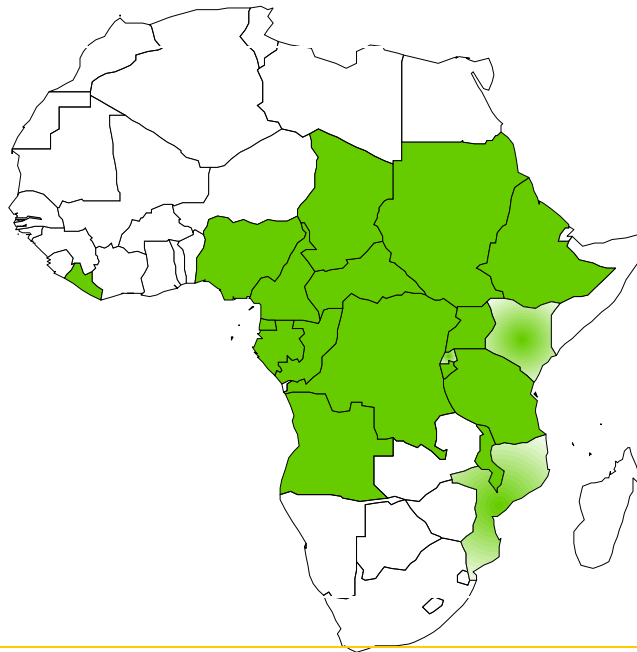


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**AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC)**

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**REPORT OF THE THIRTY-EIGHTH SESSION OF THE TECHNICAL  
CONSULTATIVE COMMITTEE (TCC)  
Ouagadougou, 10 – 14 MARCH 2014**

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## **ABBREVIATIONS/ACRONYMS**

AfDB	African Development Bank
APOC	African Programme for Onchocerciasis Control
ATO	Annual Treatment Objective
AWOL	Anti-Wolbachia
BCC	Behavioral Change and Communication
CBO	Community-Based Organisation
CDD	Community-Directed Distributor
CDI	Community-Directed Intervention
CDTI	Community-Directed Treatment with Ivermectin
CMFL	Community Microfilarial Load
CSM	Community Self Monitoring
DOLF	Death to Onchocerciasis and Lymphatic Filariasis
HKI	Helen Keller International
DEC	Diethylcarbamazine
FLHF	Front Line Health Facility
GAELF	Global Alliance for Elimination of Lymphatic Filariasis
GPELF	Global Programme for Elimination of Lymphatic Filariasis
HR	Human Resource
HSAM	Health Education Sensitisation Advocacy Mobilisation
HQ	Headquarters
HW	Health worker
IEC	Information, Education, Communication
IPM	Independent Participatory Monitoring
JAF	Joint Action Forum
LF	Lymphatic Filariasis
LGA	Local Government Area (in Nigeria)
LTS	Lohmann Therapy Systems
MDA	Mass Drug Administration
MDP	Mectizan® Donation Program
MF	Microfilaria
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
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
PC	Preventive Chemotherapy Treatment
PHC	Primary Health Care
RAPLOA	Rapid assessment procedure of <i>Loa loa</i>
RPRG	Regional Programme Reporting Group (LF)
SAE	Severe Adverse Events
SCI	Special Country Initiative
SHM	Stake Holder Meeting
SS	Sightsavers
TAS	Transmission Assessment Survey (LF)
TCC	Technical Consultative Committee (of APOC)
TOVA	The Onchocerciasis Vaccine for Africa
UTG	Ultimate Treatment Goal
VAS	Vitamin A Supplementation
WHO/AFRO	WHO Regional Office for Africa
WHO/NTD	Neglected Tropical Diseases – Department within WHO cluster of communicable diseases (WHO/NTD)

## **OPENING: Agenda Item 1**

1. In opening the Chair welcomed all participants to the thirty eighth session of the Technical Consultative Committee (TCC38) of APOC. He was glad to see all expertise attending the current session of TCC which is holding in the Conference Hall of the WHO Country Office in Ouagadougou, Burkina Faso. He said TCC38 is a very important one as it is taking place within the transition period of APOC during which a lot of changes have to be made. He looked forward to fruitful discussions in guiding APOC Management to implement those changes. On this followed the introduction of participants whose list is appended as annex 1.

2. The Director of APOC also welcomed all participants to the TCC, observing that the venue is different from the emblematic Conference Hall of APOC which is under renovation. He seized the opportunity to thank the WHO Representative in Burkina Faso for allowing APOC to use their Conference Hall. He observed that, as TCC was aware, there is a paradigm shift from control to elimination of onchocerciasis and APOC is in the transition period to PENDA, a new entity which has important implications. He informed TCC that for this reason, JAF and CSA directed the Management to strengthen the capacity of TCC with LF expertise. In addition to that, he recently obtained from the CSA, the appointment of two more LF expertise as observers in TCC. The two new observers are Drs Frank Richards and Maria Rebollo. He asked TCC to consider them on equal basis in discussions.

3. Dr ROUNGOU informed TCC that, to take into consideration JAF decisions and CSA guidance, APOC Management has determined eight priorities for 2014. These priorities are:

- i) Treatment of 120 million people for Oncho and increase LF treatment by 20%.
- ii) Be able to report countries/projects that have reached the breakpoint and can stop treatment.
- iii) Entomological assessment to make sure the breakpoint has been reached, especially in cross border foci.
- iv) Co-implementation of LF and Oncho as well as support to other PC-NTDs.
- v) Research: the need to determine what are the research priorities of the Programme.
- vi) Health System Strengthening, especially at the peripheral level.
- vii) Restructuring of APOC Management.
- viii) Resource mobilization: A P4 post is being created at Ouagadougou for resource mobilization.

4. The Director also informed the TCC of the demise on 27 January of Dr Jean Mouchet at 93. Dr Mouchet was one of the pioneers of vector control in the African continent especially through the training of several generations of medical entomologists. A minute of silence was observed in his memory.

5. Dr Yébakima also briefed the committee on the legacy left by the late Dr Mouchet for the future generations. He said that the late Dr Mouchet was a pharmacist who decided to take up the medical entomology at ORSTOM (French institute for research and scientific research overseas) in the early 1950s. He was for decades an internationally recognized authority in the field of malaria transmission and control, but he tackled also most of vector borne diseases over the world and chaired many scientific committees in France, WHO, OCCGE and other sub-regional health organizations.

He wrote the first 10-year report on OCP achievements, which was determinant for the continuation of the international community commitment at a critical phase of the Programme.

6. Dr ROUNGOU also informed the committee of the retirement in June 2014 of Dr Laurent Yameogo, Coordinator of APOC Director's Office, after more than 30 years of service in WHO/OCP and APOC.

The Chair thanked the Director of APOC for this address and observed that there is a lot to deliver in the TCC on a scientific base.

#### **ADOPTION OF THE AGENDA: AGENDA Item 2**

7. The Agenda was adopted with slight amendment for the TRC of Nigeria to make their presentation on the second day of TCC. The adopted agenda is appended as annex 2.

#### ***Security Briefing***

8. The chair allowed the UN Security Officer to brief TCC on the security situation in Burkina and particularly in Ouagadougou. He said the security level in Burkina and Ouagadougou is at level one but members should be careful about pick pockets who are common in all big towns, and to only take taxis recommended by the hotels.

#### **INFORMATION**

#### **MATTERS ARISING FROM CSA 142<sup>ND</sup> AND 143<sup>RD</sup> SESSIONS CSA AND JAF19 : Agenda Items 3 and 4**

9. Dr ROUNGOU, Director of APOC, presented a summary of matters arising from 142<sup>nd</sup> and 143<sup>rd</sup> sessions of the Committee of Sponsoring Agencies (CSA) as well as JAF19, as follows:

(i) The Transition Task Force (TTF).

10. The Transition Task Force was created in April 2013 with the role of providing technical advice on the Concept Note and the Strategic Plan of the new entity. Its membership was determined by the CSA. Now that the Concept Note and the Strategic Plan were approved by the JAF, the TORs of the TTF are being revised for the group to be able to give strategic and managerial advices to the CSA.

(ii) The Governing Structure of PENDA;

11. JAF requested that a Governance Structure be developed for the new entity, PENDA. A working group has been set up by the CSA to draft that Governance Structure and they will be working by mails and teleconferences with a meeting in Ouagadougou to finalize the document. The Director of APOC informed the Committee that the document should be ready for adoption by the JAF in 2015.



(iii) Venue of the next JAF:

12. The process of selecting the venue of JAF meetings is that countries express their willingness to APOC Management who inform JAF members of the venue. In this regard, Saudi Arabia had indicated their willingness to host the JAF and a letter was sent to them. Information received indicated that a favourable response will be received from the Saudi authorities by March 2014.

(iv) Management Review:

13. APOC Management reviewed the TORs for the Management Review which was discussed by the CSA and agreed upon. Experts are being recruited for the job. The expectation was to hire a firm or consultants who should be independent and whose job can be accepted by all partners. Independent consultants were selected for the review.

(v) 2014-2015 Budget:

14. There is a budget shortfall of 22 million US dollars. However, JAF requested the Programme to produce more result and CSA asked to do more in order to demonstrate to partners that the Programme can take up LF. Hence, the 2014 Plan of Action and Budget (PAB) submitted by APOC was 25 million US dollars. There was a lot of discussions on the PAB but finally CSA allowed the Programme to go ahead and implement the PAB but will review the implementation during the CSA of June 2014 and urged to intensify the resource mobilization efforts otherwise activities and budget would be reduced. The Director of APOC thought that effort should rather continue in resource mobilization instead of reducing the budget.

(vi) Concern expressed by LF constituency:

15. It was reported at CSA that LF constituency thinks that the TCC, as currently organized, does not listen to ideas from LF partners whereas it is not the case. Based on the advice of the CSA, in addition to the two members of the RPRG who are now attending TCC, two other experts, Dr. Frank Richards and Dr. Maria Rebollo were recommended to be appointed as TCC members. The director of APOC advised that they should be treated on equal basis in discussions and be listened to. They should also listen to TCC members and apply science based reflections.

(vii) Mechanism of Collaboration:

16. APOC Director informed TCC that during JAF19 in Brazzaville, the Regional Director said it clearly that APOC received autonomy and that this autonomy will continue with PENDA. In a teleconference during CSA 144 in Geneva in February 2014, the DPC of WHO/AFRO declared that the position of the Regional Director is that there is currently no policy or proposal concerning the mechanism of collaboration and that AFRO will adapt itself to the mechanism which will be developed for PENDA.

**TCC Comments:**

17. TCC thanked Dr ROUNGOU for the presentation and observed that there is a lot to tailor the new entity. The committee requested APOC Director to be an advocate to the LF constituency on the scientific based collaboration. The committee observed that the creation of the RPRG/TCC sub-committee is the best way of collaboration between the LF and Oncho constituencies, that TCC is

open to any discussion to push the Oncho/LF agenda forward. In any case, the two constituencies have no choice than to collaborate in order to improve the agenda of the two diseases in Africa. The committee advocated for synergy in order to move together. The committee also advised for dissemination of information at all levels including those at the field. It was observed that there is need to change the way of working and that the information process is very important.

18. It was noted from the discussions that the LF-RPRG held its last meeting in 2011. The deliberations of the group, country annual reports, drug applications reviews and country programme advices have been done through email communications. It was observed that for an effective collaboration between the TCC and LF-RPRG, it is important that WHO/AFRO management takes urgent measures to ensure that the LF-RPRG meet regularly reciprocating attendance of those meetings by APOC-TCC members.

19. For the TTF, the committee requested that the TORs be shared with them to have their input as some TCC members were worried about the duplication of functions between TCC and the TTF. The Director of APOC explained that the TTF was created by the CSA to advise the CSA on technical, strategic and managerial issues, that their advices remain at CSA level; that TCC advises APOC Management on technical issues. He agreed to share the TORs of the TTF with TCC members.

20. On the budget of APOC, the committee wondered if much could be realistically achieved given the budget constraints and how to balance the expectation put on the Management and the need to show that there is a change. The Director of APOC informed the committee that some CSA members were sympathetic to this concern but have to go ahead with that decision. He said there is hope because some major donors are expressing willingness to help. The examples of DFID and USAID was given. He said contacts have been made to bring some old donors back and that AfDB have already indicated their intention to fund PENDA. He also informed the committee of efforts made for other African countries to follow the example of Nigeria who donated five millions US dollars to the Trust Fund.

21. Regarding the approval of the Governance structure by the JAF of 2015, the committee wondered if it would not be too late to approve the Governance structure at the JAF of 2015 since PENDA should start with full speed in January 2016. The Committee was informed that defining the structure of an entity is a long process which has legal implications, that the draft document will be reviewed at the expanded CSA and the idea is to have one country representative per region to attend the expanded CSA. It is expected that a draft of the governance structure would be reviewed by JAF in December 2014 for the final document to be signed by partners at the JAF of 2015.

**NGDO: MATTERS ARISING FROM THE NGDO/NTD NETWORK MEETING:  
RECOMMENDATIONS ONLY: Agenda item 5**

22. Dr Franca Olamiju presented the key conclusions of the 43<sup>rd</sup> session of the NGDOs Group for Onchocerciasis Elimination which took place in Ouagadougou on 8 and 9 March 2014, as follows:

- (i) The group noted with appreciation the effort by GAELF to make input into the APOC concept note in order to address operational partnership towards improved coordinated MDA and coordinated stopping of treatment where necessary.
- (ii) The group noted a \$22m gap in the \$50 million 2014-2015 JAF approved APOC budgets and encouraged both old and new donors to step forward to fill the gap with all urgency.

### Update on PENDA discussions at JAF

- (iii) The group reviewed the JAF report and re-endorsed its statement on PENDA issued from its JAF breakout group session.
- (iv) The Group noted JAF report section 20 a-e in terms of five specific areas where rapid progress is needed leading up to the launching of PENDA (Annex).
- (v) The Group expressed concern as to whether LF/MDA could be scaled up by 2016. The budget of PENDA is predicated on this occurring. However, it was agreed that no budget adjustments should be made now for PENDA until after the LF and oncho mapping has progressed sufficiently by the end of 2014.

### Continued PENDA discussion

#### Key points

- a. There must be meaningful engagement of NGOs at all levels of PENDA, as well as in national management structures.
  - b. PENDA should not be a simple continuation of APOC but a significant transformation that includes the best of both LF and Oncho partnerships, and improve on what exists and what has worked. The Group reiterated its comments put forward in its JAF statement about the need for an independent technical group that provides equal footing for both oncho and LF communities. The Transitional Task Force will play this role.
  - c. There is the need for stronger national structures and government ownership facilitated by PENDA, which should help build national capacity.
  - d. The provision of technical and administrative support by NGOs to activities related to the PENDA Trust Fund should be reimbursed.
  - e. Donor mapping and coordination is important.
  - f. There are two categories of priority countries: a) those with the largest populations at risk, and b) those that are receiving little support ('orphaned'). PENDA special attention should be given to both.
- (vi) The Group was advised that AFRO/NTD Programme would adapt themselves to the structures developed for PENDA. The Group reiterated the need for continuing coordination and collaboration between AFRO, WHO Geneva and APOC.
  - (vii) With regard to broader consultation and management in the transition period of APOC, the Group supported and commended the appointment of additional LF advisers to the TCC, finalization of TOR for the TTF, the Working Group on Governance and the expanded membership of the CSA.

### NGDO LF and Oncho Groups

- (viii) The Group recommended that the Chairs, vice Chairs, and immediate past Chairs of the LF and Oncho groups form a working group to examine the possible merger of NGDO coordination activities as related to LF and oncho in Africa. Recommendations from the working group will be presented at a joint meeting planned for at the next NNN meeting in September 2014.

### Overheads for NGDO

- (ix) The group reiterated the importance of honouring the NGDO overhead provided out of the APOC Trust Fund in line with recent decisions by JAF and CSA.

### NGDO support in Geneva

- (x) The Group expressed concern that the Geneva office continue to have adequate capacity to continue their work including collection of treatment data and financial contributions by NGDO partners to provide its routine report to the JAF in December 2014, in view of the prolonged sick leave of the Geneva based GRO for onchocerciasis and the recent restructuring of the NTD department.
- (xi) The Group noted that it is the only NTD/NGDO coordination group that requires dues from its membership. This is an impediment to maintaining current members and needed expansion of the Group. These dues support the GRO post in Geneva, which currently has a deficit. Other disease specific NTD posts in Geneva have alternative funding models. This current arrangement needs to be reviewed in the development of PENDA.

