JOINT ACTION FORUM

AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL
Fourth session
9-11 December 1998

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1. OPENING OF THE SESSION: Agenda item 1

1.1 The fourth session of the Joint Action Forum (JAF) of the African Programme for Onchocerciasis Control (APOC) was held in Accra at the kind invitation of the Government of the Republic of Ghana. The session was opened at the Accra International Conference Centre and the working sessions took place at the State House Banquet Hall (the list of participants is attached as Annex 1).

1.2 At the opening, Dr Kofi Ahmed, Director of the Onchocerciasis Division of the Ministry of Health, welcomed the participants on behalf of the Minister of Health, Honourable Samuel Nuamah Donkor. Dr Ahmed stressed the importance of the current JAF session during which the Assembly would take stock of the progress made, plan future activities and ensure that the gains be maintained. He paid special tribute to the two Ghanaian oncho-pioneers, Drs Ebrahim M. Samba and K. Yankum Dadzie, for their efforts to rid the continent of this dreadful disease. He further thanked the manufacturer of ivermectin, Merck & Co., for making the drug available free of cost for as long as needed. Dr Ahmed finally referred to the partnership in APOC as an example-setting approach to public health endeavours, and to the contribution of the APOC community-direction of field operations to primary health care development and to the health sector reform.

1.3 Representing the Chair of the third session of JAF, Mr Phil Mason emphasized the fact that APOC had clearly demonstrated its capacity to decide on what to do and how to do it and at the same time show the necessary flexibility in decision-making. He was confident that the Programme would spearhead a wider role of the communities in the conduct of health programmes, thereby contributing to the health sector development. He considered the Programme a model for other drug distribution/donation activities given its minimum bureaucracy, its effective management and its cost-effective field operations.

1.4 Dr Dadzie, Director ad interim of APOC, saw the presence at the session of representatives of the various groups concerned with the Programme as proof that the unique partnership in APOC was a sound foundation for APOC which had now moved from infancy to a fully grown operation which was moving fast. There were challenges and the APOC management looked forward to receiving guidance from members of the Forum. Dr Dadzie concluded by thanking the Ghanaian authorities for hosting the fourth session of JAF under such excellent conditions.

1.5 The Director of the WHO Regional Office for Africa (AFRO), Dr Samba, expressed his confidence that APOC would succeed as it based its operational strategy on that of the Onchocerciasis Control Programme in West Africa (OCP) which over a quarter of century had showed that success was possible when all involved assumed fully their responsibility. The effective integration of onchocerciasis control in comprehensive national health programmes was a challenge for both APOC and OCP and the two Programmes could count on the support of AFRO in that direction. Dr Samba finally expressed his thanks to Ghana for inviting the governing bodies of OCP and APOC to meet in Accra.
Dr Ralf Henderson, Special Advisor to the Director-General of WHO, Dr Gro Harlem Brundtland, conveyed her greetings and best wishes for success to participants in the Forum. Dr Henderson emphasized four aspects of essence for the success of JAF, *i.e.* partnership, community involvement, integration and continued operational research and suggested that these fundamental aspects of the Programme could very well lend themselves to application also in other large-scale public health undertakings. He particularly stressed the importance of APOC being conceived as an operation integrated within the national public health systems. Dr Henderson finally recognized the importance of the close collaboration between OCP and APOC to the benefit of the two Programmes. Dr Henderson’s statement is attached as Annex II.

In welcoming participants to Ghana, Dr Mary Grant, Member of the Council of State, pointed out that her country had always been a strong supporter - and beneficiary - of international efforts to control river blindness as witnessed by the holding of the Planning Meeting on Onchocerciasis Control in the Volta River Basin in Accra during October 1972 well before the start of OCP field operations. As onchocerciasis was no longer a problem of public health importance or an obstacle to socioeconomic development in Ghana, it was now up to the country itself the maintain that achievement and Dr Grant pledged the full support of the Government and health authorities to meeting that challenge. She concluded by expressing her pleasure that the OCP experience was now being extended to nineteen African sister nations through the APOC initiative which should eventually lead to the elimination of onchocerciasis from Africa.

2. **ELECTION OF OFFICERS:** Agenda item 2

2.1 The Central African Republic was elected to the Chair (held by Dr Fernande Djengbot, Minister of Health and Population).

3. **ADOPTION OF THE AGENDA:** Agenda item 3 (document JAF4.1, Revision 3).

3.1 The provisional agenda as reflected in the present report was adopted.

4. **REFLECTIONS OF THE COMMITTEE OF SPONSORING AGENCIES:**

4.1 The Chair of the Committee of Sponsoring Agencies (CSA), Mr Gana Fofang of UNDP, congratulated, on behalf of his Committee, APOC on the speedy progress made in fielding no less than 45 projects in more than half of the 19 Participating Countries during the past two years. The Committee was, however, concerned that the staff was overreaching although it noted with satisfaction that the WHO Regional Director for Africa had assigned a staff member experienced in tropical diseases control to the OCP and APOC headquarters. CSA was also impressed by the fact that no more than 9 per cent of the budget of the Programme was spent on administration.

4.2 The Committee underlined the importance of the extensive partnership, including direct community involvement of the target communities, on which APOC relied for successful operations. Mr Fofang mentioned, in this connection, the importance of support from, and collaboration with, WHO-AFRO. In the opinion of CSA, this close synergistic partnership which was, indeed, innovative could stand as a prototype for other public health activities.
4.3 The Committee paid a special tribute to the Members of the Technical Consultative Committee who made recommendations concerning the acceptability of project proposals, had launched independent monitoring/evaluation of APOC-assisted projects and in August organized a special meeting on the Programme and its contribution to the health sector reform underway in APOC countries.

4.4 On the budgetary side, CSA expressed concern about a potential shortfall in financing the first phase of APOC operations and called upon the donor community to make the necessary efforts to fill any current and potential gaps that might arise. The Committee was pleased that the OCP and APOC managements had made special efforts to ensure a reliable management and accounting of the funds so far released for approved projects.

4.5 Mr Fofang, in referring to the collaborative arrangements between OCP and APOC, reported that CSA endorsed the recommendations made by an independent consultant regarding the location of the APOC Hqs suggesting that the current collaboration in Ouagadougou continue for the time being and that the situation be reviewed towards the end of OCP operations.

4.6 Concluding his statement, Mr Fofang referred to the new programme for global elimination of lymphatic filariasis regarding which CSA had expressed satisfaction that the operational strategy would be based on community-directed distribution as spearheaded by OCP and APOC. The reflections of the CSA are attached as Annex III.

5. PROGRESS REPORT OF THE WORLD HEALTH ORGANIZATION: Agenda item 5 (documents JAF4.2, JAF4/INF/DOCs.1,2,3,4 and 5)

5.1 A brief summary of the activities during the reported period: 16 Community-directed Treatment with Ivermectin (CDTI) projects and 3 National Plans approved, 35 Letters of Agreement signed with 9 countries, over 12 million people treated in 9 countries; vector elimination activities readied for start mid-1999; support to National Onchocerciasis Task Forces (NOTFs) for completion of Rapid Epidemiological Mapping of Onchocerciasis (REMO) and integration of REMO data into the Geographical Information System (GIS), long-term impact studies started; monitoring of 12 CDTI projects; operational research with TDR on sustainability of the CDTI strategy; and workshops on the philosophy of APOC and the concept of CDTI for 19 countries.

5.2 Between April 1996 and September 1998 joint APOC management, WHO/AFRO and Non-governmental Development Organizations (NGDOs) missions visited Cameroon, Equatorial Guinea, Central African Republic (CAR), Chad, Malawi, Nigeria, Uganda, Sudan, Tanzania and the Democratic Republic of Congo (DRC). The teams assisted the NOTFs to prepare National Plans and CDTI proposals and helped in the completion of REMO exercises. Substantial reductions of APOC contributions to the five year project costs were achieved during the visits. In 7 out of 10 countries budget lines for onchocerciasis control had been established.

5.3 From November 1997 to September 1998 the OCP Finance Officer and the APOC Administrative Officer visited Tanzania, CAR, Chad, Cameroon and Equatorial Guinea to train NOTF accountants following which funds were transferred to 21 projects in 7 countries for start-
5.4 The first of two workshops, organized in 1998 in collaboration with WHO AFRO and NGDOs, was held in Douala (Cameroon) with participation from Angola, Burundi, Cameroon, Congo Brazzaville, DRC and Rwanda. The second took place in Nairobi attended by representatives from Kenya, Ethiopia, Liberia, Mozambique and Sudan. With the three workshops organized during the preceding year, all 19 countries had thus been sensitized to the APOC philosophy and informed about the planning, implementation and financial management of CDTI projects. In all 334 persons had attended the five workshops.

5.5 On the public relations and training side, a training manual for distributors, an information pamphlet, Information-Education-Communication (IEC) pamphlets and different videos were produced during the period under review.

5.6 With the technical support from the WHO CTD/HealthMap, the initial Nigeria REMO maps were refined and the Rapid Epidemiological Assessment (REA) data validated while REMO was completed in Tanzania and Chad. REMO exercises were carried out in the Uele and Kasai regions of the DRC and national staff in Mozambique were trained in REMO procedures.

5.7 Through downscaling by the APOC Management of the proposed budgets in the thirty five (35) Letters of Agreement signed during the reported period, the originally proposed APOC contribution of a total of US$ 9,179,850 had been reduced to US$ 6,187,872 (33%) now to be paid from the 1998 budget.

5.8 Eight of the first approved project reported success in active community participation; government commitment; training of community distributors; mobilization and education of target communities aided by local women’s groups, and actual coverage rates. In all 6 424 distributors from 1,741 villages had been trained during the period under review in the eight projects in question with an overall treatment coverage of 56%.

5.9 Among the constraints reported by the eight first approved projects were lack of inadequate primary health care (PHC) infrastructure; settlement patterns; transportation difficulties; social unrest; and late disbursement of APOC funds largely due to delayed response by NOTFs to queries by the Technical Consultative Committee (TCC).

5.10 With 16 CDTI projects and 3 National Plans approved in 1998 a total of 36 CDTI projects, 4 vector elimination projects and 5 Hq’s support projects have been approved for 11 countries since 1996. In 1998, 11.7 million people were treated as compared to last year figure of 7.5 million persons treated. By the end of 1999, 15 million people would be treated and 40 million by the year 2002 as planned by APOC.

