Neglected Tropical Disease

Regional Programme Review Group

Report on the first Meeting on Preventive Chemotherapy

June 30-July 04, 2014

(including a Report of the RPRG LF Sub-Committee Meeting held on April 23 – 25, 2014)

WHO Regional Office for Africa

Brazzaville, Congo

LIST OF ABBREVIATIONS

AIDS:	Acquired Immuno-Deficiency Syndrome
AFRO:	WHO Regional Office for Africa
APOC:	African Programme for Onchocerciasis Control
AWP:	Annual Work-Plan
BMGF:	Bill and Melinda Gates Foundation
CAR:	Central African Republic
CCA:	Circulating Cathodic Antigen test
CDD:	Community Drug Distributor
CDs:	Communicable Disease Programme Area of AFRO
CDTI:	Community-Directed Treatment with Ivermectin
CIFF:	
CM:	Case management
COR-NTDs:	Coalition for Operational Research on NTDs
DOLF:	Death to Onchocerciasis and Lymphatic Filariasis
DPC:	Disease Prevention and Control
DFID:	
DRC:	Democratic Republic of the Congo
EPIRF:	Epidemiological Report Form
GNNTD:	Global Network for NTDs
GTMP:	Global Trachoma Mapping Project
GWD:	Guinea Worm Disease (dracunculiasis)
HIV:	Human Immuno-deficiency Virus
HQ:	(WHO) Headquarters in Geneva
IST:	Inter-country Support Team
ITI:	International Trachoma Initiative
JAP:	Joint Application Package
JRF:	Joint Reporting Form
JRFSM:	Joint Request Form for Selected Medicines
LF:	Lymphatic filariasis
MDA:	Mass Drug Administration
MMDP:	Morbidity Management and Disability Prevention
MoHSW:	Ministry of Health and Social Welfare
NTD:	Neglected Tropical Disease
Oncho:	Onchocerciasis
PC:	Preventive Chemotherapy
POC-CCA:	Point of Care CCA test
RAPLOA:	Rapid Assessment of the Prevalence of Loaisis
RC:	Regional Committee
RO:	Regional Office of the WHO
RPRG:	Regional Programme Review Group
SAFE:	Surgery Antibiotherapy, Facial cleanliness and Environment improvement
SCH:	Schistosomiasis

SCI:	Schistosomiasis Control Initiative
STAG:	Strategic and Technical Advisory Group
STH:	Soil-Transmitted helminthiasis
TCC:	Technical Consultative Committee
TF:	Trachoma Follicular
TFGH:	Task Force for Global Health
TIS:	Transmission Impact Survey
TT:	Trachoma Trichiasis
TRA:	Trachoma
USAID:	United States Agency for International Development
WASH:	Water Sanitation and Hygiene
WCO:	WHO Country Office
WHO:	World health Organization

NEGLECTED TROPICAL DISEASE
REGIONAL PROGRAMME REVIEW GROUP
1ST MEETING ON PREVENTIVE CHEMOTHERAPY

30TH JUNE -4TH JULY 2014

WHO Regional Office for Africa, Brazzaville, Congo

DAY 1 -30TH JUNE 2014

Session 1: Opening Ceremony

The day's session began with a general introduction of participants. Thereafter, the Director, Disease Prevention and Control Cluster (DPC), Dr Francis Kasolo, represented by the Regional Adviser HIV/AIDS/CDs, Dr Emil Asamoah-Odei declared the meeting open. In his speech the acting Director noted that new developments at global and regional levels have necessitated the strengthening and integrating the control, elimination and eradication of NTDs. In line with this, he added that the NTD Programme was re-organized with two main units dealing with NTDs amenable to preventive chemotherapy (Lymphatic filariasis, Onchocerciasis, Schistosomiasis, Soil-Transmitted Helminthiasis and Trachoma) and case management NTDs (Buruli ulcer, Human African Trypanosomiasis, Leishmaniasis, Leprosy and Yaws). A Regional NTD Strategy and a NTD Regional Strategic plan developed for the period 2014-2020. These strategic documents were endorsed by the resolution AFR/RC63.R6 on NTDs of the Regional Committee for the WHO regional Office in Africa in September 2013. The Regional Programme Review Group for Lymphatic filariasis (LF-RPRG) was expanded to cover all PC-NTDs. The DPC highlighted that the current meeting is therefore the first meeting on Preventive Chemotherapy of the expanded NTD-RPRG. While congratulating the members on their appointment into the group, he called on them to use the best of their knowledge and expertise and assist the Regional NTD Programme in reviewing performance of country NTD Programmes. Moreover, he requested members of NTD-RPRG to provide WHO with high quality, impartial, well-considered program review, recommendations and advice on policy and strategic matters, as well as provide guidance to accelerate progress towards regional and global targets for the control and elimination of PC-NTDs. The DPC called on members to also play a critical role in ensuring the reputation of the RPRG as an internationally recognized review and advisory group in the field of NTD control.

Session 2: Mapping Stakeholders' Meeting: Mapping of NTDs and the Regional Action Plan for Completing the Mapping of NTDs

This technical session started after the opening ceremony.

Presentation 1: Update on the Global Implementation of the NTD/PC Road Map (Albis & Jonathan)

The key highlights of the presentation included the following:

- There is a normative framework for the control, elimination and eradication of NTDs
- Progress of preventive chemotherapy as at 2012: 75 countries reported 699,933,038 treated which is a decrease compared to numbers of treatments of previous years, due mainly to reduced Mass Drug Administration (MDA) in India. However, some additional data from India are still expected. 96% of population requiring PC live in the 75 countries reporting.
- Though coverage is improving over the years for PC-NTDs the progress in the WHO African Region is slow and except for onchocerciasis the coverage rates are still below expectations.
- Shipment to countries of donated medicines has increased significantly. There is an increase in the number of countries completing mapping of PC-NTDs and requesting for donated medicines.