### Switch from twice per year to four times per year APOC financial transfers to countries

- (xii) The Group noted that APOC has issued a new policy for quarterly disbursement of project funds. The Group expressed concern of the potential detrimental effect on programme speed and efficiency of implementation and scale up. The Group suggested strengthening country mechanisms to support improved and timely project reporting.
- (xiii) The Group heard updates from USAID, Carter Center, MDP and Yemen. The Carter Center reported progress in implementing twice per year treatments and halting oncho and LF treatments in some areas. MDP reported on the new joint NTD application and the need to forward a copy to the MDP office. It was noted that twice per year treatment activities required special notification to enable early delivery.
- (xiv) In the Yemen report it was noted that the WHO Roadmap calls for elimination of RB from Yemen by 2015. It is urgent to move this program forward. The Group commended the work by CSSW, the Ministry of Public Health and other partners to establish the Yemen Elimination Program for Onchocerciasis (YEPO). Technical support for mapping, and implementation of preparatory phase activities, have been important work of YEPO. The Group encourages all partners to work together to complete the processes necessary to arrange a partners' meeting to raise support and also to facilitate the placement of a focal person at the Ministry of Health.

23. The group also had discussions on several countries, including Nigeria, DRC, and the Republic of South Sudan (RSS).

#### Nigeria:

- (xv) The Group requested that National steering committees and APOC to agree to the MDA end date for Kaduna, Plateau, and Nasarawa States and review elimination strategy for other States with ongoing high endemic levels, e.g. Kogi, Ondo, Edo, and Taraba, among others. Security issues are of considerable concern, but many activities have continued unabated. The Group noted the launch by the Ministry of Health of guidelines for co-implementation of LF and malaria programs.

#### DRC

- (xvi) The Group commended the government on organizing a successful NTD partnership meeting in January 2014. The plan of action was agreed to by all partners and the program was encouraged to organize applications for drugs for LF elimination through the RPRG. The upper leadership in NTDs needs strengthening. The Group encouraged continuous collaboration and coordination of all the partners.

## RSS

- (xvii) The Group noted that due to civil conflict the drugs provided for 2013 MDA will have to be delivered in early 2014, assuming the security situation improves. The Group was also informed that partners are prepared to assist distribution of these medicines at short notice, as and where possible. It was recommended that a full presentation on RSS be given at the next Group meeting.

## **TCC Comments**

24. TCC thanked Dr Olamiju for the presentation and observed that with regard to stopping treatment, TCC needs to advise countries on when to stop treatment. It is not the Director of Public Health to decide on stopping treatment. Additional information was given that, in line with the TAS document of WHO, the country can advise. However given the relationship of Oncho and LF and the likely impact on Onchocerciasis elimination there should be due consultation before stopping treatment. Countries were advised to consult the NTD Steering Committee for guidance before concluding on those decisions.

25. TCC was informed that the guidelines on when and where to stop treatment for Onchocerciasis and verification has been sent out for independent external review and that classical review will be completed by September 2014. The TCC requested for a copy of this for their information and comments.

26. Concerns on the role of TTF were raised by the members when reflecting on the key conclusions of the NGDOs meeting. The TCC observed that the TTF cannot be a replacement of TCC, which is a statutory body within the APOC partnership governance structure. The TCC advised that the independent advisory technical group to be created for the new entity should be a strong group with the relevant expertise and experience to steer the elimination agenda in Africa. On the membership of the TTF, the TCC noted the need for gender and language sensitivity. (*Also see paras 10 and 19*).

## **TCC: FOLLOW UP OF KEY RECOMMENDATIONS OF THE THIRTY-SEVENTH SESSION: Agenda Item 6**

27. Dr Fobi presented a summary of the status of implementation of the TCC37 recommendations. The full text is appended as annex 3.

28. TCC thanked Fobi for the presentation and APOC Management for actions taken. However, the committee made the following suggestions:

- (i) In the next session of TCC the Management should make sure that presentations on follow-up actions be linked with the recommendations made by the TCC.
- (ii) Regarding Angola, Management should brief the committee on steps taken regarding that country and the outcome of such approaches.
- (iii) Recommendations to be implemented in 2014 should not be identified as on-going.
- (iv) Recommendations of TCC on when and where to stop treatment should be taken as general recommendations to be addressed to all countries.

## STRATEGIC AND TECHNICAL ISSUES

### 10<sup>TH</sup> NOTF MEETING: Agenda item 7

29. Dr Noma presented the outcome of the 10<sup>th</sup> NOTF Meeting which took place in Ouagadougou from 23 to 27 September 2013. 73 participants from 24 countries and 08 partner organizations attended the meeting. The objectives were:

- i) Review of the 2012 and 2013 Country performance on CDTI implementation for elimination of onchocerciasis.
- ii) Review of the 2012 and 2013 data on treatment, co-implementation, training, NGOs' and Government contributions.
- iii) Situational analysis of the activities to eliminate onchocerciasis, the strengths, weaknesses including cross-border issues, opportunities and suggested actions for the improvement of the elimination efforts.
- iv) Review of the epidemiological and entomological evaluations; Lessons learnt and priority actions to be taken.
- v) Experience sharing of countries best practices.
- vi) Preparation of JAF19 country presentations.
- vii) Governments and NGOs' contributions to onchocerciasis control/elimination.
- viii) Training of CDDs and Health workers.
- ix) Treatment and co-implementation.

30. Key recommendations were:

- i) APOC Management should intensify advocacy to Ministers of Health to ensure their greater involvement and support for CDTI activities especially in cross border meetings.
- ii) Countries with support from APOC Management should make more efforts to mobilize needed resources from governments and other in-country stakeholders.
- iii) To demonstrate accountability to donors, countries must provide expenditure returns to APOC timely for swift processing of funds replenishment. In addition, annual PABs should be submitted early enough (by July of the preceding year) for processing by APOC Management.
- iv) APOC management should develop a road map for onchocerciasis elimination at continental and country levels with specific milestones to be used as advocacy tools as well as for monitoring implementation.
- v) NTD Master Plans: platform for coordination and integration of implementation of activities. Onchocerciasis and LF elimination programme implementation to be integrated.
- vi) Countries to strengthen supervision and monitoring mechanisms, and make efforts to identify and cover the last village to be treated and should routinely validate reported coverage data to ensure effective coverage.
- vii) Importance of community self-monitoring and the inadequate implementation by projects due to knowledge gaps and resource constraints: APOC should provide training/re-orientation to the countries for its effective scale up.
- viii) To strengthen CDI strategy within the framework of onchocerciasis elimination, NOTF operations at country level need to be revitalized especially in poor performing projects.

- ix) Planning for epidemiological and entomological activities in countries should be initiated early, possibly in November of the preceding year to enable timely and a more effective conduct of activities.
- x) Need to build capacity at country level for evaluations. In this light, technical expertise of ex-OCP countries can be utilized in strengthening capacity for entomological studies in APOC countries.
- xi) APOC management should consider and explore alternative tools for both evaluation and surveillance activities.
- xii) Cross-border meetings should be conducted on a regular basis using resources mobilized from partners and governments.
- xiii) Countries that share boundaries should step up efforts to synchronize treatments and, where required, conduct mapping at the border communities.

#### **TCC Comments:**

31. TCC thanked Dr Noma for the presentation and the management for organizing such an important meeting. The Committee however observed that the recommendations of the meeting are recurrent ones and are formulated two years to the closure of APOC. The committee also wondered if there is any structured meeting where most of the recommendations are discussed and was informed that these will be dealt with at the coming Review and Planning meeting of 17 to 22 March 2014.

### **ELIMINATION OF ONCHOCERCIASIS INFECTION AND INTERRUPTION OF TRANSMISSION: Agenda item 8**

#### **(i) Elimination of Onchocerciasis with ivermectin in Africa:**

##### *a) Update on Entomological/Epidemiological evaluations.*

32. In 2013, phase 1a and 1b epidemiological evaluations have been conducted in 15 sites, 310 villages in six countries, namely Burundi, Chad, Ethiopia, Liberia, Nigeria and Tanzania, examining more than 77,000 people. A total of 30,808 people were examined out of which 97 were Onchocerciasis microfilaria (mf) carriers, corresponding to a prevalence of 0.31%, ranging from 0.00% to 5.53%. In the overall, from 2008 to 2013, epidemiological evaluations have been conducted 1,053 villages distributed in 12 countries, examining more than 230,000 people. Highlight of some of the major findings of the 2013 epidemiological evaluations are listed below:

33. **Chad:** To date 162 villages all over the transmission zone of Chad have been evaluated. The results remain very impressive, showing a very good progress towards implementation. In 2013, 84 villages were evaluated, examining 29,311 people with an average prevalence rate of mf at 0.07%, with a range from 0-2%. Compared to the predicted level of the prevalence in 2013 the result is faster than predicted.

34. **Burundi:** Out of the total 71 villages evaluated to date, 61 were evaluated in 2013 for Phase 1a and 1b epidemiological evaluation in two CDTI projects of Bururi and Rutana and the surrounding non-CDTI areas, examining 24,998 people. The result showed an average prevalence of 0.03% with a range from 0-1.5% which is much faster than the expected 2013 predicted prevalence level.

35. **Ethiopia:** The North Gondar CDTI project Zone was evaluated in 2013 involving 20 villages, examining 2,986 people where none of the villages has mf infected people. Again, the progress compared to the prediction for the year is better than expected.

36. **Nigeria:** Seven projects (Niger, Kano, Kwara, Kebbi, Oyo, FCT and Taraba) have conducted phase 1a evaluation involving 86 villages, examining 13,256 people. Niger, Kano and Kebbi did not have any positive case while the rest of the States evaluated have also showed very good results, much faster than the expected prevalence level. Taraba State also has good progress compared to the 2009 result after which there was intensification of CDTI activities. However, due to the very high level of pre-control onchocerciasis endemicity there is need to hasten the elimination process.

37. **Tanzania:** Two CDTI projects of Tunduru and Morogoro were evaluated for phase 1a epidemiological evaluation in 40 villages, examining 6,617 people. In Tunduru, all the 20 villages evaluated have cleaned the disease with no positive cases while in Morogoro, particularly in the Morogoro rural district, the infection level is still there but less than the expected level of prevalence. In order to achieve the elimination of onchocerciasis as planned in Tanzania there is need to reconsider intensifying CDTI in Morogoro and adjacent CDTI projects.

38. **Liberia:** In 2013, phase 1a epidemiological evaluation was conducted in South West CDTI project of Liberia, a post conflict country. The evaluation was conducted in 19 villages, examining 3,554 people with an average prevalence level of 6.5% with a range from 0-18%. Compared with the predicted level of endemicity, the project is on track but still needs to strengthen CDTI in those problematic areas.

**TCC comments:**

39. The committee thanked Dr Afework Tekle for the presentation and congratulated APOC Management for the excellent job done. The committee observed that the video used at the end of the presentation could be utilized for advocacy and resource mobilization. TCC also observed that in looking at the epidemiological evaluation in general, the results are much better than predicted by the models, based on pre-control onchocerciasis prevalence. The committee also noted that some countries such as Burundi and Chad are showing very good nationwide epidemiological evaluation results.

40. TCC recommended complementing the good epidemiological results with entomological transmission assessment survey to know the situation in the vectors.

41. The Committee requested APOC Management to conduct studies on the reason or determinant factors of poor performance in some projects from previous epidemiological evaluation results.

42. With regard to stopping treatment in projects that reached the breakpoint, a social study should be carried out on how to persuade those communities to stop treatment. Two members of the committee were designated to reflect on the issue.

43. With regard to twice yearly treatment in problematic areas, TCC referred to its earlier recommendation which said that this method will be used by projects which started late, sites where there is very high pre-control data which Onchosim has predicated interruption would not be feasible with annual treatment by 2025, and that another strategy should be applied to projects not performing well because it might be managerial issues.



## **Community preparedness:**

44. The TCC considers that communities that have been receiving treatment for many years need to be prepared for treatment cessation. This priority is captured in Activity Area 2.1 of the PENDA 2016-2025 Strategic Plan. It would also be worth to document experiences regarding community preparedness for projects that have already stopped treatment, for example in Uganda. The APOC Management should urgently initiate a process of developing a toolkit for community preparedness to stop treatment.

### *b) Transmission assessment*

45. The presentation was on the update of the overall entomological activities since TCC 37 and therefore made reference to the recommendations of TCC37 and JAF19. The presentation therefore covered (1) transmission assessment and (2) delineation of transmission zones.

46. The objective of this exercise was briefly mentioned as “to determine if transmission has been eliminated and ivermectin treatment can be stopped”. This was followed by information on assessments in 3 States in Nigeria (Kaduna, Enugu and Ebonyi) which were done on an experimental basis since vector collection was for two months (November and December 2013) instead of 5-6 months for a full assessment. The planning followed close collaboration between the Entomology and Epidemiology teams in APOC and the REMO Maps were used to decide on where sampling for productive breeding sites should be done. Although the sampling were undertaken in the dry season, the data showed that good numbers of adults (8,148 at Enugu; 5,273 at Ebonyi and 2,480 at Kaduna) can be obtained if the search for productive breeding sites are done properly. The flies collected will be sent for processing at the Ouagadougou laboratory for infection status.

47. A full transmission assessment is being done in Malawi where detailed larval breeding site was undertaken in 2013 and a network of 11 vector collection sites selected, entomology technicians and vector collectors selected and trained. Sampling of adult *S. damnosum* s.l. started in January 2014 and will continue till May, 2014. It is expected that complete data analysis and conclusions will be available for the next TCC. The presentation continued with Pool screening results for samples collected in 2012-2013 for the following countries: Niger, Chad, Mali, Ghana, Cote d’Ivoire, Burkina Faso, Benin and Uganda. The results were variable and it was suggested that sampling should be standardized across endemic countries for comparable results and conclusions. Following this, the plan for 2014 was presented taking into account TCC37 recommendations that “A road map should be developed with timeframe for activities and efforts should be made to prioritize the countries in carrying out activities”.

### *c) Update on delineation of transmission zones*

48. The activities undertaken since the TCC37 included sampling and training of technicians in Ethiopia, Sudan, South Sudan, DRC and Burundi as well as cytotoxic identification of samples from Ethiopia, Republic of Congo and Sudan for analysis and developing transmission zone maps.

49. Overall, a total of 22 possible breeding sites were visited in Ethiopia, 46 in Sudan, 18 in South Sudan, 40 in Burundi and 46 in DRC. During the sampling, a total of 24 candidates were trained comprising of 8 females and 16 males. There are four from Ethiopia, six from Sudan, two from South Sudan, three from Burundi and nine from DRC.

50. Samples from Republic of Congo have been processed and two species of *S. damnosum* complex were identified. These were *S. mengense* not reported to be a vector but needs confirmation

and *S. squamosum*, a known vector but which does not migrate for long distances. This species usually have isolated populations around particular breeding sites.

51. Samples from the North Gondar focus in Ethiopia belonged to the *S. damnosum* sub-complex. However, they were different chromosomally from all described members of this sub-group found in Uganda, Sudan and West Africa. Provisionally they are termed as “Gondar form of the *S. damnosum* sub-complex”. It was suggested that sampling be done in the adjacent Metekel area as well as on the border with Sudan in the Atbara river system to determine if this is one transmission zone. While sampling has not been done in the Metekel area, the samples from Sudan were from the Atbara focus. Chromosome analysis of these samples indicates that they are similar to the “Gondar form of *the S. damnosum* sub-complex”. Thus the North Gondar focus and the Atbara focus in Sudan belong to one transmission zone.

52. The plan of delineation activities for 2014 was presented and also it was mentioned that processing of samples from Burundi, DRC and South Sudan were reported to be on-going.

#### **TCC Comments:**

53. Following the presentations, the TCC discussions centred on:

- i) The capacity at APOC for the volume of entomological activities that need to be taken. It was mentioned that APOC management is currently using capacity developed over the past couple of years, expertise from the OCP as well as expertise from external institutions to support the in-house entomological expertise available.
- ii) Selecting countries for priority entomological assessments so that the few resources available are not dispersed.
- iii) Working through universities and other institutions within the countries to obtain support for entomological activities.
- iv) On the questions as what happens when the entomological results particularly, transmission assessments of infection rates indicate possible on-going transmission such as the case in Burkina Faso, APOC management provided information on how it liaises with country programmes to initiate studies to determine the possible sources of infection and increase and improve treatment coverage rates.
- v) Collaboration between the Entomological and Epidemiological teams within APOC.

