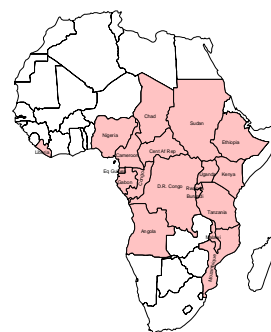
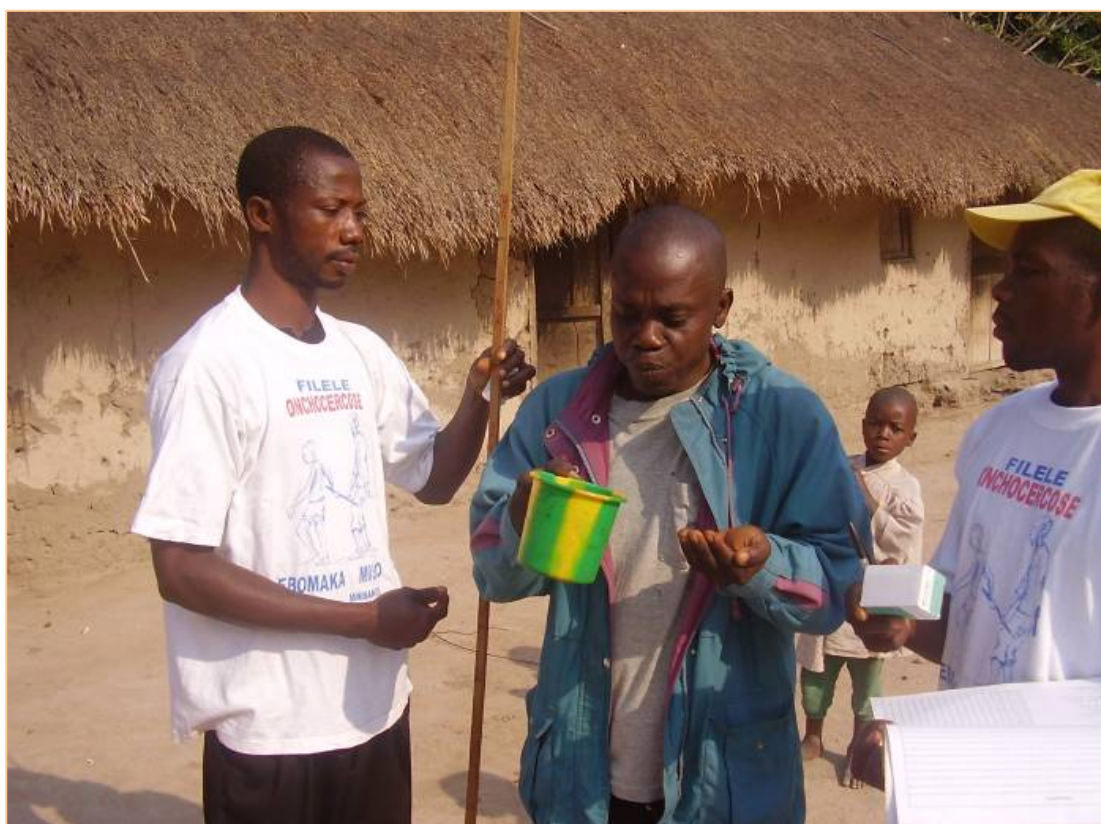


APOC



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



The World Health Organization
Year 2007 Progress Report:
1st September 2006 – 31st August 2007

The community-directed treatment approach facilitates better links between communities and health staff, and forms a crucial step in helping countries work towards their Millennium Development Goal commitments.

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List of Abbreviations/Acronyms

ADB	African Development Bank
AFRO	WHO Regional Office for Africa
APOC	African Programme for Onchocerciasis Control
BELACD	Bureau des Etudes, de Liaison des Actions Caritatives
BFO	Budget and Finance Officer
CAR	Central African Republic
CBM	Christoffel-Blindenmission (German NGO)
CCHP	Comprehensive Council Health Plan
CDD	Community-Directed Distributor
CDI	Community-Directed Intervention
CDTI	Community-Directed Treatment with Ivermectin
CHAL	Christian Health Association of Liberia
CRS	Catholic Relief Services
CSA	Committee of Sponsoring Agencies
DFID	UK Department for International Development
DOTS	Directly Observed Treatment Short-course
DRC	Democratic Republic of Congo
ECOWAS	Economic Community Of West African States
FLHF	Front Line Health Facility
GIS	Geographic Information System
GNNTDC	Global Network for Neglected Tropical Disease Control
GRBP	Global 2000 River Blindness Programme
HIA	Health Impact Assessment
HKI	Helen Keller International
HSAM	Health education /Sensitization /Advocacy /Mobilization
IEC	Information, Education, Communication
IEF	International Eye Foundation
IFESH	International Foundation for Education and Self-Help
IMA	Inter church Medical Assistance
IRC	International Rescue Committee
JAF	Joint Action Forum
LA	Letter of agreement
LF	Lymphatic Filariasis
LGA	Local Government Area
MDG	Millennium Development Goals

MDP	Mectizan® Donation Program
M&E	Monitoring and evaluation
MEC	Mectizan® Expert Committee
MTEF	Medium Term Expenditure Framework
MITOSATH	Mission To Save The Helpless
MOU	Memorandum of Understanding
NGDO	Non-Governmental Development Organization
NGO	Non-Governmental Organization (see NGDO)
NOCP	National Onchocerciasis Control Programme
NOTF	National Onchocerciasis Task Force
NTD	Neglected Tropical Disease
OCP	Onchocerciasis Control Programme in West Africa
OPC	Organisation pour la Prévention de la Cécité
OTD	Other Tropical Diseases
PMEDE	<i>Projet de Développement des Marchés d'Electricité pour la Consommation Domestique et à l'Export</i>
PMURR	<i>Programme Multisectoriel d'Urgence pour la Réhabilitation et la Reconstruction</i>
PRSP	Poverty Reduction Strategy Papers
RAPLOA	Rapid Assessment Procedure for <i>Loa loa</i>
REMO	Rapid Epidemiological Mapping of Onchocerciasis
SAE	Severe Adverse Event
SIZ	Special Intervention Zones
SSI	Sight Savers International
TCC	Technical Consultative Committee (APOC scientific advisory group)
TDR	Special Programme for Research and Training in Tropical Diseases
TSA	Technical Service Agreement
UNICEF	United Nations Children's Fund
UFAR	United Front Against River-blindness
WAHO	West African Health Organization
WHO	World Health Organization
WHO/OCP	see OCP
WHO/TDR	see TDR

Executive summary

The accomplishments of the Programme and partners for the period September 2006 to August 2007 under review are summarized below.

The establishment of sustainable national onchocerciasis control programmes in all African countries where such programmes are needed remains the key preoccupation of APOC. The mapping of the endemicity of onchocerciasis has now been completed in 12 of the 19 countries and efforts are being made in collaboration with Lancaster University in UK for a better delineation of the areas co-endemic for onchocerciasis and loiasis to guide safe ivermectin (Mectizan®) mass distribution in all countries.

Due to improved security situation in seven conflict countries, and a better system of monitoring and management of severe adverse events (SAEs) 12 new Community-Directed Treatment with Ivermectin projects (CDTI) were launched in 5 countries.. 97 of the 108 approved CDTI projects conducted treatment in 2006 and 95 of these provided treatment data.

The 95 projects covered **105,866 (88%)** out of a total of 120,602 meso and hyper endemic communities and treated **46.3 million persons**. The reported number of persons treated in 2006 represents an increase of 12.2% over the number treated in 2005 (41,213,307).

Five of the nine countries classified as stable achieved 100% geographical coverage while eight of the 9 countries maintained high ivermectin therapeutic coverage (average of 71%, the minimum required being 65%); Ethiopia with 58% being the exception.

With the exception of Burundi and Chad, the geographical coverage was below 100% in all conflict/post-conflict countries, being under 50% in Sudan, Liberia and Angola. These three countries share a long history of *armed conflict*. The mean therapeutic coverage was 41%.in five post conflict countries while ***Burundi*** and ***Chad achieved therapeutic coverage rates of 68% and 73% respectively.***

The SAE cases which occurred in Cameroon (0.1/10,000 persons treated) and DRC (0.5/10,000 persons treated), were efficiently managed with the technical and financial support given to the countries by APOC and Mectizan® Donation Program (MDP). Steps are being taken for the establishment of SAE management units in Angola and South Sudan before launching CDTI in at risk areas.

During the reporting period, (i) independent participatory monitoring was carried out in two projects in Tanzania (ii) three projects in Congo, DRC and Uganda were evaluated for sustainability and one was not making satisfactory progress towards sustainability. The weakness of the health system and lack of financial resources from the district government were among the reasons for the lack of progress in the one project. To date 57 CDTI projects have been evaluated for sustainability and over 70 % are making progress. (iii) three CDTI projects were

monitored to assess the implementation of the sustainability plans by governments. All three projects were adjudged to be satisfactorily implementing their sustainability plans.

The special initiative on the collection and management of CDTI data from community level, which commenced in the previous reporting period in Burundi, Congo, Nigeria and Uganda, continued in 2007. In this reporting period, Cameroon, DRC, Ethiopia, Liberia, Malawi, Southern Sudan, Tanzania and more projects in Nigeria were included. In December 2007, complete data on onchocerciasis endemic communities in Burundi, Congo, Ethiopia, Malawi, Nigeria, Tanzania and Uganda will be available. The database will include geographical location of communities, CDTI treatment registers; census data, and CDD workforce available per community for other health interventions.

During the period under review training workshops were financed and conducted to strengthen health systems to sustain 91 CDTI projects in 12 countries. A total of **27,104** health workers at regional, district/LGA (Local Government Area) and front line health facility (FLHF) levels and **271,113 CDDs** were trained by the National Onchocerciasis Task Forces (NOTFs).

Other trainings undertaken were on IEC (Information, Education, and Communication) and HSAM (Health education /Sensitization /Advocacy /Mobilization), GIS (Geographic Information System), data management, financial management, report/proposal writing and resource mobilisation, CDTI strategy and philosophy.

APOC Management implemented the decisions of the twelfth session of the Joint Action Forum (JAF) to amend the APOC Memorandum of Understanding. A revised Strategic Action Plan and Budget for 2008-2015 was prepared for consideration by the donors and JAF. In addition, country support missions (technical, administrative and financial supports) were organized by the Management to advocate for government release of funds from national budgets to CDTI projects and improved performance of projects.

APOC management prepared the document on "Onchocerciasis Control in Africa: current challenges and way forward" for the 57th session of the Regional Committee for Africa (RC57) and participated in the meeting of the Programme Subcommittee for RC57 and the meeting of African Ministers of Health. The Health Ministers made a Resolution in support of the Yaoundé Declaration.

Integration of onchocerciasis control in national health systems and co-implementation of multiple interventions were among high priority activities of APOC during the reporting period. Two high-level regional meetings for senior policy and decision-makers on integration of onchocerciasis into the broader health systems and co-implementation of onchocerciasis, neglected tropical diseases (NTDs) and some components of malaria were financed and facilitated by APOC. Financial support was provided to the NOTFs for operations research addressing challenges in CDTI implementation.

In the reporting period, APOC continued to give special attention to operational research. The study which began last year on monetary incentives was completed. The findings will be presented to the Joint Action Forum. APOC in collaboration with MDSC, SIZ and the countries launched a study to determine the movements of the black fly vectors across the Nigeria-Benin border and the impact on the epidemiology of onchocerciasis. Knowledge of the epidemiological situation and cross-border transmission dynamics (reinvansion of freed zones) will provide the national control programmes and APOC management data for advocacy and sensitization of governments.

All statutory meetings - the Joint Action Forum, Technical Consultative Committee and the Committee of Sponsoring Agencies were organized. Policy, strategic and implementation issues were discussed and guidance provided to the Management and the countries in the smooth running of the control activities. APOC Management participated in the meetings of the Non-Governmental Development Organization (NGDOs), Mectizan® Expert Committee (MEC), Neglected Tropical Diseases (NTDs) and in other partners' meetings where partnerships, strategic issues on onchocerciasis and other neglected tropical diseases were discussed. Efforts were made to strengthen collaboration with other World Health Organization (WHO) entities, the World Bank and the West African Health Organization.