Presentation 2: Mapping of NTDs in the WHO African Region (A. Onyeze/L. A. Tchuem Tchuente)

The presenters highlighted that:

- There is a huge mapping gap in the African region - 3152 NTD mapping surveys need to be carried out. All surveys are to be completed by the end of 2015.
- 3 phases are planned in NTD mapping and these are Phase-I (Initiation & Stakeholders' Meeting); Phase- II (Mapping surveys); and Phase- III (Taking action using the mapping data).
- Countries have been classified into 5 work streams—Ready to go countries (12 countries); mapping start-ups (14 countries); Big countries (3 countries); validation mapping 5 countries); and onchocerciasis delineation, loa loa overlap and micro-mapping (3 countries)
- A coordinated mapping guide exists which reflects the disease-specific guidelines/indicators and reflects the thresholds for interventions
- In selecting study sites sampling must not be random but purposive due to the high focalisation of the diseases. There are issues on methods for 'confirmation mapping' and the thresholds for intervention especially with relation to LF
- Country leadership and ownership of coordinated mapping needs to be enhanced.
- Collaboration is key to success

Discussions on Presentations

Meeting participants made the following inputs:

- Community and campaign-based approaches need to be strengthened and better coordination in countries to ensure improved coverage of PC-NTDs interventions
- Presentations on progress on preventive chemotherapy should capture not just the absolute numbers of those treated but also the countries that have stopped MDA with the number of those that have stopped taking the medicines.

Presentation 3: Donor Updates and commitments

The BMGF representative, Dr Julie Jacobson, noted that several accomplishments have been recorded in NTDs. She also noted that NTDs are now part of the global conversation following the recent panel discussion involving Bill Gates and the WHO DG. This event, she said, has increased awareness and therefore is putting pressure on implementers to deliver - complete mapping and up-scale interventions. She highlighted that there is an increasing commitment especially to STH control with more donors/collaborators coming on board. The BMGF representative said there is an integration survey on-going to understand the successes and challenges to integration as well as where integration will need to be further supported.

The USAID representative, Dr Emily Wainwright, said her organization is supporting PC-NTDs implementation in 16 countries. She noted that if 2020 elimination target is to be achieved 2014 and 2015 activities and interventions are critical, especially in improving integration and completing mapping. She stressed the urgency to improve treatment coverage for LF and highlighted that USAID and DFID are collaborating to complete trachoma mapping in countries.

Presentation 4: Partners updates on mapping activities and commitments

Mr Honorat Zoure, representing African programme for Onchocerciasis Control (APOC), presented on the completion of delineation of ivermectin treatment areas in 4 countries (Burundi, Cameroun, Chad, and Equatorial Guinea, with 7 countries being planned to be surveyed in July-August (Congo, Cote d'Ivoire, DRC, Ethiopia, Gabon, Nigeria and Tanzania). He noted that though a Rapid Assessment of the Prevalence of Loaisis (RAPLOA) map exists there are areas of uncertainty needing additional surveys. He stated that APOC Management is updating by district the overlap of loaisis with LF/Oncho. He added that there are requests from 2 countries (Ethiopia and Gabon) to assist in LF mapping but the major challenge is the decrease in APOC funding. It was agreed that AFRO mapping project could support the financial costs of these two surveys in Ethiopia and Gabon.

Dr Elizabeth El Hassan, Sight-savers representative, in her presentation, said the organization is leading a consortium to map trachoma under the Global Trachoma Mapping Project. Under this

project that targeted 38 countries, she said, 1,106 districts (93% of districts to be mapped) have been mapped. However, she observed that the number of suspected endemic districts continues to grow and has increased by around 600 districts that were not originally planned. She highlighted that the project had been used to coordinate mapping with other NTDs (STH, SCH, Yaws and dracunculiasis or Guinea worm disease (GWD) and other initiatives (disability, etc.).

Discussions on Presentations

- Contributions and issues raised during the discussions were:
- In the delineation of ivermectin treatment areas the threshold to commence treatment is 10% mf, and where it is less than 10% but not close to 0% additional entomological surveys will be done to establish whether transmission is on-going. The 10% cut-off point takes into consideration several assumptions and hypothesis that are fully explained in the reference document developed. Where decision to extend treatment is made the implementation unit will be the district to harmonize with LF.
- There is need for drastic changes and investments in LF intervention if coverage is to improve. In some countries the problem may be the denominator being used.
- Improved efficiency in LF mapping (conducting mapping and LF baseline at the same time) will greatly facilitate timely scale up.
- The NTD-RPRG should look at some borderline results obtained from the Global Trachoma Mapping Project (GTMP)-supported surveys and provide guidance on next steps.
- There is need for improved integration and coordination involving AFRO, APOC and GTMP to ensure all mapping needs/requests are adequately taken care of.
- Utilizing random sampling in SCH/STH may be counterproductive since they are highly focal diseases.

Presentation 5: New Diagnostics and Survey tools

A presentation from Schistosomiasis Control Initiative (SCI) on '**Development of a CCA 'true' diagnostic for active schistosomiasis infections**' highlighted the following:

- 4,405 school-age children in Cameroon, Cote d'Ivoire, Ethiopia, Kenya, and Uganda provided urine for POC-CCA assays and stool for Kato-Katz tests. By latent class analysis, one POC-CCA test was more sensitive (86% versus 62%) but less specific (72% versus ~100%) than multiple Kato-Katz smears from one stool
- However only 1% of POC-CCA tests in a non-endemic area were false positives, suggesting the latent class analysis underestimated the POC-CCA specificity. Also Multivariable modelling estimated POC-CCA as significantly more sensitive than Kato-Katz at low infection intensities (< 100 eggs/gram stool).
- The conclusion is that a single urine POC-CCA test can replace Kato-Katz testing for community-level *S. mansoni* prevalence mapping.