54. Based on the discussions the TCC recommended the following:

- i) Support the techniques being currently used in APOC and that capacity being built within the countries should be accelerated.
- ii) Collaboration with institutions both within and external to endemic countries to provide complementary support for entomological activities and also the development of newer tools should be strengthened.
- iii) Selection of countries for entomological assessments should be based on epidemiological considerations and evaluations towards the elimination goal.
- iv) Requests for candidates to be trained for entomological activities could be channelled through the links that APOC has established with Universities in Africa since they would normally have on their staff personnel who can provide such support to the countries.

- v) Encourages the continuation of cytotoxic training and studies to delineate transmission zones and encourages the collection of material that may be used for molecular studies to complement the ongoing cytotoxic work.

d) *Delineation of treatment boundaries.*

55. An update on the delineation of treatment boundaries was presented by Mr Zoure. With the shift from control to elimination, APOC embarked in the collection of additional baseline data in order to decide whether to extend treatment for onchocerciasis elimination to areas previously declared hypo-endemic (nodule prevalence < 20%) when the objective was control of onchocerciasis. Data collection was done through surveys using skin biopsies for *Onchocerca volvulus* microfilariae.

56. Thirteen countries were identified for the conduct of the surveys (Angola, Burundi, Cameroon, CAR, Chad, Congo, Côte d'Ivoire, DRC, Equatorial Guinea, Ethiopia, Gabon, Mozambique and Nigeria). Surveys have been implemented in Burundi (40 villages), Cameroon (40 villages in Littoral, South, East and Centre regions), Chad (23 villages) and the mainland of Equatorial Guinea (40 villages).

57. In Cameroon, the standardized prevalence of *Onchocerca volvulus* microfilaria ranged from 0% to 4.8% in the South region, from 0.7% to 10.8% in Littoral region, 0 – 6.22% in East region and 0 – 3.44 in Centre region. The village with 10.8% prevalence is located in Edea health district where the REMO kriging map estimated the nodule prevalence to be between 15% and 20%. There is need for extension of treatment to cover the remaining untreated part of Edea district using non ivermectin-based strategy. There is no need for the extension of treatment in the South region.

58. In Chad, only 2 villages out of the 23 had people with *Onchocerca volvulus* microfilariae; one person in each of the two village was positive. The standardized prevalence of microfilaria in all villages remained 0. There is no need for extension of treatment, however additional villages should be selected and surveyed in Benoye, Deresia, Laï, Bohobe and Bou Kebir districts during the forecoming phase 1a and phase 1b epidemiological evaluation.

59. In Burundi, only 3 villages out of the 40 had individuals positive for *Onchocerca volvulus* microfilariae, the highest standardized prevalence being 0.40%. The standardized prevalence of microfilaria in the two villages were 0.2% and 0.3%. There is no need for extension of treatment.

60. In the mainland of Equatorial Guinea, 40 villages surveyed revealed that 6 individuals in 4 villages were positive out of a total number of 2042 individuals examined. The highest prevalence was 7%. Migration information collected for the 6 positive individuals revealed that all of them lived for several years in either the rural area of Bioko island or in Gabon, suggesting that these infections may not be from a local transmission. Before concluding that there is no need for the extension of treatment in the mainland of Equatorial Guinea, additional surveys will be conducted in villages selected at the border with Cameroon and Gabon.

61. From the results of these surveys conducted in 2013, it is observed that in none of the villages, the prevalence of microfilarodermia has increased compared to the mapping prevalence. In Cameroon, there is a need to extend onchocerciasis elimination activities in the entire Edea health district and to ensure that all inhabited areas in Betare-Oya, Bertoua, Lomie, Messamena, Meyomessala, Eseka, Okola, Ngog-Mapubi, and Esse health districts are also covered using non ivermectin-based strategy.

62. It may be useful to consider entomological assessment to confirm source of infection in areas where infected individuals were reported.

63. The main challenges faced by countries and APOC headquarters are related to the funding of the survey exercise and the availability of tools for the diagnostic of onchocerciasis infection. However, possible support from AFRO/NTDs through the Bill and Melinda Gates Foundation's "Shrinking the Maps" project is an opportunity.

#### **TCC comments**

64. TCC commended APOC management for the exercise and after enquiring for some clarifications made the following comments.

65. The contribution of APOC to building national capacity on the implementation of epidemiological assessment has been recognized. However, lack of diagnostic equipment at country level may hinder the sustainability of this achievement. There is a need for APOC to find ways of equipping countries with the appropriate diagnostics tools.

66. With regard to the decision of extending interventions to areas initially classified as onchocerciasis hypo-endemic areas, the threshold of 10% microfilarodermia prevalence described in the APOC guidelines was discussed. A question on whether it is not more appropriate to give more chance to the intervention than limiting the inclusion of hypo-endemic areas was raised.

67. For ethical purpose, it was recommended that survey teams should find ways to treat individuals that will appear to be infected following the skin snip examination.

68. The representativeness of the sampled individuals in communities where the burden of the disease is assumed to be low has been discussed. In this regard, it was suggested that future presentations of the assessment results should show rate of refusal and absentees.

#### **Perceptions towards diagnostic tools:**

69. TCC recommends that community reactions to diagnostic tools, **such as skin snip and OV16**, should be systematically documented to inform programme implementers on how best to prepare communities for the investigations. It is important that all evaluations that use any of these tools document and capture the reasons for refusals in guidelines for community sensitization and evaluations. This process would require the input of social science research.

*e) Concept Note on Elimination of onchocerciasis in all hypo-endemic areas by 2020 –Revised version.*

70. Dr Afework presented the revised version of a concept note on elimination of onchocerciasis in all hypo-endemic areas by 2020 based on the input of TCC 37 in September 2013.

71. The following major changes have been made to the initial Concept Note: (i) The Concept Note objective was revised to reflect the delineation of ivermectin treatment boundary, setting up of CDTI projects in the newly identified hypoendemic areas; (ii) The concept note has been re-packaged with additional information to support why earmarking hypo endemic areas for treatment with a clear methodology, only targeting 2014 and 2015, while the rest of activities are moved to be covered under the PENDA strategic plan of the period 2016-2025; (iii) Additional activity outlined in the

concept note is loasis issue in hypoendemic areas which should be addressed by piloting test and treat strategies or using alternative drug such as doxycycline.

**TCC Comments:**

72. TCC thanked Dr Afework for the presentation and APOC Management for the revision of the concept note to address the critical issue of hypoendemic areas and recommended starting treatment as soon as possible.

73. TCC further recommended that due consideration be given to lymphatic filariasis elimination implementation activities during the delineation of ivermectin treatment boundaries.

74. TCC also recommended to accelerate the finalization of the comparative study of skin mf prevalence with onchocerciasis nodule rate which started recently at APOC level.

*f) Alternative Treatment Strategy Selection*

**Preamble:**

75. APOC management made a presentation of a list of projects eligible for alternative treatment, including twice a year treatment and test and treat strategies. Concern was raised about the selection process applied by management. TCC called for a more systematic and transparent approach for making decisions regarding eligibility for alternative treatment. TCC took the initiative to draw up a list of relevant indicators for APOC's consideration. This list of indicators is appended as annex 4.

**TCC and APOC Management comments:**

76. APOC Management found the draft indicator list generated by TCC useful. At the same time acknowledged that more work needs to be done in following areas:

*Specific comments on the indicator list:*

- The title does not fully reflect the purpose of the indicator list. A more appropriate title might be “*indicator list to guide alternative treatment decision making*”.
- The duration and quality of mass campaigns listed as an illustrative reason for considering alternative treatment should be re-categorized as a key indicator, given its influence on compliance.
- The indicator “*% of nomadic communities within project area*” should be dropped, because of foreseen measurement issues.
- Indicators to assess human resource capacity are of importance: For example, *availability of entomologists and entomological assistants*.
- Other process indicators which influence performance should be added to the list. For example “*reliability of reported coverage, operational CDDs per community, involvement of peripheral health services in different CDI, activities, national experience in epidemiological and entomological surveillance, contribution of management and finance aspects to under-performance*”.

*Comments for Way Forward:*

- There is need to further trim down the list by selecting critical and minimum indicators required to establish alternative treatment strategies.
- Following the selection of critical indicators, it will be necessary to develop a grading system, which will take into account indicators by assigned weight, for a more objective process to guide the decision making processes regarding which projects are eligible for alternative treatment.
- APOC will consider applying modelling principles to improve on the grading system decision making process. However, it was acknowledged that this process will be time consuming.
- Consider the final list of indicators to improve the existing APOC management decision making scheme.

**Conclusion**

77. TCC endorsed the ongoing initiative by APOC regarding the use of alternative treatment strategies, where this is found necessary.

*g) Update on black flies trapping and other studies related to onchocerciasis*

78. Dr Toe updated the TCC on the blackfly trapping, noting the progress made towards its implementation in the field, some of which are as follows:

- i) The design of the trap is now adopted. The Esperanza window trap has shown its efficacy in collecting the savannah species with captures at least equal to the performance of the vector collector.
- ii) Physiological age of the fly population has been determined using flies collected on the trap. The percentage of parous flies is the same when compared with the flies collected by vector collector.
- iii) Training on the use of traps was carried out for members of the national entomological team of Nigeria and members of entomological team of Burkina. In the next entomological surveillance exercise, large scale evaluation of the trap will be made in parallel with the human landing collection.
- iv) Optimization of the baits to cover the different fly species is a challenge as extending the area of use of the traps from savannah to forest flies.

**TCC comments:**

79. TCC reaffirmed the need of having a new and more efficient tool to collect flies for entomological monitoring and surveillance, and recommended that the transfer of the trap technology to national teams be accelerated.

80. TCC encouraged APOC Management to continue the support given to the research team for optimizing and implementing the use of the traps.

81. Regarding the bait formulation, TCC recommended that studies be carried out to optimize the bait formulation for the current trap design. The trap should be evaluated on the forest dwelling species of *S. damnosum* and other vector species, and optimized if necessary.

*h) Predictive S. damnosum habitat modeling in Burkina Faso and Northern Uganda*

82. Dr Toe updated the TCC on the latest finding of the study. The primary model predicting *Simulium damnosum* breeding sites was based on images extracted of Quickbird with a resolution of 0.61. A move has been done using images of Rapid Eye which are less precise (5m). 5m Rapid Eye model reduces the cost by 100 fold. Rapid Eye model is 78% sensitive vs. the sensitivity of 100% for Quickbird model.

83. The study group identified work that need to be carried out in the following domains:

- Validation of Rapid Eye model in other countries.
- Extension of approach to mapping other species breeding sites: Forest dwelling *damnosum spp.*, *S. neavei*, Canopy cover represents a technical challenge to this process.
- Application of existing models to identify breeding sites in unmapped areas.

**TCC comments:**

84. The use of breeding site modelling is to be encouraged to assist the entomology and epidemiology teams in mapping areas of onchocerciasis and for the identification of capture points and communities for epidemiological surveys.

*i) The use of skin snips for estimating prevalence of infection in hypoendemic areas*

85. Pr. Unnasch made a communication to the TCC on work performed by CDC on the use of skin snips as a primary screen for estimating prevalence of infection in hypoendemic areas. Skin snipping as a primary screening tool is problematic in communities with adequate coverage, due to low compliance by the community, the need to sample a large proportion of the population and poor sensitivity in individuals with low microfilaridemia. Research is needed to develop alternatives to the skin snip as a primary screening tool, such as employing the Ov16 assay or DEC patch test as a primary screening tool coupled with a skin snip confirmatory assay, or use of the skin scratch PCR and a primary or confirmatory screening tool. These assays should be evaluated using the skip snip PCR as the gold standard.

**TCC comments:**

86. The TCC recognized the operational difficulties that exist associated with the use of the skin snip as a primary screening tool.

**Recommendations:**

87. The sensitivity of the skin scratch PCR should be evaluated to determine if it might be used to replace the conventional skin snip. The use of other assays as a primary screening tool followed by skin snip confirmation should be evaluated as an operational tool. (*Also see para 69 on perceptions towards diagnostic tools*).

**(ii) Elimination of O. volvulus infection: New diagnostics of PATH**

88. Mr Peck presented PATH's project goals and objectives for developing a field-friendly rapid test for detecting IgG4 antibodies against the *O. volvulus* antigen Ov16. PATH has developed the test and has transferred it to Standard Diagnostics. Standard Diagnostics is conducting manufacturing scale up. When complete PATH and Standard Diagnostics will conduct activities to verify that the product performs as designed and intended. Product launch is anticipated for the fourth quarter of

2014 after which demonstration studies can be conducted. The primary use case for the rapid test is in post-treatment surveillance activities to screen children for possible exposure and by inference detecting recent reinfection of the area. Other possible uses to consider are mapping to delineate transmission zones and possible use as a tool to help in the decision to stop treatment, similar to the use of the Ov16 ELISA by OEPA. Demonstration studies should be structured to generate objective evidence about the performance, logistical feasibility, and suitability of the SD Bioline Onchocerciasis IgG4 test in post-elimination settings. PATH is seeking to reach a non-binding memorandum of understanding with APOC in order to conduct demonstration studies with respective National Onchocerciasis Task Forces. Additionally, PATH is proceeding with development of a biplex test that will detect IgG4 antibodies against *O. volvulus* antigen Ov16 and *W. bancrofti* antigen Wb123.

### **TCC comments**

89. TCC members were encouraged by the progress of the test but sought clarification on the following:

- How ready is the test for the field? The answer was that the Ov16 test is ready to be verified in the laboratory and field, preceding the product launch. After product launch the product will be ready for demonstration studies in the field. The biplex Ov16/Wb123 is in development.
- What is the sensitivity and specificity of the test? PATH said that verification activities of the Ov16 test will better define these performance criteria.
- Whether the test has been evaluated for cross reactivity with similar species, especially in African populations where *O. ochengi* is present? The reply was that Laboratory studies have been conducted with endemic negative samples and cross reactivity appears to be limited with other species, but further evaluation in field settings is important.
- How does Ov16 antibody compare to the timeline of infection and appearance of microfilaria? It was mentioned that animal models indicate that IgG4 antibodies against Ov16 appear about one year after infection, which appears approximately 3-4 months before microfilaria are detectable in the skin. This antibody response appears to persist after the infection clears.

90. TCC thanked PATH for the presentation and wished the project continued with success.

### **(iii) LF and Oncho elimination Programmes collaboration**

91. Dr Ricardo Thompson presented the outcome of the third meeting of the RPRG/TCC Joint Working Group (JWG) on LF and Oncho elimination Programmes collaboration. He recalled the rationale for the JWG, its objectives, the membership, the current context of LF and Oncho elimination, the relevance of the JWG and key activities for 2014-2015. He also spoke of the Terms of Reference (TORs) of the Transition Task Force (TTF) created by the Committee of Sponsoring Agencies (CSA) for the transition period. The full presentation is appended as annex 5 of this report.

### **TCC comments:**

92. TCC thanked the JWG for their work. Regarding the clarification on the role of the JWG and the mandate of the group, the committee recalled that the group was created in order to have a link between RPRG and TCC and that the first meeting of the JWG took place in Bujumbura in December 2012 and the outcome of that meeting was submitted to the JAF of Bujumbura which endorsed it and



requested that activities of the group be supported by APOC and AFRO. TCC therefore recommended that the RPRG/TCC JWG should remain as its activities are necessary for the RPRG and TCC during the transition period. The committee was however eager to see the participation of TCC members of the group at RPRG meetings as members of the RPRG group participate in TCC meetings. (*Also see para 18 above*).

93. With regard to the concern of the JWG vis-à-vis the TTF, and the possible duplication of activities between the two groups, the committee observed that the JWG is the fruit of collaboration between RPRG and TCC within the framework of LF and Onchocerciasis elimination. The committee recalled again that the TTF was created by the CSA to advise CSA during the transition period. (*Also see paras 10, 19 and 26 above on the TTF*).

94. Regarding the reporting format, while some advised to use reporting format designed by AFRO and accessible electronically as all indicators are in that format and it is a tool that will be used by the WHO system, it was pointed out that it is not possible for countries to be connected to the system. The committee therefore advised that data of that system can be used. However, there is need to have a standardized reporting with narratives.