Introduction

The main focus of this year's WHO Progress report is the development of the phasing-out and exit strategy Plan of Action and Budget 2008-2015 of APOC (agenda item 9) and the amendment of the Memorandum of Understanding to enable the Programme extend its operations to 2015 (agenda item 10).

The report highlights two high-level regional meetings on integration and co-implementation of neglected tropical diseases and malaria spearheaded by APOC following the decision of the 12th session of the Joint Action Forum. Seeing the potential for synergy and a means to establish sustainable CDTI before the exit of APOC, the NOTFs are increasingly relying upon CDTI as a springboard to bring multiple health interventions including vitamin A supplementation, eye care services, medicines for the treatment of lymphatic filariasis, schistosomiasis and home management of malaria to remote communities. The countries will present the achievements and lessons learned to the Joint Action Forum.

The Programme's challenges in 5 of the 7 post conflict countries, where geographical and treatment coverage rates are below 50% due to inaccessibility and acute shortage of peripheral health personnel to support communities in CDTI, are presented. However, the evidence collected during APOC's 12 years of experience now convincingly argues that using the community-directed treatment approach, good results are achievable in countries ravaged by conflict, with little in the way of existing health structures, and also shows that community-directed treatment thrives in such environments.

The findings of a multi-country study on monetary incentives, the three-year study on the feasibility and cost-effectiveness of adding other health interventions to CDTI, as well as research on resistance to ivermectin and a safe macrofilaricide will be presented to the Joint Action Forum. This report also includes important activities on CDTI community data management, the achievements of the communities and the NOTFs, the work done by the Technical Consultative Committee and APOC Management, and collaboration with the NGOs, OTD/AFRO (Other Tropical Diseases), WHO/HQ, WHO country offices, the Onchocerciasis unit of the World Bank, West African Health Organization (WAHO), NTD/Geneva, Global Network for Neglected Tropical Disease Control (GNNTDC) and other organizations.

In 2000, the report of the mid-term External Evaluation of APOC concluded, "*Communities have been deeply involved in their own health care on a massive scale*", and highlighted sustainability as a challenge. This led to the evaluation of the sustainability of 41 CDTI projects by 2004 and the publication of the findings in the Social Science & Medicine Journal¹ during this period under review. The extension of donor support to APOC operations, implementation of the Yaoundé

¹ Performance of predictors: Evaluating sustainability in community-directed treatment projects of the African programme for onchocerciasis control. *Social Science & Medicine* 64 (2007), 2070–2082.

declaration, continued social stability and the sustained commitment of national governments are critical for the achievement of the goal of APOC.

1 COMMUNITY-DIRECTED TREATMENT WITH IVERMECTIN

Establishing sustainable community-directed treatment with ivermectin in all African countries, where such programmes are needed, is the key preoccupation of APOC. There are three main aspects to attaining this objective: establishing a sustainable system for disease mapping, maintaining high coverage of ivermectin distribution and managing severe adverse events; creating adequate capacity to sustain control programmes; and ensuring effective programme management and partnerships to enhance the sustainability of control programmes.

The two main disease mapping systems used by APOC are the rapid epidemiological mapping of onchocerciasis (REMO) and rapid assessment procedure for loiasis (RAPLOA). REMO performs the key function of confirming where community-directed treatment with ivermectin (CDTI) needs to be instituted, and thus describes the geographical extent of APOC activities with respect to CDTI. RAPLOA confirms where the endemicity of loiasis is high and thus delineates within the CDTI priority areas communities at risk of serious adverse events (SAEs), requiring particular attention to monitoring for SAEs and its management in case of its rare occurrence in a patient infected with both *O. volvulus* and *L. loa*. Currently, the geographical extent of where CDTI is required is confirmed, subject to completion of a few outstanding surveys. RAPLOA has been applied to all areas where co-endemicity of onchocerciasis and loiasis is suspected, with a few outstanding exercises in Angola. Monitoring for and management of SAEs have been the main programme preoccupation, given their effect on treatment coverage and sustainability. Attaining and maintaining high coverage no longer presents a serious challenge. It appears the main determinant for good coverage is the security situation enjoyed by a country. Community-directed treatment with ivermectin (CDTI) projects in a peaceful and stable environment achieved good coverage while projects in countries afflicted with conflict and social unrest lagged behind. This is central to the progress of CDTI project implementation in 2006-2007.

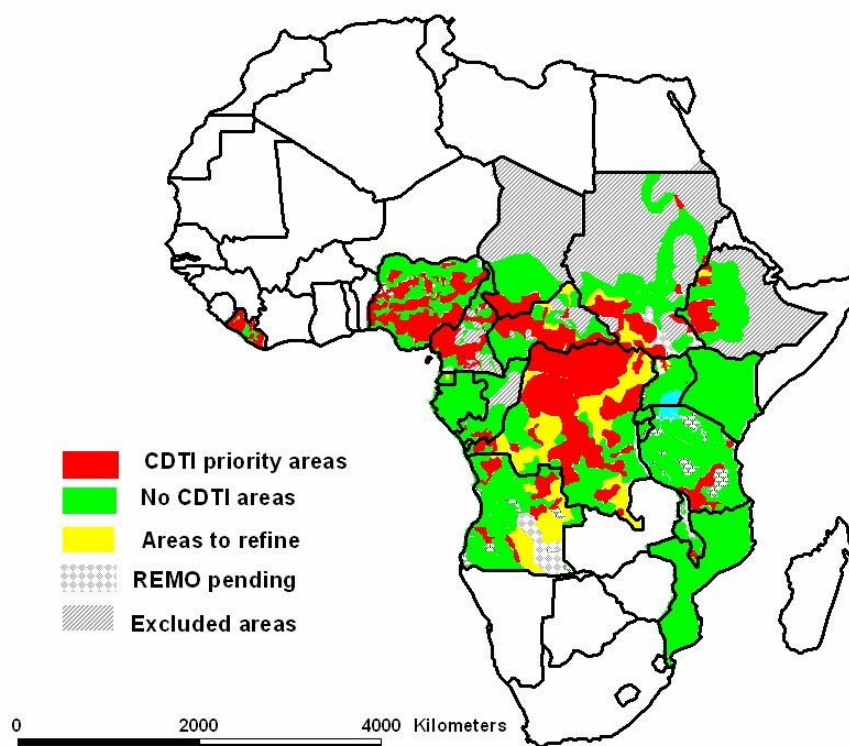
1.1 Update on Disease Mapping: REMO and RAPLOA

1.1.1 Rapid Epidemiological mapping of Onchocerciasis (REMO)

As at June 2007, rapid epidemiological mapping of onchocerciasis (REMO) had covered all the 19 participating countries of APOC (Figure 1), and had been finalized in 10 countries, largely completed in 7 and to be completed in 2 countries (Table 1).

Table 1: Status of REMO in APOC countries as at August 2007

Country	Observations
Angola	Oncho- in few foci REMO to be completed; surveys delayed because of landmines.
Burundi	Oncho – in 3 foci – REMO finalized
Cameroon	Oncho - country wide health problem. REMO finalized
CAR	Oncho - country wide public health problem. REMO largely completed.
Chad	Oncho - focus located in the southern part of the country. REMO finalized
Congo	Oncho - in few foci. REMO finalized
DRC	Oncho - country wide public health problem. REMO largely completed.
Eq Guinea	Oncho - endemic in Bioko Island. REMO completed
Ethiopia	Oncho - distributed in the western part of the country. REMO largely completed
Gabon	Oncho - hypo endemic. REMO finalized
Kenya	Oncho - hypo endemic. REMO finalized
Liberia	Oncho - country wide public health problem. REMO largely completed.
Malawi	Oncho - in 9 districts in southern Malawi. REMO finalized
Mozambique	Oncho - hypo endemic. REMO finalized
Nigeria	Oncho -country wide health problem. REMO finalized
Rwanda	Oncho - hypo endemic. REMO finalized
Sudan	Oncho - in all the southern Sudan provinces. REMO largely completed
Tanzania	Oncho distributed in foci. REMO completed
Uganda	Oncho distributed in foci. REMO to be completed in the northern area bordering Southern Sudan when security allows.
Overall APOC	REMO has been carried in all APOC countries; refinement to be undertaken in Angola, DRC, CAR, Liberia, Ethiopia, Sudan, Uganda

Figure 1: Community-directed treatment with Ivermectin areas in APOC countries as at June 2007

Activities that need to be completed in 7 countries are as follows:

- In Angola, refinement of the REMO map is ongoing in Lunda Norte, Lunda Sul, Uige, Moxico and Kuando Kubango. These refinements were delayed because of insufficient data for some areas. Additional surveys need to be carried out in Moxico and Kuando Kubango areas which were not accessible at the time the REMO exercises were conducted. It is expected that these outstanding surveys will be completed by August 2008.
- In Ethiopia, the National Onchocerciasis Task Force (NOTF) with the financial support of the Ministry of Health will complete the refinement of REMO in a small area in the North West of the country bordering Tundus focus in Sudan. This will be completed by the end of 2007.
- APOC has allocated financial resources to the NOTF of Democratic Republic of Congo (DRC) to finalize the refinement of the REMO country-wide.
- In North western Uganda, REMO will be completed when security in the area improves and stabilizes.
- In Southern Sudan, additional onchocerciasis prevalence data is needed in West Bahr El Ghazal and Equatoria. Again, due to the presence of landmines, the Upper Nile areas could not be surveyed. Additional Rapid Epidemiological Assessment of onchocerciasis (REA) needs to be done, taking these into account, to have a complete status of the endemicity of onchocerciasis in southern Sudan.
- The completion of REMO in Central African Republic (CAR) is being discussed with the NOTF.
- In Liberia, the national programme is planning the refinement of the REMO map in Gbarpolu County.

1.1.2 Rapid Assessment Procedure for Loa loa (RAPLOA)

Currently, seven countries (Angola, Cameroon, Congo, Democratic Republic of Congo (DRC), Ethiopia, Nigeria and Sudan) where Onchocerciasis and Loa loa were suspected to be co-endemic have been surveyed, though areas remain to be refined in Angola. In collaboration with Lancaster University, UK, further improvements in the analysis and interpretation of data for RAPLOA are being made. This innovation combines routine analysis of RAPLOA data with a prediction of Loiasis endemicity to develop regional and country-specific risk maps. This could be used to guide safe ivermectin mass distribution in areas where onchocerciasis and Loa loa are co-endemic. The combined mathematical model and the computer programme for generating the risk maps will be transferred to APOC HQ and participating countries by mid 2008.

1.2 Ivermectin Coverage

During the reporting period, due to improved security situation in conflict countries, and better management of severe adverse events (SAEs) by health personnel 12 new Community-

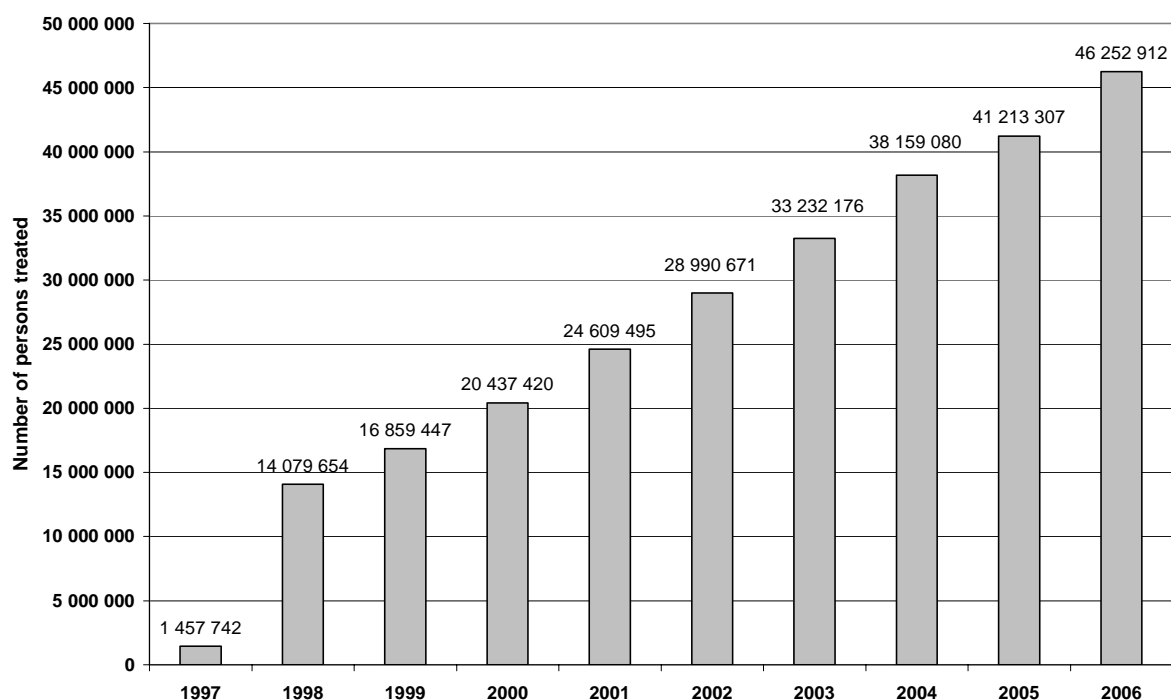
Directed Treatment with Ivermectin projects (CDTI) were launched in 5 countries – Angola, Burundi, DRC, Liberia and Sudan.