A presentation on '**Update on Disease-Specific Tools for Mapping and Monitoring**' from Dr Ottesen had the following key points:

- BMGF is supporting operational research on PC-NTDs which is being managed by the NTD Support Center at The Task Force on Global Health (TFGH) under the 'Filling the Gaps' project.
- The two objectives of the research project are to engage NTD community to set priorities by establishing a coalition for operational research on NTDs (COR-NTD) and to work closely with WHO to build evidence base for programmatic decision making.
- Outcomes of the research have the following new tools available for mapping:
    - LF- strip test
    - Schisto – CCA (discussed by SCI)
    - Oncho – Ov16
    - Oncho/LF overlap – Biplex
    - Loa – CellScope

Dr Maria Rebollo, from the NTD support Center of TFGH made a presentation on **'Lymphatic Filariasis Re-mapping Protocol** ', highlighting the following main points:

- The context is that some countries have uncertainty about whether or not to implement MDA based on their mapping results
- Three re-mapping options are to be considered
    - Repeat standard mapping of adults
    - Conduct TAS among 6-7 year olds
    - Carry out a 30- Cluster sampling survey
- The standard WHO mapping is very effective in classifying IU as endemic. The third new option is designed to be able to exclude areas with no active transmission

Discussions on Presentations

- The presentation on schistosomiasis assessment is well acknowledged as expanding knowledge limits but it may not be useful as an alternative guide to the existing mapping methodology. Countries should continue using the existing WHO guidelines until the provisions are revised by the NTD-RPRG or any other appropriate oversight/coordinating/expert body. The emphasis should not be on how to map better but on how to finish mapping as soon as possible and increase intervention.
- The new tools will be much useful for Monitoring & Evaluation (M&E) and surveillance for verifying elimination than for mapping for starting interventions.

The NTD Regional Advisor, Dr Adiele Onyeze, made a brief presentation on the mapping plan document as well as the budget to complete the mapping surveys - and requested partners to indicate their commitments. **Key Recommendations**

- Mapping needs to be completed in the African region by 2015 if the goal of elimination is to be achieved.
- Community and campaign-based approaches should be strengthened and better coordination in countries to ensure improved coverage of PC-NTDs interventions.
- Human resources gaps within the WHO offices, mainly at the Regional Office (RO) and in the Inter-country Support Teams (ISTs) should be urgently addressed to facilitate the completion of NTD mapping by 2015.

DAY 2 -1ST JULY 2014

The meeting reconvened at 9:00 am with self-introduction of participants who joined the meeting on the same day. The Chairman informed the meeting that the day will be challenging and hoped that any pending questions from yesterday will be addressed today. He pointed out that the lack of interpretation at the meeting may have limited contributions from some of the experts in the meeting due to communication challenges. Dr Adiele Onyeze recognised the challenge and encouraged colleagues who would like to speak French to do so and where interpretation may be needed, participants who are bilingual should assist with interpretation on ad-hoc basis. He appreciated the co-chair Prof Margaret Mafe and proceeded to summarize the agenda for the day.

Session 3: Regional programme Review Group and the Coordination of Technical Reviews

1.0 Regional Programme Review Group (RPRG) Terms of Reference and Mode of Operation: Adiele Onyeze

Key points:

- The 2020 Neglected Tropical Diseases (NTDs) Goals targets the elimination of Lymphatic Filariasis (LF), Blinding Trachoma, Schistosomiasis and Onchocerciasis; including the Case Management (CM)-NTDs-Leprosy and Human African Trypanosomiasis.
- The current Regional Programme Review Group (RPRG) is for all NTDs but the current participation is limited to the PC-NTDs.
- Effective coordination of programme review and guidance is essential to accelerate progress

- There are elimination goals by 2015 for LF, Schistosomiasis and Blinding Trachoma but coverage for PC-NTDs still remain low just 6 years to the target date (except for onchocerciasis)
- Relevant Policies, Strategies, Resolutions and plans and in-country commitments and coordination mechanisms are in place (AFRO Regional Strategy for NTDs, Country NTD Master Plans, and NTD focal point) but improving programme capacity remains a challenge.
- Overcoming the barriers to achieving the 2020 NTD Goals requires key programme decision points with regards to interventions, Advocacy/resource mobilization, Operational Research / Problem Solving & Knowledge Translation to Action, Overall Adequacy of Country PC-NTD and overall adequacy of the Regional NTD programme. These also summarizes the terms of reference of the RPRG.
- RPRG is a technical and advisory Group that provides overall strategic and operational reviews of country and the regional NTD programmes and aims to accelerate the control and elimination of targeted NTDs in the African Region.
- African Programme for Onchocerciasis Control (APOC) and AFRO to serve as co-secretariat for the RPRG; Meeting will be twice per year but could respond to issues on ad-hoc basis and through the establishment of subcommittees.

Summary of Discussion:

- APOC/TCC[1] Group and CM-NTD experts to be incorporated into the RPRG in due course.
- Members of the NTD RPRG were yet to receive formal letter of nomination from WHO AFRO

Recommendations

- WHO AFRO to facilitate the receipt of the formal letter of nomination by the RPRG members.

2.0 Report of RPRG LF subcommittee meeting in April 2014: Njeri Wamae

A meeting of the RPRG LF subcommittee was held on April 23-25, 2014

Key points:

[1] Technical Coordination Committee (TCC)

- The objectives of the Meeting were to review country reports, Joint Mass Drug Administration (MDA) applications and TAS reports and proposals.
- Countries and respective matters discussed include TAS 1 Reports and TAS Eligibility, Mapping and drug applications.
- TAS 1 Reports and TAS Eligibility reports were reviewed and recommendations made for Mali, Burkina Faso, Senegal, Benin, Ghana, Cameroon, Togo, Madagascar, Malawi, Comoros, Sierra Leone, Tanzania, Uganda, and DRC.
- Mapping was reviewed and recommendations made for DRC, Ethiopia, and Senegal.
- Applications for Medicines were considered for Uganda and Tanzania.

Summary of Discussion:

- Formal reports of the outcomes of the RRPRG reviews yet to be received by countries
- Involve in-country partners in the concerned countries in order to help countries comply with RPRG recommendations.
- Clear criteria for RPRG decision making should be shared with partners and national programme managers
- Need to agree on timelines for RPRG interventions for use by the RPRG secretariat.
- A reporting format has been developed for reporting RPRG feedback to countries through the WCOs

Key Recommendations

- NTD-RPRG secretariat (AFRO/NTD Programme) to send the feedback to national programmes timely.
- The WHO Guideline provides the criteria for RPRG decision making
- Disseminate the WHO Guidelines widely among the national programme partners
- Capacity building among NTD-RPRG members
- Send informal NTD-RPRG feedbacks to the national programme managers

3.0 WHO STAG and Working Group Recommendations on PC-NTDs: Jonathan King and Albis F. Gabrielli.

Key points:

- The Strategic and Technical Advisory Group (STAG) advises WHO on global policies and strategies on NTDs.
- STAG consists of 5 working groups namely Capacity Building, Monitoring and Evaluation, Access to quality-assured essential medicines, Neglected Zoonotic diseases and Investments for impact (newly created) working groups .

