (River Faleme). Starting in March 2008, data from the entomological evaluation of the consequences of stopping treatment will become available.

37. Research on community-directed interventions (CDI): In the new TDR strategy, one 'business line' will focus on research related to community-directed interventions. Research questions considered to be addressed are scaling up of CDI for NTDs and malaria, CDI in areas without CDTI (top priority is to determine cost and effort needed to implement and how to do it most cost effectively), CDI for other interventions (flexible response to community priorities, how to include non-drug interventions), other community level intervention models (e.g. urban areas, special populations: nomads, post-conflict populations, school health programmes), frameworks for co-implementation (limits, cost/benefit, type of interventions appropriate for co-implementation), incentives and empowerment (incentives and motivating factors, impact of conflicting policies, innovative approaches, community empowerment, mechanisms for communities for enforcing demand for support/supplies, mechanisms for influencing policy etc).

9. Update on macrofil

38. Among the seven countries whose Ministries of Health were approached by the Director of APOC for permission for a joint APOC/TDR mission to discuss the further clinical development of moxidectin in these countries, Liberia and DRC replied and country visits were conducted by Drs Noma, Ukety and Kuesel. Four potential study sites (one in Liberia, three in DRC) have been identified by the respective NOTF secretariat based on the availability of meso-or hyperendemic areas in which CDTI will not be implemented before 2009 and the absence of co-endemicity with Loa loa. Currently, trial implementation and budget plans are being put together for review by the Moxidectin Product Development Team. In Liberia, the feasibility of conducting the study depends on

success in identifying an ophthalmologist who is available at the study site at least three days a week for around the first 12 months of the study. The Liberians are assessing/screening two potential candidates. Should they not be successful, they have asked that TDR help them identify an expatriate.

39. In the context of the negotiations with Wyeth for further development of moxidectin, TDR brought up for discussion the issue of the maximum number of years of treatment with a macrofilaricide (or sterilizing agent) which should result in interruption of transmission through a macrofilaricide. Simulation studies have shown that critical factors for interrupting of transmission using a macrofilaricide are: treatment coverage, treatment compliance and endemicity level (Soumbey et. al. 2001). TDR has asked the Rotterdam group to conduct a sensitivity analysis with ONCHOCSIM to evaluate how the combination of different values for critical parameters determines the probability of eradication with a given number of treatment years. Based on initial small scale simulations performed, the following efficacy target product profile was proposed and accepted by TCC: efficacy consistent with interruption of transmission of the disease with six treatment rounds with 70% treatment coverage in an endemic focus. This definition will be reviewed, once the results of the detailed sensitivity analysis with ONCHOCSIM are available.

10. Update on Ueles CDTI Project by the project coordinator Dr. Tepage

40. Uélés is hyperendemic for onchocerciasis with Loiasis being co-endemic in five Health Zones. Leopard skin has prevalence between 1.3 and 39%. Ivermectin treatment was initiated in Uélés in 1991. In Dec 2001, the CDTI project was approved and CDTI implementation started in 2002.

41. Geographic coverage today is 99.9% while therapeutic coverage is 75 % in nearly all Health Zones. Around 800 000 people were treated in 2004 and 2006. No treatment was conducted in 2005 since the project was put on hold by TCC due to the potential danger posed by the oncho-Loiasis co-endemicity associated with co-endemicity with Loiasis. The only areas in which therapeutic coverage is between 65% and 75% are the five Health Zones in which loiasis is co-endemic. All health care personnel in these Health Zones have been trained in the diagnosis of early signs of SAEs and at least one person in each village was trained to recognize early signs and to notify the health care personnel in the nearest Health Areas.

42. In 2006, nearly 8000 CDDs were trained in CDTI and co-implementation of Vitamin A and Mebendazole distribution to children up to five years. Coverage for Vitamin A and Mebendazole distribution was beyond 90% for all age groups.

43. Challenges the project faces are poor road conditions in compelled with long distances (up to 1000 km from CDTI project head quarter to some communities), and high fuel costs (fuel frequently needs to be transported on bicycles). Threats to the programme are lack of government funding and low contributions from local government/communities.

44. Recommendations of CDTI coordinator: More flexibility in budget management for projects in remote areas, advocacy to increase government commitment to funding of onchocerciasis control and increasing activities to co-implement Onchocerciasis control with Vitamin A and Mebendazole distribution.

45. The organisation of the Health Care System in DRC is based on levels comprises Central, Health District, Health Zone level and Health Area levels. At Health Zone and

Health Area levels, the project is well integrated, with the CDTI project coordinator playing only a coordinating role. All nurses in charge of the Health Areas and health care personnel of the Health Zones have been trained in CDTI and are themselves training other personnel.

46. TCC congratulated the project on its achievements under extremely difficult conditions and encouraged the Project Coordinator, who is also the District Medical Officer, to further increase the integration of onchocerciasis control into the National Health System.

11. Update on Burundi CDTI Projects by national coordinator Dr. Birintanya

47. Burundi has three CDTI projects with a population at risk of around 1.16 million people. REMO was conducted in 2001 and the first CDTI project (Cibitoke-Bubanza) was approved by APOC in 2003. The first Mectizan® distribution was initiated in 2005. In 2006 the other two projects in Burundi (Bururi, Rutana) were initiated. The supporting NGDO is CBM. Two hundred and five (205) health care personnel and 10164 community distributors (CDDs) have been trained as of mid 2007. Treatment coverage in the projects areas in 2006 was 71.9%, 61.6% and 62.8% for Cibitoke, Bururi and Rutana, respectively (2^{nd}, 1^{st} and 1^{st} year projects).

48. In 2006 Government contribution to CDTI (without salaries) was 6%, CBM contribution 20%, and APOC contributions 74% of the total amount of money spent.

49. Co-implementation of other health interventions: A project has been initiated with funding from Geneva Global (around four million USD for a period of three years) for delivery of integrated control of schistosomiasis and intestinal helminths. Currently, mapping is ongoing and an action plan is being developed. Distribution of albendazole and praziquantel is ongoing in two CDTI projects. Co-implementation/integration has yet to happen on the organisational level in Burundi. The MoH is considering putting in place an institutional framework for supervision of integrated delivery of interventions for NTDs.

50. Challenges faced by the programme include: motivation and retention of CDDs in the context of competing programmes which offer monetary incentives; integration of CDTI into the health care system; high mobility of health care personnel and low government contributions.

51. Future plans: implementation of treatment of onchocerciasis infected persons in hypoendemic areas of the country, strengthening of operational research, increase use of CDTI strategy as a vehicle by other neglected tropical diseases and other health interventions.

52. The coordinator was complimented by TCC on his achievements and encouraged to ensure that onchocerciasis needs and achievements are being taken into account during the definition of the action plan for integrated control of helminth diseases in Burundi to ensure that integration can happen and that resource planning includes the need for sustainable CDTI.

12. Integration of onchocerciasis control into health systems and co-implementation of control of Neglected Tropical Diseases

53. A meeting on integration of CDTI activities into National Health Systems, Co-implementation of onchocerciasis control with other NTDs and Malaria, was held in

Ouagadougou, 12-14 June 2007 for francophone and Spanish/Portuguese speaking countries, to complement the one held in Brazzaville earlier on for the anglophone countries earlier (see Report TCC 24).

54. Meeting participants included:

(i) Directors of disease control (DDC),

(ii) National coordinators and programme managers for Onchocrciasis and Malaria control programmes of 15 French and Portuguese-speaking APOC and ex-OCP countries;

(iii) Representatives of donor organisations and countries, including the World Bank, France, Canada, The Netherlands and Belgium;

(iv) Representatives of the NGDO Coordination Group for Onchocerciasis control, WHO/Geneva, WHO/AFRO, WHO/TDR and WHO/APOC.

55. The recommendations are in Annex 6.

56. Operational research areas identified during the meeting included:

(i) Pharmacovigilance,

(ii) CDD incentives,

(iii) Obstacles and impact on health indicators.

57. Challenges following this and the Brazzaville meeting include

(i) Follow-up activities in countries: Establishment of national integration policies and development of integrated work plans (Malawi, Nigeria, Tanzania);

(ii) Co-funding of meetings and activities in countries;

(iii) Follow-up meetings to appraise the level of implementation of recommendations (Ethiopia in 2008?);

(iv) How to prevent the disruption of hard-earned gains of putting in place CDTI Strategy by new initiatives of integrated approaches for the control of NTDs;

(v) During the NGDO meeting updates on NTD activities in RTI-supported fast track countries showed some alarming happenings coined as “teething problems”;

(vi) Niger, Ghana, Mali and Uganda all complained among other things about the disruption of implementation strategies (choice of periods of distribution etc…) indicating a blatant lack of community involvement.

13. APOC Plan of Exit from countries developed by the NOTFs

58. APOC requested NOTFs to provide their post APOC plans to APOC for inclusion into the APOC exit strategy.

Submission of annual technical reports

59. TCC discussed the need for it to continue reviewing of technical reports for projects which have passed their 8th year.

60. The Table below provides an overview of ongoing projects by age. One project is expected to be initiated in 2008.

Project Year in 2007	Number of projects	Project Year in 2007	Number of projects
1	4	6	15
2	12	7	25
3	26	8	13
4	8	9	4
5	9	10	1

61. ***Tanzania, Congo, Ethiopia, Nigeria, Uganda and Cameroon either have the capacity to do the reviews within the country or could soon have the capacity through APOC capacity building. Thus, TCC recommended that the responsibility for review of reports due as of July 2008 for projects ≥8 years will be devolved on the NOTF of these countries***.

62. For other countries, TCC will still be responsible.

14. Strategic and exit plan of APOC 2008-2015

63. The Director of APOC presented the draft of the Proposed Strategic Plan for 'Phasing out and exit strategy 2008-2015' which was written based on lessons learnt about factors threatening achievements of onchocerciasis control (in particular social-political unrest and lack of political commitment) and defined timelines for milestones by country or groups of countries (in particular post conflict countries). The draft plan will be reviewed by CSA prior to finalization.

MANAGEMENT OF APOC TRUST FUND

15. Report on the Financial Management of APOC funded Projects

64. A total of 118 proposals for Letters of Agreement were to be received in 2007. 114 were received and 114 Letters of Agreement were prepared and signed, as of 31 August 2007, and funds released.

65. Out of the 657 financial returns to be received in 2007, only 249 were received and 216 (87% of the received returns) were analysed by the country Finance and Administrative Assistants and at APOC/ HQ.

66. Out of the 2631 financial returns received in 2006, 2535 (96%) were analysed by country Finance and Administrative Assistants and at APOC/ HQ.

67. As of 31 August 2007, 35 projects had red cards meaning they are more than 4 months late in submitting returns. The release of funds to these projects has been suspended until they submit the 251 returns concerned

68. The attention of participants was drawn to the fact that 96 out of 118 Plans of Action & Budget (PAB) expected for 2008 were submitted. A session for the preparation of 2008 Letters of Agreement is scheduled to take place in Ouagadougou from September 17th to 28th, 2007.

69. The review of financial returns was addressed and it was pointed out that some improvement had been made in clearing the backlog.

70. The non-compliance of the projects to APOC financial rules and regulations was addressed as well and the need for projects to follow the procedures was stressed.

16. Technical, Administrative and Financial review of APOC operations in the countries

71. As mentioned in the TCC24 report under item 22, detailed information was provided during TCC25 by APOC Finance Officers who jointly undertook with temporary advisers, (technical, administrative and financial) reviews of APOC operations in three countries: Cameroon, Nigeria and DRC (twice). The exercises focused on six aspects: (i) content of technical activities, (ii) content of financial operations and transactions, (iii) Government contribution to CDTI activities, (iv) Compliance with APOC administrative and financial rules and regulations, (v) age of the projects and (vi) decentralization of some technical activities and administrative /financial functions to countries.

72. For two to three weeks, fifteen (15) experts (scientists and economists/financial officers) were involved in the exercises and covered 38 projects out of 65 in the three countries. It was brought to the attention of the committee that the funding of the three countries by APOC Trust Fund represents roughly 56% of the annual amount allocated to the national projects. So, activities implemented by these countries between years 2006-2007 were considered and each project staff at its Headquarters (MOH & ONGDs offices included) shared with the different teams, information on technical and financial operations on the above-mentioned aspects.

73. The outcomes of these review missions within the countries are provided below by country.

74. Based on the outcome of the missions (see below), TCC recommends that:

(i) APOC should consider missions to conduct technical, administrative and financial review of projects in these and other countries each year to ensure that financial management improves and funds are used for their intended purpose.

75. This recommendation is consistent with APOC management's conclusions from the results of the mission.

DRC

76. Period under review was from January 2006 to July 2007. A total of 21 projects (20 CDTI and 01 NOTF/HQ projects) were reviewed.

77. Strengths observed were: integration of CDTI activities into national health system, appointment of more health staff and accountants to the programme, low dependency on NGDOs and availability of reports on missions, training, sensitization and supervision activities. However, some weaknesses were observed: lack of IEC material, need for computer and data management training, need for training for operational research, absence of verification/validation of CDTI data, lack of supervision and training through the NOTF secretariat, need for training of CDTI project coordinators and their assistants. Funds are transferred to projects only partially, late, piecemeal, at very high costs per transfer (cash transfer requiring purchase of air line tickets, per diems, risk of transfer of cash). Financial records do not provide appropriate documentation, justification, and explanation for expenses. There is lack of communication between NOTF secretariat and the projects, between NOTF secretariat and WR office.

78. Taking into account the administrative and financial transactions performed during the period from April 2006 to April 2007, the reviewers noticed that overall, there was poor management of Programme funds on the part of the executive secretariat of the National Onchocerciasis Task Force (NOTF) which, seriously effects on the implementation of activities. Some of the main observations are:

(i) The funds transferred to the NOCP over the period mentioned above amounts to US$1,888,207. However, the disbursement of funds allocated to the projects encountered problems, mainly: the non-agreement in dates of handover of funds to the projects after comparing the various cash books of the NOCP with those of the projects, it was noted that funds were split into smaller instalments for specific projects: there was late hand-over of funds to projects and lastly sometimes all entire or part of the funds allocated to projects was withheld by NOCP secretariat.

(ii) Lack of budgetary discipline on the part of the NOCP Management was noted. Thus the funds allocated to activities were overspent and unspent funds from other projects used to cover excess activity expenses. A similar trend was noted during a financial review mission by APOC Management in 2004. It was noted that efforts to assist the NOCP Coordination through the introduction of an appended handing-over report had not been successful. Fund balances for specific activities, including that of REMO and refinement exercises conducted in 2004 amounting to more than US$150.000 are yet to be justified. It is regrettable to note that the lack of budgetary discipline persist ongoing. It is to be noted that over the periods from April 2005 to March 2006 and then from April 2006 to March 2007, budget overruns of US$60,430 and $29,275 respectively were recorded.

(iii) An excess of cash handling was observed. Thus, the monthly cash balances amount to more than US$100.000. For example, the uncorrected cash balance of April 2007 amounts to US$ 108.049. Requests for corrections of cash balances which were noted, amounting to US$ 100 were not responded to.