As at the close of 2006, **108²** (CDTI) projects had been approved in **16³** of the 19 participating countries of APOC; 97 of these conducted treatment and 95 reported their treatment data, giving a **reporting rate of routine** treatment data of 98%.

The 95 projects⁴ covered **105,866** out of a total of 120,602 meso and hyper endemic communities, and treated **46,252,912 persons** out of a total population of 77,066,289. The reported number of persons treated in 2006 represents an increase of 12.2% (Figure 2) over the number treated in 2005 (41,213,307).

Treatment coverage was markedly influenced by the existing security conditions of the individual countries.

Figure 2: Number of persons treated between 1997 and 2006 in APOC countries



1.2.1 Treatment coverage in stable countries

Countries are classified as stable when the absence of armed conflict or social unrest has enabled CDTI to progress smoothly. **9 countries**, Cameroon, Congo, Equatorial Guinea, Ethiopia, Gabon, Malawi, Nigeria, Tanzania and Uganda fall in this category. **67** of the **68 projects** approved in these countries were under implementation in 2006 and 99% of them reported their treatment data (Table 2). The treatment data from and Gabon is not yet available.

² This figure includes a project in Gabon which is currently clinic based (non-CDTI) and is ongoing in 19 meso and hyper endemic communities. APOC Trust Fund was allocated only for one year during which CDTI was implemented.

³ Kenya, Rwanda and Mozambique do not require CDTI.

⁴ As at July 3rd 2007

Table 2: Summary of 2006 treatment data in 16 participating countries of APOC

	Status of CDTI projects			CDTI communities		CDTI population		Treatment coverage %	
	approved	treated ⁵	report ⁶	Total	Treated	Total	Treated	Geographic	Therapeutic
Stable countries									
Cameroon	15	15	15	9,397	9,311	5,460,324	4,189,350	99.1	76.7
Congo	2	2	2	770	770	611,747	416,963	100.0	68.2
Equatorial Guinea	1	0	0						
Ethiopia	9	9	9	20,625	20,625	6,355,142	3,665,682	100.0	57.7
Gabon	1	1	0						
Malawi	2	2	2	2,186	2,186	1,774,315	1,469,951	100.0	82.8
Nigeria	27	27	27	35,186	33,702	30,453,099	21,567,688	95.8	70.8
Tanzania	7	7	7	5,766	5,766	2,111,847	1,553,416	100.0	73.6
Uganda	4	4	4	4,940	4,940	2,678,241	2,029,957	100.0	75.8
Subtotal	68	67	66	78,870	77,300	49,444,714	34,893,007	98.0	70.6
Conflict/post conflict countries									
Angola	6	2	2	766	360	358,856	123,453	47.0	34.4
Burundi	3	3	3	368	368	1,114,870	756,833	100.0	67.9
CAR	1	1	0						
Chad	1	1	1	3250	3250	1,646,902	1,203,116	100.0	73.1
DRC	20	14	14	27,753	21,357	17,554,037	7,416,160	77.0	42.2
Liberia	3	3	3	4,070	1,787	3,187,648	832,009	43.9	26.1
Sudan	6	6	6	5,525	1,444	3,759,262	1,028,334	26.1	27.4
Subtotal	40	30	29	41,732	28,566	27,621,575	11,359,905	68.5	41.1
TOTAL	108	97	95	120,602	105,866	77,066,289	46,252,912	87.8	60.0

Geographical Coverage

77,300 out of a total of 78,870 meso and hyper endemic communities were treated, giving an average geographical coverage of 98%. With the exception of Gabon (for which treatment data are not reported), Cameroon and Nigeria, all the countries in this group achieved full (100%) geographical coverage. The deficit in Cameroon is due to the performance of two projects: Littoral I (a first year project) with 81% geographical coverage and North West (3rd year project) with 95.5%. In Nigeria 10 projects reported geographical coverage varying between 69% (Imo-Abia, 7th year) and 98% (Ogun, 5th year); the shortfall is more an issue of completeness and delay in reporting on time than performance of projects.

Therapeutic coverage

The number of persons treated increased by 6% between 2005 (32 969,799 persons treated) and 2006 (34,893,007 persons treated). A high therapeutic coverage (average of 71%) was maintained by all stable countries except Ethiopia (58%). 9 CDTI projects are under implementation in Ethiopia. Four of these projects attained therapeutic coverage ranging from 73% (Jimma, 3rd year) to 76% (West Wollega, 3rd year). However, in 4 projects the coverage varied between 48% (Bench Maji, 4th year) and 63% (Metekel 3rd year). The CDTI project in Gambella (3rd year) achieved a low therapeutic coverage (7%) due to interrupted distribution arising from social instability.

⁵ Number of projects which are conducting ivermectin mass distribution

⁶ Number of projects which reported their 2006 treatment data

1.2.2 Treatment coverage in conflict/post conflict countries

Countries are classified as conflict or post conflict when they are undergoing repeated social/civil unrest and/or armed conflict or are just emerging from these into a reconstruction phase as at 2006. **7 countries**, Angola, Central African Republic (CAR), Chad, Burundi, Democratic Republic of Congo (DRC), Liberia and Sudan are in this group. These conditions delayed CDTI or led to interrupted treatment.

Geographical coverage

Of the 40 CDTI projects approved in post-conflict countries, 30 (75%) implemented CDTI in 2006. Only one of these projects (Central African Republic) is yet to provide the treatment data. **28,566** out of a total of 41,732 meso and hyper endemic communities were treated. With the exception of Burundi and Chad (Table 2), the geographical coverage remains below 100% in all countries in the group. Very low geographical coverage was recorded in Sudan (26%), Liberia (44%) and Angola (47%). These three countries share a long history of *armed conflict with the associated health and humanitarian emergencies*.

Therapeutic coverage

6 of the 7 countries in this group (CAR not included) treated 11,359,905 persons out of a total population of 27,621,575, a remarkable increase of 38% over 2005. (Table 2). The mean therapeutic coverage is low at 41%. Burundi and Chad stood out with 68% and 73% respectively. Elsewhere the figures were below the threshold of 65%.

Only 2 of the 6 CDTI projects approved in Angola were being implemented in 2006; these are Lunda Norte and Lunda Sul projects. Together they treated 123,453 out of a total of 358,856 people achieving a low therapeutic coverage (34%), slightly better than in 2005 (14%).

In *Democratic Republic of Congo*, the effects of the security situation are further compounded by the co-endemicity of onchocerciasis and loiasis, inaccessibility and far distances between endemic communities; 57% of the projects conducting CDTI, in 2006, were in their first year of treatment and located in areas where onchocerciasis and loiasis are co-endemic. 14 (70%) of the 20 approved CDTI projects carried out treatment, attaining a mean therapeutic coverage of 42%, ranging from 4% (Tshuapa) to 75% (Ueles).

In *Sudan*, the average therapeutic coverage was 27%. In the northern part of the country, 84% therapeutic coverage was reached in the 126 communities treated. However in the southern part of the country where onchocerciasis is highly prevalent, the therapeutic coverage varied between 5% in West Bahr El Ghazal to 57% in West Equatoria. The difficult security environment, together with co-endemicity of onchocerciasis and loiasis (Equatoria), and limited technical expertise to assist CDDs and communities with implementation accounts for the slow geographical expansion of CDTI and low treatment coverage. To improve the performance of projects in conflict and post-conflict countries, APOC management with the support of the Technical Consultative Committee and approval of the Committee of Sponsoring Agencies

(CSA), is recruiting technical advisors to support the NOTFs of these countries for a maximum of 3 years.

In summary, for most countries classified as stable, full geographical coverage has been reached (or is close to being reached) as per APOC projections, by the third year of implementation (Figure 3). High therapeutic coverage is being achieved and sustained by countries in this group (Figure 4). Conversely, countries classified as conflict and post conflict environment show a more gradual and variable progress towards reaching the desired levels of these indicators (Figure 5).

Figure 3: Geographical coverage (%) in stable, conflict and post conflict countries, 2005-2006

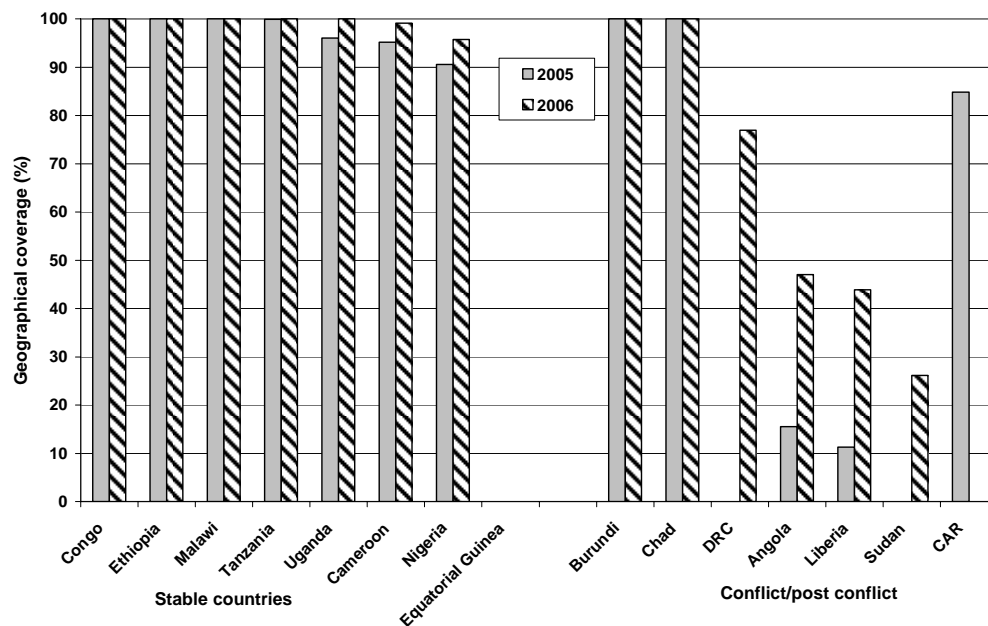


Figure 4: Therapeutic coverage (%) in conflict, post conflict and stable countries, 2005-2006