5.11 In December 1997, JAF3 approved a budget of US$ 162,821 for vector elimination in the Itwara focus in Uganda, later revised to US$ 28,186 for a one year regular monitoring of the focus and larviciding/monitoring of the sub-foci. Furthermore, US$ 106,291 had been earmarked for a feasibility study in the Mpamba-Nkusi focus. These activities would start late 1998. In the Tukuyu focus on the Tanzania/Malawi border vector elimination operations were expected to commence before end-1998 while preparatory vector elimination activities would start on the
5.12 The Programme continued to support, and collaborate with, TDR in carrying out operational research concerned with the sustainability of CDTI and its integration into health services; with the marketing of Programme activities, and with rapid monitoring of ivermectin delivery.

5.13 An effective collaboration had been established with the WHO Regional Office for Africa which provided technical and administrative support through its country offices. Furthermore the AFRO Regional Advisor on Other Tropical Diseases had been assigned to Ouagadougou where he participated actively in OCP and, particularly, in APOC activities. Also, a close collaboration continued with WHO Hqs and, in particular, with the NGDO Coordinator who participated in country visits and workshops.

5.14 The Programme continued to receive important backing from OCP in such fields as administration of personnel; budget and finance; biostatistics/information support; supplies; transport; and communication, meetings, translation and documentation.

* * *

5.15 APOC Management was congratulated by JAF members for the tremendous volume and the quality of the work performed during the period under review.

5.16 JAF noted that the denominators used by the participating countries to compute treatment coverage rates in projects’ areas varied: most used the eligible population while some few used total population as recommended by the programme. For uniformity as well as for the sake of comparing treatment coverage among projects and between countries, the forum urged all participating countries to use henceforth the total population of the projects’ areas as denominator in calculating the treatment coverage.

5.17 The forum also noted in some instances with great concern a dramatic increase up to 10 fold in project target populations from the first to the fifth year. The forum urged the countries concerned to realistically review (e.g. DRC) such figures.

5.18 JAF advised the participating countries to accord priority in project proposals development and CDTI implementation to areas as defined by REMO and the zones located in the eastern flank of the OCP area (zones between Nigeria and Benin).

5.19 The forum noted with great satisfaction that APOC management is not only making good use of the national capacity previously developed with TDR support but it is improving further what already exists while endeavoring to train new national experts in every aspect of the programme implementation.

5.20 Given the increasing workload and considering the very lean professional staff at APOC Management, JAF encouraged the programme to make more use of the WHO country offices as backstop in administrative and financial management of the projects.

5.21 Cross border issues were once again raised during the discussions on WHO progress report. In effect, some countries were concerned that their neighbors were not undertaking proper...
actions at the other side of common borders to control onchocerciasis (e.g., eastern border of Uganda with DRC) thus perpetuating the transmission of the disease on both sides. Coordinated efforts on both sides of common borders were strongly recommended to participating countries confronting such a situation.

6. **REPORT OF THE TECHNICAL CONSULTATIVE COMMITTEE**: Agenda item 6 (documents JAF4.4 and 4.5)

6.1 The Chair of the Technical Consultative Committee (TCC), Professor O. Kale, informed the Forum that during the reported period his Committee met in Ouagadougou, 30 March to 2 April and at WHO Hqs., 24 to 28 August during which latter session a special meeting was held on APOC and the health sector reform.

6.2 The TCC recommendations for approval of project proposals made during the two sessions have been summarized (see para 11). In addition, the Committee considered certain issues of relevance to APOC operations for which recommendations are summarized in the following:

- onchocerciasis distribution and endemicity to be reviewed when REMO results conflicted with historical and other data;
- earlier submission of revised budgets for the next year of ongoing projects to avoid disruption;
- funding of subsequent years of APOC-financed projects subject not only to satisfactory TCC review but also to satisfaction of the Management regarding financial returns;
- sites for impact assessment to be reduced to 13;
- implementation of joint supervision of APOC projects to be funded by the Trust Fund or the World Bank oncho unit;
- approval of APOC financial support to already well-run ivermectin distribution projects conditioned by strong justification with focus on elements requiring strengthening to achieve sustainability.

* * *

6.3 The issue of burden of reporting on field personnel was debated by the forum which agreed and requested that this aspect be streamlined. The APOC Management together with the NOTFs were asked to look into this problem and make suggestions to the TCC.

6.4 While recognizing that the first year of any CDTI project may require a relatively important amount of funds for investment (capital equipment, vehicles, to name a few) resulting in a high cost per treatment during that period, the forum was concerned about the fact that once APOC comes in to support ongoing ivermectin distribution projects, previously funded by NGDOs and with low costs per treatment, the costs per treatment tend to skyrocket. The forum saw in that phenomenon a reflection of a possible rejection by the national project managers of the norms set by TCC in view of containing costs and ensuring sustainment of the projects.

6.5 The forum expressed its appreciation to the TCC for the rigor exhibited in the assessment of project proposals submitted by the participating countries. However, when looking at the increasing number of new project proposals submitted to the TCC, the consideration of the
budgets for subsequent years of already approved projects as well as the technical and financial reports of these projects, JAF realized the burden this has put on the secretariat. Although this situation has not reached a crisis point yet, the forum requested that mechanisms and strategies should be found to ease the work of TCC and APOC Management in that regard.

6.6 Conditions to be fulfilled by the NOTFs before funds are released by APOC Management for the implementation of the projects include:

(i) Satisfactory fulfillment of conditions posed by the TCC when it recommends any project for approval by CSA. Until these conditions are satisfied, the APOC Management cannot establish the Letters of agreement which constitute the legal basis of disbursement of funds by WHO as the executing agency.

(ii) Each NOTF must open a new special bank account into which money from APOC Trust Fund will be transferred. Without such a bank account opened funds will not be transferred for the implementation of the projects.

(iii) A reliable system for managing the funds is to be put in place; this includes:
- the appointment of accountant,
- the training of the accountant in the WHO imprest system.

(iv) Appointment of two official signatories for the special bank account.

6.7 The fulfillment of each of the above conditions has been so far subject to delay in a number of instances which has impacted on the disbursement of funds to the projects concerned. The responsibility in such circumstances is shared between the NOTFs and the WHO/APOC. Efforts are underway to minimize or eliminate the delay in disbursement of funds for project implementation.

6.8 The Forum recommended that one per cent of the funds released to finance APOC supported projects be allocated for appropriate operational research on specific issues of interest to the Programme.

7. REPORT OF A SPECIAL FORUM ON APOC OPERATIONALIZATION IN THE CONTEXT OF ONGOING HEALTH SECTOR REFORMS IN AFRICA:
Agenda item 7 (document JAF4.6)

7.1 In response to a request by JAF at its third session in December 1997, a special Forum was held in August 1998 during the sixth session of the Technical Consultative Committee to consider the potential contribution of APOC operations, and particularly CDTI projects, to health sector reforms. During the one-day Forum, reports on country experiences were presented; short papers on health sector reforms were introduced; and a general discussion, leading to conclusions and recommendations, took place.

7.2 In the absence of an official WHO concept of health sector reform, the following definition was proposed: “a sustained process of fundamental change in policy and institutional arrangements to improve the functioning of the health system, and thereby peoples’ health”. Four responses to health systems change were identified: responding to change from outside the health
7.3 During the discussion several pertinent issues were raised, including:

- the training of health workers at all levels to meet the real needs of the communities;
- the need to provide community-directed treatment with ivermectin (CDTI) with sustained support, ensure integration of CDTI into existing structures to be strengthened;
- instability of key staff and very limited financial resources for innovation;
- need for continued WHO-AFRO support to APOC-initiated activities beyond 2007;
- importance of research into the magnitude of CDTI costs.

7.4 The main conclusions agreed upon during the discussion were:

- onchocerciasis control to become an integral part of the health system, included in the minimum package; advocacy to be targeted to the district level and local governments;
- partnership with communities to be strengthened with full involvement of health workers;
- the unique partnership in APOC in tune with priorities of the WHO Director-General;
- priority research objects in Participating Countries: recurring cost of ivermectin distribution; role of health education for sustainability; impact of fee on coverage; nature and cost of financing district and health centre level; and the impact of the financial situation of health workers on their motivation to be involved in CDTI activities.

7.5 JAF commended TCC and the APOC Management not only for having been able to organize and hold the special session on “the health sector reform in the context of APOC operations” but also for the constructive and fruitful deliberations that took place during that session.

7.6 JAF welcomed the report on the special forum on APOC operationalization in the context of ongoing health sector reforms convened in response to the request made by JAF during its third session. The forum could not agree more with the presenter, Prof. Prozesky, that health services is the engine that drives community participation. It encouraged APOC to continue this work.

8. REPORT OF THE NGDO COORDINATION GROUP FOR IVERMECTIN DISTRIBUTION INCLUDING SUPPORT OF THE GROUP TO APOC’S ACTIVITIES AND TO LOCAL NGDOs: Agenda item 8 (document JAF4.8)

8.1 During 1997, the NGDO Coordination Group facilitated ivermectin distribution to 12.5 million people in APOC countries and 1.26 million in OCP countries. During two meetings held in 1998, the Group agreed on certain aspects of NGDO work in relation to APOC and OCP operations:

- to make special efforts to minimize future losses of ivermectin;
- to request TCC to call for reporting procedures that would avoid delay in agreements and disbursement of funds for next year’s operations.
- to streamline reporting procedures so as to reduce the workload in the field;
- to propose guidelines on the eligibility of local NGDOs for APOC support.

8.2 NGDO staff participated in joint preparatory visits to APOC countries and in the APOC organized workshops held in Douala and Nairobi. Furthermore, the NGDO Group provided the services of a Coordinator and his office in support to the APOC management.

8.3 Concern was raised as to the roles of, and the place accorded to, the communities in the process of CDTI. Some JAF participants actually believed that the longer the list of partners in the implementation of CDTI the thinner the role of the communities will be. However, the roles of the communities will be expanding as CDTI projects evolve while NGDOs’ (international and local) interventions will be diminishing.