79. In view of the described situation, confirmed by the finance department during the last investigations on the expenditure returns submitted by the NOCP and by the various CDTI projects, in order not to penalize the affected populations, APOC Management decided on the following corrective measures:

(i) The funds allocated to the projects will be directly made available to the projects concerned, through the WHO sub-offices established in the various areas of the country;

(ii) The projects will submit to the WHO regional sub-offices formal requests in due form, in accordance with the action plan approved under Letters of Agreement. All fund disbursements shall not exceed US$15.000 at a time;

(iii) Only the funds allocated for running the NOTF HQ will be paid into the bank account of the NOCP by instalments and not exceeding a maximum of US$30.000;

(iv) The management of funds of specific activities, financed from the general budget of APOC, will be carried out by the WHO Office in Kinshasa, and photocopies of expenditure returns sent to APOC Management in Ouagadougou for follow-up;

(v) The expenditure returns will be checked by the Administrative and Finance Assistant of APOC in Kinshasa, who will return them to projects in the event of rejection, or to APOC Management in Ouagadougou after approval;
(vi) Fund balances allocated to specific activities in the past in the sum of US$244,982 will have to be transferred in whole into the bank account of the WHO/RDC;
(vii) The budget run noted will be subject to justification by each national manager concerned and, failure of convincing evidence, the unapproved expenditure will be refunded by the parties concerned to the WHO account;
(viii) In view of the facts established in 2004, and the results of the audit of the NOCP accounts, we would like to request the replacement of the current accountant of the NOTF HQ;
(ix) The Administrative and Financial Assistant of APOC in Kinshasa will have to keep cards for tracking disbursements made to projects, and advise the WHO office requests of replenishments of advance accounts of projects.

80. Considering the financial status of each CDTI project, nine CDTI projects (Tshopo, Equateur Kiri, Uélés, Kasongo, Tshuaopa, Ubangi Sud, Ubangi Nord, Bas Congo and Rutshuru Goma) qualify to receive their second instalment under Letters of Agreement (LOAs) of 2007. The four following four (04) projects (Ituri Nord, Butembo Beni, Massisi Walikale and Lubutu) have received their first instalments but are yet to start activities. Other projects, including two projects of which (Sankuru and Lualaba) have enough remaining balances and five (Bandundu, Mongala, Kasaï, Katanga Nord and Katanga Sud) with serious mismanagement of the APOC Trust Fund money need to be examined case by case for appropriate action.

NIGERIA

81. From 20th January 5th to February, 2007 two teams comprising of a finance person and a technical person visited 11 projects including the NOTF. The following projects were visited: Kogi, Ogun, Osun, Akwa Ibom, Edo, Kaduna, Yobe, Gombe, Taraba and Benue.

82. The following facts were noted during the mission:

(i) ***Technical contents of the activities carried out****: The activities were carried out for most of the projects according to the approved plans of action. Training was the main activity carried out. Therapeutic and geographical coverage was high. For almost all the projects visited, the activity reports were not available;*

(ii) ***Financial contents of the activities carried out****: For 50% of the projects visited, expenditure was in line with the approved budget line items of the Letter Agreement. At the NOTF level, the expenditure related to specific activities such as Data Collection, did not conform to approved budget line items;*

(iii) ***Government contributions****: With the exception of Kogi, Yobe, Gombe & Kaduna, government contributions are limited to salaries and vehicle maintenance. A number of State governments do not contribute to CDTI key activities. For Taraba, there was a contribution at the LGA level;*

(iv) ***Compliance with APOC financial rules and regulations****: Overall, the projects, including the NOTF do not comply with financial rules and regulations. Cases of mismanagement of funds, pre-financing, over-*

expenditure of the budget line items, missing justifications or non existent justifications, etc were discovered during the mission;

(v) ***Age of the projects**: For 80% of the projects visited, the age of the project, according to the number of years funding has been received, and the number of years activities have been carried out, matched;*

(vi) ***Decentralization of some of APOC administrative & financial functions to the countries:** The mission noted that the release of funds, the channelling of financial returns and the delivery of equipments can be decentralized.*

83. Some of the recommendations made by the mission are listed below:

(i) ***Technical contents of the activities carried out:** projects should develop the habit of writing reports for each activity carried out, the submission of progress reports should be made a prerequisite to the release of the second instalment of funds: and the projects need to fully implement the recommendations made by the evaluators;*

(ii) ***Financial contents of the activities carried out:** Funds should no longer transit through the NOTF; rather, they should be sent to the WHO/Country offices in the different states where projects are located. The mission recommended that after 31st October funds should not be released to the projects because by the time they are received, it will be too late for them to implement the activities before the end of the year; leading to unnecessary expenditure not related to the activities approved under the Letter of Agreement. Any project that overspent funds should be punished and the release of funds should be suspended. APOC Management should no longer send large amounts of money, at the same time, to the NOTF for specific activities. Funds for specific activities should be released only after the NOTF has submitted the returns for funds received previously;*

(iii) ***Government contributions:** High-level advocacy should be conducted to get governments to contribute to key CDTI activities;*

(iv) ***Compliance with APOC financial rules and regulations: The** importance of the financial and administrative rules & regulations should be stressed to the projects. Corrective actions for non-compliance with rules and regulations should be enforced. APOC Management should carefully follow up the specific activities being carried out;*

(v) ***Age of projects:** APOC Management should amend the Letter of Agreement to take into consideration the agreed age of the project (financial year compared to technical year).*

84. **Decentralization of some of APOC administrative & financial functions to the countries:** The mission concluded that the road map for decentralization could not be developed at this time. A committee needs to be put in place for the selection of criteria for decentralization, the preparation of guidelines for decentralization, and the identification of activities to be decentralized.

CAMEROUN

85. From 19 February to 4 March 2007, a three-member team, made up of a budget and finance officer and two scientists, visited six projects and the NOCP. The following CDTI projects were visited: Center 1, Littoral 1, South, Western, and South Western 1.

86. The following facts were noted during the mission:

- **Technical contents of the activities carried out:**

(i) The integration of onchocerciasis control is fully underway with integrated supervision tools. Mectizan supplies are also well organized and integrated into MOH essential drugs distribution system. Training is being organized in cascade on the management of SAEs in all the visited projects. HSAM activities are also conducted national authorities participating. The MOH established a committee which analyses and reviews the technical reports of the projects before they are sent to APOC Management.

(ii) The reviewer team observed some weakness. The ownership of the programme by nationals (MOH) is far from being achieved. The reviewers noted an abusive administration of corticosteroids contrary to the guidelines on management of SAEs. Also noted was a lack of collaboration between WHO country office and the NOCP in the planning and implementation of activities. The Onchocerciasis Project Coordinators (POCs) were not fully involved in all steps of the activities and many activities such as training were conducted without producing any report. Lack of supervision of projects by the NOTF team was also noted.

- **Financial contents of the activities carried out:**

(i) Weaknesses observed by reviewers included (i) non application of the standard per diem rates for nationals as per UN system in Cameroon. Each project and NDGO fixed the rate of per diem as they wished. The same observation was made for the Top-up to be paid to project teams. (ii) Instead of Ministry of health staff, the top-up is collected by NDGO staff/representative or in some cases the allocated fund was channelled to the NDGO bank account. Non-authorized expenditure or budgets not approved by the provincial delegates were paid from the APOC Trust Fund. (iii) Travel authorizations were signed by NDGO and allowances collected by them without justification. Financial returns from the districts are of very poor quality and it is difficult to confirm if the funds were really released to the concerned persons (CDDs or health workers); (iv) Each project or NDGO has its own supplier of IEC materials and the prices are not comparable but still high.

- **Government contributions:**

(i) In the past five years Government has made effort to contribute financially to CDTI activities in Cameroon. (i) From 2002 to 2007, CFA 223 million was released for the payment of incentives to the CDDs, but there are no reports showing that the funds were indeed paid to the concerned persons. Some projects received the Government's financial contribution for the mentioned purpose without paying the rightful beneficiaries; For instance, CFA 27 million for Western CDTI project and Francs CFA 8 million for South CDTI project were mismanaged for two years. The Government is delaying the release of this contribution which is a cause of disappointment to the CDDs. (ii) No effort has been made to appoint more staff of MOH to the programme. Only one scientist is fully in charge of the programme at national level (NOPC) and only one person (POC) at the project level. The accountants are paid by the NDGO who manages APOC Trust Fund. (iii) Efforts are being made in fund raising by other local institutions and persons but reports

were not available for review. (iv) In addition, Government has continued to pay per-diem to its staff when they undertake missions on behalf of the programme.

- **Compliance with APOC financial rules and regulations:**

(i) Efforts were made by the projects in submitting their financial returns but the process is cumbersome and many discrepancies or non compliance with APOC financial rules and regulations were observed.

(ii) (a) Non respect of the budget lines approved (over-expenditure); (b) the UN standard per-diem rates for nationals are not applied, (c) Non respect of the protocol jointly signed with WHO, NDGO and MOH in the use of the programme vehicles; (d) lack of training of project teams mainly the POC on APOC financial procedures, and guideline manuals are not vulgarized among the partners but kept by the NDGO with their accountants; (e) None of the POC or Provincial officers are aware that they are the imprest holder of the funds released under APOC Trust Fund for Cameroonian Government for onchocerciasis control activities. (f) There was neither a cashbook for specific activities funded nor for the main bank account of NOTF. (g) The requisition of project funds (cases of SW1 & SW2 projects) without refund by the Government. (h) No inventories of the programme equipments were made since year 2003.

- The ages of projects are the same as what APOC Management & NOTF have in their records.
- Decentralization of some of APOC administrative and financial functions to the countries: Many recommendations were received by the reviewers who shared them with APOC Management.
- Other issues: The last meeting of the NOTF was held in 2004 and no other meeting has been organized since then.

87. The key recommendations made by the reviewers are listed below:

(i) NOTF to find a solution for organizing the partners meeting on regular basis;

(ii) MOH needs to appropriate the programme and let the NDGO play its original role as stated in the programme document and in the MOU signed by each party;

(iii) NOTF to promote better collaboration with WHO office in Cameroon;

(iv) NOTF and projects to apply the approved rates and Top-ups (per diem for nationals) and to avoid the collection of top-up by NDGO staff;

(v) NOTF to undertake the inventory of programme materials & equipments;

(vi) NOTF to centralize IEC material purchases and get a better quotation;

(vii) Government to reinforce the project teams by recruiting new staff (support staff included) and mainly at the national level;

(viii) Government to undertake an audit of its contribution to CDTI activities;

(ix) APOC Management to organize shortly the training of project teams (POC, Provincial Delegates);

(x) APOC to request the refund of Trust Fund kept by the Government

REVIEWS

17. Report on the review by APOC Management of 1ST, 2ND, 3RD, 4TH, 5TH, 6TH, 7TH, 8TH and 9TH year progress reports and subsequent year budgets

88. An overview of the national projects to be implemented and budget allotted for 2007 were presented by Mr Agblewonu Koffi Benoît, Budget and Finance Officer of APOC. He underlined that the one hundred eighteen (118) national projects comprise of six (6) CDTI projects in their first year of activities, fifty-two (52) in their second to fifth year and forty-nine (49) above their fifth year of activities. There are also four (4) vector elimination projects and seven (7) NOTF Secretariat support projects. A total amount of US$ 5.267.000 was earmarked for 2007 instead of US$ 6.019.400 previously indicated during TCC 24.

89. To date (31st August 2007), an amount of US$ 5.862.802 has been obligated for 114 out of 118 projects. The four remaining projects were not funded due to technical reasons. These projects were identified in Angola (1), Northern Sudan (2) and Tanzania (1). In addition to funds released/obligated for countries under letters of agreement, an amount of US$ 1.314.534 was allocated for specific training within the countries, bringing the total amount for national projects to US$7.177.534. It was also indicated that US$ 12.630.806 out of US$13.500.000 approved by the 12th session of JAF was obligated as at 31 August 2007. Taking into account the mentioned amount, 94% of APOC overall budget for year 2007 was implemented.

18. Review of 1ST, 2ND , 3RD , 4TH , 5TH , 6TH , 7TH , 8TH and 9TH year annual technical reports on the implementation of CDTI and vector elimination projects recommendations on the 2ND , 3RD , 4TH , 5TH , 6TH , 7TH and 8TH YEAR implementation of the projects

90. There were no new CDTI project proposals.

91. Of the ongoing 118 projects, 30 could submit their annual technical reports in July, the remaining in January.

(i) TCC recommends that APOC management reminds the NOTF coordinators that they need to take responsibility for submitting reports in a timely manner and for the quality of reports they endorse.

Technical reports reviewed by TCC members:

BURUNDI

Cibitoke-Bubanza CDTI project: 2nd year technical report

92. ***TCC accepted this well written report of a very well implemented project.***

93. TCC recommends, for further improvement of future reports, that the authors be more narrative in the executive summary and in the section on partners.

94. TCC commends the project for:

(ii) The high CDD/population ratio;

(iii) The excellent ratio of female : male CDDs;

(iv) The good community supervision implemented;

(v) Having implemented all these activities and achieved good coverage within 3 months.

95. TCC recommends for further improvement of the project:

(i) Develop a checklist for supervision;

(ii) Avoid large stocks of Mectizan®;

(iii) Try to mobilise communities to improve the compensation they provide to CDDs.

Rutana CDTI Project: 1st year technical report

96. ***TCC accepted the report with the following observations and recommendations***:

(i) This is a very good report, but it should have been endorsed by the NGDO partner CBM;

(ii) The executive summary could be improved with an indication of the endemicity of onchocercaisis in the country and the treated zones should be included;

(iii) Efforts should be made for training of CDDs that have already been identified;

(iv) Efforts should be made to train in supervision and evaluation.

Bururi CDTI project: 1st year technical report

97. ***TCC accepted the report.***

98. TCC recommended the following:

(i) To intensify advocacy with the government and CBM for release of funds;

(ii) To mobilize more communities to support CDDs;

(iii) To increase training of CDDs in early recognition of potential SAEs and getting affected people for treatment;

(iv) Development of data collection tools and supervision tools;

(v) To initiate the development of a sustainability plan;

(vi) APOC should release funds on time manner.

CAMEROUN

NORTH PROVINCE CDTI PROJECT: 8TH YEAR TECHNICAL REPORT

99. Therapeutic coverage increased from 57% in 1998 to 76.7% in 2006. Integration into national health system and sustainability plans are being implemented.

100. ***The report was accepted*** with the observation that in future reports:

(i) The executive summary needs to be descriptive and analytic;

(ii) Consistency of numbers in the reports needs to be verified prior to endorsement.

North Province CDTI Project: 7th year technical report (resubmission)

101. The TCC concluded that project performance is very good. ***Nevertheless, the report was rejected*** and the revision should be submitted to the reviewers via APOC. The following deficiencies should be addressed:

(i) The report still contains many sections where the information provided is identical (or very nearly so) to that in the Year 6 report. Examples are:

- *Section 2.4 Community involvement*
- *Section 2.9 Supervision*
- *Section 3.1 Equipment*
- *Section 4.3 Integration*
- *Section 5 Strengths, weaknesses, challenges, and opportunities*

(ii) In future reports, if information is actually the same from one year to the next, the project is asked to specifically indicate such.

(iii) Some comments of TCC21 regarding the Year six report were addressed but not all. The project is asked to address the remaining comments.

West Province CDTI Project: 6th year technical report

102. ***TCC accepted the report*** and congratulated the project on the 100% geographic and 81% therapeutic coverage.

103. TCC recommends that

(i) The Project Coordinator in collaboration with the Coordination of the NOTF intensify advocacy to the government to release 100% of budgeted funds on time to allow the project to be sustainable;

(ii) The government continues to include CDTI in the health care budget and releases the approved funds on time;

(iii) The Project Coordinator and others responsibly involved in onchocerciasis control continue and intensify advocacy with traditional chiefs for their involvement in continuing mobilisation;

(iv) Awareness oh health care system staff and other local authorities be sensitized to the importance of CDTI so that they reduce their demands for incentives for participating in project implementation;

(v) Discuss and coordinate efforts with other health care projects to reduce or eliminate competition.

CHAD

Chad CTI project: 7th year technical report

104. Recommendations of TCC22 have been satisfactorily addressed.

(i) TCC noted that the project has maintained 100% geographic coverage since 2000 and achieved 73% therapeutic coverage in 2006, while 80% should be achievable for a project in the 7th year. In four districts, therapeutic coverage attained was only the minimum of 65%

105. The report does not follow the TCC format, a situation which forces the reviewer to search for information to evaluate the report. However, information was generally detailed and the calculations in the tables correct.