#### **(iv) Perspectives of Lymphatic Filariasis (LF) and Onchocerciasis elimination (DOLF)**

95. Dr Boussinesq made a presentation on the DOLF Project (Death to Onchocerciasis and Lymphatic Filariasis). This project, run by Professor Gary Weil (Washington University, St. Louis, MI, USA), is funded by the Bill & Melinda Gates Foundation. Its objective consists in conducting controlled and randomized clinical trials and community trials that aim at developing new treatment strategies that contribute to accelerating onchocerciasis and lymphatic filariasis elimination. After the presentation of different trials implemented as part of DOLF, Dr Boussinesq presented the preliminary results of one of the trials whose objective is to assess whether treatments with Albendazole alone, administered every six months, would lead to the elimination of lymphatic filariasis.

96. This strategy was recommended by WHO/AFRO for LF control in areas where loiasis is co-endemic and where Ivermectin cannot be administered because of the risk of occurrence of Severe Adverse Events. The trial began in September 2012 at Seke Pembe, a village in the Department of Bouenza in the Republic of the Congo. A year later, the prevalence of antigenemia (assessed by ICT test) and that of *Wuchereria bancrofti* microfilaremia did not significantly decrease at Seke Pembe (17.3% to 16.6% and 5.3% to 4.2% respectively). Because this result was probably caused by the arrival of new infected people in the village between 2012 and 2013, an additional analysis was done on a cohort of 38 people who had been surveyed in 2012 (and were ICT test positive) and also in 2013. In this cohort, it was noted that 37% of positive people in 2012 were no longer positive in 2013.

97. On the other hand, the average micro filarial load in these 38 subjects had 84% decrease. The score of the ICT tests had also considerably decreased in these subjects, leading to the belief that the two treatments with Albendazole administered in September 2012 and March 2013 had a positive impact on the viability of *W. bancrofti* adult stages. Moreover, the monitoring of the levels of infestation by soil-transmitted helminths shows that the two treatments had a moderate effect on prevalences and the intensity of infection by *Ascaris lumbricoides* and *Trichuris trichiura*, but it also shows that the impact on hookworms was very significant (decrease of prevalence from 19.7% to 0.7% and of intensity from 53 to 31 eggs per gramme of stool).

98. These preliminary results indicate that WHO/AFRO's recommendations regarding LF control in a loiasis co-endemic area are probably right. In addition, this strategy could have a significant impact on ankylostomiasis, a major cause of anemia in Africa. The Seke Pembe study is going to continue for two additional years and a similar trial will be implemented in 2014 in the Province of Bandundu in the DRC.

#### **TCC comments**

TCC thanked Dr Boussinesq for the presentation and the excellent work done in providing evidence through operational research. The committee recommended that the guidelines provided by WHO be disseminated in the countries for use in the field.

#### **(v) Presentation of the recommendations of UOEEAC (Uganda) on stopping treatment in some foci of Uganda**

99. The recommendation of the 6<sup>th</sup> session of Uganda Onchocerciasis Elimination Expert Advisory Committee (UOEEAC) was presented to TCC. The report provided background information on the Elimination project in Uganda, the rationale for the elimination policy, guidelines for certification of elimination, committees established to steer elimination activities and summary of UOEEAC conclusions from 2011-2013.

100. The epidemiological and entomological data for the two foci (Wambabya and Kashoya-Kitomi) where interventions were recommended to be halted in 2014 were also presented. The data included trend of treatment record, crab infestation, adult fly catches, mf prevalence from sentinel sites and Ov16 results for children <10 years from the two foci.

#### **TCC Comments:**

101. The key issues raised were on the status of APOC supported vector elimination projects, the level of isolation of the foci where interruption has been achieved, interventions for areas where interruption of transmission was suspected and the linkage between National Certification Committee and the WHO verification team.

102. TCC commended the effort made in elimination activities in Uganda. However, the committee underscored the need for the project to provide a dossier of projects where halting of intervention has been recommended for review by TCC members. This they emphasized was necessary for all projects that may intend to halt intervention after reaching elimination break point.

103. TCC endorsed the report and recommended that the Ugandan Programme prepare a dossier for projects where transmission of onchocerciasis has been interrupted and submit these to TCC for their review. (*Also see para 44 on communities' preparedness for stopping Ivermectin treatment*).

#### **(vi) Re-launching of CDTI activities in CAR**

104. The Central African Republic is experiencing a particular situation in its history characterized by security and humanitarian crisis that could affect the gains made by the CDTI in the country.

105. Despite the size of the country (623,000 km<sup>2</sup>), only one CDTI project has been implemented from 1998 until now with obvious coordination problems of field activities. Following the 2003 crisis, this project was seriously affected and APOC even had to suspend funding from 2004 to 2006. Then

followed a spectacular recovery phase from 2007 that brought the coverage rates to the required standards until 2012. Because of the current crisis, no operation has been possible since 2013.

106. To take up the challenges faced by the country in implementing activities and improving the performance of the project with the view of eliminating onchocerciasis by 2025, the CAR delegate presented a recovery plan of the CDTI activities to the TCC.

107. This plan intends to split the single current project into 4 projects with 3 of them being operational projects and 1 project meant to strengthen national coordination.

108. The new configuration is as follows:

- (i) Northwest Project: 2 prefectures (Ouham and Ouham Péné) with 2,288 communities and a total population of 759,136 people ;
- (ii) North Central Project: 5 prefectures (Kémo, Ouaka, Nana Gribizi, Haute Kotto and Nana Gribizi) with 2,392 communities and a population of 693,547 inhabitants,
- (iii) South-East Project : 3 prefectures (Mbomou, Basse Kotto and Haut Mbomou) with 1,362 communities and a total population of 295,072 people;
- (iv) Project for the strengthening of the NOTF Secretariat.

109. The estimate of the total cost for the recovery is CFA.F 132, 527, 157 (i.e., \$US 265, 054) for a two-year period.

#### **TCC comments**

110. TCC commended Dr. Kémata for the very rich presentation. Recognizing the current difficult situation, TCC expressed its sympathy to the national project team and highlighted the quality of previous work that contributed to bringing the project back on track and to getting good results.

111. TCC recognized the need to revive CDTI activities in CAR and approves the reorganization plan submitted, even if progressive interventions on the field are to be considered.

112. Given the situation of conflict that prevails in this country, CDTI activities cannot be set up according to a standard pattern. APOC's experiences in similar situations should therefore be taken into consideration.

#### **TCC recommendations:**

113. *TCC recommends that APOC Management take into consideration the plan and continue to provide all necessary assistance to the CAR, given the efforts already made at national level.*

114. *The committee also recommends that national authorities and APOC Management rely on international or national NGOs, accustomed to interventions in times of crisis, for the distribution of ivermectin.*

## RESEARCH ON NEW CONTROL AND SURVEILLANCE TOOLS BY COLLABORATING INSTITUTIONS: Agenda item 9

### (i) Update on APOC and TDR co-funded research

115. Dr. Kuesel provided an update on this research.

116. The data from the moxidectin Phase 3 study were presented at the European Congress on Tropical Medicine and International Health in September 2013 and at the annual meeting of the American Society of Tropical Medicine and Hygiene in November 2013.

117. The data from the Phase 2 and Phase 3 study showed that 1 year after moxidectin treatment, skin microfilariae levels were similar to those around 1 month after ivermectin treatment. These data are now used at Imperial College and Erasmus University to model with EPIONCHO and ONCHOSIM, respectively, the relative impact of annual treatment with moxidectin vs. biannual treatment with ivermectin on progress towards elimination of onchocerciasis. The EPIONCHO modelling will include modelling of the costs for control programmes.

118. WHO is in discussions with an Australian Not-for-Profit pharmaceutical development organisation interested in registering moxidectin for onchocerciasis and development of moxidectin for other neglected diseases of poverty, notably lymphatic filariasis and scabies. Time to registration and potential availability of moxidectin will depend on the amount of information on manufacturing procedures made available by the manufacturer of the clinical study supplies.

119. In each of the four CDTI naive sites in the Phase 3 study, some individuals had skin microfilaria levels 1 and 12 months after treatment with ivermectin higher than considered 'adequate' response in publications which raised concern about emerging resistance of *O. volvulus* to ivermectin. The data hence suggest that *O. volvulus* with low response to ivermectin's effects are present in significant numbers prior to ivermectin selection pressure. This will be followed up in collaboration between Imperial College, Erasmus University and TDR by modelling the effect of ivermectin using individual subject data from the moxidectin studies as well as any other studies whose investigators are willing to collaborate. The objective is to better estimate the variability of *O. volvulus* response to ivermectin prior to or early during CDTI for comparison with *O. volvulus* response to ivermectin in areas under long term CDTI.

120. The moxidectin Phase 2 study analysis which looked at the correlation between microfilariae and macrofilariae at the individual subject level showed that the macrofilariae in the palpable nodules are not representative of all macrofilariae in the body. This points to the need for quantitation of all variabilities needed to calculate adequate sample sizes for studies of the effect of drugs on macrofilariae to ensure that conclusions drawn from such studies are valid.

121. As part of the moxidectin development programme, ONCHOSIM modelling of the effect of hypothetical drugs (different levels and combinations of macrofilaricidal, macrofilaria-sterilizing and embryostatic effects per treatment round) and 100% microfilaricidal activity in areas with different levels of endemicity and with different levels of population coverage was conducted. This modelling will be repeated with the latest calibration of ONCHOSIM and expanded to include hypothetical drugs without microfilaricidal activity. The results will help researchers with compounds in pre-clinical and early clinical development not expected to kill or permanently sterilize all macrofilaria in

all individuals treated after a single dose or treatment course to assess the potential value of the compounds for onchocerciasis elimination and hence make decisions on further development.

122. In the project aimed at identifying genetic markers of low response of *O. volvulus* to ivermectin, APOC funding allowed to complete infrastructure capacity building in the collaborating laboratories in Ghana, Cameroon and MDSC and to further reduce the list of potential genetic markers to be carried forward into the next research phase. TDR funding was made available for the training of personnel in these laboratories to allow them to fully participate in the next research phase. In 2014-2015, TDR funding will be available to complement APOC funds for this project.

123. TDR will issue calls for proposals to incorporate genetic data into transmission models to estimate the probability that low response phenotypes will become a problem for onchocerciasis control programmes and to explore the utility of genetic population structure markers emerging from the ivermectin response marker project to complement entomological data for delineation of transmission zones.

**(ii) Update on the DEC patch test and legal agreement with Lohmann Therapie Systeme**

124. Dr. Kuesel reported that Lohmann Therapie Systeme (LTS) informed WHO that it will be ready to see the legal agreement between WHO and LTS going into signature in April. This can be immediately followed by a purchasing order since 'manufacturing readiness' is a pre-requisite for LTS to sign the agreement. The manuscript on the clinical study conducted by Dr. Awadzi with the LTS DEC patch is close to submission.

**TCC Comments:**

125. TCC thanked Dr Kuesel for the updates on the APOC and TDR co-funded research as well as the DEC patch test and the legal agreement with LTS. The Committee was informed that the field laboratories in Liberia and Ghana are now collaborating with DOLF, while the one in Butembo (DRC) will continue to exist with the support of the Université Catholique and that negotiations are on the way for the one in Ituri (DRC) to be used by the University of Kisangani. All information on the study sites are available at TDR website.

126. Regarding the availability of the DEC patch test, the committee was informed that if the legal agreement is signed in April, the DEC patch test can be available in July 2014.

**(iii) Progress made towards a vaccine against river blindness**

127. Professor David Taylor of the Division of Pathway Medicine, University of Edinburgh and The Onchocerciasis Vaccine for Africa Initiative (TOVA) made the presentation on progress made toward a vaccine against river blindness.

128. Onchocerciasis vaccine research spans three decades, beginning with support from the European Commission (EC) and the Edna McConnell Clark Foundation in the mid-1980s, and more recently from the National Institutes of Health (with ongoing EC support in Europe). Early efforts were devoted to understanding the immunological basis of the three main clinical presentations (hypo-responsive, hyper-responsive, and endemic normal), the production of the first recombinant proteins from *O. volvulus*, and the development of animal models to test protection against infective stage larvae (L3). In the USA, the mouse *O. volvulus* L3 chamber model and the full lifecycle of

*Brugia malayi* in jirds were utilised to screen vaccine candidates, whereas in Europe, the focus was on the development of the *O. ochengi* model in cattle in Cameroon and the successful establishment of the patent lifecycle of *Litomosoides sigmodontis* in immunocompetent mice. The latter model allowed the identification of the key immunological processes underpinning resistance and susceptibility to infection, revealing that an optimal balance between Th2 effector mechanisms and T-regulatory processes determines protection. Conversely, strong Th2 responses can drive pathology and potent T-regulatory processes generate the hyporesponsive state. The *O. ochengi* infection in cattle emerged as the most relevant system to evaluate protective immunity, due to both its extremely close relationship with *O. volvulus* and the unique opportunities presented to test protection under natural field conditions. In 2012, the US and European groups identified a convergence in three vaccine candidates that induced the highest levels of protection in their respective rodent models: these were RAL-2, Ov103, and a mutated form of cysteine proteinase inhibitor-2 (CPI-2M). These proteins can generate reductions of 40 – 70% in adult worm burden and a >90% reduction in microfilaraemia when used individually or in combination. Four American, six European and three African groups have now joined forces under the umbrella of The Onchocerciasis Vaccine for Africa Initiative (TOVA), which aims to take a vaccine based on one or more of these antigens through Phase I human safety trials by 2016, and if safe to conduct Phase II human trials in 2019 - 2020.

#### **TCC Comments:**

129. TCC thanked Prof Taylor for the brilliant presentation and encouraged the activity to continue.

#### **(iv) Potential long-term epidemiological consequences of a vaccination programme against onchocerciasis**

130. Dr Martin Walker of the Imperial College London, the London Centre for Neglected Tropical Disease Research and the Onchocerciasis Vaccine for Africa Initiative made the presentation on the modelling of the potential long-term epidemiological consequences of a vaccination programme against onchocerciasis.

131. A vaccine against *Onchocerca volvulus* would have at least two strategic roles to complement existing APOC intervention strategies based on community-directed treatment with ivermectin (CDTI). The first role is in areas where onchocerciasis and loiasis are co-endemic and where the prevalence of *Loa loa* microfilariae is above 20%, contraindicating or disrupting CDTI because of the unacceptable risk of severe adverse events. There are numerous examples of such transmission foci in the central belt of Sub-Saharan Africa, particularly in Cameroon and in the North East Democratic Republic of Congo. Overall, approximately 12 million people are at high risk of co-infection with *O. volvulus* and *Loa loa*. The second role is to provide a tool for preventing the spread of infection from foci where transmission is ongoing to areas where onchocerciasis has been eliminated. The suitability of a vaccine to fulfil these strategic roles is demonstrated using simulations of a 15-year vaccination programme undertaken with the onchocerciasis transmission model EpiOncho. Simulations were run in three loiasis-onchocerciasis co-endemic foci, of varying onchocerciasis endemicity, targeting in the first year all children aged 1-5 years and then, in subsequent years, only 1 year olds. It was assumed that the vaccine has an initial preventative efficacy of 50% (against infective larvae), and a therapeutic efficacy of 90% (against microfilariae). Efficacy is assumed to wane with time, with a half-life of 20 years. The results demonstrate that a vaccination programme would substantially reduce the intensity of microfilaridermia in children and young adults. This would be associated with a marked population health benefit since the acquisition of heavy infection earlier

in life is a critical risk factor for onchocerciasis-associated morbidity and mortality. Moreover, because the protective effect of vaccination is greatest in children and young adults—and these age groups are most numerous in rural communities in Sub-Saharan communities—a vaccine would substantially reduce the risk of infection re-seeding in areas where onchocerciasis has been eliminated. Thus, a vaccine would protect the economic and health investments of APOC and of past onchocerciasis control programmes.

**TCC Comments:**

132. TCC thanked Dr Walker for the presentation and encouraged the activity to continue.

**(v) Milestones en route to a river blindness vaccine Phase I clinical**

133. On behalf of Dr Sara Lustigman of the Lindsley F. Kimbal Research Institute, New York Blood Center, and the Onchocerciasis Vaccine For Africa Initiative, who could not make it to Ouagadougou, Dr Makepeace made the presentation on the milestones en route to a river blindness vaccine Phase I clinical trials.