8.4 The forum has also noted that NGDO support for ivermectin distribution is not covering at the moment all the participating countries. This situation was mainly attributed to the limited present network of the NGDO Coordination Group and funding restraints. Therefore, JAF encouraged new mechanisms and strategies for securing funding so as to allow the expansion of NGDOs’ support to all the APOC countries which have not yet benefitted from such support (e.g.: Mozambique, Ethiopia).

8.5 Additional possible ways of overcoming capacity constraints of NGDOs’ involvement in CDTI projects include:

(i) encouraging western countries which are not Donors to APOC to provide support to APOC projects through NGDOs,

(ii) development of mechanisms/procedures whereby international NGDOs will link up with effective local NGOs in view of supporting CDTI project implementation. In so doing international NGDOs will contribute to build up local capacity that will carry on project activities when they withdraw.

8.6 200,000 Mectizan tablets were lost out of a total 83 million tablets shipped this year by Mer&Co. to OCP and APOC participating countries. This represents less than 0.25% loss and was not deemed to have reached a critical point. Moreover, the loss was not seen as a specific phenomenon to ivermectin but instead a general problem affecting any other drugs because of the lack of these commodities in the areas where armed conflicts prevail. However, efforts are underway to set up an accountability system for mectizan delivery and management in order to reduce the level of losses.

8.7 Women in seclusion as well as some minority ethnic groups were said to be difficult to reach with ivermectin. Innovative approaches are therefore called for not only to expand treatment to those unreached above but also to facilitate their participation in CDTI process.
9. COUNTRIES REPORTS: Agenda item 9

9.1 9 out 19 APOC participating countries attended the fourth session of the Joint Action Forum and gave brief reports on the implementation of onchocerciasis control activities. As a general observation, it was felt that it is more difficult to reform an existing project into the CDTI approach than to establish a new true CDTI project. An intensive health education programme is needed to ensure that the reform will take place.

9.2 In some severely affected areas undergoing special circumstances (armed conflicts, famine, drought, flood) water and food may be most needed than ivermectin or any other drugs. Moreover, in the context of civil war, communities are not free and this can impede their participation in CDTI process and ultimately influence negatively community ownership of CDTI.

9.3 Some of the lessons learned from the implementation of CDTI in areas confronting social unrest include:

(i) there is a need of flexibility in the definition of a community as well as in the process of selection of CDDs by the community;

(ii) it is crucial to have a good relationship with the army so that they can give a hand in ivermectin distribution;

(iii) incorporating CDTI into PHC should be gradual so as to prevent the collapse of the whole system;

(iv) training and retraining is crucial for the success of CDTI.

Evidence of government commitment in CDTI activities as per country reports include:

(i) office accommodations

(ii) establishment of an oncho day for the purpose of advocacy and awareness raising;

(iii) payment of salaries of all national civil servants involved in onchocerciasis control activities (e.g. Nigeria spent this year 5 million naira only for the personnel at the federal level)

(iv) cash assistance is provided at the federal, State and local government level (e.g. 100,000 USD for Nigeria; 10,000 USD for Liberia)

(v) Participation of government officials in community mobilization and sensitization.

9.4 The delegation of Cameroon informed JAF that the Ministry of Health has decided to extend the implementation of the CDTI strategy to all reoriented and non reoriented districts of the meso and hyper-endemic areas.
9.5 The delegation of Cameroon also expressed the willingness of its government to host the JPC and JAF sessions of 2000.

9.6 As per the presentation of the delegation of Cameroon, it was noted that cost recovery is being applied in ivermectin distribution as an element of sustainability of CDTI projects. However, the treatment coverages presented were generally lower compared to the treatment coverages observed in projects implemented in other countries where such a policy is not applied. However, some few target districts did achieve pretty high treatment coverage (up to 73%).

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9.7 JAF was interested to know not only the level of the performance of the cost recovery policy in ivermectin distribution but also the real cost of treatment per person from which the proportion to be recovered is to be derived. In addition, there is a need to document thoroughly the effect of individual payment for ivermectin with a view of knowing who are those left out.

9.8 There are other means of community cost sharing which can be tried in the context of ivermectin distribution. The provincial solidarity fund was mentioned as an example by the delegation of Cameroon.

9.9 The Forum strongly recommended that the issue of cost recovery/cost sharing be addressed through operational research by the countries concerned in collaboration with the APOC Management and TDR.

9.10 Concerning REMO, exercises will be conducted with support from APOC Management during the period of:

- 28 December 1998 to 15 February 1999 in Liberia
- 15 January to 20 February 1999 in Kenya

9.11 JAF noted that Air Care International has committed itself to complete REMO exercise in Mozambique. As regards the Republic of Congo, REMO field activities previously stopped because of the social unrest have resumed and are being supported by OPC, the NGDO partner.

9.12 The Forum noted with satisfaction the progress made in the Rapid Epidemiological Mapping of Onchocerciasis and encouraged the countries and the APOC Management to continue their efforts towards a complete coverage of all Participating Countries as soon as possible.

9.13 SSI reported that it has requested a special permission from its Executive Council in order to lend support in onchocerciasis control in Liberia. This is because Liberia is not a member of the Commonwealth which is the focus of SSI. The decision of the Executive Council on this matter was expected soon. SSI intends to link up with CHAL, a local church based NGO.

9.14 Dr Stefanie Meredith, Director of the Mectizan Donation Programme (MDP), informed JAF that there have been problems recently with the importation of Mectizan into Ethiopia. NGDOs and individuals are no longer allowed to import drugs (including Mectizan) into Ethiopia. The forum requested APOC and MDP to work with the government of Ethiopia to formulate a solution in the near future.

9.15 The Forum noted with concern that contrary to the understanding reached, some countries
still imposed various forms of import duties and taxes which resulted in delays in release of Mectizan for use in control programmes. The Forum therefore urged that all Participating countries ensure the importation of Mectizan be done without any levies.

9.16 The issue of delay of release of funds for projects implementation was discussed once more under the current agenda item (see section 6.7 and 6.8 above). The Forum encouraged WHO and the NOTFs concerned to make all efforts to minimize and even avoid such delays in future.

9.17 The Forum wished to receive a list of the problems raised in the country reports and that the partners likely to help solving them be identified and contacted through proper channels.


10.1 The independent consultant, Professor Detlef Prozesky, summarized the findings of his investigation as follows:

- there were wide-ranging benefits/advantages of having APOC Hqs situated within the OCP compound both technically (professional dialogue between staff of the two Programmes), administratively (APOC benefiting from the OCP infrastructure); and financially (shared facilities, economies of scale),
- the disadvantages were fewer and less widely felt: OCP possibly dominating inappropriately, travel more difficult and costly than from a more centrally situated country; and, it could be said, the host country, Burkina Faso, getting an “unfair” advantage,
- the financial gain of APOC Hqs located within the OCP compound was calculated at US$ 240 000 a year;
- the disadvantages of moving APOC Hqs would be serious and include the disruptive effect of establishing a new administration; the existing expert administration having to be replaced, and important additional costs (US$ 80 000 for the transfer, US$ 96 000 for capital expenditure and US$ 500 000 annually for ongoing expenditures).

10.2 Professor Prozesky concluded by recommending that APOC Hqs continue to be based in Ouagadougou for the time being and that this decision be re-assessed in relation to the end of OCP operations.

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10.3 JAF members highly appreciated the quality of the investigation as well as the report itself and were happy with the conclusions and the recommendations. However, the report was criticized for the following reasons:

(i) the sample of the investigation was too narrow to safely allow far reaching inferences.

(ii) very few (only 5) NOTFs were surveyed.

(iii) nothing was said about the downscaling of OCP and how it will affect the cost of maintaining APOC/HQs in Ouagadougou and how it is accounted for.
The investigation failed to look into the conceptual development of the interrelationship between OCP, APOC and the forthcoming centre for multi-disease surveillance and control (tripartite marriage)

Though the emphasis of the investigation on the operational aspects of APOC was considered appropriate by most of the JAF participants, some said the basis of the decision on the location of the HQs of an organization has always been political and cannot be otherwise.

10.4 One of the delegations from the Participating countries therefore suggested that the question of the location of APOC/HQs be formally put by writing to APOC Participating countries which will find the proper way of consulting among themselves on the subject matter. The issue would be revisited at a later time.

10.5 It was reported that donors’ support to APOC has been growing very rapidly because of the remarkable beginning this programme has had. This is due, among other factors, to the close and efficient collaboration between APOC and OCP which are learning from one another. This situation has led to a convergent strategy for both programmes with the strategy in OCP countries starting to parallel that of APOC countries. Such an evolution was deemed highly desirable especially as OCP is entering its devolution phase.

10.6 From the standpoint of Donors as reported by Mr. Bruce Benton of the World Bank, considering the shortfall of funds for the APOC phase I of US$ 9 million, the extra costs of millions of dollars for setting up a new administration as well as the foreseen disruption of the programme’s operations for 6 months or a year, it will be unfortunate if the HQs of APOC has to be moved to another location for only political reasons.

10.7 In view of the above, the Forum:

(i) recommended that consultations be pursued with the interested parties before further consideration be given this issue in relation to the end of OCP activities;

(ii) decided that for the time being the Headquarters of APOC would remain in Ouagadougou at the OCP premises

11. CONSIDERATION OF NATIONAL PLANS AND PROJECT PROPOSALS:

Agenda item 11 (document JAF4.7)

11.1 The report showed the evolution of the number of projects approved since 1996 as follows.

(i) In 1996, 4 projects were approved: Malawi(1) and Uganda(3)

(ii) In 1997, 25 projects were approved: Uganda(1), Nigeria(10), Sudan(3); Tanzania(3), Cameroon(6), Chad(1) and CAR(1).

(iii) In 1998:

- Second year budget were approved for 11 projects for the 1998 budget:
Malawi(1), Uganda(1), Nigeria(5), Sudan (2), Tanzania(2)

- 9 new projects were approved in April for the 1998 budget: Uganda(1), Nigeria(5), Tanzania(1) and Equatorial Guinea(2)
- 7 new projects were also approved in October but for the 1999 budget: Uganda(1), Nigeria(3), D.R. Congo(2) and Gabon(1)

11.2 Altogether, 45 projects have been approved since 1996:

(i) 36 CDTI projects

(ii) 5 HQs support projects

(iii) 4 Vector elimination projects

11.3 The total projects’ budget submitted for JAF ratification during its current session was summarized as below:

(i) 2,927,286 USD were requested from the APOC 1998 budget of which 1,238,721 USD will cover the second year projects’ budget and 1,688,565 USD will be allocated to the 9 new projects approved in April 1998.