(i) The summary would have been more succinct if the data had been put together under some main headings;
(ii) The time table of activities will require further explanation in order to understand how mobilisation and training are spread out from December to October or November;
(iii) Regarding advocacy/sensitisation, the figures in the report are not found in the summary. Also, the reasons and the outcome of the advocacy are not stated;
(iv) Table 1, 3 and 7 should be filled in;
(v) The text has many typographical errors (about 137) and the tenses of the verbs are not always correct.

106. TCC rejected the report and asked for its resubmission to reviewers

(i) The revised report should use the current APOC template;
(ii) The revised report should be reviewed by all people who have to endorse it before its submission to APOC in order to improve on the style of the document by an in -depth proof reading;
(iii) During revision take in account the above remarks.

107. TCC recommends the following to the project:

(i) Continue efforts to increase therapeutic coverage;
(ii) Redouble efforts to mobilize government funds and their timely release.

CONGO

Congo CDTI project: 6th year technical report

108. ***TCC accepted this well written report*** with the recommendation to the project to intensify its efforts to increase therapeutic coverage which was only 67.8% in 2006.

Congo Extension CDTI project: 3rd year technical report

109. ***TCC accepted this well-written report*** of a project that has managed to increase its therapeutic coverage despite the co-endemicity of loiasis. The cost recovery system seems to be working well.

110. TCC recommends for further project improvement:

- *Continue efforts to resolve problems associated with the division of roles and responsibilities on the different levels of the health care system and communication between these levels.*

DEMOCRATIC REPUBLIC OF CONGO

Project funding:

111. TCC is very concerned about the delay in transfer of project funds from the NOTF secretariat to the CDTI projects and the fact that the full amount of funds destined for a project is not always provided to the project. This seriously jeopardizes and further delays the implementation of CDTI, which is already delayed because of past conflicts in DRC.

(i) TCC recommends that APOC take steps to ensure that all the money approved and released by APOC for a particular CDTI project is fully transferred immediately to the project by the NOTF secretariat.

SAE reporting:

112. TCC noted a discrepancy between the SAEs reported to MDP and those reported in the reports. TCC recommends:

(i) APOC management is to ensure that:

- ***projects have all communication equipment required for prompt SAE reporting;***
- ***all data/reports they received on SAEs be made available to TCC.***

(ii) NOTF and projects are to send to APOC also SAE reports sent to MDP;

(iii) ALL COUNTRIES are to progressively integrate pharmacovigilance on SAEs into national health systems.

113. DRC has two SAE advisors, one responsible for the West of the country (located in Kinshasa, covering 7 projects) and one for the East of the country (located in Kisangani, covering 7 projects). These SAE advisory functions are assigned special funds in the Letters of Agreement. TCC recommends with particular emphasis that :

(i) SAE reports HAVE to be e-mailed or sent via courier directly by the SAE advisors to MDP;

(ii) Notification of MDP has to occur within 48 hours of the SAE advisor having verified the occurrence of an SAE or thereafter as soon as the means of communication allow.

114. TCC further recommends that:

(i) The SAE advisors have autonomy in the management of all SAE-related activities, including access to and management of the funds allocated to SAE management, to ensure that SAE management is conducted effectively and adequately. Financial accounting should be from these advisors to APOC via the NOTF;

(ii) APOC, the coordinators of projects with loiasis co-endemic areas and the SAE advisors in DRC work together to improve the communication means to allow the transfer of SAE data to MDP within the required time lines;

(iii) MDP should send all SAE information received from DRC to APOC management;

(iv) SAE advisors and project coordinators be reminded that: All calibrated blood smears of SAEs suspected to be related to loiasis be appropriately labeled, sent to the responsible SAE advisor, be reread by the SAE advisor (and information on the results sent to MDP as follow up report to the original SAE report) and then stored there for future examinations.

Kasai CDTI project: 6th year technical report (resubmission)

115. ***TCC rejected the report because***

(i) the recommendations of TCC 24 on the original submission were not taken into account;

(ii) the summary is still in the form of a table, which includes data which are not presented in the report itself.

116. TCC recommended:

(i) to distinguish, in the tables, those ZS where CDTI activities started recently from the other ones;

(ii) to provide more details on advocacy activities, due to the difficulties encountered;

(iii) to significantly increase the number of CDDs, so that the CDD/population ratio becomes acceptable;

(iv) to explain why the FLHS personnel are not trained in health education, nor in report writing or in monitoring / evaluation;

(v) to explain why the total number of meso- hyperendemic communities varies from one year to another;

(vi) to justify why the remaining tablets are kept at the level of the FLHS, given that it might not be the most adequate place to avoid expiry of tablets;

(vii) to provide more information on the results of operational research.

117. TCC requested that in the next reports more information is provided on the way the co-implementation of CDTI and vitamin A and mebendazole treatments has been done, and on the possible difficulties in the process.

Bandundu CDTI project: 4th year technical report

118. TCC commends the project on

(i) The remarkable progress made in project implementation, which has resulted in 100% geographic coverage being reached for the first time;

(ii) The fact that each community has a community supervisor;

(iii) the efforts made to co-implement CDTI with Vitamin A and mebendazole distribution, and for the treatment coverages achieved for these two interventions, and encourages the project to continue its efforts. TCC noted the problems the project described for co-implementation and would like more information on these to be provided in the next report so that it can discuss them and potentially advise the project.

119. ***Nevertheless this report is rejected*** since it does not address the revelant recommendations of the last TCC meeting (22) but rather those of TCC 19. During revision, the authors should also take note of the following observations of TCC:

(i) The table on advocacy is very similar to that in the previous report. More information is desirable since the impression is given that advocacy is not very effective;

(ii) It look as if no CDDs were trained in three health zones. This should be explained;

(iii) Information on how the remaining tablets from the previous year were used needs to be provided;

(iv) Table 14 needs to be completed;

(v) The sustainability plan of 2007 should be provided in more detail.

120. TCC recommends that

(i) the funds requested in the report (for training in computer maintenance, SPSS and imprest accounting for the administrator) is provided.

Tshopo CDTI project: 3rd year technical report (resubmission)

121. ***The report was accepted***.

122. TCC recommended that the project

(i) Strive to improve geographic and therapeutic coverage;

(ii) Increase the proportion of women among CDDs;

(iii) Ensure that the thick blood film slides prepared from sample taken from patients who have developed a SAE be sent to APOC headquarters for re-examination.

Sankuru CDTI project: 3rd year technical report

123. ***TCC accepted the report*** since it is aware of the fact that the coordinator has to deal with very difficult external conditions, does not receive sufficient support from the NOTF secretariat and was absent on duty travel during training organized by APOC for the project coordinators.

124. TCC is very concerned with the fact that the project has never received its full amount of money released by APOC.

125. TCC observations on the project:

(i) The TCC is pleased that communities are increasing their support for CDDs. Detailed information should be provided in the next report;

(ii) TCC is aware of the logistical problems encounted in project implementation, but even taking these into account, TCC notes that project performance is below expectation, in particular the decrease in geographic coverage from year 2 to year 3 and the decrease in therapeutic coverage from 59% to 49%. It seems the reduction in therapeutic coverage is due to delays in ordering Mectizan through the PNLO.

126. TCC notes with concern the problems associated with the management of Mectizan® stocks and those associated with provision of drugs for adequate treatment of adverse events.

127. TCC recommends that

(i) The PNLO in Kinshasa ensures that Mectizan® orders are processed and sent to MDP on time manner to avoid delays in project implementation;

(ii) Efforts are made to ensure that drugs for adverse event treatment are readily available at the time of Mectizan® distribution.

Sankuru CDTI project: 2nd year technical report (resubmission)

128. Loiasis is co-endemic in two health zones within the project area. CRS (Catholic Relief Services which is a 'sub-contractor'/receives money from CBM) is the supporting NGDO.

129. ***TCC accepted the report*** despite its marginal quality in view of the facts mentioned in the assessment of the report from the 3rd year of the project.

130. For future reports, the authors need to pay more attention to detail, e.g.

(i) The table of contents should be updated to not include 'Error',

(ii) *There are references in the text to page numbers which are incorrect,*
(iii) *Chapters 3.2 to 4.3.1 are completely missing,*
(iv) *Chapters need to be re-numbered,*
(v) *Table 10 need to be redone, clearly.*

131. TCC recommends the following for improving project implementation

(i) *The CRS to respect the responsibilities it has assumed;*
(ii) *Significant efforts needed to address the low participation of women in ivermectin distribution (1,5% de DC femmes);*
(iii) *Drug management and accountability procedures need to be explained and improved. The fact that 691.650 tablets of Mectizan® expired needs justification and an action plan on how to avoid such waste in the future.*

Mongala CDTI project: 2nd year technical report

132. ***The report was rejected for the following reasons***:

(i) *The summary is really too scanty and does not give an overview of all the activities that were carried out. The SAEs should have been reported;*
(ii) *There are lapses as presented by the summary in tables An1+ An2 because the DS of Pimu does not exist any more and that of Binga appears. It is essential to harmonize or explain. The same goes for the table "training" which does not specify who and how many people are trained;*
(iii) *Under general information, the duration of the dry season is not specified because 11/2 to 2 months is not enough;*
(iv) *Most of the tables repeat year 1, 2 and 3. As it is about an annual report, a different presentation should have been found;*
(v) *The document does not present well in some areas;*
(vi) *Use of colours in the tables should be avoided since the numbers are difficult to read on a black and white print out;*
(vii) *Statistical data would have made it easier to better assess the quality of activities carried out as regards advocacy and sensitization;*
(viii) *Disagreement between information given for the reporting period and that in the tables in the summary, tables page18, 19 and 33, tables 2, 3, 4, 5 and 7;*
(ix) *Check the totals in tables 4 (number of CDDs) and 5 (FDF, LGA, Health workers);*
(x) *In Table 7, one notes 28 SAEs, but only 6 are mentioned in Tab 8; this difference must be explained;*
(xi) *The therapeutic coverage is 47.8% in the Table 7 and 49.5% in Table 9. This needs an explanation;*
(xii) *The number of left over tablets is high 437189 (36%); this needs to be explained;*
(xiii) *The funds for equipment from others partners are not indicated. This needs an explanation;*
(xiv) *The progress made by the project cannot be appreciated because there was only one round of Ivermectin distribution. However, one notes that only one DS, out of the 6 treated has a therapeutic coverage higher than 65%.*

133. The TCC rejects the report and requests that the project:

(i) Carries out distribution of ivermectin at the time chosen by the communities;

(ii) Asks FLHF to plan CDTI activities;

(iii) Sensitize the communities to provide incentives to their CDDs;

(iv) Convince the MOH to increase number of health workers involved in CDTI;

(v) Take into account the remarks and weaknesses stated above so as to improve on future reports.

Ubangi Nord CDTI project: 2nd year technical report

134. ***TCC accepted the report***, but advises the project to obtain the endorsement of the National Coordinator and the representative of the supporting NGDO.

135. The project has improved its performance considerably, but TCC feels that the recommendations made for the 1st year report are still valid:

(i) Improve the report through a summary that critically analyses project performance;

(ii) Increase the sensitization on SAEs;

(iii) Assure the availability of drugs and other materials required for treatment of SAEs prior to treatment initiation;

(iv) Increase advocacy for timely release of funds;

(v) Increase the proportion of female CDDs;

(vi) Increase advocacy with communities to compensate the CDDs;

(vii) Train trainers for Community Self Monitoring.

Ubangi Sud CDTI project: 2nd year technical report

136. ***TCC accepted the report***.

137. The report gives the impression that the Project Coordinator is investing a lot of effort into improving project performance, and that he could benefit from additional training.

138. TCC recommended:

(i) Improvement of the executive summary through a more narrative approach and inclusion of more quantitative data;

(ii) Explanation for the low treatment coverage relative to the budget;

(iii) Internal review of the project;

(iv) Initiation of the planning of a sustainability plan;

(v) Work towards integration into the public health system.

Bas-Congo CDTI project: 2nd year technical report

139. ***TCC accepted the report*** and concluded that project performance was good for a 2nd year project.

140. TCC recommended efforts for future reports to improve how all tables are filled out (in particular Table 2 and 7) and to ensure consistency of data in the report.

Equateur Kiri CDTI project: 2nd year technical report

141. Little or late availability of funds, in particular APOC funds, is mentioned as a weakness of the project. The project received only 34358 USD of the 92860 USD released by APOC.

142. ***TCC accepted the report***. The team is working hard, trying to find innovative solutions to the challenges faced in mobilising the population and recruiting CDDS.

143. The TCC recognizes that some aspects of project implementation are difficult in the project area.

144. TCC advises the project to improve future reports by ensuring that :

- *(i) All data required is provided to fill out all tables in the report, including completion of Tables 4 and 7;*
- *(ii) Table 10 is filled out correctly and good explanations are provided;*
- *(iii) Include all activities from January to December in a report.*

145. TCC recommends for project improvement:

- *(i) Measures to improve the therapeutic coverage;*
- *(ii) Generation of a sustainability plan;*
- *(iii) Implementing improved project supervision and evaluation;*
- *(iv) All funds released by APOC to the project are made available to the project for its implementation.*

Tshuapa CDTI project: 2nd year technical report

146. ***TCC accepted the report***.

147. TCC recommendations for improvement of future reports:

- *(i) Improve the executive summary which needs to be narrative and analytic, rather than tables and numbers without comments;*
- *(ii) Improve filling in of Tables 9, 10, 14.*

148. TCC recommendations for project improvement:

- *(i) Immediate measures need to be taken to increase geographic and therapeutic coverage;*
- *(ii) Increase and motivate participation of women as CDDs.*

Tshuapa CDTI project: 1st year technical report (resubmission)

149. ***TCC accepted the revised report*** and concluded that project performance was good.

150. The TCC asked that the program clarify the following report-related issues when the Year 2 report is submitted.

- *(i) The revised report indicates that a total amount of $42,740 was spent during the treatment cycle, but no details were provided regarding how much was spent towards specific activities and by which partners. Such detail should be provided in the Year 2 report;*
- *(ii) It is indicated in Table 13 that $86,545 was released but only $42,740 was spent. The project should explain why only one-half of the released funds were used and what was done with the remaining funds;*

(iii) *There was dearth of information regarding integration of CDTI into the primary health care structure. Several parts of Section 4.3 were not answered and should be addressed in future reports;*

(iv) *Future Executive Summaries should provide more text on program activities in addition to treatment such as mobilization, training, supervision, etc.*

Katanga Sud CDTI project: 1st year technical report (resubmission)

151. **The TCC rejected the report** and concluded that project implementation as presented in the report needs substantial improvement.

152. TCC observations regarding the report include:

(i) *The period covered by the report needs to be indicated and the schedule of activities adjusted accordingly;*

(ii) *The executive summary should include all essential information, in particular treatment coverage;*

(iii) *A lot of Information (e.g. general information on the project area,);*

(iv) *Inconsistent data is provided in different sections (e.g. population data in tables and text, data in tables 7 and 9, data in Table 10 and related text);*

(v) *Table 5 needs to be correctly filled out;*

(vi) *The involvement of partners is unclear;*

(vii) *There is no information on supervision;*

(viii) *No monitoring and evaluation has been conducted;*

(ix) *The management of Mectizan® appears not well organized and its description is confusing;*

(x) *Community involvement is insufficient;*

(xi) *The problems with APOC, mentioned several times need to be specified so that they can be addressed.*

153. TCC made the following recommendations for improving project performance:

(i) *The partners need to work together to come to a clear understanding of each partners responsibility and role in the project;*

(ii) *The reason for the low involvement of communities needs to be determined so that participation can be improved (e.g. no community has a supervisor coming from the community);*

(iii) *The reason for the few CDDs (only 1.5% of CDDs are women) needs to be determined and appropriate measures put in place to increase women's participation;*

(iv) *Drug supply management needs to be improved and the expiration of 85,666 tablets explained.*

154. Katanga Sud is one of the projects in DRC which did not receive from the NOTF secretariat all the funds designated for the project. The Coordinator has tried to implement CDTI without sufficient funds through collaboration with the supporting NGDO.