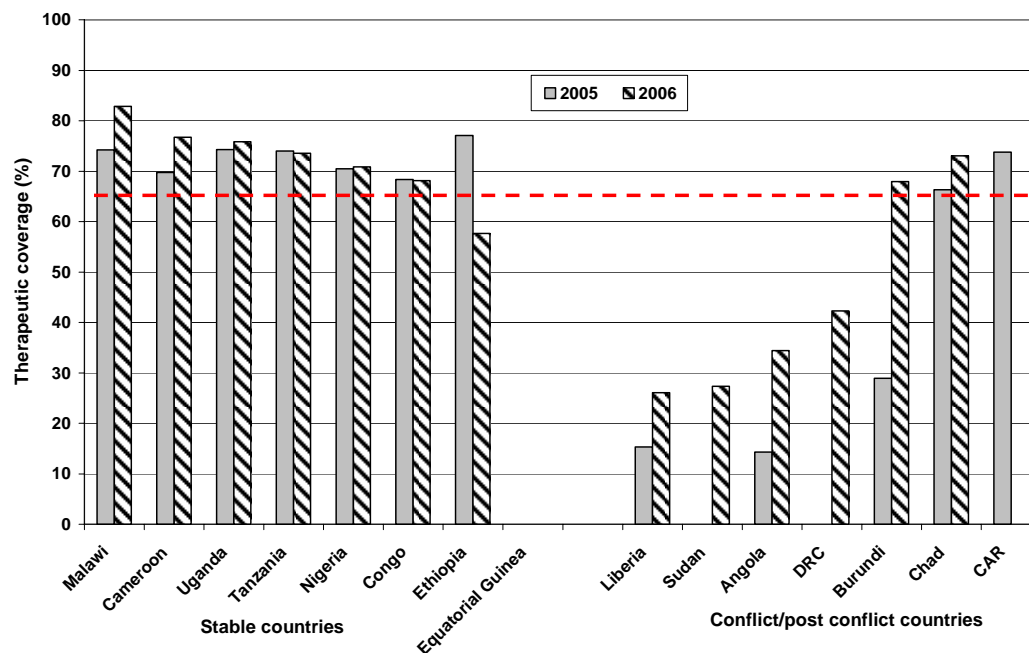
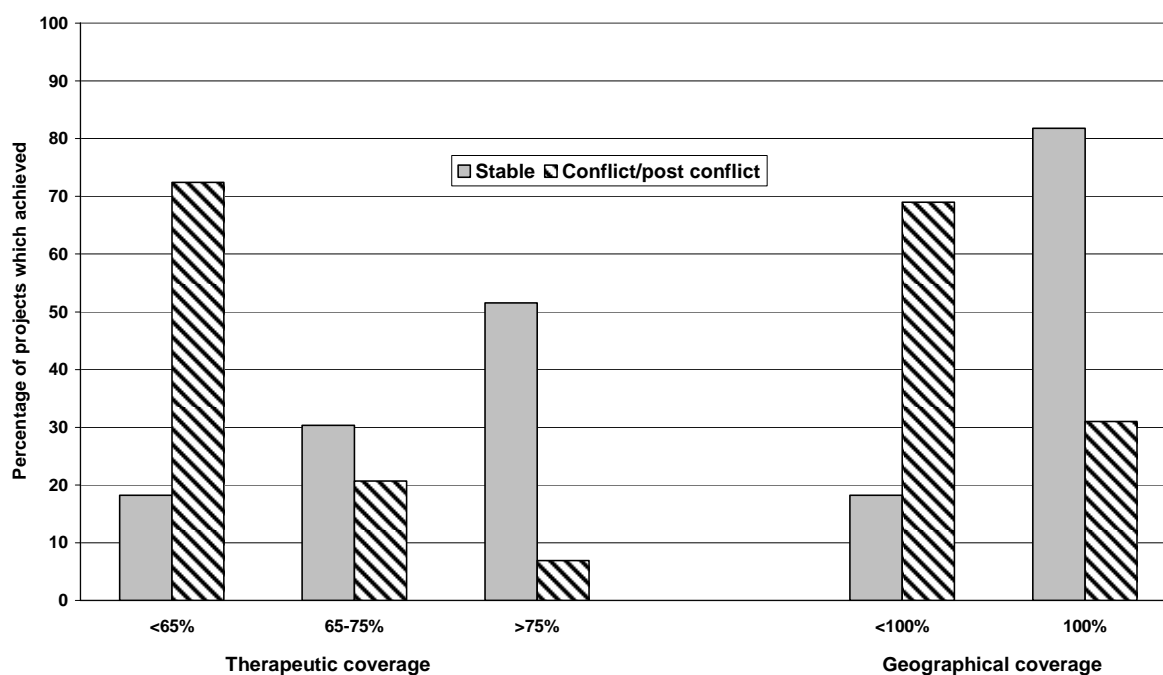


Figure 5: Percentage of projects which achieved good* coverage in stable and post-conflict countries in 2006**Table 3: Level of treatment coverage (geographical and therapeutic coverage) achieved by countries in 2006**

Country and conditions	projects which treated in 2006	Geographical coverage		Therapeutic coverage		
		< 100%	100%	< 65%	65%-75%	>75%
Stable						
Cameroon	15	2	13	1	4	10
Congo	2		2		1	1
Equatorial Guinea	0					
Ethiopia	9		9	4	3	2
Malawi	2		2			2
Nigeria	27	10	17	7	6	14
Tanzania	7		7		4	3
Uganda	4		4		2	2
Subtotal	66	12	54	12	20	34
Conflict/post conflict						
Angola	2	2		2		
Burundi	3		3	2	1	
CAR	0					
Chad	1		1		1	
DRC	14	11	3	11	3	
Liberia	3	1	2	1	1	1
Sudan	6	6		5		1
Subtotal	29	20	9	21	6	2
TOTAL	95	32	63	33	26	36

1.3 Monitoring and Management of SAEs

In 2006, severe adverse event (SAE) cases following ivermectin mass distribution were reported by two countries. The two countries are Cameroon and Democratic Republic of Congo. In these countries SAEs occurred in areas where onchocerciasis and loiasis are co-endemic. Out of the **324 cases of SAEs** recorded, 36 cases occurred in Cameroon and 288 cases in the Democratic Republic of Congo (DRC).

The incidence rate of 0.1 SAE case per 10,000 persons treated in Cameroon and 0.5 SAE case/10,000 persons treated in DRC (table 4) are lower than foreseen for similar onchocerciasis endemic areas with high prevalence of Loa loa.

Table 4: Total CDTI population, number of persons treated and cases of SAEs recorded in 2006 in Cameroon and Democratic Republic of Congo

	Total CDTI population	Persons treated	SAE cases	SAE cases per 10,000 persons treated
Cameroon	5,470,428	4,189,350	36	0.1
DRC	15,476,556	6,262,543	288	0.5
Total	20,946,984	10,451,893	324	0.3

To improve the health staff preparedness to detect and manage SAEs in DRC, a workshop funded by Mectizan® Donation Program (MDP) was conducted in Kinshasa in October 2006. Participants reviewed SAE case definition and diagnosis in order to minimize over reporting. The participants agreed on best practices for SAEs surveillance and reporting; and discussed early detection of SAEs at community level.

In 2006, to ensure monitoring and proper management of SAEs in areas where onchocerciasis and loiasis are co-endemic, APOC management and MDP provided a total financial support of US \$ 216,034. This amount does not include MDP financial support to a Loa loa Technical Advisor in Cameroon.

APOC Management and Mectizan Donation Program (MDP) are supporting the training of Loa loa focal persons in Angola and Southern Sudan, (one for each country) and the establishment of SAE management Units to ensure safe mass distribution in Bengo, Uige and Cuanza Norte (Angola) and in East and West Equatoria in Southern Sudan.

2 EVALUATION AND MONITORING OF CDTI PROJECTS

Monitoring and Evaluation (M&E) - independent participatory monitoring, evaluation of sustainability and monitoring the implementation of sustainability plans are conducted in different phases of project implementation. All CDTI projects go through M&E. To date, a total of 64 projects had undergone independent participatory monitoring, 57 have been evaluated for sustainability and 22 monitored for the implementation of their sustainability plans. Majority of the projects show good progress, particularly at community level, towards attaining sustainability.

2.1 Independent Participatory Monitoring of CDTI projects

Independent participatory monitoring is conducted by a team, consisting of 2 external and 4 monitors and takes place in the second year of a CDTI project. Two projects in Tanzania (Tunduru and Morogoro) were monitored during the period under review. The results show that CDTI has taken off in all the villages in the Morogoro and Tunduru CDTI project areas. The main findings are that:

- (i.) CDTI strategy is well understood and the process followed; the Tunduru CDTI project needs to improve the process of selection of CDDs and decision-making by communities;
- (ii.) 40% and 100% of the communities received health education in the Morogoro and Tunduru CDTI project areas respectively;
- (iii.) treatment coverage is high ranging from 67% to 76% from the household survey and CDD records respectively;
- (iv.) CDTI is well integrated into the routine health system in both CDTI projects. This is evidenced in the inclusion of CDTI in the Comprehensive Council Health Plan (CCHP) as well as the integrated implementation of CDTI activities with those of other health programmes;
- (v.) CDTI activities have been budgeted for in the Comprehensive Council Health Plan (CCHP) against the 2007/2008 fiscal year. Funds are being disbursed from the Morogoro District Council funds for CDTI activities;
- (vi.) Reporting of supervisory activities need to be improved (no checklist was available);

The partners, including Sight Savers International are pleased with the achievements of these projects and pledged to continue technical and financial support to CDTI activities in Tanzania.

2.2 Evaluation of the sustainability of CDTI projects

CDTI projects are evaluated for sustainability in the 3rd year and if a project is judged by evaluators as performing unsatisfactorily or poorly it is re-evaluated during its 5th year. Following the evaluation, feedback meetings are held with regional and district health management teams, work plans are developed to guide projects towards attaining sustainability.

A project is found to be sustainable if *“CDTI activities in the area continue to function effectively for the foreseeable future, with high treatment and geographical coverage, integrated into the available health care system with strong community ownership, using resources mobilized by the community and the government”*.

During the reporting period three projects were evaluated for sustainability using the standard indicators⁷. Phase IV CDTI project in Northern Uganda, Ueles CDTI project in DRC and

⁷ Planning, Health education/Sensitization /Advocacy/ Mobilization (HSAM), Training, Finance, Transport, Mectizan Procurement, Delivery and Distribution, Monitoring and supervision, Human Resources, Record Keeping, data collection and maintenance of therapeutic and geographical Coverage

Congo Extension in Brazzaville. Phase-IV CDTI project was adjudged as making progress towards sustainability in all of its five (5) health districts (covering 20 communities). A similar conclusion was made of Ueles CDTI in all of the 3 health districts (covering 12 communities). However for Congo Extension, following assessment in one health district, covering 8 communities, it was concluded that the project was not making satisfactory progress towards sustainability. A weak health system and lack of government financial support were the main reasons identified for the lack of progress in the CDTI project in Congo.

2.3 Monitoring the implementation of sustainability plans

A mechanism for monitoring at the end of the 4th or 6th year progress towards sustainability of projects, which no longer receive APOC funds has been put in place. The instruments are used to determine the extent to which participating governments, particularly at the district, first line health facility (FLHF) and community levels are implementing the CDTI sustainability plans developed by the authorities after the evaluation of sustainability.

In the period under review, three CDTI projects - Malawi Extension (Malawi), Ruvuma and Tukuyu (both in Tanzania) were monitored for the implementation of their sustainability plans using the standard indicators⁸. All of these projects were adjudged to be satisfactorily implementing their sustainability plans. Feedback on the outcome of the monitoring was given to all the levels involved with implementation especially those charged with policy and decision-making. It is expected that follow up action will be taken.

Overall the monitoring process revealed the following major findings:

- i.) Ivermectin supply to communities was adequate and good geographical and therapeutic coverage was achieved in all projects.
- ii.) Areas where community and FLHF were well mobilized showed good progress to sustainability, regardless of the weaknesses at higher levels, outbreak of epidemics and insecurity.
- iii.) Crucial activities such as sensitization and mobilization, monitoring and supervision are highly dependent on funding. Delay or reduction in funding affects projects' performance. Efforts are required in this area to improve government commitment of resources availability and timely disbursement.
- iv.) Co-implementation motivates CDTI projects.
- v.) Record keeping is still generally weak and more effort is required to strengthen this aspect.

⁸ Planning, HSAM, Training, Monitoring and Supervision, Mectizan supply, Transport, Record Keeping System, Status of Integration in the Health System and Treatment Coverage

3 SCALING-UP ACTIVITIES

The Programme management has placed emphasis on capacity development with the aim of ensuring adequate programme implementation, management and coordination by countries before the exit of APOC. Capacity building also serves a more strategic purpose of ensuring that country programmes are able to sustain CDTI core activities after the exit of APOC. Some capacity building activities are routine e.g. training/retraining of CDDs, others are in response to programmatic needs as they arise e.g. special training, HSAM and IEC activities whilst others fulfil a longer term strategic purpose e.g. training of nationals in financial management procedures of APOC.