(ii) 1,365,466 USD were requested for 7 new projects approved in October 1998 with the understanding that the Management will revise the budgets submitted by the NOTFs and downscale them as appropriate.

11.4 The Management was commended for the present format of the document on the consideration of national plans and project proposals which successfully put together the key points for each project including the cost per treatment;

11.5 the variability in the cost per treatment between projects ranging from 1 USD to 2USD, was questioned by some JAF members;

11.6 more attention was called for when considering the cost per treatment as it can be used for the process of improving budgets and as a predictor of sustainability;

11.7 the forum noted with satisfaction the economy of scale realized through the process of the revision of projects’ budgets (33% reduction);

11.8 concern was expressed as to the 10 fold increase in the number of persons to be treated in the Kasai CDTI project (D R. Congo) from the first to the fifth year resulting in a cost per treatment of 2 cents at the fifth year;

11.9 The APOC Management advised JAF members to be cautious in interpreting the cost per treatment presented as these are projected figures. The actual figures will be calculated as the projects are implemented.
11.10 The approval by the CSA of all the national plans and the project proposals contained in document JAF 4.7, were ratified by the forum.

12. OPERATIONAL RESEARCH: Agenda item 12

12.1 Prof. O. Kale, the acting Manager of the TDR Task Force on Community-Directed Treatment gave a brief report on the following points:

(i) REMO/GIS is now installed at APOC Management level,

(ii) rapid mapping of lymphatic Filariasis using clinical parameters (scrotal hydrocele, lymphoedema) is ongoing. It has been shown in study conducted in 8 countries that there is a good correlation between the results of night smear and those using the Circulating Filarial Antigen test (CFA) in the detection of lymphatic Filariasis infection. The sensitivity of CFA test was estimated at 97%. However, the sensitivity was found lower in India. Therefore, 2 to 3 more tests are needed to establish the sensitivity level of the CFA test in that country. The phase II of the community Directed Treatment with albendazole and ivermectin or DEC will determine whether the strategy is feasible,

(iii) studies are ongoing to determine loa loa prevalence using clinical sign (calabar swelling) in Cameroon where coinfection with onchocerciasis and severe adverse reactions to ivermectine treatment have been reported,

(iv) simple tool to be used by the community to monitor CDTI activities has been developed by researchers in Nigeria and validated in Mali. This tool is being handed over to APOC Management for the generalization of its use,

(v) reporting is still a problem. Pictorial forms are being experimented for use by illiterate CDDs to accurately report on a limited number of events in CDTI,

(vi) study on sowda was commissioned in communities where this form of onchodermatitis prevails and where nodule rates do not reflect sowda as a measure of community in need of mass treatment.

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12.2 During the discussion, the issue of financial and human resources needed for the implementation of all the studies mentioned above was raised. APOC and OCP were mentioned by the Manager of the Task Force as major contributors to the aforesaid studies. As regards human resources TDR has trained over 400 scientists in the African region who are participating in many research activities including the studies mentioned above. The task Force was requested to synchronize its research agenda with countries needs.

12.3 The Joint Action Forum acknowledge with satisfaction the fruitful collaboration between APOC and TDR in the field of operational research.

12.4 Regarding CDTI, JAF recommended that the TDR Task Force contact directly APOC Participating Countries to develop action plans for seeking answers to questions of specific interest to each country. The Forum encouraged the Task Force to pursue the search for reliable and efficient reporting tools for use at the community level.
13. **REPORT ON THE LONG-TERM ASSESSMENT OF APOC OPERATIONS.**  
Agenda item 13

13.1 Following the approval by the forum of the protocol of the long term impact assessment of APOC operations during the Liverpool session, the activities below have been carried out:

(i) The Management of the programme developed a plan of implementation of the studies and appointed 2 coordinators: one for the English speaking selected countries (Prof. Eka Braide) and the other for the French speaking ones (Dr Boussinesq).

(ii) A coordination meeting was held in Ouagadougou from 9-13 February 1998. The meeting was attended by the two coordinators and APOC staff. During that meeting, 15 study sites were selected instead of 22 as initially proposed in the protocol approved at JAF 3. Four teams of 4 members each (a total of 16 members) were constituted.

(iii) A workshop was held in Douala in April 1999 to standardize the methods and the data collection instruments. The workshop was followed by a field test. Each team had the opportunity to meet and define the timetable of its field activities

(iv) Field activities started in June 1998. 14 out of 15 sites initially selected satisfied the criteria set forth in the protocol of the study and were eventually retained [Uganda (1), Sudan (1), Tanzania(1), Nigeria(3), Ethiopia(1), Gabon(1), D.R. Congo(2), CAR(2), Cameroon(2)]. As of the date of this JAF session, 7 out of 14 sites were completed in 6 countries [Uganda(1), Sudan(1), Tanzania(1), Nigeria(1), Cameroon(2), and D.R. Congo(1)].

13.2 A data analysis workshop is planned to take place in Ouagadougou in June 1999.

13.3 The total cost of the studies is estimated at 400,000 USD, 50% of which has already been obligated. Transport and personnel were reported to be the prominent consumers of the budget.

13.4 Concerns were raised as regards the proposed 5 years time laps between the three planned cross sectional assessments. Mainly because some JAF members thought an interval of 5 years was too long and were likely to increase the attrition rate, to introduce biases and confounders in the interpretation of the study findings. After discussions it was considered, however, that a five year interval was appropriate particularly if one expects to see significant changes in the lesions of the posterior segment of the eye as a result of repeated treatment with ivermectin on the one hand and adequate number of true new cases of chorioretinitis (incidence) and not further development of existing cases on the other hand.

13.5 The selection of the assessors was deemed as a crucial factor in dealing with the issues of attrition rate and intra variation bias.
14. REPORT OF THE INDEPENDENT MONITORING OF CDTI PROJECT IMPLEMENTATION IN MALAWI, NIGERIA, SUDAN AND UGANDA: Agenda item 14 (documents JAF4/INF/DOCs 7 to 10)

14.1 1998 has seen the first exercises of monitoring CDTI projects in four APOC countries: Malawi, Nigeria, Sudan and Uganda. The report on Malawi was given by Mrs Msuya-Mpanju from the World Bank who took part in the study, whereas the summary report on Nigeria, Sudan and Uganda was presented by Dr Akogun, one of the independent scientist who performed the exercises. In Malawi, the exercise was carried out during the first quarter with technical assistance from the World Bank using a participatory approach. The focus of the exercise was on 5 components of the project:

(i) planning and implementation of CDTI
(ii) integration of CDTI into the existing health system
(iii) programme management
(iv) social and cultural influences on CDTI
(v) cross border issues between Malawi and Mozambique

14.2 The main findings of the exercise in Malawi can be summarized as follows:

(i) the project was in transition from the old CBTI to CDTI. However, a significant knowledge of the disease was found in the community visited,
(ii) there was a limited involvement of health personnel (at the district and community level),
(iii) it was noted that project management needed further strengthening to ensure long term sustainability,
(iv) the major and unique role of the Tea Estate in ivermectin distribution was acknowledged.

14.3 It was considered that participatory monitoring offered a unique opportunity to the NOTF to learn to constructively listen and interact with the community. It was also seen as a means of building ownership of CDTI within the community.

14.4 In Nigeria, Sudan and Uganda, the exercise was carried out by 23 independent scientists in September. As part of the process of monitoring CDTI projects by independent scientists, a two-day workshop was organized in Ouagadougou and brought together 10 of 23 monitors selected. During the workshop, the sampling procedure were discussed and adopted. The data collection instruments were also developed.

14.5 4 sites in Nigeria, 4 sites in Sudan and 3 sites in Uganda were monitored. The objectives of the exercise were:

(i) to document how ivermectin distribution was undertaken in samples of communities,
(ii) to determine constraints in implementation of CDTI approach,

(iii) to make recommendations to APOC Management and NOTFs for improving CDTI process,

(iv) monitors should address specific questions such as:

- is distribution of ivermectin taking place in projects sites?
- are community members involved in CDTI implementation?
- how was training of CDDs carried out by project implementors?
- was treatment supervised?
- did health staff participate in CDTI implementation?
- what are the constraints of the CDTI approach?
- assessment of treatment coverage
- assessment of the reliability of records at all levels including district and village levels
- what is the community perception of CDTI and its degree of satisfaction with programme activities?

14.6 In general

(i) the process of CDTI implementation was found similar in the three countries with minor variations between projects,

(ii) there were records of treatment in all sites; however, the quality of the records varied widely,

(iii) the community perceived the programme:

- as owned by government in Nigeria (except in Cross River where it is considered as owned by community)
- as owned by the government and the NGDOs in Sudan
- as belonging to the government in Uganda. This perception is much stronger in Uganda than Sudan and Nigeria

14.7 The strengths of the programme were described as follows:

(i) NGDOs are playing major roles at all levels,

(ii) community interest was very high,

(iii) health personnel was very much involved in CDTI implementation. There was no place where health staff was not involved in CDTI,

(iv) The commitment of CDDs was found to vary from one place to another,

(v) CDDs’ treatment records were available.
14.8 The weaknesses were summarized as below:

(i) non-treatment of absentees was common (almost all the projects monitored). This was mainly attributed to the fact that the implementors were in a hurry to hand over to the higher level treatment records,

(ii) the quality of the CDDs and health staff training was generally poor. Emphasis was rather placed on measurement, dosage determination, referrals and little attention was paid to community mobilization,

(iii) some specific groups of population were excluded from participation (to be selected as CDDs, attendance of meeting) but not from treatment,

(iv) community awareness of responsibility was rather low which accounts for marginal involvement or participation of community members in the selection of CDDs, contribution to CDDs maintenance during treatment periods.

(v) Though records were found everywhere, their quality was rather poor,

(vi) no feedback is provided, the only level this is taking place is from APOC Management to the national control programme office,

(vii) duplication of training manual and/or translation of IEC materials was not budgeted for.