155. TCC noted with concern that during the project evaluation visit by Lions Club and the audit conducted by APOC in July 2007, it was found that information on project financing, project reporting and related time lines are not being sent from the NOTF secretariat to the CDTI project coordinator.

Rutshuru CDTI project: 1st year technical report

156. ***TCC accepted this well written report*** with the following recommendations for improvement of future reports:

- *(i) Reduce repetitions;*
- *(ii) Note the absence of co-endemicity of loiasis in the executive summary;*
- *(iii) Include information on the quantity and quality of human resources necessary for project implementation;*
- *(iv) Include the recommendations from supervisions or follow-up activities;*
- *(v) It is rather surprising that exactly 20.000 tablets are left over with 5000, 10000 and 5000 at Binza, Rutchuru and Rwanguba respectively.*

157. TCC recommends for improvement of project implementation:

- *(i) Increase efforts for sensitization, information and mobilisation to reduce the number of refusals and absentees;*
- *(ii) Train more CDDs to reduce the workload of CDD;*
- *(iii) Encourage women to take an active part in CDTI;*
- *(iv) Motivate the government to become involved in onchocerciasis control and to provide financial contribution;*
- *(v) Closely monitor the distribution of Mectizan® in the hypoendemic area;*
- *(vi) Improve on the style of the next report by taking into consideration the points for improvements.*

NOTF/HQ DRC project: 7th year technical report

158. TCC notes that NOTF implemented all the recommendations of TCC 23.

159. The DRC has 20 projects but the summary is very short. It is often vague as far as some data (RAPLOA/REA, Follow-up, supervision, training) is connected. The summary should be useful for the reader to better appreciate the evolution of the projects is concerned.

160. Therapeutic coverage is increasing in all the projects (except Sankuru). However, coverage remains low, even for projects which are more than 3 years old.

161. ***TCC accepted the report with the provision that the NOTF Coordinator would provide information to APOC on the following***:

- *(i) Field activities conducted by the NOTF coordinator;*
- *(ii) Project equipment;*
- *(iii) Clarification of the results of advocacy;*
- *(iv) Clarification of number of projects and SAEs (which are inconsistent in the report;*
- *(v) Table 6 and harmonized data presented to TCC 23.*

162. TCC recommendations for improvement of future reports and project implementation:

- *(i) Provide more information on the projects in future reports;*
- *(ii) Intensity efforts for sensitization and information to increase geographic and therapeutic coverage;*
- *(iii) Verify and complete the tables for harmonization data in the report;*
- *(iv) Introduce CSM and SHM;*

(v) *Ensure intense and regular supervisory visits in the areas of co-endemicity of loiasis;*

(vi) *Include information on implementation of sustainability plans for relevant projects.*

ETHIOPIA

163. TCC noted once again that Ethiopia has integrated CDTI into their health care system in a way that separate financial reporting of CDTI project expenses, as demanded by APOC and WHO accounting rules is, to a large extent, impossible. It is not appropriate for APOC and WHO to stress to countries the necessity for integration of health care interventions meanwhile the financial rules of APOC/WHO in a way counteract this integration or penalize countries who successfully integrate.

164. TCC asked that APOC, AFRO and HQ address the inconsistencies in policies promoted in countries and accounting requirements and ensure that these are resolved.

165. TCC refers the NOTF to its previous recommendations of TCC 23 of September 2006 and note that some of these are ***still relevant*** and need to be addressed by the NOTF.

166. After the review of the 2006 Annual reports submitted to this meeting, TCC observed that there were cross cutting issues on training, turn over rate of health workers, delays in reporting and quality of reports and census. Other issues are the unacceptable high numbers of expired or remaining tablets (***974,929 expired drugs and 723,474 remaining tablets)***, high numbers of absentees and refusals and under-utilization of APOC funds. Under-utilization of funds deprives projects of the much needed finances for implementation of CDTI.

167. The following recommendations were made to the NOTF:

(i) ***Training:*** *Training of all health personnel in CDTI project areas to address the high staff turnover and work load at the Woreda and FLHF. Training should also include record keeping, timely reporting, calculation of UTG and Mectizan® inventory;*

(ii) ***Census update:*** *Census update in communities to ascertain the population and quantity of Mectizan® tablets required for each project;*

(iii) ***Mectizan® inventory*** *Review each project's Mectizan® inventory from inception to date and identify the number of tablets that expired in each project per year. Each project should ensure it orders the quantity it can utilise and tablets should be retrieved from communities at the end of the treatment period. Ministry of Health to properly dispose of expired tablets;*

(iv) ***Agreement on timeline for CDTI activities with communities:*** *Projects should agree on timeline with communities for CDTI and comply with such to reduce absentees. Health education and mobilisation of communities should be intensified to address refusals;*

(v) ***Underutilisation of APOC funds:*** *NOTF should support projects in addressing delays in accounting for expended funds.*

Kafa Shekka CDTI project: 6th year technical report

168. The report was well written. The project used the comments of the previous TCC report to improve on the current report. However, this is a sixth year project and efforts should be made to attain the UTG.

169. Expiration of 69,897 Mectizan®tablets is unacceptable and inventory at all levels need to be reviewed. The NOTF needs to address this and dispose of expired Mectizan® tablets appropriately.

170. ***Report was accepted with the following suggestions to improve future reports:***

(i) Provide information on government equipment,

(ii) Provide information on implementation of sustainability plan.

171. TCC recommendations for improving project implementation

(i) Continue discussions on collaboration on operational research with University of Jimma. Possible issues are weaknesses identified i.e. delays in reporting at lower levels, accounting for funds expended;

(ii) Continue integration of CDTI into PHC as a means of addressing high turnover rate of health staff at Woreda and health facility levels;

(iii) Explain expiration of 69,897 Mectizan® tablets and check drug inventory;

(iv) Make efforts to attain UTG.

Bench Maji CDTI project: 4th year technical report

172. This is a well-written report of a CDTI project, which is well run and integrated into routine PHC activities. APOC has consistently given less money than budgeted for due to late retirement of disbursed funds by the projects.

173. ***TCC accepted the report with the request that the corrections/clarifications listed below be sent to the reviewers (via APOC).***

174. TCC recommendations for improving report

(i) Need to reconcile total population data and recalculate UTG;

(ii) Explain why Maji district had a therapeutic coverage of 64.2%;

(iii) Describe the slightly modified way in which the CSM was carried out;

(iv) Explain why therapeutic coverage has declined from 83% in the 3rd year to 73% in current 4th year.

175. TCC recommendations for improving project performance

(i) 1 CDD: 210 persons is too low a ratio, therefore train more CDDs;

(ii) 342,548 left over Mectizan® tablets is too high. Project advised to calculate needs more accurately next cycle and deduct remainder from request. Store remaining tablets correctly for usage in 2007;

(iii) Agree on treatment period with communities and comply with it;

(iv) Intensify health education and mobilisation of communities;

(v) Encourage selection of female CDDs;

(vi) NOTF to address the delays in pooled financial management of APOC and other counterpart funds.

North Gondar CDTI project: 3rd year technical report

176. This project area is on the border with Sudan which means that it is very remote and also prone to insecurity.

177. Therapeutic coverage has progressively increased from 68% at the inception of CDTI to 73%. Mectizan® delivery, training, monitoring and supervision and funding are integrated into PHC. There are also plans to integrate CDTI into the health extension

package programme designed for kebeles. The project is commended for following up on the recommendations of the mid term review. Expiration of 116,943 Mectizan® tablets is unacceptable and inventory at all levels need to be reviewed. The NOTF needs to address this and dispose of expired Mectizan® tablets appropriately.

178. ***TCC accepted the well written report with the following recommendations for improving future reports***

(i) General information should include climate and aspects of population,

(ii) Provide information on health extension package.

179. TCC recommendations for improving project implementation:

(i) Increase on number of health staff involved in CDTI in project area;

(ii) Retrain FLHF staff to address high turnover, poor record keeping, delays and quality of reporting;

(iii) Provide information on status of MoH equipment;

(iv) Improve participation of women in Quara;

(v) Carry out operational research on attrition of CDDs with a view to addressing this;

(vi) Carry out mobilization of communities and mop up treatment to address absentees, refusals and attainment of UTG;

(vii) Explain expiration of 116,943 (18%) Mectizan® tablets and check drug inventory at all levels.

Jimma CDTI project: 3rd year technical report

180. The report shows that the project has taken the recommendations of TCC 23 into account. TCC commends the project for the number of CDDs trained; this has facilitated their work because each one takes care of only about 74 persons. TCC encourages the project to continue using the « Kabele » and the "Garee" to enhance the establishment of CDTI. CDTI performance has led to 100% geographic coverage and therapeutic coverage above 65% for all the projects (71% average). The awareness of health personnel and the acceptance of programmes by the population have helped to increase the therapeutic coverage. However, the treatment period should be that which is chosen by the community members.

181. TCC advised the project to pay attention to the weaknesses identified in the report and project implementation.

182. ***TCC accepted the report and recommended that the next one provide information on:***

(i) The role of each partner;

(ii) Reason for finalizing treatment in June, and supervision in September;

(iii) The suggestions for improvements after advocacy;

(iv) How the project intends to improve sensitisation and mobilisation;

(v) The reason for the large number of expired ivermectin tablets (419726 tablets i.e. 29.5% of those ordered);

(vi) Equipment provided by other partners in Table 12.

183. TCC recommendations for improvement of project implementation:

(i) Increase therapeutic coverage in communities where it is relatively low;

(ii) Respect the treatment times chosen by the communities which will help increase therapeutic coverage.

East Wollega CDTI project: 3rd year technical report

184. The project has submitted a report indicating a year of CDTI activities with good geographic and therapeutic coverage. However, the financial situation is unclear. There were sections of the report in which no information was provided. TCC conditionally accepted the report.

185. ***TCC conditionally accepted the report subject to provision of the following information to APOC:***

(i) Carefully fill in the forms to provide requested information;

(ii) TCC recommendations with regard to the previous report should be addressed;

(iii) Future Executive Summaries should specify the treatment period;

(iv) The general information should be more systematic and avoid dilation; it should also contain ethno-linguistic information on the project area population;

(v) All required data in table 9, page 14 (trends of treatment achievement) must be provided to enable interpretation of figures. Must use formula as provided in page 13 to calculate % of UTG coverage;

(vi) Provide more complete description of Mectizan® cycle (from application to MDP to the CDD);

(vii) Section 3. In table 13 page 17. There is no financial figure in the column Year 2: Does that mean no CDTI was conducted in Year two? Can project explain why there is delay in sending the money to the zones and how this is being addressed?

(viii) Provide information (opportunities) on integration (#4.3.).

186. TCC recommended for improvement of project implementation:

(i) The project should diversify the financing sources in order to sustain the achievements;

(ii) The project should start training in to implement it;

(iii) The project should justify the number of Mectizan® tablets used (540,666 treatments) to treat 479,662 persons (or an excess of 61,000 treatments).

Illubabor CDTI project: 3rd year technical report

187. This is a fairly well written report of a fully integrated and well functioning project and yet experiences delays in release of APOC funds.

188. ***TCC accepted the report with the provision that data on Mectizan® tablet is submitted to APOC.***

189. TCC recommended that to improve on the reports, the project should

(i) Give the correct total population figures and correct the Annual Treatment Objective and UTG accordingly;

(ii) Explain reason for reduction in number of woredas from year 1 to 2. Was this due to restructuring?

(iii) Review the Mectizan® inventory to reflect the true situation. NOTF should be involved and explain reason for expired large number of tablets.

190. TCC recommendations for improving project: The project should:

(i) Avoid distribution activities during the rainy season with the resulting absenteeism;

(ii) Ensure advocacy is carried out to political leaders;

(iii) Increase the number of female CDDs;

(iv) Improve on liquidation of funds utilized to reduce delays in release of APOC funds;

(v) Continue to address reporting and document handling during training;

(vi) Improve on calculation of number of tablets needed to avoid excess and expiry.

Metekel CDTI project: 2nd year technical report

191. ***TCC accepted the report*** and commended the project on achieving 100% geographic coverage and 67% therapeutic coverage in its second year.

192. TCC recommended the following for improving subsequent reports

(i) Describe activities and results fully; particularly as concerns advocacy, sensitization, capacity building, supervision, and monitoring. Suggestions for improvement for the next round should be included;

(ii) Although the use of non-health staff (teachers + development agents) to support the program is commendable, information as to how many were involved, if they were trained and what they did, should be included;

(iii) Collect data on and report any minor side effects, as this seemed to be a reason for refusals;

(iv) Recalculate and account for all the Mectizan®. 7757 tablets are not accounted for;

(v) The National Coordinator be provided with guidance on the concept of UTG and how to calculate it.

193. TCC recommended the following for improving project performance:

(i) To reduce absenteeism and refusals even further, the IEC message should emphasize the need for all eligible community members to participate every year and also emphasize the transient nature of minor side effects;

(ii) Start using MOH funds for equipment/vehicle maintenance, as soon as possible, but at least by year 3;

(iii) Set a more realistic ATO for year 3. 70 to 75% of total population is a realistic ATO, instead of 80-100%;

(iv) Although 1 CDD:128 persons is good, only 18% of communities have a female CDD. The project should make an effort to recruit more female CDDs.

Gambella CDTI project: 2nd year technical report

194. Some areas have very low geographic coverage, but there is no explanation provided. Very high geographic coverage in other areas results in good average coverage. In 2005, there was no CDTI distribution at all, no reason for this was provided.

195. ***TCC accepted the report with the provision that clarifications requested will be sent to Reviewers/APOC***.

196. TCC recommendations for improvement of future reports:

(i) The project is using the total population of the treatment area as the UTG. This is incorrect as there are always a portion of individuals not eligible for treatment (e.g children who do not meet the weight/height criteria, pregnant women, etc.). The UTG needs to be recalculated. This recommendation was already made in the previous TCC review, but was not addressed in the present report!;

(ii) The data on training in the executive summary is not consistent with that in Table 5. This should be addressed;

(iii) The timeline of activities is only from January to July 2006, whereas the project period is from November 2005 to October 2006. This should be explained;

(iv) Table 4 should be corrected as it contains several miscalculations;

(v) Tables 7, 13 and 14 should be completed. There is no information about the number of absentees, refusals, etc;

(vi) The project should provide information on expenditure.

197. TCC recommendations for improving project implementation:

(i) Update the census;

(ii) The involvement of community members in the supervision is low and effort should be made to improve it;

(iii) Increase the number of women CDDs their participation;

(iv) No activities were conducted in 2005. This must be clearly explained;

(v) The number of drugs expired (89852), remaining and wasted are proportionally very high. This should be explained.

LIBERIA

North West CDTI project: 5th year technical report (resubmission)

198. The project has addressed TCC 24 recommendations and submitted the report in the new format. ***The report was accepted with the provision that the missing information must be provided to the reviewers***.

(i) Give an explanation <u>for the low number of tablets per person treated;</u>

(ii) Review the geographic data (is it really 100% when some communities were not treated?) and therapeutic coverage data where it is over 87%;

(iii) Provide treatment data for years one to four;

(iv) Provide information on community involvement;

(v) Give details of the monitoring carried out.

199. Suggestions for improving project performance

(i) Increase advocacy in next treatment round and carry out CDTI activities in a shorter time frame;

(ii) 5^{th} year project, therefore should be addressing integration and sustainability issues. CSM and SHM are to be introduced;

(iii) Need to increase advocacy for more funds from the MoH;

(iv) Need to address integration;

(v) Train more district and health staff and also more CDDs;

(vi) CSM and SHM are to be introduced.