- Main recommendations in 2014 include supporting countries to increase coverage with integrated interventions; Establishing principles and processes for validation, verification and certification ; Positioning NTDs in the global health/development agenda, sustainable Development Goals (post-2015) Universal Health Coverage, Mobilizing resources for yaws eradication, Accelerating the work to control NZDs and Responding to the dengue epidemic
- Moving national programmes forward would involve monitoring implementation, incorporating new diagnostics and supporting national programme decision making.
- Expanding the RPRG requires 2 types of specific support: Technical and managerial support (hands-on); and Support for technical/strategic programmatic decisions for all PC diseases.
- **Joint Application Package (JAP)** was rolled out as an integrated planning tool and is composed of Joint Request for Selected PC Medicines (JRSM), Joint Reporting Form (JRF), Annual Work Plan (AWP) and PC Epidemiological Data Reporting Form.

Summary of Discussion:

- Countries are increasingly using the Joint Request and Reporting forms
- There is a progressive increase in the number of countries applying for donation of medicines but there is a need to ensure that donated drugs reach the end-users. Logistic capacity at country level is critical.
- The Joint application package should contain the scale-up plan and drug needs.
- All forms could be found online on WHO website
- Late arrival of donated medicines and expiration on shelves at country level
- Delay between mapping and starting MDA.
- Spending too much on mapping may short-change implementation funds
- Need to increase the momentum for LF Elimination by 2020
- The reason why countries do not submit their work plan should be understood and addressed
- Need to translate the WHO Guideline into French

Key Recommendations

- Countries to begin to express interest for 2015 drug needs
- Ensure that drug request and scale-up plan match
- Make national programme managers accountable for drugs requested
- Assign country liaisons in the RPRG to follow up very closely with the national programmes in order to ensure that RPRG recommendations are implemented.
- Countries should establish coordination mechanisms to effectively manage the operations of the national programmes.
- Provide WHO Guideline translated in French.

- Strengthen planning and coordination between national programmes within the MOH and between the MOH and other partners in the country.
- Integration of NTD programmes should be standardized and uniform at country level
- Countries should indicate to the RPRG the challenges that the programme implementers are facing.

4.0 APOC/TCC Updates: Francisca Olamiju

Key points:

- African Programme for Onchocerciasis Control (APOC) was set up in 1995
- APOC Strategy is the Community Directed Treatment with Ivermectin (CDTI)
- The strategy aims to establish within a period of 12 to 15 years, effective and sustainable, community-directed treatment with Ivermectin throughout the endemic areas within the geographic scope of the programme, and, if possible, to eradicate the vector in selected and isolated foci, by using environmentally safe methods.
- Role of APOC/TCC is to track countries from where they are working through the country office level
- Strategic and Technical Issues discussed at the 38th TCC meeting held in March 2014 included Perceptions towards diagnostic tools; Concept Note on Elimination of Onchocerciasis in all hypo-endemic areas by 2020 –Revised version; Alternative Treatment Strategy ; Death to Onchocerciasis and Lymphatic Filariasis (DOLF); Re-launching of CDTI activities in CAR; Rolling Out New Tools to Support the Elimination of Lymphatic Filariasis and Onchocerciasis
- APOC is to recruit a resource mobilization officer to work closely with partners including the Global Network for Neglected Tropical diseases (GNNTD).
- APOC is to transform into PENDA

Summary of Discussion:

- APOC's target of 20% to scale up LF coverage increase is inadequate.
- Guidance required on how to handle APOC's transition at country level
- Engaging humanitarian organizations to implement in countries facing civil conflicts
- AFRO to receive all LF reports and link up with the Joint working Group.
- APOC/TCC to become a sub-committee of NTD –RPRG eventually.

Key Recommendation

- Explore opportunities of working with humanitarian organizations in areas in civil conflicts

Session 4: Review of mapping data and results

1.0 Country dossier folders Structure and key documents for review by RPRG: Alexandre Tiendrebeogo

Key points:

The structure of the folder and the key documents for review by RPRG were presented as follows:

- Structure of the country dossier folder
- Contents in the country dossier folder: National plan, treatment data reporting forms, drug request form, mapping, TAS, etc.
- Key documents for reviewing scale-up plan
- Key documents for thematic review-Drug request, TAS, Mapping

2.0 RPRG Summary Recommendation Form (Module: MAPPING): L.A. Tchuem Tchuente

Key points:

Brief summary review of the documents to be submitted concerning mapping of NTDs using the questions below

- Methodology used and adherence to WHO recommended standards.
- Quality assurance
- Appropriateness of programme decisions
- Resources available

3.0 Country Progress Reports on PC-NTDs implementation

1) Nigeria; LF, Schistosomiasis and STH

Key points:

- Nigeria carries 25% of Africa's NTDs burden
  Most of these diseases are co-endemic in all the States

Challenges:

- Few advocacy champions from the political and corporate organizations.
- Inadequate trained personnel and logistics for supervision, monitoring and evaluation at the zonal level
- Late and non- release of counterpart funds
- Irregular meetings to monitor levels of compliance to State plans
- Poor resource mobilization skills of programme managers.
- Low motivation of personnel to perform tasks, especially reporting
- Medicines arrive at different times constraining coordinated/integrated distribution.
- Insufficient trained health personnel to carry out Community-wide drug distribution using existing health systems
- LF base line in 21 Senatorial districts in 9 States not yet done which hinders scale up
- Support for mapping CM-NTDs and MMDP still minimal
- Medicines arrive at different times constraining coordinated/integrated distribution.
- Insufficient trained health personnel to carry out Community-wide drug distribution using existing health systems
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Key Recommendations

- More advocacy champions targeted at the various geo-political zones and support by government and partners needed.
- Funding support required to complete mapping and baseline studies for LF as well as up-scale training and distribution (particularly for LF MDA).
- Improved funding support for coordination and supervision/monitoring by HQs and zonal offices
- Greater visibility and support for CM-NTDs needed. So far, they seem to be the 'neglected' in Neglected Tropical Diseases.
- Coordinated shipment of medicines donated for PC-NTDs.
- More coordination of NTDs with Malaria and HIV/AIDS to improve support for community implementers.