134. In the last 5 years 8 vaccine candidate antigens were studied under controlled conditions, using two protein expression systems, *Escherichia coli* and the yeast *Pichia pastoris*, and their vaccine efficacy was evaluated using a single harmonized immunization protocol using two animal models; the mouse *O. volvulus* L3 chamber model and the *Brugia malayi* infection in gerbils model. Three vaccine candidates, 103, RAL-2 and CPI-2M, were able to induce repeatedly significant reduction in establishment of L3 (up to 40%) or adult worms (up to 70%), in the *O. volvulus* or *B. malayi* efficacy models, respectively, using alum as the adjuvant. Alum was selected because of its ability to induce Th2 responses, known to be protective against filariae, and because of its acknowledged safety in humans. The use of the two animal models had increased the probability that results obtained in both animal hosts will reflect what we ultimately want to elicit in vaccinated humans. Both systems were used to eliminate vaccine formulations that induce potentially pathogenic IgE and eosinophil responses, and the *B. malayi* model was also used to eliminate vaccines that promote the development of pathology in immunized jirds. The *Litomosoides sigmodontis* mice model confirmed that these proteins alone or in combination can reduce worm and microfilariae burdens in the immunized mice when using the DNA vaccine platform.

135. Once we have selected the most promising 3 vaccine antigens for a Prophylactic River Blindness Vaccine, we are now ready to move to the pre-clinical product development stage which is needed en route to Phase I safety trials in humans. This includes: 1) Continue with the mathematical modelling of vaccine efficacy and delivery as well as cost-effectiveness. 2) Continue systems analyses to identify specific molecular interactions between parasite antigens and host immune systems to assist with formulation of the vaccine for greatest efficacy and importantly, to avoid any interaction that may lead to adverse reactions including allergic and physiological responses. 3) Optimize immunization strategies using the 3 filarial small animal models. 4) Conduct efficacy trials using the *O. ochengi*-cow model under conditions of natural exposure. 5) Finalize the process development for recombinant or synthetic vaccines, including scale-up, formulation, assay development, quality control and stability. 6) Technology transfer for cGMP manufacturing of vaccines. 7) GLP toxicology testing of vaccines. 8) Regulatory filing. 9) Conduct studies assessing the immune responses of children up to 9 years age who are exposed to *O. volvulus* infections in preparation for phase II trials.

136. These pre-clinical milestones will be accomplished by establishing a partnership between TOVA and the Sabin Vaccine Institute Product Development Partnership (PDP). The Sabin Vaccine Institute PDP has been successful in the past years to move at least two helminth vaccines into clinical trials; the Hookworm and the Intestinal Schistosomiasis vaccine initiatives. The Sabine Vaccine Institute PDP is also known for its ability to rapidly transition vaccine projects from R&D into Phase I testing. Their key working principles include: establishing strong and transparent collaborations; running comprehensive but lean programs (making the process affordable); shorter timelines for process development and scale-up; early involvement of manufacturing and clinical partners; calculated steps to mitigate product and clinical risk; and build and strengthen capacity and infrastructure in the endemic countries where the vaccines are needed (to ensure sustainability).

137. Thus, once the Onchocerciasis Vaccine for Africa (TOVA) initiative is endorsed by the stakeholders, TOVA will start a major advocacy campaign and secure the needed funding from government and private agencies. With such support we believe that we can accomplish all the milestones en route to a river blindness vaccine Phase I clinical trials in 2016, and if these vaccines are safe, move to Phase II clinical trials in 2019 - 2020.

**TCC Comments:**

138. TCC thanked Dr Makepeace and Dr Lustigman for the presentation and encouraged the activity to continue.

**(vi) From bench to bed-side transitional research projects to support a river blindness Vaccine**

139. Dr Ben Makepeace of the Institute of Infection and Global Health, University of Liverpool and the Onchocerciasis Vaccine for Africa Initiative made the presentation on from bench to bedside: transitional research projects to support a river blindness vaccine.

140. As vaccine candidates for onchocerciasis begin to be taken forward through preclinical toxicity, production at “good manufacturing practice” grade and ultimately Phase I human trials, research must continue at the bench to ensure that the right decisions are made regarding implementation. A key initial decision to be made before scale-up of the vaccine candidates is the type of immunogenic molecule to take forward – whether recombinant protein, a DNA vector or synthetic peptide. Equally important is the choice of adjuvant to ensure that the immunogenicity of the vaccine is optimal. Although to date, the vast majority of vaccines have been formulated in alum, several novel adjuvants are now available (viral vectors, lipid analogues, and proprietary derivatives of squalene and saponins) that have the potential to enhance protective immunity. The newly available filarial genome sequences, including those of *Litomosoides sigmodontis* and *Onchocerca volvulus*, are beginning to bear fruit via the application of high-throughput technologies (such as proteomics) to identify additional vaccine candidates that may be suitable to combine with the three currently prioritised molecules. A newly emerging strategy is to target immunomodulatory molecules secreted by gravid female worms that protect the microfilariae from host effectors. This strategy provides cause for optimism that a safe therapeutic vaccine to block patency in infected individuals could be developed to safeguard the successes of MDA, treat individuals in loiasis-endemic areas, and prevent the spread of ivermectin resistance. In addition, the highly conserved nature of many of these immunomodulatory molecules underlines the potential of a “panfilarial” vaccine that could also be used to prevent microfilaraemia in lymphatic filariasis and loiasis. Historical animal studies on crude microfilarial vaccines and more recently, with recombinant protein or DNA vaccines, have demonstrated that microfilarial loads can be reduced by >85% even where the adult worm burden is



not significantly affected. Finally, a critical research priority before implementation of an onchocerciasis vaccine is to determine the impact of MDA on the infection status and immunoreactivity of young children. Previous studies have demonstrated that maternal infection increases susceptibility in progeny and alters immune responses to both onchocercal and non-onchocercal antigens. However, it is not clear whether the reduction in endemicity will improve paediatric immune responses (due to reduced maternal infection) or weaken them (due to reduced exposure to infective larvae).

**TCC Comments:**

141. TCC Thanked Dr Makepeace and encouraged the activity to continue.

**TCC Recommendations on Onchocerciasis Vaccine for Africa Initiative (TOVA):**

142. TCC was impressed by the four presentations which are complementary and observed that the new tool in addition to the existing ones will boost Onchocerciasis elimination efforts in Africa. TCC therefore strongly encouraged these research studies to continue in order to have a new tool for the Onchocerciasis elimination agenda.

**(vii) Rolling Out New Tools to Support the Elimination of Lymphatic Filariasis and Onchocerciasis**

143. Dr. Ogoussan from the Neglected Tropical Disease Support Center (NTD-SC) of Atlanta made a presentation on rolling out new tools to support the elimination of LF and Onchocerciasis. The presentation aimed at offering the best candidate tools to address the main challenges on delineation of treatment boundaries, pointed out such as less invasive and rapid diagnostic tools test need; and the insufficiency of skin snip punches as well as the increasing low skin-snipping compliance. He stated that the WHO guidelines for Lymphatic Filariasis (LF) Transmission Assessment Survey (TAS) has provided a robust tool for LF monitoring based on well-defined sampling strategy in school-aged children and Immunochromatographic test (ICT). Because of ICT challenges, a new format supported by Bill and Melinda Gates Foundation (BMGF), a lateral flow strip test was developed. The new test with 95% sensitivity and 100% specificity does not require cold chain and the cost is lower.

144. Ov16 serology has played an important role for the Onchocerciasis Elimination Program for the Americas (OEPA) to indicate absence of transmission in addition to the absence of infection in black flies. But the ELISA format has limited uptake thus the support of BMGF to PATH for the development of the Ov 16 rapid diagnostic test (RDT).

145. Since the post mass drug administration surveillance is currently based on repeat TAS, and that the TAS is not powered to detect antigen changes, antibody detection may provide new options. From various research studies published in PLOS in 2012 by Hamlin et al and by Steel et al, antibodies for LF developed prior to detectable antigenemia or microfilaremia. Also MDA reduces transmission and/or microfilaremia and prevents development of antibody in children. There are commercially available assays for *W. brugia* but cross reactivity limits their use in Africa. Rather the Wb123 assay for *W. bancrofti* does not have the cross reactivity and thus more suitable for Africa for LF monitoring. The diagrammatic illustrations of lateral flow immunoassay Wb123 and the biplex Wb123/Ov16 were presented.

146. With regard to co-endemicity of LF, Oncho, and *Loa-loa*, tools are being developed with the support of BMGF through the research project such as Test and Treat (Boussinesq et al) and the development of Cellscope (Nutman et al). The cellscope is a digital microscopy system made of commercially available mobile phone, microscopic objective, image forming optics, and LED flashlight.

Micro-mapping technique will help define the critical transition areas where Oncho and LF overlap with *Loa-loa* and where most of the severe adverse events (SAEs) would occur. The Bas-Congo region from Democratic Republic of Congo case was presented as illustration. However there is a need to refine the technique with more *Loa-loa* microfilariae data so to move to the following step of ground thru-thing.

147. Finally, Dr Ogooussan mentioned that with the BMGF support for Operational Research and mapping of NTDs in AFRO, tools and resources are available to: i) Resolve persistent uncertainties about the distribution and overlap of LF/oncho/Loa; ii) Develop harmonized M&E strategies to assess the impact of MDA on LF and oncho; iii) Develop surveillance strategies to provide an increased level of confidence that elimination goals have been achieved.

#### **TCC Comments:**

148. TCC thanked Dr Ogooussan for the presentation on the new tools for elimination of Onchocerciasis and LF as well as the research opportunities offered by the BMGF supported NTD-SC/Task Force for Global Health. The committee endorsed the operational research need identified by NTD-SC/Task Force for Global Health in order to scale up interventions.

149. On the issue of Operation Research (OR) grants, the committee was informed that, for any OR related to PC-NTDs the NTD-SC/Task Force for Global Health is available to fund. TCC therefore recommended APOC Management to liaise with the task force and share research priorities, consulting earlier topics indicated to the TCC but not funded. Identify mapping /OR needs at country level that APOC could not sponsor due to budgetary constarints.

#### **REMARK BY TECHNICAL ADVISORS TO APOC MANAGEMENT: Agenda item 10**

150. The three technical advisers to APOC Management (Prof Abiose, Drs Boussinesq and Ilunga) expressed their appreciation for the progress that is being made by the Programme, especially the movement from control to elimination, the collaboration between the TCC and the RPRG, on Oncho/LF collaboration, the research on new control and surveillance tools. They made the following remarks:

##### The Future plan for APOC and the transformation to PENDA:

- (i) Concern about the coordination of the various on-going activities initiated by TCC and the CSA and how they will be harmonized for maximum benefit of this transition without having overlaps or interference.
- (ii) A lot of trust should be built among the various players as it seems the process in the transition period is difficult and involves players who do not trust each other.
- (iii) The TORs of all involved in the transition period need to be clarified. Perhaps there should be a roadmap to facilitate the process.

- (iv) Even though endemic countries should be the most important in the Oncho/LF collaboration, they don't happen to have adequate information at the country level. Because of rapid changes and very rapid demands, information should flow among the countries.
- (v) The advisers are pleased to note that the method of Trust Fund used for APOC will be used for PENDA.
- (vi) The MDSC: The MDSC facility was very useful for OCP and APOC and will be useful for the PENDA.
- (vii) Alternative strategy: As regards the process for the use of alternative strategy for treatment in the elimination of onchocerciasis, the advisers strongly support TCC's view on the matter and advised that unless it is absolutely necessary alternate treatment should not be recommended.
- (viii) With regard to collaboration, they appreciated TCC collaboration with the RPRG and recommended the collaboration to continue.
- (ix) Regarding the epidemiological and entomological evaluation results, APOC should rapidly transfer information available on those evaluations to countries to enable them take programmatic decisions. Countries need to take the leadership in this transition and ensure that partners working with them at countries' levels actually fall in line with the guidelines as some of the partners seem to be stronger than the countries.
- (x) Stopping of treatment: the advisers were surprised to note that some projects stopped treatment without the intervention of TCC. An algorithm should be developed and followed strictly by projects who have reached the break point and willing to stop treatment.
- (xi) For the elimination targets, some countries like DRC, South Sudan, and CAR need particular attention because of their strategic positions.
- (xii) In term of resource mobilization, efforts should be made toward endemic countries to be donors because countries need to manage their programmes.
- (xiii) Efforts should be made to reduce meetings of partners for economy reason.

151. TCC endorsed the remarks and thanked the advisers for their inputs.

## **REVIEW OF OPERATIONAL RESEARCH PROPOSALS: Agenda item 11**

### **Summary of Review of operational Research proposals:**

152. The introduction on operational research has been made by Dr F. Sobela, indicating the current status of proposals already approved, the follow up of TCC35, 36 and 37 recommendations, and also the new operational proposals received from countries submitted to TCC38.

153. Following this presentation, TCC expressed concerns about i) the long process in taking into account TCC recommendations, ii) the finalization of operational research projects and iii) the mechanisms to put in place to address the outstanding issues in this transition period. TCC recommended that APOC Programme:

- Continue efforts to provide support in operational research, as opportunities exist. APOC should encourage partners to find opportunities, ways to continue supporting countries while minimizing/reducing " the back and forth " that causes delays.

- Update the list of operational research that has been published. TCC insisted on the subject of operational research projects that should help solve problems, and any publication of the results would be a bonus.
- Take the two programmes (oncho and LF) into account from now on in the submission of operational research proposals.
- Strengthen collaboration with partners in supporting countries' capacity for operational research, with researchers and expertise available in the countries.
- Develop a roadmap, taking into account all the points raised by TCC for the new Technical Officer in charge of operational research.

**Reviews:**

- a) *Determinants of refusal and absentees to CDTI in the Western Region of Cameroon in 2014*

**TCC Comments and Recommendations:**

154. The proposal is relevant and scientifically sound. The justification and the literature review are good. The objectives and research questions are clear. The methodology used e.g. collection and analysis of data/questionnaire and guidelines for discussions/forms for consent/ethical consideration are good. The research team is competent and the budget is reasonable.

155. *TCC accepted the proposal for funding.*

- b) *Strategies for Community ownership and sustainability of CDTI in Rural areas of Cameroon*

**TCC Comments and Recommendations:**

156. The research proposal is relevant and will bring responses to the establishment of CDTI sustainability in Cameroon, especially in projects where the strategy failed in the past. The proposal is well written and is feasible. Its coherence is due to the fact that three methodological approaches are used aiming at bringing responses to some pertinent key questions. The methodological approach of individual and group interviews with the populations and the processing of data should be validated by a specialist of TCC. A special attention should be paid to the selection of the study areas in order to have the real situation of onchocerciasis infection and its control at the local level.

**Conclusion:**

157. *Although the budget is high as compared to APOC norms, TCC recommends the approval of this proposal for funding, subject to reservations mentioned above.*

158. *TCC also recommended that the two proposals be translated into English and sent to the two social science specialists of the committee for their inputs.*

**MANAGEMENT OF THE APOC TRUST FUND**

**REPORT ON THE FINANCIAL MANAGEMENT OF APOC FUNDED PROJECTS: Agenda Item 12**

159. The presentation started by highlighting the total JAF approved budget (USD 23,233,000) and the actual amount mobilized for the year 2013 (USD 18,062,571) underscoring that the year started with a funding gap.

160. It was indicated that a total amount of USD 5,308,808 was earmarked to fund 116 projects for USD 3,565,033; four country programmes allocated USD 275,385 and 6 NOTF Secretariats allocated USD 290,247 as well as other projected specific activities worth USD 578,000.

161. It was highlighted that the total amount budgeted for projects, country programmes, NOTF Secretariat and specific activities, was overrun by the actual amount committed due to unforeseen priority activities that arose from the implementation. The final amount committed was USD 6,108,665 but at the end of the year, only USD 5,205,338 was actually disbursed or 85.21%.

162. Overall, out of the total budget available for the year (USD 18,062,571) only USD 17,284,094 have been implemented showing a implementation rate of 95.69 which reflects a good absorption capacity.

163. Participants asked why some budget lines were overspent while others are underspent, and it was indicated that planning figures are estimates and the priorities might change during the implementation and this triggers an adjustment of budget allocation as it is within the CSA and Director's mandate.

164. The issue of low expenditure under Gender mainstreaming was raised, and it was recognized that efforts by the technical unit should be made so as to improve the implementation rate under this budget item or reduce the allocated budget.

165. The 4.31% of balance carried over to 2014 resulted from the fact that projects do not request for the second instalments as they are also not capable of submitting financial and technical reports to justify the use of the first instalment, hence the new changes on DFC operational guidelines.