South West CDTI project: 1st year technical report (resubmission)

200. ***TCC accepted the report with the provision that the following will be addressed o***:

(i) The report should include endorsements of partners;

(ii) General information should include the administrative structure in the project area (as described elsewhere in section 2.3. Mobilization, sensitization;

(iii) Present data of the reporting period (2006) for table 3 (page 9) instead of 2007;

(iv) Correct percentages calculated in table 4 (row B6 and B11);

(v) Complete the project challenges in section 5 by population movement, health staff and CDDs turnover issues as highlighted in the executive summary.

201. The issue raised in section 6 could be considered as one of the project's opportunities

South East CDTI project: 1st year technical report (resubmission)

202. ***The report was accepted with the provision that it is endorsed by all partners and that explanations for the figures are provided to APOC***.

203. TCC recommended for project improvement:

(i) Intensify training at all levels,

(ii) Encourage involvement of more women as CDDs and Supervisors.

MALAWI

Thyolo CDTI project: 10th year technical report

204. ***The report was rejected for the following reasons***:

(i) The report has not been endorsed;

(ii) The report does not include responses to the recommendations of TCC23;

(iii) It is not clear to the TCC why the section on 'Advocacy' is labelled as non-applicable;

(iv) Data on therapeutic coverage for previous years was not provided;

(v) It is not clear why the geographic coverage is reported to have increased over the past years while the number of treated communities and those to be treated remains the same;

(vi) Table 10 seems to include errors regarding Mectizan® tablets;

(vii) More information on the meso-endemic communities, which were not treated, needs to be provided.

The resubmission should be sent to reviewers via APOC.

NIGERIA

Kaduna State CDTI Project: 9th year technical report

205. ***TCC accepted the report with the following recommendations***:

(i) Ensure accuracy of figures in tables in future reports;

(ii) Initiate CSM as soon as possible.

Kogi State CDTI project: 9th year technical report

206. ***TCC accepted the report***.

207. TCC made the following observations:

(i) The trend in LGA and State release of funds for CDTI activities raises concerns for the sustainability of CDTI;

(ii) The high CDD: population ratio and the CDD attrition rate are of great concern.

Anambra State CDTI project: 8th year technical report

208. ***TCC accepted the report*** and commends the project for maintaining coverage over the past 6 years at 70-72% at very low cost.

209. TCC recommended the following:

(i) Timing of activities: it seems that supervision started several months after distribution began (or ended) in all LGAs and mobilization was done after distribution in a few, therefore TCC suggests starting supervision with distribution and undertaking mobilization before distribution;

(ii) Although coverage is high and the kinship strategy is being used. 1 CDD/270 persons is not sufficient – TCC suggests that more CDDs be recruited and trained;

(iii) Cost per treatment (out including volunteer time) is very low. TCC suggests that the project apply the cost study guide as an interesting case study of a mature project with high coverage. Perhaps to submit as an operational research proposal.

210. TCC advises APOC management:

(i) To help the project undertake more advocacy visits with participation from APOC, TCC and NOCP to convince policy makers to budget and release more funds;

(ii) To support the state for the training of more health workers and CDDs and to hold more CSM and SHM in 2008.

Enugu State CDTI project: 8th year technical report

211. ***TCC accepted the well written report***.

212. TCC recommended the following to improve project performance

(i) One CDD/276 persons is not adequate, although coverage is high. TCC suggests to select and train more female CDDs, availabity of funds. The project noted that APOC should consider approving 2007 sustainability plan and fund kindred system training;

(ii) Percent of ATO achieved at all levels was very low due to lack of funds, although the range varied considerably across LGAs. In addition, although the number of health personnel involved in CDTI is 77% of total (with some LGAs like Udenu, Udi, Uzo Uwani being lower), more FLHWs and LGA staff could be trained in LGAs with the lowest number of health staff to compensate for frequent transfers;

(iii) Continue advocacy, sensitization and mobilization of policy makers to ensure release of sufficient funds;

(iv) Improve TOT;

(v) Continue scaling up CSM and SHM in all communities;

(vi) Ensure maintenance of equipment to support monitoring and supervision;

(vii) Identify operational research issues and partners to collaborate with;

(viii) Identify additional on interventions.

Kano state CDTI Project: 8th year technical report

213. The project is commended for maintaining geographical coverage of 100% and therapeutic coverage of more than 80%.

214. The project has carried out advocacy at both state and LGA level leading to strong support for CDTI. The project is encouraged to train more CDDs so as to reduce their work load.

215. ***The report was accepted*** with the following observations for improvement of future reports:

(i) For a mature project, like this one, the ATO and the UTG should be the same with the therapeutic coverage at 84%;

(ii) The project shoulder re-check the census data (confer TCC 23 para. 120) and re-estimate the total population;

(iii) The project should respond to the TCC 23 query (reference above) on incorrect messages received by women in Purdah (page 15 of the report);

(iv) Table 2 should be reviewed and corrected because the UTG is higher than the total population;

(v) Table 13 should be corrected to indicate bicycles as in table 14.

216. TCC suggestions for improving Project Implementation:

(i) The project is encouraged to strengthen integration ties with other programmes to maintain the gains already made;

(ii) The project should explore better ways of reaching the women in Purdah and thus improve women's participation in CDTI;

(iii) The project should actively pursue community advocacy and mobilization to ward the award of incentives to the CDDs;

(iv) Intensify advocacy to LGAs and state authorities for early release of funds.

Osun State CDTI Project: 8th year technical report

217. ***The report was accepted*** with the following recommendations.

(i) Sort out the issue of CDDs demand for incentives. This could be done by training more CDDs per population treated;

(ii) Conduct census update;

(iii) Make an effort to repair or replace furnish project equipment such as motorcycles;

(iv) Ensure availability of the project of treatment records by furnish community;

(v) Provide reasons why a large number of UTG (180,034 people) was not treated;

(vi) Raise more funds for CDTI activities from state ad LGAs.

Osun State CDTI Project: 7th year technical report

218. ***TCC accepted the report*** with the following observations:

(i) The project has responded to some TCC 21 recommendations by using the new reporting format;

(ii) The data on LGAs and communities has been harmonized;

(iii) The ratio of CDDs to the treated population has improved;

(iv) The number of absentees/ refusals has reduced significantly;

(v) Progress has been made in integrating project into the PHC and other health programmes (NPI);

(vi) Geographical coverage is 100% and therapeutic coverage is 87%.

219. Suggestions for improving the Report:

(i) The project should respond to the TCC21 recommendation on the reduction of the treatment period. The response "the treatment period was reduced from January to April" is very inadequate;

(ii) The data in table 13 should be checked and funds from other sources shown in tables 13 and 14;

(iii) Check table 3 for accuracy because supervision goes from October to August (11 months).

220. Suggestions for improving Project Implementation:

(i) The project should improve on the maintenance of motor cycles and bicycles (52 motor cycles and 83 bicycles grounded);

(ii) Intensify sensitization and advocacy to communities and community leaders to support CDDs;

(iii) Conduct formal training to reduce maladministration of drugs and poor record keeping;

(iv) Review the timeline of activities to reduce training and drug distribution time;

(v) Train communities in CSM;

(vi) Intensify advocacy to LGA and state authorities for early release of funds.

Imo State CDTI project: 7th year technical report

221. ***TCC accepted the report***.

222. TCC made the following observations and recommendations for project performance improvement:

(i) This is a 7th year project, and 2nd year of sustainability plan; however, the non release of counterpart funds at all government levels, the overall decrease in funds over years, and the low involvement of health staff in CDTI raise serious concerns about the sustainability of the project. Indeed, after 8 years of treatment;

(ii) The geographic coverage is only 96% and the therapeutic coverage only 68%;

(iii) The government needs to commit and release funds for the implementation of the project, to ensure sustainability;

(iv) Effort should be made for maintenance/repair and management of equipment;

(v) Sustainability plan should be implemented;

(vi) Training of health staff needs to be increased and efforts undertaken to limit the frequent transfer of trained personnel;

(vii) Clarify the motivation of CDDs (incentives);

(viii) Increase sensitization and IEC to maintain people's interest in onchocerciasis control activities, including the need to continue taking the drugs.

223. TCC recommended the following for report improvement

(i) The timeline should be properly presented in logical order;

(ii) Information on the implementation of activities should be provided;

(iii) Information on community responses, rate of attrition of CDDs should be included;

(iv) Table 9 should be completed and data provided for year 2005;

(v) The difference in the number of persons treated reported in the text (pages 2, 15) and in Table 7 should be addressed. Information on the place of storage of Mectizan® to provide.

Abia State CDTI project: 7th year technical report

224. ***TCC accepted the report with the following observations***:

(i) This is a 7th year project and in its 2nd year of sustainability plan. Due to non release of counterpart funds at all the government levels (despite a lot of advocacy visits to policy makers by project team), the sustainability of CDTI is hampered;

(ii) ATO training was not reached;

(iii) Few supervision visits were carried out and monitoring was not done;

(iv) Geographical coverage was not reached, therapeutic coverage is only 71%;

(v) In some communities, there is little support to CDD, resulting in risk of attrition of CDDs, the health staff are also not motivated;

(vi) The CDTI budget is integrated in the PHC budget but the government doesn't release the funds!!

225. TCC consequently urge the government of Abia state to release the funds promised and budgeted.

226. TCC recommends to the project:

(i) to intensify sensitization and mobilization of communities and to increase the number of CDDs through kindred selection;

(ii) to reinforce the additional interventions in order to raise the population's interest in Onchocerciasis control activities.

Niger State CDTI project: 7th year technical report

227. ***TCC accepted the report*** and noted that there are serious issues and challenges that must be dealt with to ensure successful and sustainable CDTI in Niger state.

228. TCC recommended:

(i) a fact-finding mission by the NOTF/TCC to try and resolve population data and ivermectin inventory issues;

(ii) *reduction in frequent transfer of health staff;*
(iii) *release of budgeted funds at state and LGA levels;*
(iv) *replacement of vital Capital items such as vehicles, motorcycles, and computers.*

Edo State CDTI Project: 7th year technical report

229. The project has implemented a few TCC 24 recommendations. The NOTF is commended for carrying out an internal review. However, it needs to support the project to ensure implementation of all TCC recommendations. Identifying ways of addressing its challenges would deal with issues such as poor logistics, incentives, community ownership, CDD: population ratio, census and attitude of health personnel. The project has requested support in advocacy from APOC, NOCP and NGDO to policy makers.

230. **TCC accepted the report**.

231. Recommendations for improving the report:
(i) *Provide cost per treatment,*
(ii) *Review Table 7.*

232. Recommendations to improve Programme Implementation:
(i) *APOC to support advocacy visit to state policy makers,*
(ii) *Ensure release of funding for maintenance of motorbikes to support monitoring and supervision;*
(iii) *Ensure health education and mobilization of communities and updating of census (Esan Southeast and Etsako East) to address refusals and absentees;*
(iv) *Improve CDD: population ratio to address demand for incentives;*
(v) *Improve therapeutic coverage in Esan Northeast (64.4%), Igueben (51.9%) and Owan West (65.3%);*
(vi) *Identify NGOs and CBOs active in the state, within and outside the health sector;*
(vii) *Ensure up implementation of CSM and SHM in all communities;*
(viii) *Continue implementation of the recommendations of the sustainability evaluation and internal monitoring;*
(ix) *Identify operational research issues and partners to collaborate with;*
(x) *Check sufficiency of drugs requested and drug inventory.*

Delta State CDTI Project: 7th year technical report

233. ***This well-written, detailed and informative report was accepted***.

234. Suggestions for improving report
(i) *Zonal coordinator to promptly review and sign report when submitted by the project;*
(ii) *Cross-check the Mectizan® figures in view of high number of tablets used per person as in TCC 21 recommendations.*

235. Suggestions for improving project
(i) *Advocacy to LGAs to encourage them to give counterpart funding;*
(ii) *Project to facilitate introduction of CSM and SHM as recommended in TCC 23;*
(iii) *Train more CDDs to increase the CDD: population ratio as in TCC 21 recommendations;*
(iv) *Train more female CDDs.*

Nassarawa State CDTI Project: 7th year technical report (resubmission)

236. ***TCC accepted the report***.

237. The project is well integrated in the PHC and serves as a vehicle to provide other health interventions (malaria and other NTD control). TCC made the following recommendation for project improvement:

(i) Continue advocacy for the release of counterpart funds.

Jigawa State CDTI Project: 7th year technical report

238. This is a project in its 7th year and the geographical coverage has reached 100% and the therapeutic coverage is 81%. There are no responses given to the TCC 19 recommendations. There are two sets of recommendations (pages 6 and 7).

239. ***The report was rejected for the following reasons:***

(i) The project report is difficult to read and has too many incomplete tables and sections;

(ii) The Executive Summary does not reflect all the information in the report;

(iii) Many tables are incomplete (Tables 1a, 1b, 4, 10);

(iv) The number of persons treated in table 14 is incorrect and the total sums in table 13 and 14 do not correspond.

240. TCC made the following suggestions for improving the report:

(i) Reconcile the figures regarding the number of communities (page 8, 13) and population figures in pages 8, 13 and 21;

(ii) Insert and correct the totals in tables 1a, 1b, 4 and 10 and complete table 10;

(iii) Review and correct table 4 and use the table in the new reporting format to present data on capacity building;

(iv) Correct tables 13 and 14 and indicate funding from NGDO and communities including the use of these funds;

(v) Use the complete new reporting format instead of taking part from the old format and new.

241. TCC recommendations for improving Project Implementation:

(i) Intensify advocacy at the State and LGA level for the provision and early release of funds;

(ii) Use loud speakers to send messages to women in "purdah" since they cannot sit with the men for any meetings;

(iii) Encourage the selection of CDDs to reduce the CDD/population ratio;

(iv) Continue efforts to involve women in CDTI activities.

Oyo State CDTI Project: 7th year technical report

242. The report gives a good description of the project, which has achieved overall high geographic and therapeutic coverage. The implementation of operational research is encouraged.

243. TCC noted with concern that the incentive issue constitutes a serious threat to the implementation of CDTI activities. Indeed, CDTI was not implemented in some communities due to incentives. This issue should be carefully addressed.

244. The other major concern is the low community ownership and involvement in the CDTI activities and supervision.

245. ***TCC accepted the report*** with the following recommendation for future reports:

(i) More attention should be paid on the writing of the report to avoid mistakes and inconsistency. For example, the table on page 8 is not complete and is confusing.

246. TCC commendations for improving project implementation:

(i) The planning of activities should be better designed. It is not clear why some activities are planned at the same period in all Districts, whereas others are scheduled in completely different periods, with up to 8 months for drug distribution in some districts. The timing for different activities should be carefully addressed;

(ii) Further efforts should be made on sustainability and integration.

Kebbi State CDTI Project: 7th year technical report

247. ***TCC accepted this well written report*** but advises the project to verify the accuracy of numbers in tables and text in future reports.

248. TCC noted with great concern that geographic coverage has decreased and recommends the following for improvement of project performance.

(i) Improve project performance to increase therapeutic coverage,
(ii) Develop a sustainability plan,
(iii) Take measures to initiate CSM,
(iv) Increase the number of women CDDs.

Zamfara State CDTI Project: 7th year technical report

249. ***TCC accepted this well written report*** with the provision that the following missing information is provided to APOC:

(i) Explanation for the UTG (97% of total population);

(ii) Why training was conducted in September after funds had become available when distribution had been completed in June?

(iii) Why only a minority of CDDs was included in the training.