2) Ethiopia: Schistosomiasis and STH

Key points:

- 5 ecological zones
- The National Survey on Blindness, Low Vision and Trachoma of Ethiopia in 2006:
- Currently, the Onchocerciasis programme has been integrated well with the community based health programme (HEP) with strong participation of Women Health Development Army

Challenges:

- Assigning clearing agent without knowledge of Federal Ministry of Health (FMOH) leading to delay in drug clearance from customs, thus impacting on MDA timeline
- Delay in budget disbursement
- Financial shortage for MDA

3) Cote d'Ivoire: LF, Schistosomiasis and STH

Presented the NTD programme overview and mapping data.

The country is co-endemic for ten NTDs of which the 5 PC-NTDs and 5 CM-NTDs (Buruli ulcer, Guinea worm disease, Human African Trypanosomiasis, Leprosy and Yaws). All PC-NTDs overlap country-wide exception of Trachoma which appears to be limited to some regions of the country.

To address these diseases, the country established an integrated NTD programme which covers PC and CM NTDs and is funded by external donors and national budget, which contributions for 2013 were USD 740,501 and 521,920 respectively.

Mapping of PC-NTDs is still incomplete with the following gaps (14 districts for LF, 39 districts for SCH and HTS and 12 districts for Trachoma). PC Coverage is still low for LF (10 %%) but high for Onchocerciasis (98%). Treatments have not yet started for the 3 other PC-NTDs (SCH, STH and TRA). Expected first TAS is scheduled in 2016.

4.0 Group work: RPRG Assessment of the NTD Mapping data and results –Adiele Onyeze

At 4:00PM there was an introduction to Group work on RPRG Assessment of the NTD Mapping data and results. Participants were assigned to 3 Groups; each Group was to work on the Dossier of Nigeria, Ethiopia and Cote d'Ivoire respectively. RPRG members, rapporteurs and secretariat officers were assigned to each Group.

Each Group was expected to present their report at plenary the next day.

The meeting closed at 5:30pm.

DAY 3 -2ND JULY 2014

Session 5: progress towards elimination of PC [2] -NTDs and review of PC-Medicine Applications

1.0 Report of Group Work on Review of mapping surveys and data

The RPRG sub committees presented summary recommendation for the three countries (Nigeria, Ethiopia, and Cote d'Ivoire) on the applications submitted concerning mapping of NTDs using the standard RPRG evaluating format.

The subcommittee of the RPRG looked at the mapping report country by country considering the methodology used by countries for mapping, use of WHO standard protocols, quality assurance processes and availability of resources.

Based on the above parameters and outcome of the review, RPRG has granted the following general and country specific recommendations.

General recommendations

- WHO to develop more structured reporting format for countries to submit their country report on mapping of NTDs to RPRG.
- Consolidate inputs on the RPRG evaluation format and develop a standardized reporting format. Small group to review as per the consolidated inputs.
- An iterative process between the country office and the secretariat (AFRO) to support the development of on time proposals. The RPRG should then be made aware of issues in the application that require a judgment call
- The secretariat (AFRO) should provide clear instructions to countries so that complete reports including quality assurance procedures are reported in the future.
- We should avoid confusion between "ecological zone" and "geographical zone". Ecological should be referred to environmental factor favourable for the transmission of schistosomiasis (SCH). Therefore, districts/sub districts or equivalent administration geographic zone should be IUs as needed rather than using ecological zone as IUs.
- Use of retrospective university data for mapping should be looked at carefully and the methodologies used should be explicitly scrutinized and can be brought to the attention of RPRG for decision.

Specific observations and recommendations by country

1) **<u>Nigeria</u>**

Observations

[2] Preventative Chemotherapy

- The program didn't receive specific instructions on how to report their mapping results and therefore they have only submitted a table indicating the list of LGAs by state and results. However, the national NTD programme manager has confirmed to RPRG that they have done it using the standard WHO mapping methodology.

- The program manager has reported to the RPRG that the mapping procedure meets the minimum WHO recommended standards.

- In addition, "US Fund for UNICEF" is considered to provide funding support for two states.

Recommendation

The RPRG has approved the mapping date and advised the program to go ahead and submit drug application for those LGAs with ICT results of 1% and above.

2) **Ethiopia**

Observations

The RPRG has noticed that AFRO Guidelines were used; threshold for action was met for the mapping exercise of LF, SCH/STH, TRA and ONCHO, enough evidence that mapping followed WHO guidelines and interpretation of results is acceptable and fit for request for medication. Efforts to validate reported results/Process of quality assurance were not done for LF. However, validation was done by re-examining 10% samples by an independent observer for SCH/STH.

Recommendations

- The RPRG has approved the mapping date and advised the programme to go ahead and submit drug application for those districts with ICT results of 1% and above.

- For the four non-malaria districts where the LF prevalence 1% or above, the RPRG has advised the programme to go for Mass Drug Administration (MDA) and conduct operational research to supplement the mapping results.

3) **Cote d'Ivoire**

Observations

No sufficient data to review the mapping report of Cote d'Ivoire and the RPRG recommended the following.

- The review subcommittee to closely follow up with the country programme manager and get sufficient information to review their application before the end of the meeting.
- The programme manager to submit the adequate information by tomorrow.

2.0 Progress and elimination of PC - NTDs

Presentations on elimination of Lymphatic Filariasis (By Dr Amadou Garba), Elimination of Onchocerciasis in the African Region (by Dr Francisca Olamiju), Elimination of blinding trachoma (By Dr Paul Emerson) and Control and elimination of SCH/STH (by Prof Alan Fenwick) were presented and the following key points were highlighted from these presentations.