#### **TCC Recommendations:**

166. TCC thanked Mr Bizimana for the presentation and observed that the amount of financial reports due by projects is alarming and that the situation might be due to incompetency of some project accountants. The committee therefore recommended that projects accountants be trained during APOC Management field visits and work with projects to restore the situation.

#### **REPORT ON THE REVIEW BY APOC MANAGEMENT OF THE FINANCIAL CONTENT OF 1<sup>ST</sup>, 2<sup>ND</sup>, 3<sup>RD</sup>, 4<sup>TH</sup>, 5<sup>TH</sup>, 6<sup>TH</sup>, 7<sup>TH</sup>, 8<sup>TH</sup>, 9<sup>TH</sup>, 10<sup>TH</sup>, 11<sup>TH</sup>, 12<sup>TH</sup>, 13<sup>TH</sup>, 14<sup>th</sup> and 15<sup>th</sup> YEAR PROGRESS REPORTS AS AN INTRODUCTION TO THE REVIEW EXERCISE: Agenda Item 13**

167. As a background, the presenter indicated that there are two types of financial reports required from funded projects: monthly financial reports and FACE (Funds Authorization and Certification of Expenditures).

168. With regards to financial reports, it was indicated that out of the total 1530 due reports as at 31 December 2013, only 829 have been received and 701 still outstanding. This means that the submission rate was only 54% against an outstanding rate of 46% which is a very serious situation in terms of accountability.

169. The ageing report showed that 46 projects have a total of 523 outstanding returns for six months and more.

170. Regarding the FACE reports, a comparison of 2012 and 2013 shows that in 2012, out of 297 due reports, a total of 240 or 81% were received by the year end, whilst in 2013, out of the 281 due reports, only 54 have been received showing only 19% of submission rate.

## **TCC Comments and recommendations**

171. TCC expressed concerns about this and suggested several measures including suspension of further instalments; to check if projects do not have excess money as they receive funding from three partners and there is no joint planning at field level. They also recognized the need to review the way funds are channelled to the projects in order to prompt them to implement planned activities and report accordingly.

## **REVIEW OF 1<sup>ST</sup>, 2<sup>ND</sup>, 3<sup>RD</sup>, 4<sup>TH</sup>, 5<sup>TH</sup>, 6<sup>TH</sup>, 7<sup>TH</sup>, 8<sup>TH</sup>, 9<sup>TH</sup>, 10<sup>TH</sup>, 11<sup>TH</sup>, 12<sup>TH</sup>, 13<sup>TH</sup> 14<sup>TH</sup> AND 15<sup>TH</sup> YEAR ANNUAL TECHNICAL REPORTS: Agenda Item 14**

172. The presenter indicated that two operational research budget proposals from Cameroon are being submitted for the TCC approval. The first proposal is entitled “*Strategies for Community ownership and sustainability of CDTI in Rural areas of Cameroon*” while the second research proposal is “*Determinants of refusal and absentees to CDTI in the Western Region of Cameroon in 2014*”.

173. The first project requests for a grant amounted to USD 27496; while the second one request for USD 18750.

174. It was highlighted that, the technical content, the expected outcomes and the justifications for APOC funding will be presented by the technical units in charge of CDTI projects.

175. The proposals were submitted for TCC review.

## **REVIEWS OF ANNUAL TECHNICAL REPORTS**

### **CAMEROON**

#### ***NOTF/HQ 14<sup>th</sup> year annual technical report***

176. The report is fairly well written and well presented with key information that helps appreciate the NOTF efforts. The executive summary contains results that allow the appreciation of the overall performance of all the projects and the key challenges to take up as well. The report also provides the details of the trend of therapeutic coverage of each project from the past 7 to 14 years.

177. TCC encourages sensitization and mobilization efforts towards other ministerial departments, the availability of a detailed plan of action and a supervision standard form for 2014.

178. However, the NOTF should proceed to further analyses to explain the jigsaw trend of the projects’ coverage rates for the past 14 years, the high rates of absentees and refusals.

179. The ratio of CDD/population to be treated of 1/179 has not improved.

### **TCC Recommendations:**

#### To the NOTF:

- Continue the efforts for implementing CSM at the level of all the projects.
- Set up a mechanism to reinforce weak projects, particularly for the management of SAE cases where they have been frequently observed.
- Complete the development of the documents for the reorientation of the SAEs management strategy.
- Make efforts to improve the CDD/inhabitants ratios and women participation.

To APOC Management:

- Continue to support the NOTF in carrying out activities planned in its 2014 plan of action.

180. *TCC accepted the report.*

**GHANA**

*Ghana CDTI Project 4<sup>th</sup> year annual technical report*

181. The project did only one round of treatment in 90 endemic districts, and performance has been steadily increasing as evidenced by coverage improved rates. The therapeutic coverage rate increased from 70% in 2010 to 78.2% in 2012 (1<sup>st</sup> round) to 81.7% in 2013.

**TCC Recommendations:**

To improve the quality of the report:

- Limit executive summary to one page.
- Provide update regarding any progress regarding lobby to include oncho indicators as part of routine indicators. The lobbying effort has been going on for a while, since 2011.
- Table 2 – Explain the reason for the decrease in population at risk from 4,687,774 in 2012, to 4, 404, 669 in 2013, given the increase in total districts and total endemic communities.
- Table 7 – Clarify inconsistencies in the data for TAIN. The geographic coverage is 65.7%, yet the number treated (18,429) surpasses the ATRO for the district (18,039).
- Table 10 - Clarify the reason for the significant increase in the quantum of Mectizan ordered for 2013. Four times as many Mectizan tablets were ordered in 2013 compared to 2012. The reason for the change in terms of needs is not clear.

To improve programme implementation

- Scale up geographic coverage rates to 100%, and improve on therapeutic coverage rates for Fanteakwa, Ho Municipal, Ho west, Kpando, showing therapeutic coverage of less than 70%.
- Recruit more CDDs. At 1 CDD to 398 persons, the work burden for CDDs is rather high.
- Provide update on the steps taken to solve challenges uncovered during supervision.

Question for APOC

182. The Ghana project is due for Participatory Independent Monitoring, mid-term evaluation and 5 year sustainability evaluation. What are APOC plans for conducting these evaluation activities?

183. *TCC accepted the report.*

**TANZANIA**

*NOTF/HQ 14<sup>th</sup> year annual technical report*

184. The format of reporting limited the amount and details of information provided. It was not therefore possible to assess progress made on most of the critical project indicators. However, there is commendable progress on integrated NTD approach, partnership, resource mobilization and transition to the district as the IU.

185. TCC recommends the following:

To improve on the report:

186. APOC/TCC to advice on minimum reporting requirements for countries implementing integrated NTDs who may not be able to submit reports using the Annual Technical Report template. TCC recommends the inclusion of the following as key activities of HQs:

- Advocacy activities; outline issues and outcomes.
- Monitoring and supervision.
- Mectizan utilization and treatment data validation.
- Partner financial contributions details.

To improve on project implementation:

- Seek the support of NGDO partners or APOC for the acquisition of IEC/BCC materials and MDA registers.
- To conduct follow up Epidemiological and Entomological surveys in Tunduru CDTI Project for three consecutive years before interruption of transmission can be confirmed.

187. *TCC accepted the report despite inadequate information provided but advised the country team to report against the minimum requirement advised in their next report.*

## **ONLINE REVIEWS**

### **BURUNDI**

#### ***Bururi CDTI Project 8<sup>th</sup> year annual technical report***

188. This is an eighth year project whose report is well written. Detailed responses were provided to the TCC recommendations (number and quality of staff mobilized in the project, quantitative elements relating to advocacy, mechanism of integration in health system). The project covers a population of 380,780 people (of which 109,206 in hyper-endemic zones) distributed in 3 districts, 6 administrative communes, 76 hills (communities). The epidemiological evaluation conducted in 2013 showed only 2 positive cases out of 8,621 people surveyed. 2,282 CDDs (1,284 men and 998 women) were mobilized in 2013; 308,743 people treated, i.e., 1CDD/125 people. The therapeutic coverage is constantly increasing: 78.9% in 2011; 80.5% in 2012; 81.1% in 2013. CDTI is well integrated and joint activities are implemented: Mectizan + Praziquantel + Albendazole. The committee underscored the financial efforts by the MoH which regularly provide its contribution with APOC and other partners: CBM, MDP.

189. The project team is urged to continue working this way.

#### **Recommendations:**

- Report related: provide precision on the 2013 total budget (not indicated) and on the additional budget (\$US 28,355).
- Project related: Conduct CSM training activities, as the training on this module has been referred to as a weak point of the project. Specify steps taken to replace the obsolete equipment.



190. *TCC accepted the report.*

***Cibitoke-Bubanza CDTI Project 11<sup>th</sup> year annual technical report***

191. Excellent report full of information that proves a great control of the subject, analytical capacity and increased prospect. The thinking often goes beyond the requirement of the APOC evaluation plan and is illustrated by several tables and even by diagrams.

192. There are however some gaps to be corrected. These are as follows:

- The hydrographic map should be linked to the situation and to the epidemiological and entomological evaluation.
- Specify what is required to take population census.
- The treatment plan should be aligned with seasons when farmers are available.
- The issue of harmonizing CDDs should be explicit and the impact of such initiative on the number of CDDs and incentives for them should be analysed.
- Avoid thick report and redundancies during the evaluation of follow-up actions in the second part of the report.

193. At the level of the APOC Management, in addition to the weaknesses referred to in the report:

- APOC should provide information on its capacity to meet budgetary needs.
- Reports should be reviewed so that decision is made regarding CSM.
- Integrate the results of epidemiological surveys assumed to be satisfactory or promising without any proof.
- Develop national entomological capacity adapted to the entomological evaluation needs expressed in the report.

194. *TCC accepted the report.*

***Rutana CDTI Project 8<sup>th</sup> year annual technical report***

195. The report is of good quality, generally comprehensive and precise and shows dynamism due to its analyses and prospect. A better presentation of the project area would be useful (provide maps) in showing mostly the features that influence epidemiology and its control strategy.

196. The initial levels of endemicity have not been reminded and the infection seems to be disappearing in the areas treated (hyper-meso) and to have virtually disappeared in hypo-endemic areas. By being exhaustive, this report shows some of the weaknesses of the programme.

197. The harmonization operation seems to have an impact on the number of CDDs (inadequate) and to affect their commitment.

**Recommendations:**

- Present harmonization and its consequences on the CDTI.
- Suggest ways to carry out at least training and key CDTI activities, given difficulties encountered getting APOC and foreign funding
- National teams to participate in the process of presenting epidemiological evaluations to compensate the lack of practice
- Address the lack of entomological experience by initiating a consistent policy and by developing national capacity

Recommendation to APOC:

- Take necessary actions to set up national autonomous systems for epidemiological and entomological evaluation/surveillance.

198. *TCC accepted the report.*

**General Remark to all projects:**

199. It should be mentioned once again that the evaluation grid of advanced project reports is now obsolete, because it does not take into consideration either integration in NTD project or the implementation of the entomo-epidemiological evaluation related to progress towards elimination.

**CENTRAL AFRICAN REPUBLIC**

*CAR CDTI Project 11<sup>th</sup> year annual technical report*

200. The report is well written, concise and easy to understand. Errors noted in previous reports were corrected.

**Recommendation to improve the report:**

- Table 10: Integrate the remaining stock of Mectizan of the previous year
- Add the table of expenses per section to estimate the cost per person treated.
- Reduce the descriptive part of the country in the report to key information linked to onchocerciasis control.

201. In 2012, the project performance seems to be improved, particularly with an increase of CDDs, 10 times more the number of CDDs in 2010. And the percentage of women shifted from 4% to 18% in two years.

202. Continue efforts in order to:

- Improve therapeutic and geographic coverages.
- Improve the impact of women on CDTI.
- Improve CDD/population ratios.
- Maintain the gains of the advocacy mission carried out by APOC Director by reinforcing IEC, sensitization and mobilization.

203. *TCC accepted the report.*

**DEMOCRATIC REPUBLIC OF CONGO**

*Ituri Nord CDTI Project 7<sup>th</sup> year annual technical report.*

204. Responses were provided to TCC recommendations. The total population of the project area is 1,170,575, distributed in 1,620 communities, all located in meso-hyper endemic zones. 11,019 CDDs (9,760 in table 2) of which 1,251 women. 952,896 people treated (for UTG of 983,283); i.e., 1CDD/87 people. Compared with 2012, the geographic and therapeutic coverages slightly decreased in 2013 (100% and 99.8%. 81.7% and 81.4% respectively). The report is fairly well written but contains some gaps and the sections are not always informed.

## **Recommendations:**

- Report related:
  - Adjust figures relating to CDDs.
  - Inform annual financial contributions of different partners.
  - Better describe the mechanism of integration of CDTI.
- Project related:
  - Explain the reasons why indicators have decreased (Geographic Coverage and Therapeutic Coverage).
  - Specify steps taken to solve the problems identified during the supervision.
  - Continue efforts in training.
  - Develop a sustainability plan.

205. *TCC accepted the report.*

### ***Kasongo CDTI Project 8<sup>th</sup> year annual technical report.***

206. Responses were provided to TCC recommendations. The project covers a total population of 1, 379,852 people distributed in 2,082 communities, all located in meso-hyper endemic zones. In 2013, 1,119,158 people were treated by 7,850 CDDs (3,065 women and 4,785 men; i.e., a ratio of 1:1.6 women to men). Treatment ratio is 1 CDD /142 people. The geographic coverage is 100%; the therapeutic coverage has been >80% for three years. This project is in oncho/loiasis co-endemicity zone, but no SAE case was reported in 2013. CSM and SHM activities were only implemented in one health area (out of 10).

207. Partners are: MoH, MDP, UFAR-NGDO, and APOC. However the MoH does not provide direct financial support to the project.

## **Recommendations:**

- Report related:
  - Inform table 14 and 15 better.
  - Inform section 4 better relating to sustainability.
  - Specify expenses stated for the management of the SAEs when no case of SAE was reported.
- Project related:
  - Intensify efforts in training, namely regarding CSM.
  - Address important weaknesses reported in section 5: reduction of the number of registers; weak capacity of data analysis by teams; weak supervision of communities during treatments.

208. *TCC accepted the report.*

### ***Katanga Sud CDTI Project 8<sup>th</sup> year annual technical report***

209. The report is well written, concise and easy to understand. TCC37 recommendations were taken into consideration. However, some inconsistencies still exist in figures contained in the tables, namely the number of health staff of the area, the number of CDDs trained, the stock of Mectizan and the number of communities with supervisors from communities.

210. The project performance has improved with a therapeutic coverage rate of 81% and a geographic coverage rate of 100% since 2008; a strong female participation in CDTI with female coordinator; and a ratio of 1CDD/108 inhabitants. But on the other hand, some facts not quite well explained, namely the lack of precision regarding the provincial government support and the disbursement of the budget allocated to by the State, conducting CSM and the SHM in a slow process.

**Recommendations:**

Reports related:

- Be more cautious in the verification of figures in the tables.
- Specify community contribution to CDTI.

Project related:

- Extend the CSM, SHM and sustainability process to all the communities.
- Multiply the initiatives regarding co-implementation and integration of CDTI in PHC.
- Explain the important differences in project performance from one year to another.

211. *TCC accepted the report.*

***Katanga Nord CDTI Project 8<sup>th</sup> year annual technical report.***

212. Good report with adequate information despite some contradictions and ambiguities regarding some texts of the report, protocols or the relations in conducted activities.

213. Coverage results are good even though uncertainties exist regarding CDD training and management in the periphery.

**Recommendations:**

To the project:

- The presentation of the project is comprehensive but should focus on some points (hydrography and hydrology, population settlement and farming activities, description of health systems, etc.) linked to the epidemiology of the disease and its control. The project map should be improved for future epidemiological and entomological evaluations.
- Epidemiological analyses done in Ouagadougou from project data and planned studies should be referred to. In the near future, activities conducted on the spot and their results should not be disconnected.
- Better attention to inventories and purchase orders of Mectizan should help avoid the repetition of the delivery of tablets that are about to expire.

To the National authorities and APOC Management:

- A disbursement rate corresponding to the government allocated budget should be provided and maintained for the project's sustainability.
- International NGOs should be seriously sought to act as the project sponsors.