250. TCC noted with concern that:

(i) Less than 20% of funds budgeted by the state were released (95 000/500 000);

(ii) It still has not been possible to train female CDDs and females still do not participate significantly in meetings;

(iii) Late financial returns to APOC have made it impossible for APOC to ensure a timely release of funds. Coupled with the situation of no or few funds released by the state, this lack of funds puts CDTI in jeopardy. TCC encourages the project to provide financial returns to APOC on time so that the project can at least receive APOC funds.

251. TCC recommends the following for project improvement

(i) CSM and SHM need to be implemented as a matter of high priority.

Zamfara State CDTI Project: 6th year technical report

252. The ***report was accepted***

253. TCC noted with concern that the state did not release any funds and that due to lack of funds, TCC 21 recommendations were not implemented.

254. TCC recommended for project improvement:

(i) Implement TCC 21 recommendations;
(ii) A better and acceptable way of reaching, educating, involving and treating women in purdah should be identified and implemented;
(iii) More CDDs need to be trained, including women CDDs;
(iv) A better strategy for counterpart fund release at state and LGA levels needs to be developed and employed.

Benue State CDTI Project: 6th year technical report

255. **TCC accepted this well written report** but noted that in its 6th year, the project should have achieved higher geographic and therapeutic coverage

256. Furthermore, the 5th year project report has not yet been received by APOC.

257. TCC recommendations for project improvement:

(i) Provide sustainability plan to APOC;
(ii) Implementation of CSM and SHM;
(iii) Census update by CDDs;
(iv) More CDDs need to be trained and especially the number of female CDDs needs to be increased;
(v) Review procedures for determining the amount of Mectizan® tablets to be ordered.

Oyo State CDTI Project: 6th year technical report

258. The report is well written according to the template. Data is well presented and commented upon.

259. Project performance is good with continuing increase of therapeutic coverage

260. ***The report is accepted*** with the following recommendations for improving future reports:

(i) The use of funds should be clearly justified even if CDTI is carried out together with other activities;
(ii) Provide number of CDDs by gender.

261. TCC recommendations for project improvement:

(i) Finalize sustainability plan.

Ekiti State CDTI Project: 6th year technical report

262. ***TCC accepted the report***.

263. TCC recommends for improvement of project implementation

(i) To ensure good record-keeping through training and supervision of CDDs as well as provision of good registers;

(ii) To identify an effective strategy for ensuring regular and timely release of state and LGA funds to CDTI activities;

(iii) To focus on training new and many CDDs. The current ratio of 1 CDD per 661persons is unacceptable.

Ondo State CDTI project: 6th year technical report

264. ***TCC accepted the report*** but advises the authors that extensively copying from previous reports makes it difficult for TCC to assess the report and project performance.

265. The Project achieves good therapeutic and geographic coverage and is encouraged to maintain what has been achieved while continuing advocacy on a regular basis.

266. The project has successfully implemented nearly all TCC recommendations. There is still a need to encourage communities to have supervisors; CSM and SHM still need to be scaled up.

267. Subsequent reports should be reviewed prior to submission for consistency of the data provided.

Kebbi State CDTI project: 6th year technical report

268. This is a 6th year report which was well written, but submitted a year late. ***TCC accepted the report.***

269. TCC recommended the following for improving project performance:

(i) CSM and SHM should be introduced;

(ii) Attention should be directed at integrating CDTI into the PHC system;

(iii) More advocacy should be directed at ensuring release of budgeted funds by all tiers of government;

(iv) Clarification is needed on why funds budgeted by APOC were not released;

(v) Calculation of tablets needed should be improved upon to avoid over-requisition as happened in reporting year. (538,000 requested, 460,667 received and 20,169 left over);

(vi) Although this is common to all Nigerian projects, a mature project in the sixth year should be able to order Mectizan® directly though the NOCP without depending on a partner NGDO;

(vii) Given the traditional and religious context of the programme area, more effort should be made in increasing the uptake of treatment rather than increasing the number of female CDDs (this issue should be discussed during the September meeting);

(viii) A sustainability evaluation needs to be carried out as soon as possible and sustainability plans written;

(ix) It is important to ensure that the recommendations of the independent monitoring exercise carried out in 2004 are being implemented in the 2006 report which is also due.

Gombe State CDTI Project: 6th year technical report

270. ***TCC accepted the report***.

271. TCC recommendations for improvement of project implementation:

(i) To ensure a mechanism for keeping CDTI records for each community at the LGA level is established;

(ii) To strengthen ivermectin delivery system from LGA to community;

(iii) Train more new CDDs;

(iv) To provide registers for household census update and treatment records in each community;

(v) To ensure state and LGA funding.

Gombe State CDTI Project: 5th year technical report

272. ***TCC accepted the report*** with the following observations and recommendations:

(i) The report is detailed and clearly identifies the challenges and problems encountered;

(ii) Geographic coverage is 100% and the increase in therapeutic coverage, though not much, is appreciated by the TCC;

(iii) The number of CDDs is still too low and the project has to continue its efforts to recruit CDDs, including CDDs older than the current ones;

(iv) TCC noted that 40% of funds are used for the training of health care personnel and just a small percentage is used for training of CDDs. This needs to be changed;

(v) TCC observed with concern that the number of women CDDs is still extremely low;

(vi) The TCC noted with interest that the time lines for CDTI activites are negatively impacted by the implementation of other programmes. Such problems could be minimized if other health care activities were co-implemented with CDTI;

(vii) Information needs to be provided on the contribution of communities.

Ogun State CDTI Project: 5th year technical report

273. The project has achieved high geographic and therapeutic coverage, and the report is well written. However, there is no explanation why geographical coverage in 91% is the District of Obafemi/Owode, whereas it is 100% in all other Districts.

274. ***The report was accepted*** with the following recommendation for improvement of future reports:

(i) The use of the remaining drugs should be clearly explained.

275. The following recommendations were made for project improvement:

(i) The planning of activities should be better designed; and the timing for different activities should be carefully addressed;

(ii) The number of trainees is identical in all Districts/LGA (Table 5), and do not take into account the population size, etc;

(iii) Efforts should be made on sustainability, CSM and integration.

Ogun State CDTI Project: 4th year technical report

276. ***TCC accepted the report*** with the following recommendations.

(i) Improve mobilisation of APOC funds,

(ii) Provide in future reports information on financing in the previous years.

Bauchi State CDTI Project: 4th year technical report

277. ***TCC accepted this report*** with the provision that the following information is submitted to the reviewers via APOC:

(i) Explanation about the impact of the new LGAs and communities;

(ii) How were new LGAs/communities mobilized, and what happened to the old LGAs?

(iii) Why were geographic and therapeutic coverage so low (with 1 LGA 33% GC&TC)?

(iv) More information on passive treatment (mentioned only in Exec. Summ) is required

(v) Why was updated REMO implemented so late?

(vi) Why hasn't the program implemented CSM and SHM yet?

(vii) Not all APOC funds have been used, what happened?

278. TCC recommendations for improvement of project performance:

(i) Conduct more advocacy for release of funds;

(ii) Training of more health personnel;

(iii) Initiate CSM and SHM;

(iv) Improve geographic and therapeutic coverage;

(v) Review procedures for determining the amount of Mectizan® tablets required/to be requested.

Bauchi State CDTI Project: 3rd year technical report

279. ***TCC accepted the report, but*** wonders why it was submitted one year late. More information should have been included in the report and TCC requests that the project take this and the following into account for future reports.

(i) Has census been done?

(ii) Why did 468 (26%) of CDDs leave in a year?

(iii) Why did it take so long for REMO data to be collected?

(iv) Was treatment coverage in Toro LGA so low?

(v) What is the reason for inconsistent treatment coverage?

(vi) Why were so much APOC funds left-over?

(vii) Why no support from UNICEF?

Akwa-Ibom State CDTI Project: 3rd year technical report

280. ***TCC accepted the report*** which is well written and is easy to read.

281. The project is commended for reaching geographical coverage of 100% during the first year. Unfortunately, in the third year, therapeutic coverage is only 62%. Advocacy visits have been undertaken to the State, LGAs and communities and trained personnel exist at all levels.

282. TCC suggestions for improving the Report:

(i) *The project area is well described but the summary is scanty and not detailed enough;*

(ii) *The project is encouraged to respond to those TCC 23 recommendations which have not been addressed in the appropriate section, i.e.: the separation of information on community involvement along community/district lines to show clearly the areas that need help;*

(iii) *Explain the meaning of 'Oncho Office' (this is probably clinic based treatment whose data should not be included in the calculations of population and coverage), rather should be reported separately as additional but very useful information;*

(iv) *Verify the figures in every table to be sure that errors in coverage calculations are detected (tab. 7);*

(v) *Include more details in the Executive Summary relating to information on Sustainability and integration.*

283. Suggestions for improving Project Implementation:

(i) *Commence SHM and CSM since training for CSM was conducted July/August 2006 at the state and LGA level;*

(ii) *Train more CDDs (the present ratio of 1:627 is too high) to reduce CDDs work load;*

(iii) *Select and train women CDDs because the project has no women CDDs supporting CDTI activities;*

(iv) *Increase advocacy to the communities so as to increase their cash contributions;*

(v) *Intensify sensitization at communities level to reduce absenteeism and refusals;*

(vi) *Treat during the dry season, and not during the farming season (April – May is already rainy);*

(vii) *Conduct sustainability evaluation.*

NOTF/HQ Project: 9th year technical report

284. ***TCC accepted this report*** with the recommendation that inconsistencies in the report in the number of projects in the executive summary and the body of the report be reconciled.

285. TCC notes with concern the issues raised by the NOTF:

(i) *Poor performance of some projects with low therapeutic coverage;*

(ii) *Poor counterpart funding. Include budgeted amount and reason for gap if any;*

(iii) *Effort at integration is commendable and should be encouraged.*

286. TCC made the following recommendations for improvement:

(i) *Encourage projects to shorten period of CDTI activities and avoid the rainy season;*

(ii) *Train more TOTs (18%) and CDDs (67%) who carry out the drug distribution, rather than project staff (86%);*

(iii) *NOCP should focus on states with low therapeutic coverage, Akwa Ibom, Bauchi and Osun to ensure they improve, and request Zamfara to correct its therapeutic coverage rate currently given as 87 to 98%, which is too high;*

(iv) *NOCP HQ should support projects to institute/scal upe CSM and SHM.which is currently in place only in 33% LGAs;*

(v) *Improve on census, calculation and ordering of Mectizan®, as left-over of 4 million tablets is unacceptable;*

(vi) *Effort at improving counterpart funding in projects is essential, but NOTF and projects should also explore other funding sources like NEEDS as recommended by TCC 23;*

(vii) *Nigeria should begin to put in place a national drug distribution system and storage facility instead of depending on partners;*

(viii) *NOTF to fully investigate reports submitted by projects so far, identify where reports are missing and ensure such reports are submitted to APOC.*

SOUTH SUDAN

East Bahr El Ghazal CDTI Project: 2nd year technical report

287. This Year 2 report is from a project establishing CDTI in a post-conflict area. The project is commended for treating over 400,000 people (a dramatic increase over previous years) during a year when project funding was delayed and the turnover of project staff was high.

288. ***TCC accepted this well-written and comprehensive report*** with the provision that the missing financial information in Tables 13 and 14 will be submitted to APOC management.

289. TCC recommended the following to improve project performance:

(i) *From the information provided in Section 1.2 of the report, the total number of communities in the project area (and their corresponding total populations) has not yet been determined. Thus, geographic and therapeutic coverage are difficult to accurately determine. The project is encouraged, when the situation on the ground permits, to fully document its communities and their population so that the project's progress can be monitored;*

(ii) *The UTG provided in Table 2 is 100% of the stated total population of 778,920 people. While the TCC understood that the total population of the treatment area is currently unknown, the UTG should typically only be 80-84% of the total population and thus should have been calculated differently;*

(iii) *The TCC acknowledges the difficulty in recruiting and maintaining skilled staff. The project is encouraged to increase training of available health staff in the project area in an attempt to reduce this constraint to project progress;*

(iv) *The project reported delays in the release of APOC funds. APOC Management is requested to review the situation and to work with the project to resolve this problem so that approved funds are released without delays in the future.*

290. TCC recommended the following for report improvement

(i) *CSM training was carried out in 2006. It seems from the text provided that it was carried out successfully, but the project did not provide data regarding the number of communities that implemented it. Such data should be provided in future reports.*

West Equatoria CDTI Project: 2nd year technical report

291. ***TCC accepted the report***

292. TCC recommendation for improving the report:

- *(i) Clarify inconsistencies in population, number of communities in project area and community leaders trained;*
- *(ii) Complete Tables 13 and 14;*
- *(iii) Provide cost per treatment.*

293. TCC recommendations for improving project performance:

- *(i) Continue advocacy to policy makers for improved financial support;*
- *(ii) Train additional health staff in project area on CDTI;*
- *(iii) Improve CDD: population ratio;*
- *(iv) Carry out population census;*
- *(v) Ensure communities carry out CSM and SHM to strengthen community involvement, participation and sustainability;*
- *(vi) Identify and address reasons for and improve low therapeutic coverage;*
- *(vii) Provide cost per treatment;*
- *(viii) Review UTG;*
- *(ix) APOC management to review logistics support to project.*

East Equatoria CDTI Project: 1st year technical report

294. ***TCC accepted the report***

295. TCC recommendation for improving the report:

- *(i) Complete Tables 13 and 14,*
- *(ii) Provide cost per treatment*

296. TCC recommendations for improving project performance:

- *(i) Continue advocacy to policy makers for improved financial support;*
- *(ii) Train additional health staff in project area on CDTI;*
- *(iii) Improve CDD: population ratio;*
- *(iv) Complete population census;*
- *(v) Ensure communities carry out CSM and SHM to strengthen community involvement, participation and sustainability;*
- *(vi) Identify reasons for low therapeutic coverage and address;*
- *(vii) Provide cost per treatment;*
- *(viii) Review UTG;*
- *(ix) APOC management to review and address reasons for delays in release of funds.*

Upper Nile CDTI Project: 1st year technical report

297. ***TCC accepted the report***, but noted that Tables 1, 2, 7 and 14 are incomplete or incorrect and should be carefully reviewed prior to submitting subsequent reports.

298. TCC recommended for project performance improvement:

- *(i) To organize training courses to quickly have a personnel in quantity and quality;*
- *(ii) To continue with steps to include CDTI in the budget of the MOH;*

(iii) To update census because of population management;

(iv) To carry out the CSM and SHM;

(v) To review the period chosen for distribution of ivermectin (rainy season);

(vi) To review the definition of UTG.

SSOTF/HQ: 2nd year technical report

299. ***TCC accepted the report***.

300. TCC recommended

(i) Delays in transferring APOC funds need to be sorted out;

(ii) Attrition of CDDs and health workers needs to be addressed to ensure sustainability;

(iii) There should be periodic household census in order to monitor population dynamics;

(iv) Equipping county supervisors with reliable transport is important;

(v) Total population is different from UTG (See Table 1), and since census has not yet been done, and population movements are ongoing, ATO should be used.

TANZANIA

Mahenge CDTI Project: 8th year technical report

301. The project is commended for integration of Malaria, TB and Leprosy and Mental health into CDTI 50%, districts funding of the activities and gender equity in CDTI activities.

302. ***TCC accepted the report*** with the following observations for improving subsequent reports:

(i) Complete implementation of TCC recommendations ;

(ii) Provide additional information on implementation of recommendations of sustainability plan;

(iii) Correct error in CDD: population ratio.

303. TCC recommendations for improvement of project implementation:

(i) Timely ordering of Mectizan® tablets;

(ii) Improve number of health staff in project area involved in CDTI (ATOs at district and health posts);

(iii) Improve CDD: population ratio to 2:250;

(iv) Ensure treatment of communities before farming season;

(v) Intensify health education and mobilization to address refusal;

(vi) Carry out mop-up treatment to improve therapeutic coverage;

(vii) Carry out operational research on high number of refusals.