14.9 Constraints to CDTI implementation identified by the monitors were the following:

(i) delay in the release of funds

(ii) absence of functional health services in some project sites

(iii) demand for incentives by CDDs (major problem in Uganda)

(iv) poor financial support at the local level

(v) social and political instability in different areas

(vi) accessibility/transportation

(vii) cost covery policy (e.g. payment of 100shgs per person treated)

14.10 Some innovations in CDTI implementation were observed and included:

(i) military involvement in CDTI process (in Sudan, they released their jeeps and provided TV set for mobilization),

(ii) appointment of non-health personnel as an element of social mobilization,

(iii) purchase of an adverse reaction kit by the community (Cross River)
14.11 The recommendations of the monitors were the following:

(i) emphasis should be placed on process building at this stage and not only on achieving high treatment coverage

(ii) bureaucracy concerning funds transfer to project sites should be streamlined,

(iii) Continuous monitoring by project implementators should be encouraged

(iv) Feedback should be provided to all levels including the community level

* * *

14.12 The forum noted with satisfaction the important and useful information collected by the teams of scientists commissioned for this task in connection with the follow up of CDTI projects. The findings of scientists were considered by JAF participants as significant and near to the reality. The forum commended the APOC Management, the NOTFs and all the scientists involved in this exercise and expressed the wish that the recommendations listed in the reports produced by the different teams be carefully studied and promptly implemented if appropriate.

14.13 However, some concerns were raised as to the issue of:

(i) timing and partnership in the conduct of this first exercise of monitoring by independent scientists,

(ii) the community which did not see clearly its responsibilities in CDTI implementation,

(iii) the need to develop simpler tools which community can use for self monitoring of CDTI activities;

(iv) absentees not getting treated because possibly drugs are not kept sufficiently long in the community and possible ways of overcoming this problem (e.g. need for an alternative packaging).

14.14 The Forum therefore recommended that the involvement of communities be enhanced in all projects and expressed the wish that a speedy solution be found to the problem of treatment of absent members of the community.

14.15 JAF approved the proposal to develop a simple tool for use by projects and communities to carry out self-monitoring of CDTI activities.

14.16 The Management of APOC informed the forum on the following points:

(i) letters have been sent to the NOTFs requesting them to react on the reports of the monitoring teams,

(ii) two meetings will be convened next year further to this first monitoring exercise:

- one will bring together the scientists involved in this exercise so that they can refine all the data collection instruments, develop and adopt uniform procedures for data analysis as well as a single format for report writing. In so doing the
quality and reliability of the data during subsequent exercises will be further improved,

the other will gather national coordinators, representatives of NGDO partners, local/district CDTI project managers, all the scientists involved in this first exercise as well as APOC staff to further discuss the lessons learned and develop plans of action to implement the recommendations set forth by the independent scientists as well as the points raised by the forum.

15. PLAN OF ACTION AND BUDGET FOR 1999: Agenda item 15 (document JAF4.3)

15.1 For 1999 it was planned to implement and manage in 14 countries 49 CDTI projects, 4 vector elimination projects and support to 8 national secretariats in all 61 projects of which 45 already approved and 16 new to be prepared before 31 January 1999 at the latest.

15.2 Workshops on CDTI project management and improvement of community-distributor training would be organized as would the training in Rapid Epidemiological Mapping (REMO) and in the Geographical Information System (GIS). The integration of REMO data into the GIS files would be technically supported by WHO Hqs.

15.3 Independent monitoring of CDTI projects would continue and mid-term evaluation of projects having reached their third year of implementation would be initiated. Also the collection and analysis of baseline data for the APOC long-term impact study would continue.

15.4 The Programme would collaborate with the Special Programme for Research and Training on Tropical Diseases (TDR) in operational research activities and contribute together with OCP and TDR to the cost of the Macrofil project.

15.5 The management would continue its collaboration with the WHO Regional Office for Africa and its country offices, with WHO Hqs. and with the NGDO Coordination Group (paying half of the salary of the secretary of the NGDO Coordinator and his travel cost).

15.6 The APOC Manager would participate in the sessions of the Committee of Sponsoring Agencies (CSA) and arrangements would be made for holding two sessions of the Technical Consultative Committee during 1999.

15.7 The proposed budget for 1999 operations of APOC amounted to US$ 14 984 000.

* * *

The discussions focused on the following main points:

15.8 According to some JAF participants some line items were lacking in the distribution of the expenditures (contingencies, translation of the training manual into local languages, etc). The APOC Management justified the absence of contingencies line item in the general budget of APOC as follows:

- the budget of the first phase of the programme has a deficit of 9 million USD,
- the budget submitted is based on the experience of last year,
- there is a contingency line in each project budget.
As to the translation of the CDTI training manual in local languages, the Management admitted that it was not accounted for in the budget but this expenditure can be dealt with without increasing the budget.

15.9 Some delegates queried whether vector elimination implementation in Tanzania and Equatorial Guinea was not more expensive than initially planned? The answer was that only Equatorial Guinea may be concerned by this issue. However, no significant variation was expected in the costs of the implementation of the vector elimination project in Bioko island because APOC will borrow from OCP a great deal of the equipment and materials needed.

15.10 A decrease of 25,000 USD in the proposed 1999 budget compared to the 1998 approved budget in connection to the NGDO liaison office in Geneva was noted and some delegates wondered why? The explanation provided by the Representative of WHO/HQ was that the decrease on this budget line is due to the foreseen decrease in the activities of the office (less travel for technical support to participating countries for the development of national plans and CDTI project proposals).

15.11 Some JAF delegates questioned the 9% administrative costs of the Programme and argued that this figure would rather reflect the fact that the lean professional staff is tapped to the maximum limit of its capacity. While recognizing that 9% administrative costs partly reflect the limited staff of APOC, the Management also pointed out that the efficient collaboration with OCP in part accounted for this 9% administrative costs. However, if the Programme were to recruit say one administrative officer, an epidemiologist and a social scientist, this figure of 9% may no longer stand, the APOC Programme Manager said.

15.12 The REMO budget line was found to be increasing steadily over time: 10,000 USD more in 1997 compared to the figure of 1996, 82,184 USD in 1998, 250,000 USD proposed for the 1999 budget. If the last figure is approved as part of the 1999 budget, the forum would expect to have a more detailed report on REMO/GIS next year.

15.13 The forum queried about the budget absorption capacity of the Programme and was assured that most of the approved 1998 budget as well as the proposed 1999 budget will be utilized.

15.14 The Forum approved the proposed Plan of Action for 1999 and the corresponding budget in the amount of US$ 14 984 000.

16. **FINANCING OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL**

**Financial situation**

16.1 The Manager of the World Bank Onchocerciasis Unit, Mr Bruce Benton, informed the Forum that an average annual amount of US$ 19 million would be required for OCP (1998-2002) and APOC (1998-2007) together, i.e. 15% less than for OCP alone during the past decade with a sharp decline, however, from the year 2001.

16.2 To finance APOC, Donor contributions of US$ 66 million would be required during Phase I (1996-2001), and US$ 60 million for Phase II (2002-2007) with an average of US$ 10.5 million per year over the life of the Programme. The donor contributions of the two phases are
now estimated at US$ 126 million i.e. 5 million less than initially projected. From the point of view of the Bank, the resulting savings is attributable to the effective work of the management of the programme and the rigor of TCC in projects’ consideration.

16.3 To meet the financial requirements for Phase I (US$ 66 million), Donor contributions totalling US$ 56.9 had been secured to which should be added US$ 0.4 million in investment income. The financial gap for APOC Phase I was thus estimated at US$ 8.7 million. So far, five OCP Donors had not yet committed to APOC, and their support was in serious doubt. Special efforts were underway to bring new Donors into the Programme and three new Donors had recently joined APOC. However, without additional new Donors in the Programme, the current donor community would need to increase its total contributions to Phase I by 14% in order to fully fund that Phase. Nevertheless, APOC appeared to be fully funded by 1999.

16.4 Mr Bruce Benton also reported that the Bank has not been able so far to build up a contingency reserve for APOC because of the pace of the implementation of the programme. As a matter of fact, as soon as money comes into the Trust Fund it leaves out for project implementation. Unless the 9 million deficit were filled through an increase in the current financial support, the present growth rate of implementation of APOC funded projects could not be sustained and ongoing CTDI activities might have to be curtailed.

16.5 JAF therefore recommended that the current efforts to increase the number of financial contributors be pursued.

16.6 As the upper limit for APOC financing was set at 75% of the total expenditures, the remainder would be financed by the Participating Countries and by the Collaborating Non-governmental Development Organizations.

16.7 The supply by Merck & Co. of ivermectin free of cost constituted a major contribution, ranging in the hundred of millions of dollars, which considerably reduced the financial burden on Donors.

Pledging of Donor contributions

16.8 Once finalized, the list of pledges will be transmitted to participants in the Forum.

16.9 The Bank proposed to convene a donors’ meeting next year tentatively October 6-7, 1999 in Paris to discuss how the 9 million USD shortfall can be met over the coming years.

16.10 Although all the Representatives of the Donor community reiterated their firm commitment to continue to support APOC, some did mention that budgets allocated by western countries for North-South cooperation are constantly going down. This constitutes a threat to the financing of APOC operations.

17. OTHER MATTERS

17.1 A joint session of JPC19 and JAF4 was held in the morning of Wednesday 9 December, the report of which is attached as Annex 4.
18. **DATE AND PLACE OF THE FIFTH SESSION**

18.1 Given that negotiations concerning the venue of the session were still going on, the place and date would be communicated to JAF participants at a later date. The likelihood was that the session would be held during the first or second week of December 1999.

19. **APPROVAL OF THE FINAL COMMUNIQUE**

19.1 The final communique with the attached conclusions and decisions adopted after the consideration of each agenda item, was approved with a few modifications (see Annex 5).

20. **CLOSURE OF THE FOURTH SESSION**

20.1 Following a statement by the Chair, the session was declared closed (see Annex 6).
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CSA REFLECTIONS FOR JAF4

Excellencies, Ladies and Gentlemen,

Since the inception of the African Programme for Onchocerciasis Control in late 1995, the committee of Sponsoring Agencies has taken on the responsibilities of overseeing operations, management and financing of APOC and approving individual APOC projects. I am therefore pleased to report to JAF on the major issues regarding APOC considered by CSA during its four sessions in 1998.