3.1 Improving the capacity of communities to manage Ivermectin treatment

Given the workload of CDDs particularly in dispersed populations and the resultant implications of this on treatment coverage, the TCC recommended that projects should train more CDDs in order to reduce their workloads, improve therapeutic coverage and enhance the quality of implementation.. Consequently, in the period under review, a “special country initiative”, was launched by APOC Management aimed at increasing the CDD: population ratio of each project to a maximum of 1:100.

This initiative is on-going in Burundi, Uganda and Nigeria and is being implemented by the NOTFs. It is expected that by December 2007 the three projects in Burundi, one project in Uganda and ten in Nigeria would have trained and/or retrained additional **117,631 Community-Directed Distributors (CDDs), 13,243 health workers and 63,240 community Supervisors** in the CDTI strategy. (Table 5).

To ensure the best outcome for this initiative, high quality IEC and training materials are being made available to CDDs and health workers for use in their activities during and subsequent to training. These materials include posters/stickers (21 550), CDD brochures (98 000), flip charts (9 150), reporting forms (105 000), leaflets (3 500), measuring sticks (1 100) and T-shirts (3 869).

Table 5: Targets for the Special Country Initiative

Country	N° of communities sensitized	Additional CDDs		Additional Health Workers		Additional Supervisors	
		trained	retrained	trained	retrained	trained	retrained
Burundi ⁹	-	2 429	6 060	300	-	1850	-
Nigeria	17 072	65 629	29 471	11 666	-	59 600	-
Uganda	-	14 042	-	104	1 173	1 790	-
Sub-Total	17 072	82 100	35 531	12 070	1 173	63 240	-
Total	17 072	117 631		13 243		63 240	

⁹ 8,254 CDDs were identified by the programme in 2006. Of these 6,060 were trained in 2006. The remaining 2,194 will be trained in 2007 in addition to a further 235 identified for training in 2007 bringing the total to 2,429. This will bring the CDD: population ratio to 1:100.

3.2 Establishing comprehensive community database

At the eleventh session of the Joint Action Forum (JAF), a decision was taken to make available CDTI data per community since the inception of APOC. Following this, an initiative to build a comprehensive community database for all onchocerciasis endemic areas, was launched in 2006. The system will provide on each CDTI community, information on total population, persons treated, number of CDDs trained and geographical location of communities (latitude and longitude). Direct benefits of this initiative include: availability of CDTI community registries; updated treatment and census data, workforce (CDDs) available per community for monitoring of other health interventions at community, project and country levels. Indirect benefits include rapid assessment of access of communities to central drug collection points and health facilities; dynamics of populations (e.g movement).

The initiative commenced in May 2006 in Burundi, Congo, Nigeria and Uganda. It continued in 2007 in Burundi, Cameroon, DRC, Ethiopia, Liberia, Malawi, Nigeria, Southern Sudan and Tanzania. In-country support missions were organized to train and brief the health workers, from the Ministry of Health, and NGDO partners in the management of data, provide technical assistance to improve the reporting tools used by the CDTI projects and plan the collection of historical CDTI data.

As of July 2007, community data is available for ten¹⁰ countries (Burundi, Congo, DRC, Cameroon, Ethiopia, Liberia, Malawi, Nigeria, Tanzania and Uganda). The completeness of data, however, varies from one project to another and from a given year to the next. Table 6 shows an update on the community data available as at July 2007 compared to October 2006, and Annex shows more detail. It is expected that by December 2007, complete community CDTI data for Burundi, Congo, Ethiopia, Malawi, Nigeria, Tanzania and Uganda will be available.

Table 6: Update on community data available at NOTF and APOC headquarters levels

Country	Number of CDTI Projects being covered by the initiative	Number of projects with at least 1 year detailed data by community	
		as at October 2006	As at July 2007
Burundi	3	1	3
Congo	2	2	2
DRC	20	0	5
Cameroon	15	8	11
Ethiopia	9	0	5
Liberia	3	0	3
Malawi	2	2	2
Nigeria	27	8	23
Tanzania	7	3	7
Uganda	4	0	4
Total	92	24	65

The total amount spent from APOC Trust Fund to support the development of the community database system in the different countries during the period under review is US\$ 476 934.

¹⁰ Liberia is not yet part of the initiative

Lessons learnt from the exercise include the fact that CDD ivermectin treatment registers are available in most of the communities, filing systems at the FLHF level are weak, and the culture of documentation and computerizing data for programs is weak at all levels in most of the projects.

3.3 Training to build community capacity and sustain CDTI

3.3.1 Health workers and CDDs trained

National programmes, as part of routine annual CDTI implementation activities, carried out training sessions for health workers and other stakeholders in project areas. Topics covered during the training sessions are sensitization, mobilization of communities, advocacy for the involvement of community leaders, CDTI strategy and APOC philosophy (roles and responsibilities of communities and other partners), supervision of CDDs, management and inventory of ivermectin tablets, management of adverse events, data reporting and empowering communities to own CDTI.

In 2006, 91 CDTI projects in 12 countries trained/retrained a total of **27,104** health workers at regional, district/LGA and front line health facility (FLHF) levels under the coordination of the NOTFs (Table 7), representing a 44% increase over performance in 2005 (18,882). The 6,990 health workers newly trained in Nigeria and DRC contributed significantly to this increase.

A total of 94 projects in 13 countries trained 271,113 CDDs representing a 30% increase over 2005 (208,611).

Table 7: Number of health workers and CDDs trained/retrained in 2006 by NOTFs

Country	Health workers trained or retrained					CDDs trained or retrained				
	Trained	retrained	Total	% newly trained	Projects involved	Trained	retrained	Total	% newly trained	Projects involved
Angola	108	0	108	100	1	724	405	1,129	64	1
Burundi	88	44	132	67	3	7,011	1,239	8,250	85	3
Cameroon	431	1,973	2,404	18	15	10,265	14,395	24,660	42	15
Chad	159	80	239	67	1	5,116	1,705	6,821	75	1
Congo	62	115	177	35	2	499	1,355	1,854	27	2
DRC	2,067	2,273	4,340	48	16	40,536	26,520	67,056	60	15
Ethiopia	details not available		2,605	20	9	details not available		51,428	25	9
Liberia	128	273	401	32	3	3,604	8,933	12,537	29	3
Malawi	details not available					details not available				
Nigeria	4,923	7,801	12,724	39	26	18,088	43,937	62,025	29	26
Sudan	369	283	652	57	6	2,542	1,889	4,421	57	6
Tanzania	59	445	504	12	7	295	10,212	9,825	3	7
Uganda	details not available		2,818		2	15,993		15,993		4
Total			27,104		91			271,113		94

3.3.2 Report and proposal writing and resource mobilization

A series of workshops on reporting, proposal writing and resource mobilisation were held to improve the skills of health and NGDO personnel, and to enhance projects' resource mobilisation capabilities to make them self-sustainable, in view of APOC's imminent exit.

The first of these workshops, held at APOC HQ from 18 to 22 September 2006, brought together 25 participants from 13 countries (Cameroon, Congo Brazzaville, Angola, Equatorial Guinea, Malawi, Sudan, Nigeria, Ethiopia, Liberia, Uganda, Tanzania, Burundi and the Democratic Republic of Congo).

Subsequent workshops were held to extend the numbers benefiting from this special training. The workshops were in:

- (i) Nigeria (from 12 to 16 February 2007, with 28 participants, all from Nigeria);
- (ii) Cameroon/Anglophone (from 20 to 24 February 2007, with 17 participants, including 5 from Liberia);
- (iii) Cameroon/Francophone (from 1 to 3 March 2007, with 34 participants, including 5 from Equatorial Guinea);
- (iv) Uganda (from 16 to 20 April, drawing 22 participants, including 8 from Tanzania); and
- (v) Democratic Republic of Congo (from 30 April to 3 May, with 27 participants, including 6 from Burundi and 1 from Chad).

Participants were drawn from project staff, Ministries of Health of participating countries and from supporting NGOs. APOC Management will monitor for the impact of the training on reporting, proposal writing and resource mobilisation.

3.3.3 CDTI strategy and philosophy

During the reporting period, technical assistance was provided for training activities on CDTI strategy and APOC philosophy in Central African Republic, Burundi and Equatorial Guinea. Training in the CDTI strategy and philosophy was provided to new projects; the empowerment of the communities to plan and manage drug distribution was emphasized.

This is well appreciated by District Executive Managers as experienced in Morogoro, Tanzania where the Deputy District Executive Director, during an independent participatory monitoring exercise expressed his satisfaction as follows: *"We are very happy with the initiative of community participation which promotes ownership. We are using it in every aspect of the District planning wherever applicable such as forestry. Communities are partners and we don't pay their volunteers. We are not happy with NGOs that pay volunteers and have a policy to stop this. We regulate what they do in our district to avoid those ruining things for us. We don't encourage cash for meals called lunch. The lunch should be provided otherwise they see it as an allowance. We support NGOs that bring in-kind support and we regulate the way it is given to avoid a volunteer having more than one bicycle as one NGO did a while ago."*

In addition to this routine training done by NOTFs, APOC facilitated and supported capacity building activities. These are shown in the Table 8 below and will be presented to JAF under agenda item 5.

Table 8: Capacity building activities supported by APOC at country-level

Area of capacity building	Countries	Number of people trained/retrained
Information, Education, Communication (IEC) and Health Education, Sensitization, Advocacy and Mobilization (HSAM)	Democratic Republic of Congo	34
Training of health workers in the use of Healthmapper in creating maps and analyzing data for decision-making.	Burundi - newly-launched CDTI projects of Rutana and Bururi	27
Comprehensive CDTI data collection initiative workshops for health workers on the minimal list of variables for all technical reports, training on the use of a computerized database programme	Nigeria (60), Burundi (27), D.R. Congo (32), Tanzania (23), Ethiopia (35), Sudan (southern) (10) Cameroon (39) and Malawi (22) participants.	248
Financial Management Capacity building session on the analysis of project proposals and the preparation of letters of agreement was organized for nationals from	Nigeria, Congo, South Sudan, and Tanzania	60
Training of CDTI coordinating teams in financial management procedures to improve their compliance with WHO financial regulations	Angola, Equatorial Guinea, Malawi, Ethiopia, Tanzania and Nigeria	60

4 OPERATIONAL RESEARCH

4.1 Reducing the risk of transmission of onchocerciasis

Cross-border issues relating to transmission remain an important aspect of APOC activities. Maintenance of the gains of control efforts is sensitive to changes in the political environment, to shifting health priorities, and in particular, to the conflicts which have affected and continue to affect some countries. In Sierra Leone, Liberia, Côte d'Ivoire, and Guinea Bissau, civil disturbance and consequent migration have caused major disruptions in onchocerciasis control operations. This could have implications on the epidemiological situation in Mali, Ghana, Guinea and Burkina Faso which have maintained the achievements of the OCP.

Until recently, the entomological and epidemiological situation in the Upper Oti and Upper Oueme river basins in Togo and Benin have remained unsatisfactory after several years of combined vector control and ivermectin treatment. The uncontrolled movement of black flies and intensified migration of human populations within the region carries with them the risk of transmission. APOC, thus actively promotes cross border collaboration between affected countries to coordinate operational research and control activities. The fly movement study combined with the infectivity rates evaluation being undertaken between Benin and Nigeria and between Sierra Leone, Guinea and Mali is part of this cross border collaboration effort. This collaboration is also useful for advocacy to maintain political motivation and for resource allocation.

4.1.1 Study on black fly (onchocerciasis vector) movement

Studies in the early nineties, carried out in Benin, showed increasing populations of *Simulium soubrense* Beffa form in the Oueme and Beffa basins, from May to September each

year. Transmission follows the same pattern. Unfortunately the origin of these flies is not known as no study has been conducted on the Nigerian side of the border. Better knowledge of the epidemiological situation will assist the countries and their development partners to make informed decisions. It will also provide the control programmes data for sensitization of policy makers and advocacy in the countries.