Lymphatic Filariasis Elimination

Key points

- Status of the Programme to Eliminate LF in Africa, by country, 2012
    - MDA not started: Angola, Chad, Congo, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Gabon, Gambia, Guinea, Sao Tome and Principe, Republic of South Sudan, Zambia, Zimbabwe
    - MDA <100% geographical coverage: Central African Republic, Côte d'Ivoire, Guinea-Bissau, Senegal, Madagascar, Benin, Cameroon, Ethiopia, Ghana, Kenya, Liberia, Mozambique, Uganda, United, Republic of Tanzania
    - MDA at 100% geographical coverage: Burkina Faso, Comoros, Ghana, Malawi, Mali, Niger, Sierra Leone
    - Post-intervention Surveillance: Togo
- MDA Scale-up: Uneven Progress in Countries and Need to focus on the Big 4 countries
- Transmission assessment survey in 2014
    - Togo stopped MDA, TAS 3 planned in 2015
    - 15 countries need to conduct TAS in 2014 (B.Faso, Benin, Cameroon, Ethiopia, Ghana, Madagascar, Malawi, Mali, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, Guinea Bissau)
    - Need to organize training workshop on TAS for NTD programme managers
- Challenges
    - Slow move from mapping to implementation
    - Low geographical coverage in high populated countries (Nigeria, Ethiopia, Angola, Mozambique, DRC, Cote d'Ivoire)
    - Late and slow MDA implementation after the mapping
    - Timely request for PC medicines
    - Funding for MDA implementation and M & E

    - Weak coordination mechanism
- Scale up interventions towards elimination of targeted NTDs NEEDS "Coordination of MDAs" through;
    - Effective country coordination mechanism
    - Coordination of support to countries
    - Resource sharing
    - Timely drug forecast and delivery

Elimination of Onchocerciasis in the African Region

Key Points

- New Objectives for APOC: "Eliminate onchocerciasis in 80% of endemic countries in Africa by 2025."
- 23 African countries may achieve national onchocerciasis elimination by 2020. However, 3 additional years support are required for post-treatment.
- Good Epidemiological Results from Burundi, Chad, Ethiopia and Malawi
    - What can we learn from these countries?
    - What shall we do to start stopping treatment?
- Poor epidemiological Evaluation results in Cameroon, Congo, Nigeria, DRC and Tanzania
    - Cross border issues- movement between countries, Burundi-DRC; Uganda-DRC-S. Sudan; Malawi-Mozambique; Tanzania-Burundi; Chad-Cameroon-CAR; Nigeria-Benin; Ethiopia-Sudan; Congo-DRC
- Sites with satisfactory phase-1a and phase-1b results are expected to submit dossier to the APOC TCC[3] for guidance

Elimination of blinding trachoma

Key points

- 21 countries in the African region are endemic to trachoma. In 2013, 19 out of 23 endemic countries distributed Zithromax in 1361 districts. A total of around 46, 731, 579 populations reported to have received Zithromax in 2013.
- Currently only 33% of the known endemic districts are actively engaged in the programme.

[3] Technical Coordination Committee (TCC)

- Map of trachoma will be completed in the African Region by April, 2015.
- Focus countries: Ethiopia, Tanzania, Nigeria and Chad. 40% of the efforts should be put in Ethiopia

Challenges

- Efficient use of financial resources by countries and implementing partners (New resources are coming).
- Provision of surgical service and supply of consumables
- Political commitment
- The capacity of country level MoH and partner staff to deliver and monitor based on the new guidelines
- Another greater challenge is TIME.
  "Perfection is illusive and waiting for perfection is a problem"

Control/elimination of SCH/STH

Key points

- WHO estimates of numbers needing treatment: 250, 000, 000
- 2012 estimates of schistosomiasis treatments: 42,107,931

Partners Support for African Country

- USAID support: Benin, Burkina Faso, Cameroon, DRC, Ethiopia, Ghana, Guinea, Mali, Mozambique, Niger, Nigeria, Sierra Leone, Togo, Tanzania, Uganda
- DFID support: Cote D'Ivoire, DRC, Ethiopia, Liberia, Niger, Nigeria, Malawi, Mozambique, South Sudan, Tanzania, Uganda, Zambia, Zanzibar.
- SCI support: Burundi, Rwanda, Madagascar, Mauritania, Seychelles, Sudan, Zimbabwe.
- End fund: Angola, CAR, Namibia, Rwanda, Zimbabwe
- Others: Botswana, Chad, Congo, Eritrea, Gabon, Gambia

PZQ donations for 2014 implementation

Donor	Tablets donated (600mg)	Recipient countries
Merck KGaA	75,025,000	18
USAID/RTI-FHI	91,000,000	10
DFID/SCI	79,300,000	10
World Vision	41,283,000	5
World Bank	18,000,000	1 (Yemen)
TOTAL	160,314,500	33 (due to overlapping)

- Elimination of Soil-Transmitted Helminthiases (STH)
  - LF elimination programmes treat STH
  - GSK and Johnson and Johnson donations mean the drugs are available for school aged children
  - New funding for implementation and operational research available (CIFF[4] and Gates Foundation) announced in Paris in April 2014
  - But the drugs do not clear 100% of worms
  - Reinfections may be rapid because treating only children has no chance of stopping transmission

Key points that came out of the discussion on the above 4 presentations

- Strengthening Linkage of WASH and NTD in general and trachoma in particular (taking in to consideration SAFE strategy). Importance of integrating WASH in the NTD programme. The need for High level advocacy and tools for integration.
- Explore the new partnership and collaboration in the area of WASH and of strong engagement of our WASH colleagues for SCH/TRA/SCH;
  - Water Aid, Care, SAFE, DFID, UNICEF are interested. Children Without Worms (CWW) to pool them.
- High level advocacy visit to big countries to bring government commitment and strong coordination mechanism at country level
- High level AFRO leadership for big 5/6 countries
- There is a need for huge financial resource for the implementation of all aspects of NTD interventions (Mapping , MDA, Post MDA surveillance and M&E)
- Once the RPRG is fully established, issue of technical guidance should come from RPRG for SCH/STH
- Strengthening Post MDA surveillance to secure the gain made in countries where LF are eliminated.

Specific recommendation for Gambia

- Gambia to formally submit the report for RPRG
- RPRG to look at the report of Gambia and provide technical guidance based on the review.