Madame Chair, CSA is impressed by the rapidity with which APOC has prepared and launched projects. The first year of the life of the Programme - 1996 - was spent on establishing APOC structure and preparing for field operations. We noted that 45 projects in eleven of the nineteen Participating Countries have been approved and are under implementation. This progress exceeds our expectations.

But this rapid development has only been possible because the staff at headquarters has worked overtime throughout the year. As I understand it, action is currently being taken to recruit a full-time Director. The Committee has also noted with some satisfaction that the WHO Regional Director for Africa has assigned a staff member experienced in communicable diseases control to the OCP and APOC management groups in Ouagadougou. This will to some extent alleviate the workload on the current staff. CSA wishes to underline, in connection with the staffing situation that not more than 8 per cent of the budget of APOC is spent on administration. In comparison with operations of similar nature it is a note worthy achievement.

The cornerstone of APOC is partnership. CSA would like to stress that the Programme in a very short time has established effective collaboration with its partners ranging from Participating Countries and numerous local communities actively involved in APOC operations, the health services, the donor community and Merck &Co., to the UN system, scientists and, not the least, non governmental development organizations. Another important partner is the WHO Regional Office and the WHO country network which provides administrative and managerial support to APOC field operations. In the opinion of CSA, this synergistic partnership is indeed innovative and could very well serve as a model for other major public health initiatives.

CSA would particularly like to pay tribute to the Members of the Technical Consultative Committee who during their twice annual sessions lay the ground for the work for APOC and provide technical opinion and recommendations regarding the acceptability of project proposals. Also, this Committee has been instrumental in preparing for, and launching, at this early stage independent monitoring and eventual evaluation of APOC-assisted projects.

Madame Chair, at the request of your Forum at its session in December last year, the TCC held a special meeting on the issue of APOC and health sector reform. That report is before you at this current session. CSA would like to draw your attention to the primary conclusion of this meeting that the APOC operations are compatible with, and will reinforce ongoing health sector reform, through the emphasis on partnership with the health services, communities, non governmental development organizations and pharmaceutical industry. It was stressed that many of the priorities of the newly elected Director-General of WHO are reflected in the APOC programme.
On a less optimistic tone, CSA wishes to draw the attention of JAF to the funding situation. Mr. Bruce Benton of the World Bank will inform the Forum in some detail so I shall only emphasize that there is a considerable gap in the financing of the first phase of APOC operations and that a shortfall is projected for the immediate future and additional contributions are urgently needed.

The Committee remains optimistic that the donor community will act soon to ensure that this programme which has had such a remarkable start and holds such promise for integrating disease control in Africa rural areas, is not undermined solely by financial shortfalls.

As regards financial management of approved projects, CSA would like to stress the cost-effectiveness and financial soundness of the Programme. The Committee is pleased to note that APOC and OCP management working with the NGDO group have made a special effort to enhance the capacity of National Onchocerciasis Task Forces to satisfactorily manage and account for funds disbursed for the first round of approved projects. This important managerial issue will be further developed in the presentation of the Progress Report.

Madam Chair, let me refer briefly to the collaboration between OCP and APOC and, more specifically, to the location of APOC HQ. The report of an independent Consultant will be considered by JAF at this session. The CSA has had an opportunity to scrutinize this report and endorses fully the recommendations of the investigator. The Committee initiated the idea of a combined headquarters when APOC came into being and has since then realized that the advantages of sharing headquarters far surpasses the CSA’s initial expectations. In CSA’s estimation, it would be prudent and advantageous to continue the present collaboration in Ouagadougou with the understanding that the situation be reviewed once OCP is brought to a conclusion at the end 2002.

My final point relates to the item on the agenda for the joint JPC-JAF session this morning which dealt with the control of the lymphatic filariasis in Africa. As members of the Forum were told during that session Merck and SmithKline Beecham have offered to donate ivermectin and albendazole respectively to control lymphatic filariasis in Africa. CSA has noted with satisfaction that the operational strategy of controlling lymphatic filariasis is entirely compatible with that of OCP and APOC and the advantages of addressing lymphatic filariasis through the same community-directed treatment systems used for onchocerciasis should be fully explored.

In closing, I would like to wish the Joint Action Forum a successful session. CSA will continue to give APOC all possible support required to attain its objective in the Participating Countries.

Thank you, Madame Chair.
STATEMENT BY DR RALPH HENDERSON,
SPECIAL ADVISOR TO THE DIRECTOR-GENERAL OF WHO,
TO THE FOURTH SESSION OF THE JOINT ACTION FORUM
OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

Excellencies, Ladies and gentlemen,

The Director-General of WHO, Dr Gro Harlem Bruntland, has asked me to convey to you her greetings and best wishes for success in your deliberations during the coming two and a half days.

I would like in this brief address to refer to four aspects of APOC which are, to my mind, of essence for success of the Programme namely partnership, community involvement, integration and continued operational research.

Successful implementation of public health programmes requires close and active collaboration among the interested parties, although such collaboration is often constrained by lack of creative communication and by managerial shortcomings. APOC, I believe, has overcome these constraints. Its constructive partnership is clearly demonstrated in the Joint Action Forum in which all the partners are represented. They all contribute on equal terms to the setting of policy, the determination of strategy and the continuing monitoring and evaluation of progress.

Furthermore, this partnership is reflected also in the National Onchocerciasis Task Forces which included country expertise and non-governmental development organizations, the main actors moving the Programme to the field. The Task Forces are supported by the APOC management to ensure that project implementation conforms with the decisions of JAF. I would suggest that this close and effective partnership at the central and operational level could serve as a prototype to other large-scale public health undertakings.

Another fundamental aspect of APOC operations is the reliance on communities for the distribution of ivermectin. Community-directed Treatment with ivermectin, spearheaded by APOC and OCP, is now recognized as the most cost-effective mode of distribution. It reaches the greatest number of people with the highest expectation of attaining sustainability. Involvement of communities is fully in line with the concept of primary health care and APOC therefore has the potential to strengthen primary health care systems in the Participating Countries. Again, I am confident that the APOC - and OCP- approach to community involvement lends itself to application to other activities in the public health field.

I wish to stress that APOC is not another vertical programme. It forms part of, and is integrated within, the national public health systems given that community delivery of ivermectin depends on, and is supervised by, local health centers. Also, monitoring and surveillance of APOC supported projects will, with time become an integral part of comprehensive multidisease surveillance and control systems now being developed with the support of WHO-AFRO.
Although APOC has been launched on a solid scientific and sound technical basis, there will always be room for improving operations in the field. The Programme is therefore involved in operational research activities oriented to enhancing the prospect of success and improving cost-effectiveness of control. An important field research project, supported by APOC and coordinated by TDR, deals with the issue of ensuring sustainability of community-involvement in drug distribution.

Before closing, I wish to congratulate the APOC Management for the considerable progress made during the last year in expanding the activities of the Programme. Today 45 projects are being fielded in more than half of the 19 Participating Countries. Knowing what it takes to bring a project to the operational stage, I appreciate that this expansion could not have been achieved without putting a heavy workload on the secretariat. In this connection, I would also like to recognize the importance of the close collaboration between OCP and APOC in scientific, technical and administrative matters which has been made possible by the location together of the two headquarters in Ouagadougou.

I wish to express the gratitude of WHO to all the Partners in APOC without whose support and participation, the Programme could not, and will not, succeed.

And finally, let me thank our host country, its President, government and people for the warm welcome extended to all the participants in this session of JAF and for the excellent arrangements made to ensure its success.

Thank you.
JOINT PROGRAMME COMMITTEE
OF THE ONCHOCERCIASIS CONTROL PROGRAMME IN WEST AFRICA
and
JOINT ACTION FORUM
OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

JOINT SESSION
Accra, 9 December 1998

Report

1. Participants in the nineteenth session of the OCP Joint Programme Committee (JPC) met together with participants in the fourth session of the APOC Joint Action Forum at the State House Banquet Hall during the morning of Wednesday 9 December 1998 with Mr Samuel Nuamah-Donkor, Minister of Health of Ghana, in the Chair. A summary is given in the following of presentations of the issues on the agenda.

2. Macrofil

2.1 Dr Janis Lazdins, the manager of Macrofil (OCP/APOC/TDR jointly financed project), defined as the primary objective of the project the discovery and development of safe and effective drugs for the treatment of onchocerciasis and lymphatic filariasis. Such drugs should kill the adult worms after a single treatment cycle, be easily field applicable and potentiate or synergize ivermectin as regards efficacy or prevention of resistance. The secondary objectives of the project are: a) discovery and development of a back-up microfilaricide to ivermectin that could be more advantageous (e.g., longer interval between treatments) or that could be a substitute for ivermectin in case of resistance, and b) development of a molecular biology diagnostic tool/method that could be used to detect *Onchocerca volvulus* resistant to ivermectin.

2.2 The Macrofil project had now been fully integrated within the operational, administrative and managerial structure of TDR/TDP, which had one drug discovery steering committee for all TDR diseases. This integration yielded synergistic use of resources available at TDR as well as in disease endemic regions. It also resulted in an enhanced partnership with industry and NGOs. Macrofil benefited from the availability of TDR in-house professionals in the fields of chemistry, planning, pre-clinical and clinical activities. The progress assessment of Macrofil sponsored activities was conducted on a monthly basis through a TDR R&D Committee.

2.3 Resulting from the above restructuring of the project the following achievements have been made:
   - a meeting aimed towards identification of molecular targets for the discovery of new drugs against filariases was sponsored by Macrofil, the conclusions of this meeting constituted the basis for soliciting for novel grant applications for innovative drug discovery projects.
   - the drug screening strategy in animals has been modified to allow assessment of a larger number of chemical entities in a faster mode (since March 1998: 725 compounds evaluated, four new “leads” are currently under evaluation)
- the flow of chemical structures from several sources (Walter Reed Army Institute of Research, Glaxo/Wellcome and several academic institutions) has been optimised through the use of a company that provides the logistic support as well as with the “in house” availability of a chemistry expert.

- identification / evaluation of a private company that can provide a relevant high throughput in vitro parasite screening system. The use of this facility could allow the eventual “bridging” of the high throughput molecular screen and the more time consuming animal screening systems. This company could also provide access to chemical libraries of synthetic and natural products.