214. *TCC accepted the report.*

### ***Lualaba CDTI Project 8<sup>th</sup> year annual technical report***

215. The report is well written. Responses were provided to TCC recommendations, except for the recommendation on CSM. The project covers a population 238,105 people distributed in 382 communities, all located in meso-hyper endemic zones. The 2013 treatment covered 196,448 people (for a UTG of 200,000 people). 677 CDDs (639 men and 38 women, i.e., a ratio of 16/8). Treatment ratio is too high (1CDD/290 people!). The geographic coverage has been 100% and the therapeutic coverage 80% for the past three years. Partners are essentially the MoPH, MDP and APOC. CDTI is well integrated in other activities: LF, bed net distribution, Schistosomiasis, soil-transmitted helminthiases, Vitamin A. The key equipment is functional; but it is noted that 100 bicycles and other little equipment were approved by APOC in 2010 and 2011 and not delivered until now. The two major weaknesses of this project are the lack of NGDO partner and the lack of the financial contribution from central and provincial governments.

#### **Recommendations:**

- To improve project performance and sustainability :
  - Continue training activities, namely CSM.
  - Continue efforts to mobilize an NGDO partner.
  - Continue efforts to mobilize the provincial authorities that promised to provide financial contribution to onchocerciasis control in Katanga (Advocacy mission by APOC Management and TCC, July 2012).

216. ***TCC accepted the report.***

### ***Lubutu CDTI Project 7<sup>th</sup> year annual technical report.***

#### **Report related:**

217. The report is well written and well presented. The executive summary is concise and easy to understand but some inconsistencies exist in the data: figures of the population of the area, government financial contributions and drug stock.

#### **Project related:**

218. Project performance has improved with a geographic coverage rate of 100% and a therapeutic coverage rate of 78.8%, a CDD ratio of 1CDD/149 inhabitants.

219. However, the number of communities with a therapeutic coverage rate <80% is still high (57.4%). Moreover, the number of endemic communities that shifted from 1,003 to 671 in 2011 should be justified.

220. The project coordination team should endeavour to:

- Improve the consistency of the data in the future;
- Improve women participation in CDTI activities;
- Upscale CSM activities and develop a sustainability plan.

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

### ***Masisi-Walikale CDTI Project 7<sup>th</sup> year annual technical report.***

222. The report is well written and has less errors compared to previous reports. Its weaknesses are related to the UTG figures being inconsistent, to the management of the stock of Mectizan, and to the variation of the number of communities.

223. The project performance has decreased with a geographic coverage rate of 84.2% and a therapeutic coverage rate of 61.2%; the CDD ratio is 1CDD/357 people and the male/female CCD ratio is 2/2.

#### **TCC Recommendations:**

##### Report related:

- Improve the executive summary by providing data on the UTG, CDDS and the management of Mectizan.

##### Project related:

- Improve the geographic and therapeutic coverages;
- Improve CDD/Population ratio;
- Improve women participation in CDTI;
- Conduct the CSM and sustainability process;
- Multiply initiatives of co-implementation and integration of CDTI in PHC;
- Initiate operational research.

224. ***TCC accepted the report.***

## **EQUATORIAL GUINEA**

### ***Bioko CDTI Project 13th year Technical Report***

225. Observations made on the 12<sup>th</sup> year report are generally the same for the 13<sup>th</sup> year report. The performance of this project should be better than the one reported until now, mostly due to the little size of the territory and the population involved. The unique direct source of funding comes from APOC. The equipment is in good state. The project area covers a population of 81,318 people (table 2) and 129 communities, 119 CDDs (63 men and 56 women, i.e., a ratio of 1/12) have been mobilized. The Red Cross volunteers are also mobilized for the distribution of Ivermectin, particularly in urban setting in Malabo. The values of treatment indicators are contradictory: GC (79% in table 7; 66% in table 23); TC (53% in table 7; 12% in table 23).

226. The results of the last epidemiological evaluation showed low rate microfilaria carriers. Globally, it is worth noting the good results achieved in Bioko in the *Simulium damnosum* vector control, thanks to APOC continued support.

#### **TCC Recommendations:**

- To improve the presentation of the report:
  - Avoid inconsistencies in figures.
  - Provide information on partners' financial contributions (table 13) with the 2013, 2012 and 2011 figures.
- To improve the project performance:

To national authorities:

- Mobilize adequate financial resources.
  - Mobilize health personnel for the implementation of CDTI activities.
  - Train a greater number of CDDs to reduce workload.
  - Increase therapeutic coverage.
- To APOC Management:
- Continue to assist the national team to maintain the good results of vector control and consider onchocerciasis elimination in Bioko in the future.

227. TCC recommends that APOC Management should continue to contact national officials to mobilize more financial resources for onchocerciasis and other NTDs control.

228. *TCC accepted the report.*

## SUDAN

### *Sudan CDTI Project 12<sup>th</sup> year annual technical report.*

229. The project has provided some update on activities carried out in 2013 but issues raised by TCC 35 regarding 10<sup>th</sup> and 11<sup>th</sup> year report is yet to be addressed and are still the same issues to be addressed in the current report. These relates to imprecise executive summary, poor data on activities about Abu Hamad project, high therapeutic coverage among others.

### **Recommendations to Improve on the Report/Project:**

230. Rewrite the report taking into account recommendations by TCC35 because they stand for 2013 since it was copy and paste in a lot of the sections. The project will need to respond to TCC concerns in order to know current situation and receive appropriate guidance.

### **Recommendations APOC:**

231. APOC to consider visiting this project to clarify issues that will guide to plan for further collaboration and support.

232. *TCC rejected the report.*

## TANZANIA

### *Mahenge CDTI Project 15<sup>th</sup> year annual technical report*

233. This is a well-written report that reflects good progress with Onchocerciasis elimination programme integrated with other NTD interventions.

### **Recommendations for improving the report:**

- Clarify why training output is low in table 5 despite the fact that substantial trainers were available.
- Crosscheck table 3 to confirm that census period was not swapped between Ulanga and Kilombero.

**Recommendations for improving the project:**

- Train more Health workers to support ongoing interventions.
- Sustain high therapeutic and geographic coverage.
- Ensure that distribution commence early in the year to reduce number of absentees.

**Recommendation to APOC:**

234. It is recommended that APOC consider replacing the project vehicle and motorcycles for this project, which has been written off.

235. *TCC accepted the report.*

***Tanga CDTI Project 12<sup>th</sup> year annual technical report***

236. This is an acceptable report although there are tables that should be corrected by the project team.

**Recommendations on the report**

- i) Re-calculate the UTG for Muheza. The total population is 63,503 while the UTG is given as 64,240. Re-do table 2 for accuracy.
- ii) There is an error in Table 4 on the total number of communities for Muheza, which should be corrected.
- iii) The calculation of the ATO as presented in Table 9 is wrong (81.9%). This has implications on the interpretation of the data. Recalculate the ATO and UTG to report accurately.
- iv) The report shows that APOC only contributed USD 3,746 in 2013, which is far below the USD 104,000 released by APOC in the reporting period. This should be corrected.

**Recommendations on the project**

- i) Continue paying attention to the therapeutic coverage for Lushoto where 205 out of 540 communities are not reaching 80% of their ATOs. Lushoto continues to register the lowest treatment coverage.
- ii) Address the high number of absentees in Mkinga (at 12%). This could be achieved by allocating adequate time for census update and treatment. The current report indicates that these activities were run concurrently in all sites during the month of November.
- iii) Although the proportion of health providers involved in CDTI activities increased in the reporting period, it is notable that the total number of health providers in the project site reduced remarkably - from 292 in 2012 to 252 in 2013. It is not clear from the report whether this is a reporting problem or a health system issue. There is need for the project team to investigate this reduction because it has implications on health service delivery in general and in particular the implementation of CDTI.
- iv) There is a need to adequately manage tablets to limit the risk of expiring. It is notable that for Muheza just half of the 312,856 tablets that remained in 2012 were used in 2013. It is not clear from the report how the project team managed the tablets to ensure that the other half are not.

237. *TCC accepted the report with minor changes.*



### ***Tukuyu CDTI Project 13<sup>th</sup> year annual technical report***

238. This is a mature project in its 13<sup>th</sup> year of implementation. The project is implemented in three districts in the Mbeya region. It is a small focus of 305 communities, with a total population of 118,559 persons in the meso and hyper endemic.

239. The project has met all APOC monitoring and evaluation obligations including phases 1a and 1b evaluation in which no infection was found. During the current reporting period, the project reached 100% geographical coverage, 78% therapeutic coverage, and a UTG of 93%. Strong features of the project include relatively high female participation as CDD (51%), integration of oncho activities with other NTD activities and use of CDI approach and structures in other health prevention programmes including LF, malaria, schistosomiasis STH, and vitamin A supplementation.

#### **Recommendations to improve on the content of the report**

- i) Table 2 – Double check the table. The data in the table imply that there are no hyper endemic communities in Ileje district, yet the same table gives population data for hyper endemic communities in Ileje as 2259.
- ii) Table 4 – correct the % of communities with community members as supervisors. The correct value is 77% and not 85%.
- iii) Table 5 – correct % achievement for CDDs – The correct value is 92%.
- iv) Table 7- Correct the Therapeutic Coverage (TC) – The value for Ileje is 84% and overall TC rate is 80%.
- v) Table 12- Confirm whether NGO provided equipment and update content on partnership (SECTION 1.1.2) by identifying the partner NGO.

240. ***TCC accepted the report.***

### **TECHNICAL REVIEW COMMITTEES REPORTS: Agenda item 15**

#### **NIGERIA**

##### **Nigeria Technical Review Committee: Report of the 12<sup>th</sup> meeting (TRC12)**

241. Prof Eka Braide, Chair of the TRC/Nigeria, presented the report of the 12<sup>th</sup> meeting of Technical Review Committee (TRC) of Nigeria, held in Calabar from 17<sup>th</sup> to 21<sup>st</sup> February 2014. She recalled the background of the setting up of the TRC of Nigeria in 2008 and indicated that 204 technical reports and 35 Operational Research proposals were reviewed up to date. During the 12<sup>th</sup> meeting, TRC/Nigeria reviewed 13 technical reports from Akwa Ibom, Cross River, Delta, Ekiti (8<sup>th</sup> year re-submission and 9<sup>th</sup> year reports), FCT, Jigawa, Kano, Kebbi, Nassarawa, Ogun, Osun and Zamfara, accepted 12 and rejected the Ekiti 9<sup>th</sup> year technical report. The committee also reviewed the extent of implementation of TRC11 recommendations, and received updates from the NOCP Coordinator on NOCP activities, UNICEF assisted advocacy, and on epidemiological evaluations and entomological assessments taking place in Nigeria. The format developed by the TRC to review technical reports of mature projects was used in scoring the projects. The committee also received report on Ondo/Edo cross border joint monitoring, jointly carried out by independent monitor from MITOSATH, three zonal staff, two independent monitors from TCC and five SOCTs from each of the two states.

242. Zonal Coordinators for Zones (A, B, C, D) also presented reports on supervisory activities in their zones. TRC commended the efforts made by the zonal Coordinators and their reports and made the following recommendations:

- Zonal Coordinators should subsequently give highlights on the trend of activities in their reports to TRC.
- Zonal Coordinators should make presentation on the extent of implementation of recommendations on monitoring exercises.

243. TRC/Nigeria also made the following recommendations to:

#### **APOC**

- Support training and up scaling of CSM and SHM in all projects.
- Provide one more vehicle for the fourth zone (B Zone) in Nigeria.
- Support NOCP HQs to strengthen CDTI implementation in poor-performing projects and hard-to-reach areas.

#### **NGDOs**

- Continue to build capacity of programme personnel and work within the framework of the National Health Plan.
- In order to enable projects identify funding gaps for implementation of activities NGDOs should clearly indicate activities they wish to support.

#### **NOCP (including zonal offices)**

- Map out hard-to-reach areas in each State and carry out special interventions.
- Conclude advocacy visits to projects not yet visited to solicit for improved funding by States and LGAs.
- Zonal coordinators should in their subsequent reports to TRC provide information on extent of implementation of recommendations made on past presentations on Zonal activities.

#### **SOCTs and LOCTs**

- Train members of CBOs, managers of other NTD programs, NYSC members, teachers, traditional leaders, religious leaders for participation in CDTI.
- Conduct CSM and SHM in all communities.

#### **Future of TRC Nigeria**

244. With regard to the future of the TRC/Nigeria, the committee observed the following:

- 6 years of existence of TRC Nigeria.
- 12<sup>th</sup> TRC meetings held.
- NOCP staff, Zonal Officers is now capable of effectively reviewing technical reports.
- CDTI is now part of NTDs in Nigeria.
- SOCTs and LOCTs are now overseeing NTDs.
- Co-implementation, collaboration, integration in MDA for NTD commenced.
- Joint reporting format for NTDs exist.
- NTD Steering Committee is now effectively steering NTDs activities in Nigeria.
- NOCP staff, Zonal Officers, programme officers for each NTD and TRC chairman are part of the NTD Steering Committee.

245. TRC/Nigeria wonders for how long it will continue to function as a review committee for CDTI only, or should TRC/Nigeria (sometime in the future) merge with the NTD Steering Committee and operate as a sub-committee of NTD Steering Committee with mandate expanded to cover other NTDs?

246. TRC 13 will hold within the period of 30<sup>th</sup> June to 4<sup>th</sup> July 2014 in Calabar, Nigeria.

**TCC Comments:**

247. TCC noted the report, commended Nigeria TRC for detail report, full of thoughts.

248. With regard to the future of TRC/Nigeria, TCC recommended that the TRC be merged with the NTD Steering Committee of Nigeria as one committee and that TRC reports go through the NTD Steering Committee before coming to TCC since the NOCP/HQ and zonal officers are already part of that Steering Committee.

249. Concerning the rejection of Ekiti project's 9<sup>th</sup> year report, the committee observed that TRC/Nigeria should pay an advocacy visit to the State.

**OTHER MATTERS: Agenda item 16**

**i) Tribute to Dr Laurent Yameogo:**

250. At the end of the second day of the session, TCC wished to honour, thank, and recognize Dr Yaméogo, Coordinator of APOC Director's Office, prior to his forthcoming retirement.

251. On behalf of TCC members and advisors, Dr Philippon briefly traced back the key steps of Dr Yaméogo's career that lasted 32 years, completely dedicated to OCP and APOC, while highlighting how it has been original and exemplary.

252. Dr Yaméogo joined OCP in 1982 as a consultant. Trained as a hydrobiologist, he was appointed as officer responsible for the hydrobiological surveillance network within the Vector Control Unit that was the spearhead of OCP. He then became the Chief of that unit until the closure of OCP when he joined APOC as Coordinator of APOC Director's Office, post he occupied up to date.

253. Dr Philippon highlighted Dr Yaméogo's high professional ethics, his dedication, his relentless commitment for onchocerciasis elimination, and his in-depth knowledge of APOC. He expressed TCC's gratitude for the valuable assistance continuously received from Dr Yameogo with constant availability and equanimity in all circumstances.

254. In his address to Mrs Yaméogo, he warmly thanked her for the sacrifices made as a spouse and mother to allow her husband to devote himself so intensively and for so long to his duties for the greater benefit of OCP and APOC.

255. Re-affirming the TCC unanimous feelings of admiration for the work done by Dr Yaméogo and its gratitude towards him, Dr Philippon assured him of the long lasting friendship from each TCC member. On behalf of all the participants, he offered their warm and best wishes of happiness to Dr Yaméogo and his spouse and success in the new phase of life that is opening up for them.

256. The ceremony ended with the presentation of gifts to Dr Yaméogo and his spouse and a toast of friendship.

**DATE AND PLACE OF THE THIRTY-NINTH SESSION OF THE TCC: Agenda Item 17**

257. The 39<sup>th</sup> session of the Technical Consultative Committee (TCC39) is scheduled for 08 to 12 September 2014 in Ouagadougou, Burkina Faso.

**CLOSURE OF THE SESSION: Agenda item 19**

258. In his closing remark, the Chair thanked all TCC members, co-opted members, researchers as well as APOC staff for excellent presentations. He thanked the interpreters for their patience in staying after the normal accepted hours and observed that they now belong to the Oncho family. On this he declared the 38<sup>th</sup> session of the TCC closed.