4) NTD medicines

Presentation made on NTD Medicine and RPRG medicine application and PC scale up plan template.

[4] Children's Investment Fund Foundation

Key points from NTD medicine presentation

- Forecasting (medicine & ICT Card)
    - Master plan including TAS plan for all the LF programs
    - Intensified advocacy for funding
- Timeliness of the drug delivery to the countries
    - Ensure purchase orders placed on time: Creation of the NTD supply chain forum to share experiences and discuss efficiency strategies
    - New taxes imposed on the shipments (informatics taxes) with drugs held at the airport
- Rational use of the medicines
    - Improve programme and drug application review (annual report with transparent inventory report, annual plan, epidemiological data)
- Safety
    - Promote best practices ---> Training of the distributors (teachers and Community Drug Distributors (CDDs))
    - Need to report all adverse events to comply with the new FDA & EMA regulations on safety (discussions are ongoing)

Key point from RPRG medicine application and PC Scale up plan template presentation

- Joint Application Package (JAP)
    - Introduced in each WHO Region in 2013
    - A planning tool, rather than just an application form for WHO-managed drug donations
    - MoHs are invited to submit the JAP to WHO electronically, at annual intervals
        - Deadline for submission is 15 August
        - In 2014 you report on <u>2013 implementation</u> and plan/request drugs for <u>2015 implementation</u> 2-year transition phase (2012-2013)
- Applications are reviewed by independent bodies established in each Region and coordinated by WHO ROs

Issues presented

- Inconsistent data on sub-national level endemicity status and coverage among different forms/documents
- Delay in submission of the annual reports and drug applications, resulting in delays in drug shipment
- Many national programmes are not well informed of transition from the old disease-specific forms to the JAP and submission deadline
- Lack of comprehensive programmatic review and guidance to the national programmes

Discussion and recommendations

- Strengthen donor Coordination to improve the timeline of drug shipment. There is an existing effort and a forum by drug donors to coordinate themselves to ship drugs at the same time
- The need for careful, well and advance planning and forecasting of drug
- Make sure that RPRG has all level of information during the review (implementation process, drug application, distribution, donor shipment timeline)

Session 6: Review of PC-NTD Scale up Plans (Group Work)

See the group work reports on the review of Country PC-NTD Scale up Plans for Cote d'Ivoire, DRC, Ethiopia, Nigeria, and Tanzania.

DAY FOUR: 3RD JULY 2014

The meeting began at 8.35 AM with the introduction of new members. These were mainly from Global Network for NTDs (GNNTD) and the Schistosomiasis Control programme in Kenya.
This was followed by two presentations for day 4 which were made by Ms. Juliet Ochieng (WHO AFRO) and Mr. Neeraj Mistry from GNNTD.
Also addressed were the report of the group work of previous day's agenda items on "PC medicine, NTD Scale up plans and Transmission Assessment Survey (TAS) plans", was presented by the groups. These items in Session 6 were presented after the above-mentioned 2 presentations included in Session 7 were done to allow one presenter to catch his return flight.

Session 6 (Continued): Feedback from Group work – PC medicine, NTD Scale up plans and TAS plans

Highlights: See presentations

Discussion Points:

Different groups presented their findings which have been included in the summary reports for each country. However, other general points discussed were,

- Kenya to provide formal feedback on reasons for Praziquantel drug expiry to support RPRG decision. However, it was noted that the packaging of drugs could be among key reasons that contributed to the expiry of the three million tablets.
- Angola: Since MDA in Angola has been extended to December 2014, the approved PC medicines to be shipped to Angola should now be channelled to Ghana. Angola country office should be supported to provide more technical support to the MOH in Angola.
- Cote d'lvoire: The country should make effort to follow up progress on the establishment of LF sentinel sites and also adhere to recommendations made during the 2nd Partners meeting held with APOC, CNTD, SS and SCI. Correct feedback should consistently be provided by the country to all Partners. Partner commitments should also be sought so that the programmes don't stop before results are achieved.
- Tanzania: The country should provide data available on initial LF mapping and any other that took place thereafter to enable RPRG provide constructive feedback on the scaling up plan.
- Malawi: TAS request from Malawi was commendable. It was agreed that MDA should start and followed by TAS.
- Ethiopia: Drug request for Ethiopia was for 2014 MDA. The country was requested to submit a request for 2015 by the 15 Aug and ensure all relevant documentation is submitted.

General recommendations for the day

NTD Coordination and Advocacy:

1) There should be proper packaging of NTD messages, preferably those addressing an integrated approach to NTDs. This should be uniform for AFRO. There should be prior knowledge on what to voice, to whom, and through what messages. The needs at the country level are of utmost importance and should be closely followed and supported.

2) WHO country offices should play the convening role to ensure countries are supported to reflect resources that will be required to speed efficiency in countries as a whole and not a slice of it.

3) RPRG focus at strengthening such support in countries; and where possible, leverage power by building in-country strengths that would avail them time for technical guidance.

Discussions on PC medicines/treatment:

4) There is need for team be in place to prepare an accountability framework for NTD Donated drugs

(Pharmaceutical companies – provision of drugs; WHO –guidance and efficiently delivers the drugs to countries; RPRG – review requests, approves and provides technical guidance to national programmes; countries – getting the drugs to people)

5) Packaging of Praziquantel needs to be reviewed.

6) Communities should be prepared on stop of NTD treatment.

TAS:

7) We could start thinking on integrated TAS

Session 7: Advocacy and Resources Mobilization for National NTD Programmes

Presentation 1: Progress towards Improving Advocacy, Coordination, and Resources mobilization for the National NTD Programmes

Highlights:

The presenter, Ms Juliet Ochienghs, begun by recalling the vision and goal for NTDs, and the World Health Day Theme on vectors 2014, which reads – *Small Bite, Big Threat*. She reiterated on the growing momentum against NTDs globally and that all Member states, Partners, and multilateral organizations are indebted to put more effort to ensure elimination is achieved by 2020. She shared the various resolutions, guidelines, strategies and commitments made at the global and regional levels that have further raised the NTDs portfolio and momentum. Few examples were "Accra call to Action", NTD Master Plans in 36 countries, WHA66.12 Resolution on NTDs, RC66 Adopting Regional NTD Strategy and Resolution, Guide for NTD Country Coordination Mechanisms, the social media and NTDs, and other HLMs, African Union (AU), and Economic Community of West African States (ECOWAS), and workshops that are to take place this year.