- moxidectin (a registered product for veterinarian use from American Cyanamid) is currently being examined in the dog and cattle animal disease models. While having a simimilar mechanism of action as ivermectin (potent microfilaricidal) it has shown a significantly different pharmacokinetic profile with a longer half life. This has resulted in clear sterilizing effect of adult female worms as well as death of adults in some models. If current observations are validated, moxidectin could be a candidate for evaluation in humans in 1999.

- oxytetracycline has been shown by Macrofil sponsored researchers to have an effect on killing adult worms in the animal models. This action is presumed to be mediated through the effect of the antibiotic on a micro organism (Wolbachia) present in the filarial parasites, including Onchocerca. Further ongoing studies (in animals) are addressing selection of optimal antibiotics as well as determination of minimal dose and treatment regimens, these studies could lead to the rapid evaluation in humans.

- work on UMF 078 compound has been terminated due to prohibitive gene toxicity.

- in the clinical field Macrofil was currently sponsoring the evaluation of combinations of ivermectin with other drugs as potential macrofilaricidals in the Onchocerciasis Chemotherapy Research Centre (OCRC) in Hohoe, Ghana. In this context OCRC in collaboration with a specialised laboratory addressed the pharmacokinetics parameters of ivermectin and albendazole when combined. This work, the first of its kind, is not only important for onchocerciosis but is essential to support the use of drug combination in lymphatic filariasis.

OCRC also had conducted a safety study examining the combination of levamisole plus ivermectin or albendazole. This study would be further extended during 1999 with the aim to evaluate the macrofilaricidal potential of this novel combination. Through the support of a TDR expert in Good Clinical Practice OCRC is conducting the above studies adhering to the GCP standards.

- Macrofil continued to support basic research to elucidate at the genetic level changes associated with parasite resistance to ivermectin. In this context Macrofil had liaised the researchers from academia with those on the field towards focussing the above studies on Onchocerca volvulus. As well as to identify potential partners for the eventual development of a diagnostic tool able to detect ivermectin resistance in patients.
2.5 Professor David Molyneux, Chair of the OCP Expert Advisory committee, in commenting on the progress of Macrofil, suggested that EAC should be more directly involved in the decision-making process for drug development. In addressing the ivermectin resistance activities he proposed that Macrofil should ensure the possibility of assessing "retrospectively" the genetic status of Onchocerca volvulus material representative from endemic regions with different exposure to ivermectin. This could be achieved by creating a "parasite repository" at the molecular biology laboratory in Ouagadougou.

2.6 Professor Molyneux finally recommended that OCP and APOC define the various scenarios for the use of a macrofilaricide including identifying priority areas and undertaking modelling to provide information for the introduction of a new drug for control.

2.7 Members of the JPC and JAF indicated that the results and achievements presented by Macrofil were in line with the mandate of OCP and APOC. It was recommended that the reported observations should be submitted for publication and made available to the scientific/medical community as soon as possible.

3. Integration

3.1 In the past, many public health programmes targeting specific health problems had tended to operate independently each with its own structure, staff and facilities with little attempt at coordination, not to say integration, of activities.

3.2 Increasingly, the move now, was towards joining together separate programmes using polyvalent staff and common facilities to carry out integrated control of the health problems, hitherto tackled on an individual basis.

3.3 Integration resulted not only in economies of scale, but made also for increased consumer satisfaction, given that the target populations would no longer be exposed to separate visits of different teams. A potential move towards integration at the consumer level was being spearheaded by OCP and APOC which, through the community-directed treatment with ivermectin (CDTI), opened the door for similar approaches to drug delivery in control of other public health problems.

3.4 The Regional Director of WHO AFRO, Dr Ebrahim M. Samba, stressed that Africa was in the lead in integration by applying a wholistic approach to public health measures.

4. Sustainability of CDTI

4.1 The importance of ivermectin treatment being continued for as long as needed and at the required coverage was stressed as a conditio sine qua non for the success of APOC and OCP. Both coverage and duration of treatment bore on the reduction of morbidity and, to some extent, of transmission and needed to be maintained at the required level. Furthermore, sustained control was required uniformly across district, provincial and national boundaries.

4.2 Indicators to measure sustainability included community involvement; flexibility to change CDTI approach according to local experience; availability of ivermectin and credible
distributors; leadership and integration within local health systems; community stability; perceived benefits of ivermectin; and availability of local resources to maintain distribution.

4.3 The findings of APOC independent monitoring teams as regards conditions for success were summarized as follows: availability of sufficient government funds to continue operations after five years without depending unrealistically on NDGO contributions; reinforcement of Primary Health Care systems for CDTI integration; prompt release of funds; adequate counterpart support within health systems; intensification of health education; and enhanced involvement of women.

4.4 As to the advocacy for sustainability the following targets were identified: decision-makers at the national and provincial levels; NGDOs and National Onchocerciasis Task Forces; national managers and district health teams; and the beneficiary communities.

4.5 The following key/special issues of importance to CDTI operations were listed: ownership; role of health centres; cost effectiveness/benefit; funding commitment; drug delivery systems; cost recovery/cost sharing; and incentives.

4.6 As major threats to sustainability the presenter, Professor Oladele Kale, singled out unreliable volunteers and inadequacy of incentives; instability of key staff at district level; dependence on outside funding; inadequate commitment and funding at the national level; and donor fatigue at the international level.

5. OCP-APOC collaboration

5.1 This collaboration operated at the management level; in the field of administrative support; and in respect to technical issues, including operational research. As regards management, the Director of OCP and the Manager of APOC spoke with the same voice when it came to advocacy and awareness building. The Director, whenever travelling, spoke for both programmes and promoted fundraising, together with the World Bank, for both OCP and APOC. There was constant exchange of view for decision-making between the Director and the APOC Manager. This close partnership resulted in economy of scale of the two operations.

5.2 The support from, and collaboration with, the OCP administration had made it possible for APOC to launch 45 projects in record time. The administrative staff of APOC had tapped the OCP experience in their domaine and APOC continued to benefit from administrative assistance from OCP in such fields as personnel matters; budget and finance; purchase of supplies and equipment; and transport - not without imposing a considerable workload on the concerned staff of OCP to which APOC provided financial compensation. It was stressed that when it came to the implementation of projects, the APOC management was solely responsible for execution.

5.3 On the technical side the two programmes shared field experience and expert advice. The initiation of the CDTI approach by OCP had thus laid the basis for APOC operations. Both OCP and APOC participated in the work of the TDR Task Force on Sustainability and contributed on equal terms to the Macrofil project.
6. Lymphatic filariasis elimination

6.1 More than 120 million persons in 73 countries, including countries in the OCP and APOC areas, were infected by lymphatic filariasis transmitted by mosquitoes and causing disabling swelling of the legs and genitals.

6.2 The elimination of the disease in individual communities - and its eventual global eradication - appears feasible by annual treatment of the affected communities with either albendazole together with ivermectin as in Africa or albendazole in combination with DEC in other parts of the world. It was expected that annual treatments over a period of four to six years would stop disease transmission. Such treatment would, however, not alleviate the symptoms of those already infected. For those patients much of the pain and suffering could be prevented by good hygiene and remedial exercise.

6.4 To launch the elimination programme, SmithKline & Beecham would provide albendazole free of cost for as long as required together with other support, and Merck & Co. would supply ivermectin at no cost to the implementation of the elimination programme in Africa. These commitments were confirmed to the Joint Session by Mr Charles Fettig of Merck & Co. Inc. and Dr Brian Bagnall of SmithKline Beecham.

6.5 In continuing his presentation, Dr Ralph Henderson, Representative of the WHO Director-General, commented on synergy. He referred to OCP and APOC as pioneers in community-directed drug treatment, the lymphatic filariasis elimination programme would adopt this approach, possibly starting in Africa in communities with OCP or APOC CDTI programmes. Other potential similarities between this new programme and OCP and APOC could be the use of rapid epidemiological assessment and the use of geographical information systems. It might therefore eventually make sense to place the additional staff needed for regional coordination and monitoring with OCP and APOC Hq's staff.

6.6 Although not all communities included in OCP and APOC operations suffered from lymphatic filariasis, they practically all had a problem of intestinal parasitosis - affecting in particular the physical and mental growth of the child - which would be alleviated by treatment of pre-school and school children with albendazole and ivermectin. This would be another synergy to take advantage of.

6.7 Non-governmental development organizations (NGDOs) would have an important role to play in the elimination programme, especially in supporting community-directed treatment through the establishment of community self-help groups.

6.8 For a programme like lymphatic filariasis to succeed, partnership between the countries concerned, who would play the principal role, the bilateral development agencies, the UN system and NGDOs would be essential.
AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL
JOINT ACTION FORUM (JAF)

Fourth session,
9-11 December 1998, Accra, Ghana

FINAL COMMUNIQUE

The fourth session of the Joint Action Forum (JAF) of the African Programme for Onchocerciasis Control (APOC) was held in Accra at the kind invitation of the Government of the Republic of Ghana. The session was attended by delegations from the Participating Countries, from the Donor community, from members of the Committee of Sponsoring Agencies (UNDP, FAO, the World Bank and WHO), from Non-Governmental Development Organizations, from the Carter Center and from the Mectizan Donation Programme (the list of participants is attached as Annex 1).

Participants were welcomed by Dr Kofi Ahmed who read a statement on behalf of the Minister of Health of Ghana, Mr Samuel Nuamah Donkor, followed by statements by Mr Phil Mason, representing the Chair of JAF3, Dr K. Yankum Dadzie, Director ad interim of APOC, Dr Ebrahim M. Samba, Regional Director WHO-AFRO and Dr Ralph Henderson, Representative of the Director-General of WHO.

The key-note address was delivered by Dr (Mrs) Mary Grant, Member of the Council of State, who underlined the importance of a true partnership, so crucial for the success of APOC, a partnership exemplified by the participation of representatives of the various groups at this assembly in a constructive dialogue. Dr Grant also referred to the full participation of the communities in the Programme, of which they are the principal stakeholders, as an essential element for the success of APOC. She finally wished the Forum full success in its deliberations.

A vote of thanks was moved by Miss Yaa Oforiwaa-Acquah.

The agenda for the session is attached as Annex 2. For each of the items for which conclusions were arrived at, and/or decisions made, a brief summary is given in the following pages.

At the closure of the session, the Joint Action Forum expressed its gratitude for the warm welcome extended to the participants, the hospitality received and the excellent arrangements made by the host country for the organization and deliberations of the Forum.