## Annex 1. List of participants

### 38<sup>th</sup> SESSION OF THE TECHNICAL CONSULTATIVE COMMITTEE *Ouagadougou, 10-14 March 2014*

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*PRO/APOC-13.03.2014*

## Annex 2: TCC38 Agenda

1. Opening
2. Adoption of the Agenda

### **Information**

3. CSA: matters arising from the 142<sup>th</sup> and 143<sup>th</sup> sessions
4. JAF: matters arising from the 19<sup>th</sup> session: decisions
5. NGDO: matters arising from the NGDO/NTD Network Meeting : recommendations only
6. TCC: follow-up of the key recommendations of the thirty-seventh session

### **Strategic and technical issues**

7. 10<sup>th</sup> NOTF Meeting
8. Elimination of Onchocerciasis infection and interruption of transmission:
  - (i) Elimination of Onchocerciasis with ivermectin in Africa
    - a) Update on Entomological/Epidemiological evaluations
    - b) Transmission Assessment
    - c) Update on delineation of transmission zones
    - d) Delineation of treatment boundaries
    - e) Concept note on Elimination of Onchocerciasis in all hypo endemic areas by 2020 – Revised version
    - f) Alternative Treatment strategy selection
    - g) Update on black flies trapping and other studies related to Onchocerciasis
    - h) Predictive *S. damnosum* habitat modelling in Burkina Faso and Northern Uganda
    - i) The use of skin snips for estimating prevalence of infection in hypo-endemic areas
  - (ii) Elimination of *O. volvulus* infection: New diagnostics of PATH
  - (iii) LF and Oncho elimination Programmes collaboration
  - (iv) Perspectives of Lymphatic Filariasis (LF) and Onchocerciasis elimination (DOLF)
  - (v) Presentation of the recommendations of UOEEAC (Uganda) on stopping treatments in some foci of Uganda
  - (vi) Re-launching of CDTI activities in Central African Republic
9. Research on new control and surveillance tools by collaborating institutions:
  - (i) Update on Moxidectin and Target Product profile for drug for Onchocerciasis control via mass treatment
  - (ii) Update on the DEC patch test and Lohmann
  - (iii) Progress made towards a vaccine against river blindness
  - (iv) The potential long-term epidemiological consequences of a vaccination programme against onchocerciasis
  - (v) Milestones en route to a river blindness vaccine Phase I clinical trials
  - (vi) From bench to bed-side transitional research projects to support a river blindness vaccine
  - (vii) Rolling out New diagnostic tools to support the Elimination of Lymphatic Filariasis and Onchocerciasis
10. Remarks by Technical Advisors to APOC Management
11. Review of operational research

### **Management of APOC Trust Fund**

12. Report on the financial management of APOC funded Projects

## **Reviews**

13. Report on the review by the APOC Management of the financial content of 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup> and 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup>, 15<sup>th</sup> years projects progress reports as an introduction to their technical review
14. Review of New project proposals and 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup> and 7<sup>th</sup>, 8<sup>th</sup>, 9<sup>th</sup>, 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup>, 15<sup>th</sup> years annual technical reports of projects
15. Technical review Committee: Cameroon and Nigeria
16. Other matters:
17. Date and place of the thirty-ninth session of the TCC
18. Conclusions and recommendations of TCC38
19. Closure of the session

**Annex 3: Follow up of the key recommendations of the 37th Session of TCC**

Subject/Topic	Action to be taken	Status of implementation
<p><b>Follow up of TCC36th recommendations</b></p>	<p><u>Angola</u></p> <ol style="list-style-type: none"> <li>i. The WHO Regional Director for Africa should be contacted to assist in removing the bottleneck to the implementation of activities in Angola;</li> <li>ii. APOC Management should continue working with the WHO Representatives and other partners at country level to clearly make a case.</li> </ol>	<p>Done for (i) and work in progress for (ii)</p>
	<p><u>JAF19: Participation of Ministers</u></p> <p>A one-page information document on APOC, JAF19 and elimination of onchocerciasis and other PCT/NTDs be prepared and sent to the Ministers of Health with the invitation letter. This should be done through the WRs in the countries, preferably by the Regional Director of WHO, instructing them to encourage active participation of the Ministers. A letter by the Regional Director to the Permanent Secretary of the African Union for the Ministers of Health would also be of paramount importance.</p>	<p>Letters were sent to the Ministers by the RD but for the African Union, it was found prudent to defer action after careful examination of the issue.</p>
<p><b>MATTERS ARISING FROM CSA 138<sup>TH</sup> AND 139<sup>TH</sup> SESSIONS AND JAF18</b></p>	<p><i>Update on endemic countries - Epidemiological evaluation results</i></p> <p>A sub-committee set up recommended to continue with the existing protocol and agreed to enable APOC to sample in phase 1a at least 30 villages to enable early start of entomological evaluation when parasitological evaluation results indicate trend towards elimination of Onchocerciasis infection</p>	<p>This started being implemented in Burundi and Chad</p>
	<p><i>Delineation of treatment boundaries.</i></p> <p>Ivermectin distribution should not be carried out in hypo-endemic areas endemic with loa loa. In these areas, Doxycycline could be used on a test and treat basis. The committee also noted that the post control nodule prevalence in Burundi was very high and do not tally with the microfilariae prevalence data. There is need to ensure that the nodule palpation method is standardized</p>	<p>Noted and work is being done on nodule palpation method</p>

Subject/Topic	Action to be taken	Status of implementation
	<p><b><i>Concept Note on Elimination of onchocerciasis in all hypo-endemic areas by 2020.</i></b></p> <p>TCC observed that the concept note needed to be re-packaged with additional information to support why earmarking hypo endemic areas for treatment with a clear methodology, targeting 2014 and 2015 while the concept note on the future of APOC will cover 2016-2025. There is need to specify in the concept note that the hypo-endemic areas are the hypo-endemic areas which were existing when APOC started its activities 18 years ago.</p>	<p>A revised concept note will be presented under agenda item 8ic.</p>
	<p><b><i>Update on delineation of transmission zones</i></b></p> <ol style="list-style-type: none"> <li>i. A road map should be developed with timeframe for activities;</li> <li>ii. Training of entomologists. The job of cytotaxonomists should be given due consideration. Young researchers from universities could be trained. Channels of vice-chancellors at the universities could be used for reaching these young researchers;</li> <li>iii. Owing to the limited number of entomologists, the use of university researchers for such activities could be considered;</li> <li>iv. In carrying out activities efforts should be made to prioritize the countries having the biggest foci first. Countries should also be classified by category, e.g. those having means to carry on the study first, those having knowledge but not having means and those which are important but having no means and knowledge in the entomology activities;</li> <li>v. Entomology and Epidemiology teams in APOC should work closely;</li> <li>vi. The entomology aspects should be put in the concept note on the future of APOC with clear definition of requirements.</li> </ol>	<p>The road map is being developed and the other recommendations are considered by APOC management for the implementation of the entomological activities (info will be given under Ag 8a&amp;d)</p> <p>the recommendations are considered by APOC management for their implementation</p>
	<p><b><i>Update on black flies trapping and other studies related to onchocerciasis</i></b></p> <ol style="list-style-type: none"> <li>i. The transfer of the trap to the</li> </ol>	<p>While finalizing the trapping system, capacity building of nationals of Nigeria was conducted and preliminary data are being collected</p>

Subject/Topic	Action to be taken	Status of implementation
	<p>national teams should be accelerated. The traps should be used in parallel with the human landing collection in a primary phase while continuing the research;</p> <p>ii. TCC encourage APOC to continue its collaboration with the research team.</p>	(up date agenda item 8e)
	<p><b><i>Predictive S. damnosum habitat modeling in Burkina Faso and Northern Uganda</i></b></p> <p>i. The use of breeding sites modeling should be encouraged and implemented in the field to assist the entomology team in the mapping of the main areas of blackflies production and the identification of capture points. This would also support the epidemiology team with the identification of communities for epidemiological surveys.</p> <p>ii. The model should be expanded to the identification of breeding sites for other Simuliidae species (e.g. <i>S.neavei</i>).</p> <p>iii. The model should include a parasitic component.</p>	Progress made in the area will be presented under agenda item 8ie
<p><b>REVISED CONCEPT NOTE FOR THE POST 2015 PERIOD: TCC CONTRIBUTION TO THEIR FINALIZATION</b></p>	TCC made observations/suggestions to improve the draft revised Concept Note	<i>The observations/suggestions were taken into account and the Concept Note was finalized and approved by JAF19 in December 2013.</i>
<p><b>PROTOCOL FOR THE MULTI-COUNTRY STUDY ON COMMUNITY SELF MONITORING (CSM): Agenda item 9</b></p>	<p>i. Definition of CSM: define the criteria to be considered in determining the CSM status of the projects to be reviewed;</p> <p>ii. Scope of the study: prioritize the research objectives and questions to ensure that the core questions of interest on whether and why CSM is working are captured;</p> <p>iii. Additional questions: assess community structures that enhance the potential for CSM.</p> <p>iv. Site selection: consider replacing Kwara with another project in the far North of Nigeria (e.g. Jigawa project) in order to improve the geographical spread;</p> <p>v. Study design: given that the study intends to show associations it</p>	Will be implemented in 2014

Subject/Topic	Action to be taken	Status of implementation
	<p>would require a wider scope with higher cost implications;</p> <p>vi. Interpretation of the results: clarify in the proposal what decisions will be made in the event that wide inconsistencies are found between reported treatment coverage rates and the rates established by the study? How will the findings influence the categorization of the sites during data analysis?</p> <p>vii. Number of project sites: consider reducing the number of the project sites to reduce the study costs;</p> <p>viii. Use of the results: document clearly in the proposal how the results will be used.</p>	
<p><b>PROTOCOL FOR INDEPENDENT MONITORING OF TREATMENT COVERAGE OF CDTI PROJECTS: Agenda item 10</b></p>	<p>During the pre-test, collect information on the cost of monitoring coverage by other programmes (e.g. the LF programme) in an effort to rationalize the proposed cost of Euros 61,000 per project for the survey and Euros 5,000 – 10,000 per project for the self-monitoring tool that was considered rather high.</p>	<p><i>The recommendation is noted and will be considered by those who will conduct the pre-testing.</i></p>
<p><b>MANAGEMENT OF THE APOC TRUST FUND</b></p>	<p><b><i>Rate of implementation of 2013 budget</i></b></p> <p>TCC members also recommended deployment of vehicles to field offices to facilitate the operations.</p> <p>It was also recommended to the APOC management to consider sending vehicles to some countries (Uganda, Cameroon, etc.) where there is an urgent need for such equipment.</p> <p><b><i>APOC accountability framework: Out of 1296 financial returns expected from projects for the 2013 and previous years 590 are still delinquent.</i></b></p> <p>TCC recommended that reminders be sent to projects with outstanding reports through higher levels at the Ministry of Health for a better impact and follow up</p>	<p>Implemented in Nigeria, Uganda and Tanzania. In addition, other vehicles were ordered towards the end of 2013 for CAR, Congo DRC, Ethiopia, Nigeria and South Sudan.</p> <p>Reminders were sent but the situation is still worrying. A presentation will be made under agenda item 13.</p>

## **Annex 4: TCC SUGGESTED LIST OF INDICATORS TO SUPPORT DECISION MAKING FOR ALTERNATIVE TREATMENT STRATEGIES**

### **Baseline**

- Pre-treatment prevalence (endemicity level)
- % of communities with more than 60% prevalence

### **Coverage Profile**

- No of years of treatment
- Average geographic coverage over last 5 years
- Average treatment coverage over last 5 years
- Minimum and maximum coverage ( GC and TC) over last five years
- % of communities with less than 80% treatment coverage in 2012 and 2013
- Reliability of reported coverage ( using qualitative information)
- % of absentees and refusals over last five years

### **Community Level Profile**

- CDD population ratio – 2013
- Average number of CDD per community
- Average number of operational CDDs PER community
- % of communities without CDDs
- % of communities co endemic with Loa Loa
- Urban Project ( Yes/No)
- % of post conflict communities within project area
- % of nomadic communities within project area
- # of new communities added to project since 2010
- # of communities which cannot be accessed

### **Health System**

- Involvement of peripheral health services in different CDI activities
- Local experience in co implementation of oncho and LF ( and other NTDs)
- Availability of national expertise (e.g. entomologists and entomology technicians)

### **Entomology Parameters**

- Identity, seasonal distribution and densities of vectors
- Vector infectivity

### **Evaluation Status**

- Result of epidemiological evaluation – Phase 1A ( Prevalence, CMFL)
- Most recent entomological status (Species identity, seasonal distribution pattern and abundance, Infectivity rate)

### **Finance Related Indicators**

- Timelines in submitting financial returns for 2013 ( *report submitted within 1-3 months, 4-6 months, 7-12 months of due date*)
- % of APOC funding received in 2013



**Illustrative Reasons (To be determined using a consultative process with countries)**

- Geographical access issues
- Nomadic populations
- Determinants of noncompliance and refusal
- Duration and quality of mass campaigns
- Countries ( Projects and country coordinators) should report on and share their experience when for ATS already in use in their project

APOC should clearly define criteria and conditionalities for different ATS scenarios.

## **Annex 5: LF and Oncho elimination Programmes collaboration**

### **The Rationale for the Joint Working Group (JWG):**

- i) Formed and endorsed by APOC and WHO-AFRO in 2012.
- ii) Aimed at promoting collaboration and coordination in the implementation of LF and oncho activities in order to maximize the use of resources and accelerate progress towards elimination.
- iii) Recognition of overlap in endemicity and use of similar tools for control.

### **Objectives:**

- i) Work on common strategic issues towards LF and Oncho elimination.
- ii) Provide advice on common technical approaches for disease elimination.
- iii) Propose to both TCC and RPRG annual joint action plans.
- iv) Conduct joint country missions as agreed in the joint action plans.

### **Membership:**

- i) Dr. Ricardo Thompson (RPRG & Chair)
  - ii) Dr. Mary Amuyunzu-Nyamongo (TCC)
  - iii) Prof. Njeri Wamae (RPRG)
  - iv) Dr. Andre Yebakima (TCC)
  - v) Dr. Francisca Olamiju (TCC)
  - vi) Prof. Oladele Akogun (RPRG)
  - vii) Dr. Yao Sodahlon (MDP)
- \*Discussion during TCC 38 supported by Prof. Traoré and Mrs. Yumkella

### **The Current Context of LF and Oncho Elimination:**

- i) Key developments globally in the progress towards the integration of LF and Oncho elimination activities.
- ii) In Africa, the development of a Concept Note and Strategic Plan of Action and Indicative Budget 2016-2025 for the Programme for the Elimination of Neglected Diseases in Africa (PENDA).
- iii) Formation of the Transitional Task Force (TTF) with the goal of working closely with APOC, WHO AFRO and CSA to facilitate the launch of PENDA by JAF in December 2015.

### **Relevance of the JWG:**

- i) Recognition that countries have to expand and sustain treatment coverage and build up to beginning of 2016 in order to meet the set elimination targets.

- ii) The JWG therefore will play:
  - An advisory and supportive role to countries in the transition period.
  - Providing technical guidance to APOC and AFRO in preparation for the launch of PENDA.

### **Key Activities for 2014-2015**

- i) Document the NTD context in endemic countries through consultations with countries and implementing partners:
  - The distribution and endemicity of NTDs (with a focus on LF and Oncho).
  - On-going or past interventions on any of the diseases.
  - The geographic coverage of implementation partners. Country contributions to the implementation should also be mapped.
- ii) Review and harmonize guidelines for LF, Oncho and other NTDs (e.g. start and stop treatment, drug delivery strategies, etc.).
- iii) Map the existing structures for addressing NTDs in WHO country Offices.
- iv) Develop a new narrative reporting format in line with penda with the involvement of countries and implementing partners.
- v) Review the current tors of the apoc tcc and if RPRG, and input where necessary to emerging strategic penda issues.
- vi) Develop tors for the strategic information unit including it is required size, technical competence, structure and strategic approach.
- vii) Identify key research questions.

### **The TTF TOR:**

- i) The TTF is a CSA committee set up to advise it on transition issues.
- ii) Mandate contained in the JAF 19 report.
- iii) The TORs are in draft (not clear what changes have been made on the same already).
- iv) Comments from TCC:
  - The mandate of the TTF should be to advice CSA.
  - Gender and language balance should be ensured.
  - Clear links between the TTF, JWG, TCC, RPRG among other technical groups.
- v) Critical for APOC to ensure coherence in transitional actions to avoid duplication and confusion to the countries (especially).