Ruvuma CDTI Project: 8th year technical report

304. ***The report was accepted***.

305. Female CDDs are present in 100% of communities and constitute 48% of CDDs.

306. TCC recommendation for improving project implementation:

(i) Ensure a good strategy for release of adequate funds from councils;
(ii) Provide a strategy to replace or repair of aging capital equipment e.g. motor cycle by government or APOC;
(iii) Keep on sensitizing new political leaders;
(iv) Improve treatment and ivermectin data management.

Tanga CDTI Project: 6th year technical report

307. The project is commended for integration of LF into CDTI, attaining 95.4% of the ATO for training at the district, 100% at health post, TOT and CDDs. It has also greatly improve therapeutic coverage from 75% in 2001 to 80% which has been sustained for four years.

308. ***The report was accepted*** with the request to include Cost/ treatment in USD in the next reports, clarify disparity in sum released and expended in Tables 13 and 14, and to explain the high cost of drug delivery of USD 12,560 from HQ.

309. TCC suggestions for improving project implementation:

(i) Ensure timely ordering of Mectizan®;
(ii) Improve number of health staff in the project area involved in CDTI;
(iii) Intensity health education and mobilisation of communities on roles and responsibilities in CDTI.

Tukuyu CDTI Project: 6th year technical report

310. ***TCC accepted this fairly well written report*** with the request that for future reports, the following is taken into account:

(i) Clarify the actual number of communities and reconcile the issue of number of communities versus female CDDs;
(ii) Correct the UTG calculation;
(iii) Indicate if sustainability plan has been approved and is being implemented;
(iv) Give the conversion rate of Tsh to dollars;
(v) In the financial contribution table, reconcile write-up with actual financial data and explain why no APOC funds were received in years 4 and 5.

311. TCC recommended for project improvement:

(i) Train more health staff, if possible all health staff on CDTI to overcome the issue of frequent transfers;
(ii) Scale-up CSM and SHM;
(iii) Increase number of CDDs;
(iv) Carry out more advocacy to government and council authority to increase funding support to CDTI;
(v) Ensure that there is no further decline in therapeutic coverage as happened between 5th and 6th year.

Tunduru CDTI Project: 5th year technical report

312. ***TCC accepted this well-written report*** of a well-run project, fully integrated into PHC and routine functions of the DMO. Mectizan® collection and distribution is carried out within the routine drug distribution channels. The project reached 100% geographic and 71% therapeutic coverage within the first two years.

313. TCC commends this project on the remarkable achievement within the first two years.

314. TCC recommends for project improvement:

(i) More health staff be trained and involved in CDTI;

(ii) The project should agree with communities to carry out distribution outside the farming season, to reduce absenteeism;

(iii) Funds should be internally mobilized to carry out repairs on equipment, rather than using NGDO funds;

(iv) Sensitisation to enhance to remove misconception on effect of Mectizan®;

(v) Prompt retirement of allocated funds be carried out to avoid late disbursement of funds by APOC;

(vi) CSM and SHM should be introduced as soon as possible;

(vii) Operational research topics be identified and proposals written for same.

Kilosa CDTI Project: 5th year technical report

315. The project is commended for maintaining 100% geographic coverage and for good integration of CDTI into the public health system.

316. TCC notes with concern that therapeutic coverage, which should be at least 80% for a 5th year project, is still below 75%.

317. ***TCC accepted the report with the provision that corrections of the Tables 5 and 14 be sent to reviewers via APOC.***

318. TCC requests that future reports include:

(i) a more comprehensive executive summary which covers all activities,

(ii) a list of abbreviations used and updated.

319. TCC recommends for project improvement:

(i) Continue advocacy to government authorities about the importance of timely release of funds for CDTI activities;

(ii) Try to maximize the number of health care workers and CDDs trained to reduce workload on individuals;

(iii) Ensure that community has required training and supplies;

(iv) Distribute ivermectin during the periods selected by the communities in order to reduce the number of absentees;

(v) Increase sensitization and information to reduce the number of refusals;

(vi) Encourage, train and facilitate CSM and SHM;

(vii) Increase/improve IEC material.

Morogoro Focus CDTI Project: 3rd year technical report (resubmission)

320. ***TCC accepted the report with the provision that response to the reviewers comments be sent to APOC Management.***

321. TCC noted the following regarding project performance:

(i) The project should explain why the number of people treated (238,423) plus the number of refusals (21,104) add up to 259,437 which is less than the UTG of 260,172. Thus, it seems that there are some people eligible for treatment who are not accounted for in this report. The project should explain;

(ii) The project should make an effort to reduce refusals which they say are due to misconceptions about Mectizan® and inefficiency in drug distribution;

(iii) The project's finances are a bit difficult to judge. In Table 13, it is indicated that no funds were released from the MOH; however, there were expenditures in Table 14, and it is indicated later in the report that funds were provided by the government for fuel and supervision;

(iv) It is indicated in Table 14 that an amount of $36,217.70 was spent. In Table 13, it is indicated that $58,652 was released. What happened to the additional funds released but not spent?

(v) Advocacy to government for counterpart funding needs to be intensified;

(vi) Prompt financial reporting to donors should be done to ensure prompt release of budget;

(vii) Feedback should be given after supervision;

(viii) Need to train in CSM and implement it;

(ix) Extend SHM to all communities.

322. TCC recommendations for improving future reports:

(i) The project is requested to provide information regarding the outcomes of advocacy and strategies for improving mobilization and sensitization;

(ii) Prior to submission, the project is requested to check the report for inconsistencies. For example, in the body of this report (page 16), it is stated that attrition is not a problem, but CDD dropout is listed as a program challenge (page 32). Moreover, low therapeutic coverage is listed as a weakness of the project; however, the project's therapeutic coverage was 75% which is considered acceptable;

(iii) The next report should be harmonized to cover the calendar year. Ideally, the current one should have covered November 2005 to December 2006;

(iv) Greater attention should be paid to training in data entry and report writing by health workers.

NOTF/HQ Project: 8th year technical report

323. NOTF headquarters had addressed and taken action on recommendations of TCC 22. The executive summary, as well as the report, are well written and comprehensive. Geographic coverage was 100% for all projects, whereas therapeutic coverage varied from 71% (Kilosa, Tunduru) to 80% (Tanga). Over the years, the therapeutic coverage increased from 39% in 1997 to 79% in 2005.

324. ***TCC accepted the report but asks that the Coordinator takes the following into account for future reports***:

(i) Provide better insight into progress on implementation of the sustainability plans of the projects;

(ii) Ensure that reports are submitted on time by the CDTI Projects;

(iii) Conduct drug distribution at the period chosen by the communities;

(iv) Ensure communities undertake CSM and SHM to reduce refusals and absentees;

(v) Sensitize communities for project ownership;

(vi) Add the Total summation in Table 5. Data in tables should be clear and precise. If there is nothing, one should put "0", as "-" may also mean that the information is not known;

(vii) Add APOC contribution in Table 12;

(viii) Clarify the inconsistency in data on referred SAEs between tables 6 and 7;

(ix) Address the problem of used equipment (non-functional).

UGANDA

Mpamba-Nkusi focus vector elimination CDTI Project: 6th year technical report

325. ***TCC accepted the report***

326. TCC recommended the following:

(i) Focus on treatment in lower Nkusi, which is the source of re-infestation of the river Mpamba and Rwabutuji;

(ii) Use the budget already available for these activities;

(iii) Provide a report for TCC 26 or TCC27;

(iv) Include a summary of the CDTI data in the next report;

(v) Evaluate the entomological situation at the end of 2007.

Itwara focus vector elimination CDTI Project: 6th year technical report

327. ***TCC accepted the report***

328. The vector is absent from the main Itwara focus since 1997. No vector has been detected in the sub foci of Siisa and Aswa since 2004.

329. TCC recommended the following:

(i) Initiation of procedures for the certification of vector elimination;

(ii) Budgets for potential entomological activities that may have to be conducted in the focus should be integrated into the Minimum Activity Package.

19. Other matters

TASK FORCE ON OPERATIONAL RESEARCH AT COUNTRY LEVEL

330. Establishment of Operational research Task force in each APOC-supported Country as part of devolving APOC activities to the countries is necessary in order to ensure that the review of operational research proposals and results are conducted by countries with the appropriate capacity. The mandate of the Operational Research Task Force will include not only onchocerciasis-related research, but also research on neglected tropical diseases (NTDs) and other diseases using the Community-Directed Interventions (CDI) strategy.

331. Type of operational research to be supported:

(i) Questions and challenges arising from collection and analysis of routine programme (CDTI) data;
(ii) Validation of program performance, which may include coverage and impact studies;
(iii) Questions arising from impact studies in sentinel communities;
(iv) Creative/ new initiative related studies.

332. Capacity building (in conjunction with MOH relevant department) to be conducted

(i) Strengthening or building relevant laboratory capacity;
(ii) Encouraging recruitment of relevant skills by the Ministries of Health;
(iii) Strengthening field surveillance skills for onchocerciasis and other NTDs;
(iv) Strengthening analytical skills;
(v) Establishing research Task Forces within the frame work of NTDs.

333. Funding of research studies will be through country internal funds or country raised funds. For funding with money provided by APOC, money will be paid through WHO offices according to WHO procedures and will have to be accounted for according to WHO rules.

334. Draft terms of reference of Operational Research Task Force proposed by TCC are provided in Annex 5: TCC proposed terms of reference for Task Force on operational research at country level.

Review of operational research proposals from the countries

335. TCC noted once again that research proposals are coming from a very limited number of countries.

(i) TCC recommends that other countries evaluate their projects for operational research needs and submit research proposals;

(ii) Where in-country capacity is insufficient in this regard, technical assistance should be provided, including support from TCC members;

(iii) TCC recommends that APOC management reconsider the current funding ceiling of USD 10000 in light of the financial requirements for good quality operational research.

336. *Proposal from Cameroon*: Dr MANJO Matilda, Mr TENDONGFOR Nicolas, Mrs. MAH Cicilia and Mrs NGU Ruth: "Assessment of the principal causes of withdrawal of community directed distributors of ivermectin". This is a descriptive retrospective study to assess the principal causes of withdrawal of CDDs from the CDTI project in South West 1 in Cameroon and to identify the role of the community in retaining CDDs for a longer time. Funding requested was 7823 USD. **The authors should resubmit the proposal, having taken into account the following TCC recommendations:**

(i) The number of 'drop out CDDs' interviewed should equal the number of CDDs who are still working;

(ii) The study should be conducted in at least two different areas to ensure that more than one 'cultural perspective' is obtained;

(iii) Validate the proposal and ask for final advice from NOCP;

(iv) Adjustment of the planned budget to the changed scope of the research plan;

(v) The investigators can approach TCC members for advice.

337. *Proposal from Cameroon:* Dr. SOCPA Antoine., Dr. TAKOUGANG Innocent. "Alternative à la politique de recouvrement au Cameroun"(An alternative to the cost recovery policy). The objective is to measure the impact of change of cost recovery system in Cameroon on CDTI delivery. Until 2002 there was a cost-recovery system (100 Franc CFA) in Cameroon designed partly to pay CDDs and partly to ensure sustainability of CDTI. This system was abolished and from 2002, the state decided to pay 25 CFA to the CDDs for each subject treated. The study is designed to compare CDTI performance under the two cost recovery/payment systems. This study is assessed as very difficult to conduct since one part is retrospective, and specific objectives have not been defined in sufficient detail. The investigators propose to do the study via report review, in-depth interviews and focus groups, but detailed description on sampling, methods, and questionnaire is not provided. Time lines and budget seem insufficiently planned (e.g. will the vehicles that are assumed to be provided by the NOTF really be made available?). The subject of the study is very interesting but there is need for improvement on the following points:

(i) The specific objectives must be clearly defined. As they are expressed now, they are somewhat broad and vague;

(ii) The authors must give assurance relative to the availability of data for the period prior to 2002;

(iii) The sampling methodology (number of districts and villages) must be justified;

(iv) Data collection questionnaires, as well as interview guides, must be appended to the protocol;

(v) Qualitative and quantitative data must clearly be defined;

(vi) Aspects relating to "cost" are not taken into account in the analysis. This is unfortunate, when one considers the fact that the project relates to cost recovery. A health economist needs to be included as co-investigator;

(vii) The task of each of the investigators must be specified;

(viii) The total cost of the survey must be included in the table, including that relating to vehicles. Assurance must be given as to the availability of vehicles;

(ix) The schedule of activities (survey of two villages per day) is not realistic, if the study is to be properly conducted.

338. *Proposal from Cameroon:* Mr. MBOUA Célestin et al "*The impact of stress experience, trauma, symptoms and lesions on psycho-pathological decomposition observed in patients suffering from simulium-related complicated filariasis*" TCC members were informed of the potential involvement of some TCC members who were then asked to leave the room during discussions on the project. The subject is of interest and upon reading the document, the following are noted:

(i) The team of researchers for the project is competent and comprises specialists in the various aspects of the study;

(ii) The " Preliminaries ", rich in information for specialists in this medical field, could have been summed up into broad outlines;

(iii) Certainly, in the " Observations " section it was impossible to mention the entire work, but it is essential for " ORSTOM " and " OCCGE " to be highlighted;

(iv) Entomology is among the first studies on onchocerciasis; this aspect does not appear under the items mentioned in the "Problem" section. This could be corrected, because the first successes on this affection are due to the larviciding campaigns;

(v) It is essential to explain the acronyms as they appear in the text to make the document easily understandable. One has to wait until page 9 to know the meaning of DSM-IV-TR, which appears on page 5;

(vi) The presentation on «Problem" concluded by the concept of clinical tables from the psychological and psychiatric view point. However, the psychiatric aspect does not appear in the research issue, why?

(vii) The assumption of research project 1 (HR1) is it another formulation of the general assumption (HG)?

(viii) There four specific objectives and three research assumptions. As the objectives aim at answering the assumptions, it is necessary to inform the reader while specifying which objective is corresponds to which assumption;

(ix) Methodology gives a report on a questionnaire on perceptions of the populations on black fly, its action and the associated pathologies. This questionnaire should have been included in the document;

(x) The methodology expatiates on "DSM-TR", “CIDI" and "WHOQOL-26"; giving reasons for the choice of these methods and some bibliographical references would have reduced the text. The limits of each instrument could be raised during the discussion on the results;

(xi) In the timetable, does month one correspond to January or October?

(xii) The numbering of the titles of paragraphs of the project is to be re-examined: for example, 1 is found on pages 2, 7 and 9. In addition, in the presentation of research tools and instruments, one goes from paragraph 4 to paragraph 6. The same goes for paragraphs 9 (Interest of research) and 15 (expected outcomes);

(xiii) The table "Budget" remains to be checked for the headings on repulsive, inquiries about perception, testing Rorschach, clinical analyses.

339. In conclusion, this study has to be carried out, for it could bring additional information on the onchocerciasis disease and in particular on the "Epilepsy-Oncho" issue. However, this document must be reviewed. In addition, with regard to the amounts of the fixed prices of the items "Statistical analyses", "clinical Analyses " and " Drafting of the report", there is need for explanation.

340. **TCC rejects the study and recommends that**:

(i) The document be revised taking into consideration the above observations;

(ii) All co-investigators should be informed of the study and accept their participation in the study by signing the document;

(iii) The document should be sent to APOC via the NOTF

341. TCC will look for appropriately qualified external advisors to review the resubmitted proposal.

342. *Proposal from Cameroon*: Mr. WAMBOPONE Josué, TAKOUGANG Innocent: "Perception of TB and its influence on the efficacy of Community-Directed Implementation of DOTs". Based on the specific objectives of the proposal, TCC considers that funding of such a proposal is not within the mandate of APOC. ***TTC recommended that the researchers submit the proposal to a TB treatment and research focussed organization.***

343. *Proposal from Nigeria*: Studies on coverage and sustainability of community-directed treatment with Ivermectin (CDTI) among nomads of Taraba State, Nigeria.