To this end APOC, in collaboration with MDSC, SIZ and the governments of Nigeria and Benin, is carrying out a study to determine the movements of the black fly across the Nigeria-Benin border and its impact on the epidemiology of onchocerciasis. In March 2007, a team of experts from MDSC visited Nigeria to carry out preparatory work for this activity. During the visit a draft of the study protocol was prepared, study sites were selected and a training programme was developed for the technicians who would be participating in the study.

In May 2007 the principal investigator of the study was invited to Ouagadougou for further discussion on the study. The elements for preparation of technical services were agreed. In May/June 2007 a one-month training session in entomology for technicians was held in Sierra Leone. Seven (7) technicians from Nigeria participated in the exercise. A Technical Service Agreement (TSA) and the Letter of Agreement (LA) have been signed between APOC/SIZ and Nigeria for the TSA and Benin for the other. The study will last from August 2007 to July 2008.

4.2 Phase I study on incentives for community volunteers: Final Report

The purpose of this study is to document the policies of different health programmes, relating to external monetary incentives for community volunteers, investigate the determinants of these policies and determine to what extent the policies overlap at the implementation level. The research is being conducted in 10 sites in Nigeria, Cameroon, Uganda and Ethiopia. In July 2007 a data analysis workshop, for the study, was held in Abuja. It is expected that the report of the study will be ready by the end of 2007. The final report will be presented to the JAF under the agenda item 7.(iii).

4.3 Multi-country, multi-site study on community-directed Intervention (CDI)

The study is a key component of APOC's strategy for co-implementation. Its purpose is to determine the extent to which the CDI process can be used for the integrated delivery of health interventions with different degrees of complexity, effectiveness and efficiency of CDI as compared to current systems and to identify critical factors that facilitate or hinder effective implementation and integration. The study is being carried out in Nigeria, Cameroon, Tanzania and Uganda, in multiple sites in each country. Interventions being investigated in addition to CDTI are Vitamin A distribution, distribution of insecticide treated nets, DOTS (Directly Observed Treatment, Short-course) and home management of malaria. The results to date indicate that the CDI approach is more effective than current delivery approaches for all studied interventions

except the treatment component of DOTS. The final result of this important study will be presented to the JAF under agenda item 7.(i).

4.4 Health Impact assessment (HIA) of APOC operations

Preliminary results of a rapid health impact assessment of 10 years of APOC operations were presented to the 12th session of the Joint Action Forum (Dar es Salaam, United Republic of Tanzania) by a team from Erasmus University. Preliminary results of the health impact assessment of APOC indicate that in 10 years of operation the prevalence of infection has declined to about 64% of its pre-APOC level by the year 2005 and it is expected to decline further to 7% of the pre-APOC level in the year 2015. The Forum also made a number of decisions relating to APOC activities which could be found in JAF13.4 document.

JAF was pleased and looked forward to more detailed results. Subsequently, APOC, with the support of WHO/TDR (Special Programme for Research and Training in Tropical Diseases) has reviewed a proposal for a comprehensive health impact assessment of APOC by the Erasmus University team. The aim is to undertake an in-depth assessment of APOC's health impact (considering not only blindness, low vision and severe itching, but also other clinical manifestations of onchocerciasis,) along with a sensitivity analysis. The simulation model, ONCHOSIM, will be adapted to enable comprehensive analysis. Efforts will be made to improve the evidence base for prediction and validation of results. Estimates will be provided by country and project, for direct use in management and planning of control activities.

4.5 Macrofil project

The WHO/TDR -APOC Macrofil programme has made remarkable advances in the search for a potential macrofilaricide for Onchocerciasis elimination/eradication. The first study of moxidectin in subjects infected with *O. volvulus* is currently ongoing at the Onchocerciasis Chemotherapy Research Centre in Ghana. The owner of moxidectin, Wyeth Pharmaceuticals, has pledged financial support for the phase 3 clinical studies. In February 2007, the Moxidectin development team met in Accra (Ghana) to review the existing data and the independent members recommended that phase 3 studies be initiated in July 2008 at the latest. TDR and APOC have conducted joint missions to Liberia and DRC, which are judged suitable for conducting the studies and whose Ministries of Health have responded positively to APOC's and TDR's request for approval of the mission. The objectives of the joint APOC/TDR missions were:

- To present the moxidectin development objectives, plan and the role of phase 3 efficacy and safety studies and to learn whether the countries are interested in participating in these studies
- To obtain information on country specific regulatory and ethical review requirements for approval of clinical trial conduct
- To discuss the feasibility and operational requirements for initiating the phase 3 study in adults in July 2008 and to obtain feedback on the draft study protocol.

An update on the outcome of the feasibility assessment and site selection will be presented to the JAF under the agenda item 7.(iv) in December 2007 in Brussels.

4.6 Phase 2 Study on compliance to ivermectin treatment

Phase II of the study on compliance to ivermectin treatment was completed in March 2007. The aim of the study was to determine the rates of individual and community compliance to annual and long term treatment with ivermectin in onchocerciasis endemic areas, and to document factors that affect compliance. The study was conducted in Cameroon, Nigeria and Uganda. The main finding was that 59% of the eligible population had complied with ivermectin treatment at least five out of 8 times. The study further determined that demographic factors did not affect compliance, however perceptual factors did. Consequently a recommendation of the study was for an increased focus on health education of communities and IEC.

5 Vector elimination activities

APOC's mandate in this area is limited to four foci: Itwara and Mpamba-Nkusi (Uganda), Bioko Island (Equatorial Guinea) and Tukuyu focus (Tanzania), and restricted to ground larviciding except in Bioko Island where combined ground and aerial spraying was undertaken. In all the foci vector elimination has been very successful.

In Uganda, the vector of the disease, *Simulium naevi*, was eliminated in 1997 in Itwara focus and in 1999 in its sub foci of Siisa and Aswa. Similarly, in Mpamba-Nksui, *S. neavei* has not been caught, from January 2007 to date.

Intensive entomological surveillance from May 2005 to June 2007 has not found larvae or adult *Simulium yahense Bioko form* and confirmed Bioko Island as one of the first known focus where *S. damnosum* complex has been eradicated.

In Tukuyu focus, ground larviciding, conducted between 2003 and 2005, resulted in virtual elimination of the vector, *S. thjolense*. APOC financed a completed entomological assessment, including collection of larvae and adult black fly in order to provide samples for cytogenetic and molecular identification. The aim of this assessment is to provide scientific evidence that non-anthropophilic species have replaced *S. thjolense* in Tukuyu focus. The entomological assessment which was delayed by heavy rainy season will be completed by December 2007.

6 PROGRAMME MANAGEMENT AND PARTNERSHIP

Early in the reporting period, the report of the Working Group on the future of onchocerciasis control in Africa was presented, discussed and endorsed at a Partners' meeting in Yaounde. The 12th session of the Joint Action Forum approved the recommendations of the Group with some modification. The activities of APOC Management for the period under review have been influenced by these new developments and the decision of the JAF to reposition

APOC. In addition to dealing with routine programmatic issues to improve programme implementation, APOC management has implemented some of the recommendations of the Working Group, the most fundamental of which are those relating to the legal and operational framework for APOC to continue its pro-poor operations to 2015. These include:

6.1 Activities of APOC Management

6.1.1 Amendment of the Memorandum of Understanding

The Memorandum of Understanding (MOU) of APOC was reviewed, and the agreed amendments drafted by the WHO Legal Counsel and submitted to the CSA for consideration. The amended MOU for Phase II (2008-2012) and Phasing-Out Period (2013 -2015) will be circulated to donors and participating governments for consideration and signature.

6.1.2 Proposed Strategic Action Plan and Budget 2008-2015

As recommended by the 12th JAF session, a proposed Phasing Out and Exit Strategy, Plan of Action and Budget of APOC covering the period 2008-2015 has been prepared taking into consideration the suggestions and comments of donors and other partners to the first version. The proposed plan has been submitted to CSA for review and will be presented to the JAF for consideration.

6.1.3 Human resource /Staff development and Temporary advisors

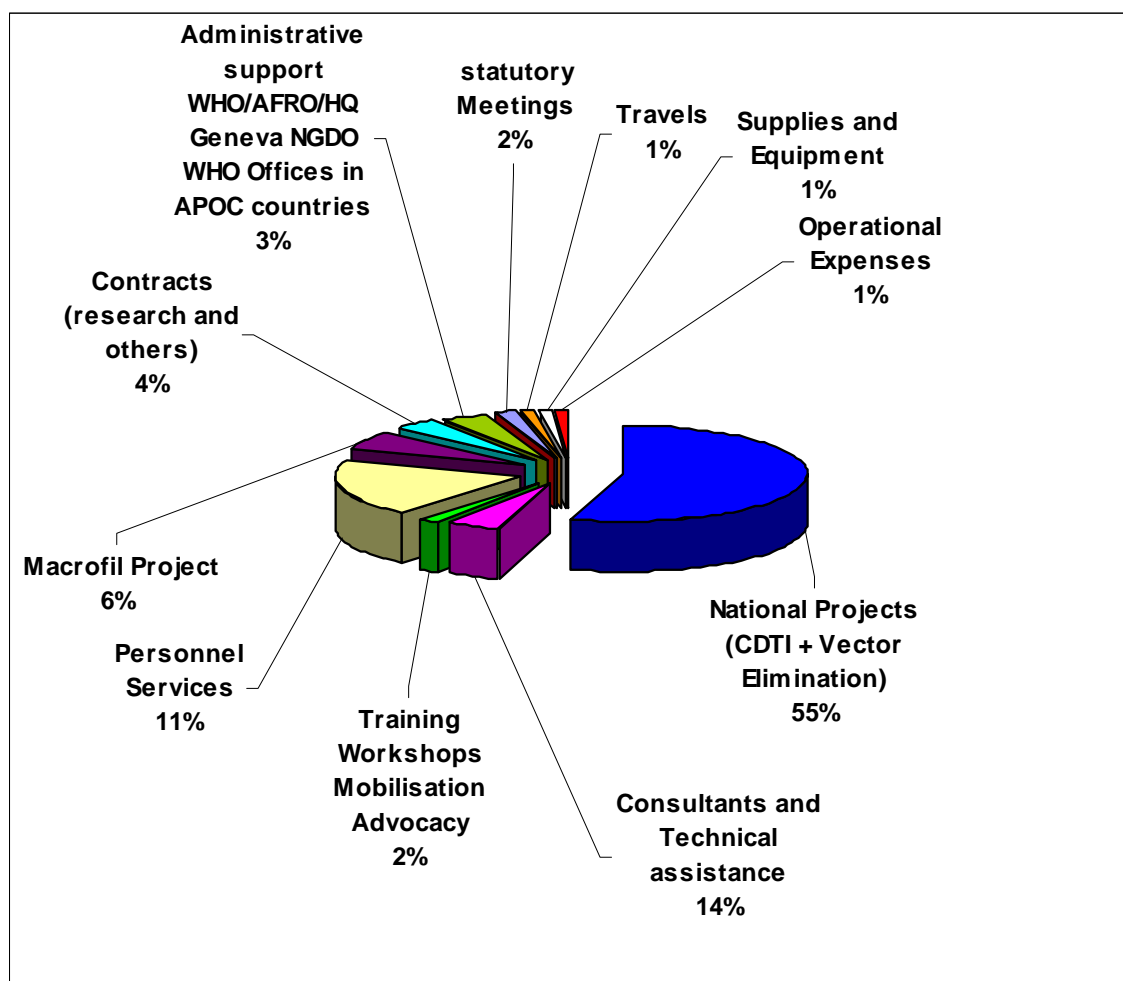
Five temporary professional positions were transformed to fixed term posts according to WHO rules and the necessary recruitment process is underway.

Similarly the transformation of temporary positions of Administrative and Finance Assistants to fixed term posts is ongoing in WHO country offices in Cameroon and Nigeria. Two Administrative and Finance Assistants were recruited in Angola and Burundi and the process of recruitment for similar positions in Ethiopia and Tanzania is ongoing. The recruitment of technical focal persons for post-conflict countries - Angola, CAR, Chad, DRC, Liberia and South Sudan is underway and two will be completed before the end of 2007.