Participants will receive the full report of the session at a later date.
Conclusions and decisions

PROGRESS REPORT OF THE WORLD HEALTH ORGANIZATION (agenda item 5):

1. The Forum expressed its satisfaction with the quality and timeliness of the development of APOC supported project proposals since the launching of the Programme. JAF commended the APOC Management and all the NOTFs concerned for the good results obtained.

2. The Forum also greatly appreciated the team spirit prevailing within the APOC Management and congratulated its staff for the quality and harmony exhibited in the presentation of the 1998 progress report.

3. To ease the work load of the APOC Management team, JAF recommended that WHO Representations in the Participating Countries become more involved in the technical, financial and managerial support to APOC project activities.

4. The Forum recommended that the denominator applied by NOTFs to compute mass treatment coverage rates be the total population figure to allow comparison between projects and countries.

REPORT OF THE TECHNICAL CONSULTATIVE COMMITTEE (agenda item 6):

5. The Forum recommended that 1 (one) per cent of the funds released to finance APOC supported projects be allocated for appropriate operational research on specific issues of interest to the Programme.

REPORT OF A SPECIAL FORUM ON APOC OPERATIONALIZATION IN THE CONTEXT OF ONGOING HEALTH SECTOR REFORMS IN AFRICA (agenda item 7):

6. JAF welcomed the report on the special forum on APOC operationalization in the context of ongoing health sector reforms convened in response to a request made by JAF during its third session. It encourages APOC to continue this work.

REPORT OF THE NGDO COORDINATION GROUP FOR IVERMECTIN DISTRIBUTION INCLUDING SUPPORT OF THE GROUP TO APOC'S ACTIVITIES AND TO LOCAL NGDOs (agenda item 8):

7. The Forum noted with satisfaction the significant contribution of international NGDOs to APOC operations. It welcomed their commitment and urged all partners to promote closer collaboration with the local NGDOs.

8. JAF recommended that the APOC community (CSA and the NGDOs group) undertake efforts to extend NGDO support to all those APOC countries which have not yet benefited from such support. JAF notes the funding restraints to NGDO expansion and encourages new mechanisms and strategies to secure funding necessary for such expansion.
COUNTRY REPORTS (agenda item 9).

9. The Forum noted with satisfaction the decision taken by Cameroon to extend the implementation of the CDTI approach to all reoriented and non-reoriented districts of the meso- and hyper-endemic areas.

10. JAF acknowledged the progress made by some Participating Countries in the application of cost-recovery in ivermectin distribution programmes as an element of sustainability in CDTI projects. However, given the results presented, the Forum expressed concern about the possible negative effect of this policy on the coverage rate of mass treatment and therefore strongly recommended that the issue be addressed through operational research by the countries concerned in collaboration with the APOC Management and TDR.

11. The Joint Action Forum commended the national teams for the several issues raised by the delegations present, the mobilization and commitment of the communities, the commitment of governments and the initiation of the CDTI process even in communities facing social unrest. However, the Forum wished to receive a list of the problems raised in the country reports and that the partners likely to help solving them be identified and contacted through proper channels.

12. The Forum noted the factual explanation of the APOC Management concerning the factors which delayed the release of funds for project implementation. It encouraged the Executive Agency (WHO) and the NOTFs concerned to make all efforts to minimize and even avoid such delays in future.

13. The Forum noted with satisfaction the progress made in the Rapid Epidemiological Mapping of Onchocerciasis and encouraged the countries and the APOC Management to continue their efforts towards a complete coverage of all the Participating Countries as soon as possible.

14. The Forum noted with concern that contrary to the understanding reached, some countries still imposed various forms of import duties and taxes which resulted in delays in release of Mectizan for use in control programmes. The Forum therefore urged that all Participating countries ensure that the importation of Mectizan be done without any levies.

REPORT OF AN INVESTIGATION INTO THE LOCATION OF THE HEADQUARTERS OF APOC (agenda item 10).

15. The Forum, after study of the report of the investigation concerning the location of the headquarters of APOC,

- recommended that consultations be pursued with the interested parties before further consideration be given to this issue in relation to the end of OCP activities;

- decided that, for the time being, the headquarters of APOC would remain in Ouagadougou.
CONSIDERATION OF NATIONAL PLANS AND PROJECT PROPOSALS (agenda item 11):

16. The Joint Action Forum ratified the approval of the national plans and project proposals contained in document JAF4.7.

OPERATIONAL RESEARCH (agenda item 12):

17. The Joint Action Forum acknowledged with satisfaction the fruitful collaboration between APOC and TDR in the field of operational research.

18. Regarding CDTI, JAF recommended that the TDR Task Force contact directly APOC Participating Countries to develop action plans for seeking answers to questions of specific interest to each country. The Forum encouraged the Task Force to pursue the search for reliable and efficient reporting tools for use at the community level.

REPORT OF THE INDEPENDENT MONITORING OF CDTI PROJECT IMPLEMENTATION IN MALAWI, NIGERIA, SUDAN AND UGANDA (agenda item 14):

19. The Forum noted with interest the important and useful information collected by the teams of scientists commissioned for this task in connection with the follow-up of CDTI projects. While commending the APOC Management, the NOTFs and the scientists involved in this exercise, the Forum expressed the wish that the recommendations listed in the reports produced by the different teams be carefully studied and promptly implemented if appropriate.

20. The Forum further recommended that the involvement of communities be enhanced in all projects and expressed the wish that a speedy solution be found to the problem of treatment of absent members of the community.

21. JAF approved the proposal to develop a simple tool for use by projects and communities to carry out self-monitoring of CDTI activities. This would contribute to improving and strengthening the participation of both the communities and the partners in the monitoring of project activities.

PLAN OF ACTION AND BUDGET FOR 1999 (agenda item 15):

22. The Joint Action Forum approved the Plan of Action for 1999 and the corresponding budget in the amount of US$ 14,984,000.

FINANCING OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL: (agenda item 16):

23. The Forum noted the report of the World Bank on the financing of Phase I APOC and took note also of the estimated US$ 9 million funding gap stated in the report.

24. The Forum pointed out that unless this deficit were filled through an increase in the current financial support, the present growth rate of the implementation of APOC funded projects could not be sustained and ongoing CDTI activities might have to be curtailed.
JAF therefore recommended that the current efforts to increase the number of financial contributors be pursued.

DATE AND PLACE OF THE FIFTH SESSION (agenda item 18):

The date and place of JAF5 would be communicated to JAF participants at a later date. The date would likely be either during the first or second week of December 1999.
CLOSING REMARKS BY THE CHAIR OF
THE FOURTH SESSION OF JAF

Your Excellencies the Ministers of Health of the Participating Countries;

Honorable Representatives of the Donor Countries;

Mr Representative of the Director General of the World Health Organization;

Distinguished delegates of the APOC Member Countries;

The Director a.i. of the APOC Programme;

Ladies and Gentlemen Representatives of the Non Governmental Development Organizations,

Ladies and Gentlemen.

First, allow me to express on behalf of this august assembly and in my own name our deep gratitude and sincere thanks to the people and the Government of the Republic of Ghana for the warm welcome and brotherly hospitality they have bestowed upon every one us since we set foot in this nice and wonderful country.

Next, allow me, Excellencies the Ministers and Honorable Delegates of the Participating countries, and you Distinguished Representatives of the Donor community, to tell you how honored my country and myself have been by the trust you have placed in us in electing me for one year to the Chair of this Programme which, hardly after its birth, is already our pride and joy because of its inspires and gives not only to us all who are gathered here but first and foremost to the rural populations faced with the ravage of this dreadful disease called river blindness.

Our deliberations which are about to end have inspired me a few reflections which I would like to share with you.

I had the feeling that all of us gathered here are embarked on a true pioneering venture. Indeed, this strategy of mass treatment through the community directed approach is providing us in the vast field of public health, a unique opportunity for creation, for contributing to a reorientation of health care activities and approaches to hope to reach the noble objectives of the Programme in our respective countries despite their diverse situations.

Pioneering work, or rather three month old baby as one of the Distinguished Delegates put it, all this may sound like fumbling for words. And yet, at a closer look, it is not so. In fact, in listening to both the participating countries and the other speakers, we have all been impressed by the distance already traveled and especially by the solid foundations which have been laid. Of course the difficulties and obstacles which are not lacking when one embarks on such a venture have been widely referred to. However, it was my impression that far from intimidating us, they were unanimously considered as stimulating, as a call for greater efforts, creativity, wise flexibility and refusal of complacency.
together we will win the battle against river blindness and achieve the alleviation of poverty in the affected rural areas. I have come to understand that the involvement of the rural community, the sustainability of CDTI projects and true partnership are the tripod of the success of our programme. Therefore, it is within the framework of partnership that must operate the "third commitment" referred to in one of the documentaries we have watched during this session.

As every one of us knows, this pioneering venture could not have seen the light without the charitable donation of ivermectin by Merck & CO to the populations exposed to river blindness. That is the reason why I would like once again to express our sincere gratitude to Merck for its generous donation. This may sound repetitious and boring but I am firmly convinced that we will never express enough thanks for such a major contribution which is in fact a capital asset graciously made available for the development of our countries' rural areas.

Turning to the NGDO Group whose action on the side of the NOTFS and APOC Management gives us hope in overcoming onchocerciasis, we wish to not only express our thanks but also encourage them to pursue and expand their action so that all the Participating Countries become covered. We realize how difficult their task is but we remain convinced that together we will tread the right path.

Excellencies the Ministers, Honorable Delegates, before I conclude my remarks, I would like to make two wishes:

The first is that by the next session of the Joint Action Forum, the governments of the Participating Countries will have increased their financial contributions to the activities of the APOC supported projects.

My second wish is to see the 61 approved projects to be implemented next year in 14 of the Participating Countries yield satisfactory results. This is extremely important and cannot but contribute to strengthen our hope and convictions.

Allow me, Ladies and Gentlemen to take this opportunity to congratulate the APOC Management for their brilliant performance.

Ladies and Gentlemen, let us live up to the ambitions and expectations of the concerned populations who themselves are already mobilizing for victory in the framework of CDTI projects.

I wish you all a safe journey back to your respective homes and I declare the deliberations of the fourth session of the Joint Action Forum closed.

Thank You.