(i) TCC regards this as a very important study and recommended that Dr. Katabarwa provides support to the researchers in elaborating the research proposal for resubmission to TCC.

344. **TCC recommended that**

(i) all operational research proposals should be signed by all co-investigators mentioned in the proposal;

(ii) NOTF should be provided with the opportunity to comment on the proposals prior to their submission.

20. DATE AND PLACE OF TCC 26

345. The 26th session of the TCC will take place from 10-15 March 2008, in Ouagadougou, Burkina Faso.

Annex 1

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Annex 2: MATTERS ARISING FROM THE 30TH MEETING OF THE NGDO COORDINATION GROUP FOR ONCHOCERCIASIS CONTROL

346. The 30th session of the NGDO Coordination Group for Onchocerciasis Control in conjunction with the 2nd NGDO Lymphatic Filariasis Network and the International Coalition for Trachoma Control was held from 5-7th September 2007 at APOC Headquarters in Ouagadougou, Burkina Faso.

347. Participants discussed two recent publications on possible ivermectin resistance. It was recommended that a press release to express confidence in the programme be developed and released immediately, emphasizing the positive health benefits of ivermectin treatment in APOC, former OCP and OEPA countries where coverage met distribution targets.

348. All countries with two or more NTDs should develop national plans for integrated NTD control as a first step to securing the necessary resources to implement comprehensive control programmes

349. It was noted that community involvement was critical to the planning and implementation of NTD control and that communities should be encouraged to drive the programmes if they are to be sustainable.

350. The Group was informed that WHO and partners were developing NTD Monitoring and Evaluation guidelines. A draft copy of the guidelines would be shared with the Group in October 2007. The Chair proposed to include the M&E guidelines as an agenda item for the next meeting.

351. The Group recommended that trachoma should also be included in the Guidelines.

352. The meeting benefited from the contributions made by coordinators of the National Programmes. The Group recommended that some coordinators be invited to future meetings.

353. It was noted that the five fast track countries benefiting from USAID funding had experienced a number of serious problems that prevented timely implementation of planned activities and modification of implementation strategies. It is recommended that some flexibility be allowed to ensure proper implementation of all planned programme activities. It is important to monitor progress in year two and to improve consultation and coordination. The Group would communicate with WHO to consider this recommendation as part of the planned evaluation.

354. The Group expressed its continued commitment to ensuring that the non-MDA components are included in all NTD programmes, and requested that this be addressed in the proposed evaluation coordinated by WHO.

355. The Group emphasized the need to look at all aspects of disease control and not just MDA, this would include identifying exit strategies. There will be important roles for health economists and social anthropologists in helping define these strategies. The group will invite a representative from the OEPA programme to the next meeting to discuss the lessons learned from the successful elimination of onchocerciasis in the Latin American foci.

356. Surveillance and impact evaluation requires prioritization within integrated programmes but it was recognized that the objectives and mechanisms would need to vary for each of the targeted diseases.

357. Although appreciating the expectations of donors, National programmes should ensure that their needs and priorities are well articulated, understood and respected by donors and not 'donor driven'.

358. The Group is developing Terms of Reference for the Technical Working Group.

359. It was recommended that the Technical Working Group's remit include consideration of options for establishing appropriate coordination mechanisms for NTD programmes.

360. APOC management urged programme planners to build on the lessons learned from the success of the onchocerciasis control programme to ensure active community involvement in decision making and implementation for sustainability. The group had been influential in the evolution of APOC and CDTI and has a powerful role to play in advocating for well designed NTD country and community driven programmes.

361. While the NGDO Groups recognize the advantages integration offers, the priority must be effective disease control which may not always include integration.

362. Interested NGDOs were requested to consider the possibility of supporting CDTI activities in Chad and the Group also recognized the request from CSSW for help to support the programme in Yemen.

363. The Group recommended the early development of integrated mapping tools for NTDs together with monitoring and evaluation by WHO.

364. The conclusions and recommendations of the working groups stressed the need for improved planning and coordination with all stakeholders. New NTD initiatives should be built into existing health programmes.

365. The diversion of drugs was discussed. It was recommended that mechanisms for

the importation, storage and tracking of drugs required better management and monitoring to enhance supply chain and inventory security and avoid diversion. APOC requested that they be informed of any future diversion of drugs as they had mechanisms already in place to address the problem.

366. Sponsorship from the Carter Center and RTI to support the attendance of the National and Deputy National Coordinators for the prevention of blindness (Mali and Niger) and onchocerciasis control and LF elimination (Ghana and Uganda) was gratefully acknowledged

367. Participants recorded their sincere appreciation to the Director and staff of APOC for generously hosting the meeting and providing the appropriate logistics.

368. The next combined meeting would take place in six months time - the place and dates to be determined.

Annex 3: IMPLEMENTATION OF TCC 24 RECOMMENDATIONS AND SUGGESTIONS

TCC recommendations	Follow up action taken
Angola • APOC management should recruit a Technical Advisor on CDTI implementation on a limited contract (2 -3 years), with clear Terms of Reference. The candidate should be fluent in Portuguese and should receive adequate training in the APOC philosophy and CDTI strategy (para. 23.i). • APOC management should undertake an advocacy visit to the highest level of government in Angola (para. 23.ii)	• Selection process completed at Country level and we are waiting for the decision of the AFRO selection committee taking into account the new regulations in WHO. • Not done at country level but discussions were held with the Director of health services as well as with other officials during missions in Geneva and Brazzaville.
Strategy for the elimination of onchocerciasis • POC continue to focus its resources on reaching high therapeutic coverage with ivermectin in meso-/hyper-endemic areas, and providing CDTI projects with support for clinic-based treatment in hypo-endemic areas (para. 28.i). • Mass treatment with ivermectin in areas hypo-endemic for onchocerciasis and co-endemic for loiasis should be avoided since the risk of L. loa-related SAEs may outweigh the benefit of treatment (para. 28.ii).	Noted and applied as needed. Noted and applied where applicable
Integration and co-implementation: • WHO should use available mapping data on onchocerciasis from APOC, who has already conducted 85% of the mapping. This will limit duplication of work and resource wastage (para.36).	Is being implemented in Burundi and will be done in Equatorial Guinea as well as in any other APOC country.
Operational research proposals: • The investigators submitting the proposal on infectivity rate of Simulium damnosum in cross-border communities in Ogun State, Nigeria, be invited to join the APOC study team to achieve their objectives (para. 39).	The investigators as well as technicians were trained by APOC and are now ready to conduct the fly movements study in Nigeria;
Operational research proposals:	

• Compliance study (para. 45):
  • Documentation of compliance should be institutionalized with annual summary columns in village registers and report forms;
  • Health education materials should be geared to specific low compliance groups and their perceptions and beliefs;
  • Ensure that the ivermectin stays long enough (3 months) toreach low compliers (e.g. younger and more mobile people);
  • Programs must continue to provide adequate and timely supplies of drugs to enable villagers to comply annually;
• The Committee advised APOC management to inform countries that received the special country initiative funds to ensure they revise the IEC materials in view of the results of the compliance study.
• TOR of the Task Forces on operational research at country level
	The process of revision of the registers is going on;
	
	Will be taken into account in the production of new Health education materials;
	
	Recommendation shared with all projects
	
	Recommendation shared with all projects
	
	The process is launched
	
	TCC promised to work on it

Final assessment of vector elimination in Tukuyu focus (para. 70): • The study must be conducted without delay; • The analysis be conducted by experienced laboratories that have a background in this type of examination; • The budget must be reduced by taking into consideration the number of cycles of captures/prospections, and the logistics requested by the project and	Done and the report available; Samples will be examined in the DNA laboratory of MDSC with the support of a cytotaxonomist of the former OCP and under the supervision of Prof. Rory Post who elaborated the protocol; Done by APOC Management.
Recommendations to APOC Management on Liberia (para.77): • APOC Management to ensure that the NOTF receives this correct reporting format. • Assistance be provided to the NOTF and the CDTI Projects by APOC Management, namely that APOC Management hold a workshop in Liberia on CDTI and report writing before TCC25	Correct reporting format sent to the NOTF: Workshop on APOC Philosophy and CDTI strategy conducted at county level. 2007 Ivermectin mass treatment completed in South East and commenced in September 2007 in North West and South West projects. Assistance was provided through a consultant and an APOC staff member. Advocacy conducted by the National coordinator with the support of the

to assist the NOTF and project staff with project implementation and reporting.	consultant for the parliamentarians agree on a budget for onchocerciasis control in Liberia;
Recommendations to APOC Management on Liberia (para.77): (cont'd) • • The new Liberia NOTF Coordinator be provided with an opportunity, if possible, to visit another APOC country to gain insight through the experience and lessons learned elsewhere. The Coordinator should also attend a TCC meeting within the next year, timing of which is deemed appropriate by APOC Management.	Will be implemented at a later date during Independent participatory Monitoring and Evaluations of projects. Will be implemented at a later date during Independent participatory Monitoring and Evaluations of projects.

Annex 4: TCC statement on efficacy of ivermectin

Ivermectin (Mectizan) remains effective for onchocerciasis (river blindness) control

The control of onchocerciasis (River Blindness) through the Onchocerciasis Control Programme (OCP) in West Africa and the African Programme for Onchocerciasis Control (APOC), with unwavering commitment from affected communities, national governments, non-governmental development organizations and an international donor collaboration involving both the private and public sectors, is widely recognized as one of the paramount public health successes in the developing world.

For 20 years the scourge of river blindness has been successfully controlled through regular treatments with ivermectin, alleviating poverty and improving the lives of millions of people in Africa. The publication by Osei *et al*.[1] in the Lancet suggesting that 'resistant adult parasite populations which are not responding as expected to ivermectin (Mectizan®) are emerging', has generated public concern.

The Technical Consultative Committee (TCC) of APOC, after careful review, concluded that the study findings are not conclusive and that possibility of other explanations exist that are not related to Ivermectin resistance. TCC, therefore, recommended surveys to clarify the situation in the field within the next 6 months. Furthermore, TCC stressed that the study by Osei et al, as well as other recent studies in Africa, provided compelling evidence that ivermectin is as efficient a microfilaricide today as it was in 1987 when its large scale use in onchocerciasis control was initiated. The TCC therefore strongly recommended the continuation of the current strategy for control of onchocerciasis through annual treatment with ivermectin.

The committee recognizes that population-wide treatment with a single anti-parasitic drug brings the risk of emergence of resistance and it will continue to monitor the effectiveness of ivermectin as the operational control tool. TCC supports the continuation of basic and applied research for better monitoring tools for potential appearance of ivermectin resistance as well as research for new methods for control, including a safe field-suitable macrofilaricidal drug.

[1]Osei-Atweneboana MY, Eng JKL, Boakye D, et al. Prevalence and intensity of Onchocerca volvulus infection and efficacz of ivermectin in endemic communities in Ghana: a two-phase epidemiological study. Lancet 369, 2021-2029, 2007

Annex 5: TCC proposed terms of reference for Task force on operational research at country level

a) Responsibilities: The task force members in each country will be responsible for:

(i) Assisting CDTI projects to come up with priority operational research topics and proposals based mainly on issues encountered during the implementation of the projects;

(ii) Selecting research topics that will be of importance to the implementation of the projects;

(iii) Facilitating workshops on research methods and developing acceptable research protocols with emphasis on practical exercises and case studies;

(iv) Reviewing proposals (technical and financial aspects) and making decision on financing;

(v) Assisting (as mentors) in the planning of research studies and in the implementation of approved studies of young researchers, and providing technical assistance during: the planning of field activities; data collection; data centralization; data analysis and report writing.

(vi) Advising the NOTF or any other body concerned by research on the use of findings;

(vii) Advising stakeholders on improving field methods, laboratory and research (quantitative and qualitative) capacity.

(viii) Meeting twice a year and determine procedures for convening the taskforce meetings

(ix) Reporting once a year, by 31 December, to TCC on decisions /funding/results.

(x) Ascertain the amount of funding (from country internal or external sources) available for research projects in the coming year.

(xi) Members of the task force will not receive per diems from a research proposal that the task force decided to fund.

b) Other responsibilities: The taskforce will

(xii) Specify guidelines for Request for Proposals (RFPs) and specific period of the year when they should be circulated. The RFPs will be circulated twice a year (January, July) through a focal point/secretary nominated by the Coordinator of the NOTF. Circulation should allow applicants at least 3 months to submit proposals.

(xiii) Specify the format for proposals (e.g. 1-2 page letter of intent prior to submission of a full proposal, full proposal) and reports (e.g. interim, final).

(xiv) Determine guidelines for proposal review and criteria for funding decisions based on importance of the research for the programme, cost of the study, and proposal inherent criteria (adherence to the format, clarity, scientific quality).

(xv) Determine the maximum amount of funding coming from country sources. For studies to be financed through APOC, APOC will provide guidelines and a cap on a year by year basis based on its approved budget.

(xvi) Determine rules under which members of the Task Force can submit proposals and, if appropriate, for evaluation of their proposals to avoid conflict of interest.

(xvii) Determine the rules for financing (recipient, instalments) and accounting for funding of studies financed through country funds (if not determined by country / MoH / donor regulations/guidelines).

(xviii) Specify funding of Task Force

c) Composition and Financing of the Task Force The Task Force will include members from the World Health Organisation (WHO), MOH, partner NGOs and other institutions deemed relevant by NOTFs who have the necessary disease control and/or research experience.

(i) The members will be selected by the NOTF. The chair of the NOTF will recommend the members to the relevant authority.

(ii) The Task Force will have a maximum of 5 members, with additional expertise being sought on an ad hoc basis.

(iii) Duration of membership should be 2 years, renewable once.

Annex 6: Recommendations of the meeting on integration of onchocerciasis control into the health systems and co-implementation of control of neglecgted tropical diseases

To participant countries

(i) Carry out advocacy to give NTDs recognition as a health priority and obstacle to national socio-economic development.

(ii) Include NTDs in the focus of Poverty Reduction Strategic Papers (PRSP) and the Medium Term Expenditure Framework (MTEF). Draw up by June 2008, national strategic plans with a component for a gradual take-over of activities by countries.

(iii) Increase the budget allocated to health, in conformity to the Abuja and Yaounde Declarations (15% of national budget), and effectively make national resources available for the control of onchocerciasis, other NTDs and malaria;

(iv) Establish and ensure the functionality of a consultation framework involving all stakeholders (ministry of health and related sectors, NGDOs, private sector, communities) for the planning and co-implementation of activities of control of onchocerciasis, other NTDs and malaria;

(v) Promote the Community-Directed Intervention (CDI) strategy, and if necessary, the school network in the co-implementation of the control of onchocerciasis, other NTDs and malaria.

To WHO

(vi) Assist countries in drawing up strategic plans, in co-implementation, follow-up and coordination of NTD control activities, documentation and dissemination of good practices.

(vii) Request the WHO Regional Director for Africa to earnestly plead with the President of Burkina Faso, His Excellency Blaise Compaore, to continue his advocacy for the control of NTDs at future African heads of State summits.

(viii) Develop and distribute technical guides on advocacy and co-implementation of NTD control activities, taking into account the language specificities of countries.

To APOC

(ix) Continue advocacy with governments and sub-regional and regional organisations with a view to mobilising national financial contributions for the control of onchocerciasis, other NTDs and malaria;

(x) Appoint goodwill ambassadors to enhance advocacy in favour of the control of onchocerciasis, other NTDs and malaria;

(xi) Build the local resource mobilisation capacity of countries and communities for the control of onchocerciasis, other NTDs and malaria.

To NGDOs

(xii) Streamline resource disbursement procedures for further flexibility in the planning of activities in the countries.