6.1.4 Financing

One hundred and seven CDTI projects were funded. This includes five new CDTI projects launched in 2007 in DRC (3) and Angola (2), as well as six NOTF Secretariat- support projects. Two projects in North Sudan (Northern Sector CDTI project and NOTF Secretariat) were not funded because the project did not present a plan of action and budget. All projects that complied with WHO/APOC financial rules and procedures received funds from the Trust Fund for their activities. 55% of the approved budget was allocated to national projects. In total, 100% of US\$ 13.5 million representing the total approved budget under 2007 APOC Plan of Action and Budget was executed as indicated in Figure 6.

Figure 6: Annual expenditure by major activities under Trust Fund Funding



6.1.5 Country support missions

The APOC management undertook several missions to 14 APOC countries, in collaboration with the Technical Consultative Committee (TCC) members, the Non-Governmental Development Organizations (NGDOs) Coordination Group members, and other external experts during the period under review. These were for technical advice on collaboration with other programmes; advice on integration and co-implementation with malaria plus initiative; meetings with policy and decision-makers to improve CDTI through integrated approach; review of the onchocerciasis control situation; and clarification of the role and contribution of different partners. The missions reviewed and advised on administrative and financial operations of CDTI projects; re-launching CDTI activities in some countries, facilitated training workshops on APOC philosophy and the CDTI strategy for project managers; trained accountants in the WHO accounting system and collection of CDTI data.

In addition, a mission was undertaken to Benin, (a Special Intervention Zone of ex-OCP country) for advocacy with the Ministry of Health to take over residual onchocerciasis activities at the closure of SIZ at the end of 2007.

The overview of these visits is presented in Table 9.

Table 9: Support missions to APOC Countries

Country	Mission/purpose
Benin	<ul style="list-style-type: none"> Advocacy visit to the highest authorities in the Ministry of Health for take over of onchocerciasis control activities and SIZ personnel at the closure of the SIZ in December 2007 Study of black fly cross border movement between Benin and Nigeria
Burundi	<ul style="list-style-type: none"> Training on data management and geographical information system (GIS)
Cameroon	<ul style="list-style-type: none"> Partners' meeting of APOC Administrative and financial review of APOC field activities in South West I, Western province, NOTF/HQ, Adamaoua I, Centre 1 and Littoral I CDTI projects
CAR	<ul style="list-style-type: none"> Reorganization of the management of NOCP/CAR Technical support to the NOCP in re-launching of CDTI activities in CAR
Chad	<ul style="list-style-type: none"> Search for new partners and integration of CDTI and Vitamin A.
Congo	<ul style="list-style-type: none"> Meeting on the preparation of multi-country presentations Meeting on integration of onchocerciasis control in the health system and co-implementation of NTDs Meeting of interested parties to identify technical issues and integration of interventions for neglected tropical diseases and malaria Exchange programme visit of National Coordinator of Equatorial Guinea.
DRC	<ul style="list-style-type: none"> Administrative and financial review of APOC activities in North Ubangi, Tshopo CDTI project and NOTF/HQ
Equatorial Guinea	<ul style="list-style-type: none"> Meeting with decision makers to discuss re-launching of CDTI activities and an integrated approach for the control of onchocerciasis, lymphatic filariasis, schistosomiasis and helminthiasis Workshop on APOC philosophy and CDTI strategy Social sensitization, mobilization and advocacy in rural and urban areas on CDTI activities Advocacy and planning of 2007 activities Planning of integrated mapping of NTDs in Equatorial Guinea Training of health workers and supervision of training of CDDs in rural areas Supervision of census -taking in rural areas Entomological surveillance
Ethiopia	<ul style="list-style-type: none"> Preparatory workshop on country presentations Meeting with the NOTF on CDTI activities Presentation of APOC activities at the Conference on strengthening of community health in the Africa Region. CDTI data collection
Liberia	<ul style="list-style-type: none"> Assistance to NOTF in the implementation of CDTI in Liberia Joint mission on selection of sites for phase 3 clinical trial of Moxidectin Technical assistance to the CDTI projects and to the NOTF Secretariat Facilitation of a workshop on APOC philosophy and CDTI strategy
Malawi	<ul style="list-style-type: none"> Entomological Evaluation in the Zomba district Administrative and Financial training of CDTI project accountants
Nigeria	<ul style="list-style-type: none"> Meeting on collaboration of malaria plus project with Onchocerciasis control Programme in Nigeria Meeting of APOC management and NGOs on improvement of APOC projects in Nigeria and maintaining the achievements. Study of black fly cross border movement between Benin and Nigeria Workshop on data collection and planning of CDTI data collection activities
Sudan	<ul style="list-style-type: none"> CDTI data collection in South Sudan
Tanzania	<ul style="list-style-type: none"> Training workshop on independent monitoring Independent participatory monitoring exercise in Morogoro and Tunduru
Uganda	<ul style="list-style-type: none"> Launching of Onchocerciasis elimination in Uganda

6.1.6 Review of Technical, Administrative and Financial Activities of Projects

Joint Technical, Administrative and Financial review missions of APOC operations in DRC, Nigeria and Cameroon were conducted and several recommendations were provided to the project teams to facilitate better compliance with financial procedures. Technical advice/guidance and support were also provided to the projects visited.

One thousand one hundred and sixty-three (1163) financial returns were received from projects, of which 947 have been analysed and feedback sent to the projects. Many improvements have been noticed but some weaknesses remain mainly in late and non-submission of financial returns. All the financial transactions have been submitted to external auditors who have given their opinions on the good compliance to WHO rules.

To accelerate the financial transactions and minimize delays in funding implementation of field activities, 91% of the projects in nine (9) countries have administrative and financial assistance at country level from staff paid through a co-financing mechanism between APOC and WHO country offices.

6.1.7 Statutory meetings

The management of APOC organized all the statutory meetings - the 12th session of the Joint Action Forum (JAF) of APOC, two meetings each of the CSA (115th, 116th) and the Technical Consultative Committee (23rd, 24th).

6.2 The Technical Consultative Committee (sessions 23 & 24)

The twenty-third and twenty-fourth sessions of the Technical Consultative Committee (TCC) of APOC were held in Ouagadougou, Burkina Faso, in September 2006 and March 2007 respectively. The 23rd meeting, amongst others recommended the cessation of the Cabinda CDTI project, a final assessment of the vector elimination activities in Tukuyu/Tanzania the formation of operations research task forces in Cameroon, Uganda and Nigeria, and reviewed four proposals on the integration of Vitamin A into CDTI for one year funding. The committee also reviewed forty annual project technical reports.

The 24th meeting discussed strategic and technical issues including the report on the workshop on management of SAEs held in DRC, the performance of CDTI projects in Angola, strategic plan for the elimination of onchocerciasis in Uganda, MACROFIL, integration of onchocerciasis control in national health systems and co-implementation of the control of neglected tropical diseases. The TCC also recommended the recruitment of a technical advisor to assist the Angola Onchocerciasis Control Programme and the recruitment and training of more CDDs to attain higher treatment coverage.

6.3 Partnership and Collaboration

6.3.1 NGDOs and lymphatic filariasis (LF) NGDO network

Partnership with the NGDOs (Table 10) continues to be a corner stone of APOC achievements particularly in the coordination of CDTI field activities.

Table 10: NGDO Partners in onchocerciasis Control in APOC countries, as at 2007

Country	NGDO partner
Angola	Sole, World Vision
Burundi	CBM
Cameroon	HKI, IEF, Perspectives, SSI, The Carter Center
CAR	CBM
Chad	BELACD
Congo Brazzaville	OPC
D.R. Congo	CBM, CRS, HKI, IMA, IRC, Lions Club, UFAR
Ethiopia	The Carter Center, Light of the World
Equatorial guinea	
Gabon	OPC
Liberia	SSI/CHAL, UNICEF*
Malawi	IEF
Nigeria	CBM, HKI, IFESH, MITOSATH, SSI, The Carter Center, UNICEF*,
Sudan	CBM, The Carter Center
Tanzania	HKI, IMA, SSI
Uganda	CBM, SSI, The Carter Center

* Although UNICEF is included here, it is a partner but not NGDO

APOC Management participated in the *29th meeting of the NGDOs and LF NGDO network* in Chicago, March 2007, and presented progress in the mapping of onchocerciasis and loiasis in APOC countries and the role of APOC in integration of onchocerciasis control into national health systems and co-implementation. Discussions of the meeting covered areas such as NGDO support to countries (highlighting that Chad and Equatorial Guinea were without NGDO support), weaknesses in reporting costs supported by NGDOs for onchocerciasis control and the mapping of onchocerciasis, loiasis and LF. Other discussions focused on the onchocerciasis elimination campaign in selected foci in Uganda and the importance of studies on transmission in hypo-endemic areas in relation to control/elimination activities.

6.3.2 The Onchocerciasis unit of the World Bank, Merck& Co. Inc and Mectizan® Donation Program

During the period under review, the Onchocerciasis unit of the World Bank and APOC management undertook *joint resource mobilization* missions to UK Department for International Development (DFID) (February 2007) African Development Bank (ADB), Tunis (April 2007) and to Belgium.

Merck & Co.Inc. has reiterated its unwavering commitment to APOC through the donation of ivermectin to the poor for as long as needed. Collaboration with its affiliate, MDP, has been important in the management of SAEs. (see section 1.3).

6.3.3 Collaboration with West African Health Organization (WAHO)

In February 2007, collaboration between APOC and WAHO, to include the *Community-Directed Intervention strategy in the curriculum for Medical and Nursing schools* commenced. APOC financed a meeting held in Ouagadougou for experts in public health, education and research from health training institutions and standardization and accreditation bodies in Africa. The purpose of the meeting was to develop a curriculum for use in training institutions of health professionals, which would impart the knowledge, attitude and skills for applying the CDI strategy

to health care delivery and evaluate its outcome. The curriculum was duly developed with an action plan for adoption and incorporation into existing training programmes.

In March 2007, WAHO organized a meeting in Bobo Dioulasso, to harmonize training programmes of schools of nurses and midwives in the ECOWAS region. The meeting was attended by members of the Experts Committee of the Cotonou Forum, representatives of WHO, APOC, 14 ECOWAS (Economic Community Of West African States) member countries, professional bodies and training institutions. At this meeting, the training module on the *CDI strategy was presented to the Expert Committee*. The representatives from Niger and Benin offered to host pilot testing of the curriculum in their countries. The meeting recommended that there should be wider dissemination of information on the curriculum to other training institutions. APOC will contribute to this effort.

6.3.4 Collaboration with other arms of the WHO

Cooperation with various arms of WHO - WHO/NTD, WHO/TDR and OTD/AFRO continued during this reporting period. The main focus was on integration and co-implementation. Research study on the cessation of ivermectin treatment and the multi-country/multi-site study on CDI, both by WHO/TDR continued. The meeting in Brazzaville was jointly funded by APOC, NTD, TDR and AFRO. The cost of the Ouagadougou meeting on integration was funded by APOC.

APOC management prepared the document on “Onchocerciasis Control in Africa: current challenges and way forward” for the 57th session of the Regional Committee for Africa (RC57) and participated in the meeting of the Programme Subcommittee for RC57 and the meeting of African Ministers of Health. The Health Ministers made a Resolution in support of the Yaoundé Declaration.

The Multi-Disease Surveillance Center (MDSC) provided technical assistance to APOC in the area of surveillance. The Centre performed parasite identification for APOC studies on impact of ivermectin treatment on transmission in Bolo/Cameroon, Zinga/Centrafrigue and Inga/Democratic Congo. Other activities include identification of *Onchocerca* sp larvae collected in the Togo and Benin river basins. Currently, APOC/MDSC/SIZ have launched research to study the epidemiology of onchocerciasis vector migration from Sierra Leone to Mali and from Nigeria to Benin. (see section 4.1).

7 INTEGRATION OF ONCHOCERCIASIS CONTROL AND CO-IMPLEMENTATION OF CDTI WITH OTHER HEALTH INTERVENTIONS

7.1 Integration of onchocerciasis control in national health systems

APOC is supporting integration of CDTI into health systems, facilitation and exchange of best practices on co-implementation of CDTI with other programmes. Between 2002 and 2005, APOC evaluated 55 CDTI projects and their levels of integration in the health system were

assessed. Twenty of these projects were fully integrated in the health system. The projects in Uganda, Ethiopia, Malawi, Congo and Tanzania were in this category. However, 28 were integrated at lower levels and not at central or state/regional levels and 7 were not integrated. . Projects in conflict countries were in this group, since there were no defined health structures to integrate with. The management of APOC, assisted by consultants, prepared a document on the potential of community-directed treatment to strengthen health systems through integration (JAF/INF/DOC.3).

7.2 Co-implementation of CDTI with other health interventions

The co-implementation of CDTI with other health interventions, particularly, in remote areas and in post conflict countries with weak health infrastructure is considered an optimal method to improve and sustain high treatment coverage. During the reporting period more than 50 projects in 10 member countries used CDTI as a springboard to bring essential and multiple health interventions to millions of people in need in communities where routine health services are either weak or non-existent. (Figure 7).

Meetings on integration and co-implementation of CDTI and other health interventions

A high-level meeting was held in Brazzaville, February 2007, to discuss integration of Onchocerciasis control into national health systems, co-implementation of onchocerciasis control with other neglected tropical diseases (NTDs) and some components of malaria control. The meeting, which brought together national Directors of Disease Control & Public Health along with project coordinators for onchocerciasis, malaria and NTDs (46 participants) from 10 Anglophone countries in Africa, concluded that countries must formulate national policies and plans for NTDs, establish management structures and allocate adequate resources for co-implementation. It recommended that donors and partners should support co-implementation and enable flexibility in the use of funds for field activities. It also recommended that communities be empowered in health care delivery, that decision-making on interventions must be evidence-based and called for inter-country collaboration mechanism for integration and co-implementation. A target of December 2008 was set for the development of national policies, strategic implementation plans and guidelines on integration of neglected tropical diseases, including onchocerciasis, into the health system. The recommendations of the meeting being implemented by governments will be presented by the coordinators under the agenda item 11.(iv).

A similar meeting for 15 francophone countries was held in Ouagadougou, in June, 2007.

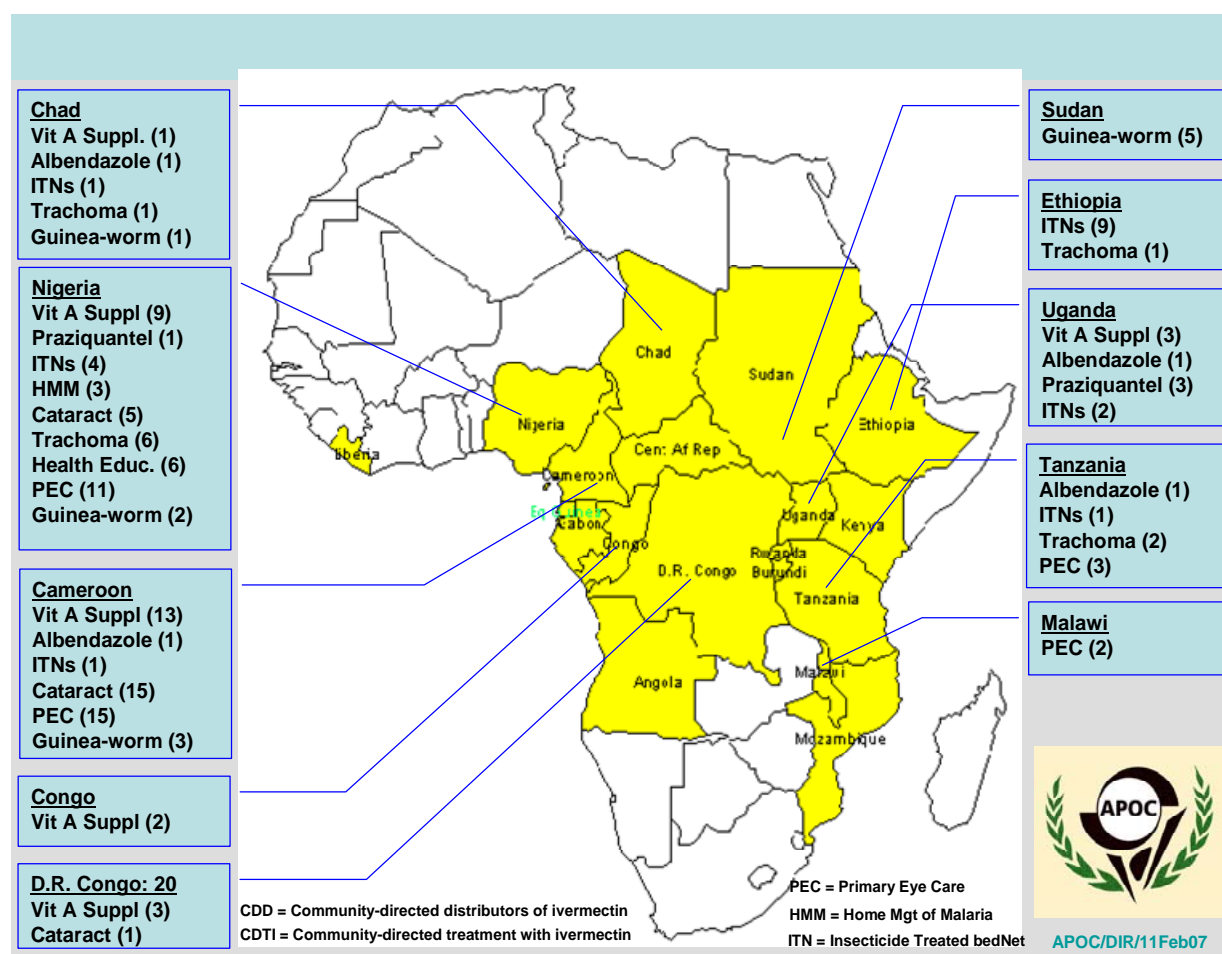
This meeting was attended by 64 participants including the Directors of Disease Control and Public Health and representatives of the World Bank and 4 donor countries- France, Belgium, The Netherlands and Canada, Learning from the Brazzaville meeting, a session on mechanisms for sustainable financing of NTDs was included in the agenda.

Recommendations that differed from those made during the Brazzaville meeting included: in-country advocacy to give NTDs recognition as a health priority and as an obstacle to national

socio-economic development; building NTDs into the priorities of Poverty Reduction Strategic Papers (PRSP) and the Medium Term Expenditure Framework (MTEF); increasing the budget allocated to health, in conformity to the Abuja and Yaounde Declarations (15% of national budget), and making national resources available for the control of onchocerciasis, other NTDs and malaria. The WHO Regional Director for Africa was requested to petition the President of Burkina Faso, His Excellency Blaise Compaore, to continue his advocacy for the control of NTDs at future African heads of state summits. APOC was requested take specific steps to secure enhanced support for the control of onchocerciasis, other NTDs and malaria. Such actions include continued advocacy with governments, sub-regional and regional organisations to mobilize financial contributions at the national level, appointing goodwill ambassadors to enhance advocacy and to building the local resource mobilisation capacity of countries and communities.

Main areas of operational research in the co-implementation of integrated onchocerciasis and NTD control activities identified by both meetings were pharmacovigilance and CDD incentives.

Figure 7: Number of CDTI projects with CDDs delivering other health interventions



8 CONTRIBUTION OF GOVERNMENTS TO ONCHOCERCIASIS CONTROL

To ensure that governments continue to support control activities after the exit of APOC progressive increase in governments' financial contributions to control activities should occur, leading to full financial responsibility. This is an important aspect of APOC's exit strategy. JAF at its 10th session, in Kinshasa, requested that countries should specify the nature of government contributions. During this reporting period, APOC Management undertook high level visits to countries to secure from governments reliable funding for control activities. Some advocacy visits undertaken by management are presented below.

8.1 Advocacy and mobilization of resources in APOC countries

In February 2007, the Director of APOC undertook a mission to Equatorial Guinea to solicit financial support of the government for entomological surveillance and ivermectin distribution. This is yielding positive results. The representative of WHO and APOC management will oversee onchocerciasis control activities and integrated mapping of onchocerciasis, loiasis, lymphatic filariasis and soil transmitted helminths. .

The nuisance of *Simulium damnosum* , represents a real problem on the Inga Dam and the two neighbouring health zones (Inga and Seke-Banza), particularly during high water period of the river between October and December. 163,823 persons live in the area. Since the cessation of the vector control activities three decades ago, the daily biting rate has increased from 10 to 13,000 bites/man/day. This has serious negative health, social and economic effects on the workers and their families, in particular, on school children, impairing their assiduity and performance at school.

Following the complaints of the population and workers of the dam, the National Onchocerciasis Control Programme (NOCP) requested the support of APOC to control the nuisance. Through advocacy APOC management has been instrumental in securing a World Bank grant of US\$ 2,880,000 for the control of blackfly nuisance in the Inga Dam area of the DRC as a health component of the electricity project (PMEDE: *Projet de Développement des Marchés d'Electricité pour la Consommation Domestique et à l'Export*) being sponsored under the multi-sector project for urgent rehabilitation and rebuilding (PMURR: *Programme Multisectoriel d'Urgence pour la Réhabilitation et la Reconstruction*). APOC has followed up with a planning and coordination mission.

8.2 Government financial contributions to Onchocerciasis control

During an APOC Partners' meeting in Yaoundé, Cameroon in September 2006, Ministers of Health, in their declaration, urged endemic countries to make annual budgetary commitments for onchocerciasis control activities as part of their national budget and include onchocerciasis control into the PRSP and in line with the Millennium Development Goals (MDGs). In November

2006, 11 countries, Angola, Burundi, Cameroon, Congo, Chad, Democratic Republic of Congo, Ethiopia, Malawi, Nigeria, Tanzania and Uganda met in Addis Ababa and Brazzaville to harmonize and standardize governments' financial contribution to four key CDTI activities. The table 11 shows the contributions of governments (excluding staff salaries) to 77 CDTI projects in 2004 and 2005. Government contributions in 2006 will be presented under the agenda item 14. An update on governments' financial contributions will be presented to JAF 13.

Table 11: Government financial contribution to 77 CDTI projects in 11 countries

Key CDTI activities	Year 2004	Year 2005
Mobilization, advocacy, sensitization and health education	\$426,184	\$347,021
Training of Community-distributors and peripheral health workers	\$185,404	\$209,636
Supervision, monitoring and evaluation	\$268,463	\$342,060
Ivermectin delivery and management of severe adverse events	\$291,141	\$237,603
Total	\$1,171,192	\$1,136,320

9 PREPARING FOR THE EXIT OF APOC

9.1 Development and implementation of country plans on APOC exit

As an important step in preparing for the exit of APOC, the Management encouraged three countries (Uganda, Tanzania and Cameroon) with projects that had received more than 8 years of Trust Fund support to produce their own strategic plan, describing activities that needed to be strengthened at the operational levels for a smooth exit of APOC, and how government will take over control activities. This is meant to compliment the CDTI sustainability plans developed by a number of projects following evaluation.

In the reporting period, Uganda forwarded its strategic plan to APOC Management for consideration and in March 2007, Letters of Agreement governing the three year plan were signed. Meanwhile, NOTF/Tanzania has submitted its plan and NOTF/Cameroon is expected to submit before December 2007. In 2008, this initiative will be extended to Nigeria, Ethiopia and other APOC countries. It is expected that the implementation of the Yaoundé Declaration by participating countries will provide CDTI projects regular allocations from national budgets.

ANNEX**The status of data collected as at July 2007**

SN	Country	Total number of projects	Total number of communities which distributed ivermectin in 2006	Number of communities with at least 1 year detailed data	% of communities with data	Total number of communities with geographical coordinates available
1	Burundi	3	368	368	100.0	72
2	Cameroon	15	9,311	5,423	58.2	2,157
3	Congo	2	770	773	100.0	336
4	DRC	20	21,357	9,913	46.4	
5	Ethiopia	9	20,625	11,609	56.3	
7	Liberia	3	1,787	971	54.3	
6	Malawi	2	2,186	1,357	62.1	
8	Nigeria	27	33,702	26,158	77.6	6,326
9	Sudan	6	1,444	0	0.0	
10	Tanzania	7	5,766	4,198	72.8	212
11	Uganda	4	4,940	1,759	35.6	
TOTAL		98	102,256	62,526	61.1	9,103