A situational analysis 2012 of the existing coordination structures in the MOHSW, i.e. the NTD Secretariat, Technical working groups and Steering committees where all reported to be below 50 percent. The same was also reflected in the few countries that were present in this meeting. The presenter shared the required structures and Terms of Reference for all bodies emphasizing need for coordination bodies in countries. She said RPRG should be informed on those responsible within Ministries of Health to assist timely and reliable feedback should an imperative decision be made.

Presentation 2: What role can RPRG play in Strengthening advocacy and resource mobilization for national NTD Programmes

Highlights:

The presenter, Mr Neeraj Mistry, begun by informing all present that they are the ones who know NTDs very well. Therefore, they have the responsibility of conveying the right messages to the rest of the world. He reassured everyone that one does not need to have a particular type of skills set to be able to properly advocate for NTDs, but rather, it's a role that everyone need to play and apply through the skills they already have. He briefly highlighted on the definition of advocacy stating that it's a concerted effort to influence policies and, or budgets by gaining the support of key decision makers. In-country advocacy for NTD therefore comprises the efforts to ensure country ownership and predictable, long-term financing.

The presenter mentioned the various challenges facing effective NTD control and implementation in countries some of which include, governments being challenged by competing health related plights, financial and human resource constraints, lack of advocacy and resource mobilization capacity by the programme teams but also lack of avenues where discussions regarding NTDs could be held with high level officials in the Ministry.

He gave few recommendations which included proper packaging of NTD messages, preferably those addressing an integrated approach to NTDs, creation of avenues in countries that facilitate NTD discussions in high level policy meetings and bilateral and multilateral meetings. The NTD team should know what to voice, to whom, and through what messages. The needs at the country level are of utmost importance and should be closely followed and supported. He reiterated that RPRG will be an instrumental group in supporting countries to ensure good linkage of the NTD agenda with other developmental issues happening at country level.

Discussions and Recommendations from the two presentations

Members acknowledged the significance of the two presentations and further shared various weak points already noted in NTD coordination and implementation in countries. Amongst them were, NTD programmes not riding in the entire health system structures, weak coordination at both national and districts levels, some partners personalizing relationships with few NTD officials in countries. It was therefore stressed that RPRG focus at strengthening such support in countries before it is too late; and where possible, leverage power by building in-country strengths that would avail them time for technical guidance. WHO country offices should play the convening role to ensure countries are supported to reflect resources that will be required to speed efficiency in countries as a whole and not a slice of it. GNNTD reported that they were now moving to supporting in-country advocacy of which will soon commence in India and Nigeria. Donations from the non-health sectors will be explored. GNNTD was advised to tap private sector resources mobilization skills from the End Neglected Diseases (END) Fund.

Dr Onyeze reported that WHO is moving towards this direction and that RPRG subgroups will be formulated to address the various key important areas.

DAY FIVE: 4TH JULY

The Chairperson Pr. Moses Bockarie and the vice-chair Dr Bertrand Sellin opened the meeting and noted the items in the previous day agenda.

Session 8: End-Game Decision Making

8 A: Transmission Impact Surveys for Trachoma

Trachoma Transmission Impact Surveys (TIS) Assessment & Surveillance Plans

Highlights of the presentation:

Trachoma TIS survey results were provided by the presenter. On the basis of the results of these TIS, Burkina, Burundi, Mali, Mauritania, and Gambia performed very well with the intervention and had achieved the goals of the minimum of TT and TF prevalence.

Ethiopia in contrary had not achieved the goals and need to continue for another 3 years before conducting TIS.

However Niger and Guinea performances were intermediary, they have not achieved the goal but they are on satisfactory track.

Discussion Points:

The timing to conduct the Trachoma TIS should be after implementing 3 years of effective MDAs.

- Trachoma Transmission Impact Survey (TSI) in school: School population is not the appropriate target to evaluate Trachoma intervention through Trachoma TIS. Since the method uses to generate the prevalence of TT and TF to trigger intervention is based on the community, to evaluate the impact of the intervention, the survey target should be a good representation of that community. Since school, especially when the school rate is low does not represent the community. Several studies concluded that such sub-group attending school cannot represent the entire population/community.
- The participants noted that Tanzania also had conducted TIS, but these results were not reported in the presentation.
- It was pointed out by Dr Emmerson that the end-game is the elimination of the blinding Trachoma.

Recommendations:

The meeting pointed out that it would be necessary for the RPRG to review Trachoma report alongside the other NTDs. Dr Onyeze informed the meeting that Trachoma reports will be reviewed by the RPRG at the next RPRG meeting.

8 B: Transmission Impact Survey for Schistosomiasis and Soil-transmitted helminthiasis

Highlights of the presentation

Discussion Points

- The time has come to agree on elimination goals and develop the guidelines for country.
- There is a need of ancillary measures to MDAs to achieve the elimination of SCH. These ancillaries include WASH measures, social mobilization and community participation, as well as case management or morbidity management.
- SCH programmes were at the beginning set up for morbidity control only. Now, there is a momentum change and programmes are shifting to elimination goal. Therefore, if a country wants to move to elimination, there are guidelines developed by WHO that speaks to the strategy, what was missing is the verification guidelines which WHO should work on to guide countries.
- Nevertheless, the meeting noted that many countries are fare from reaching the elimination milestones due to the insufficient of donated drugs donated to countries for MDA at this stage.
- There is a draft strategy for SCH control and elimination for African region that could be put before the RPRG for further recommendations to finalize the guideline.

Recommendations:

- The meeting emphasized on the fact that countries and programmes should follow WHO guidelines for disease control/elimination

Session 9: RPRG Assessment reports and recommendations

Presentation by Dr Tiendrebeogo, the groups work format and tasks.
Dr Onyeze, call for making sure that the groups work to have a final recommendations and report to send to countries.

RPRG Members closed door meeting

They informed the meeting that there is a closed door session for RPRG members from 12:30 to 2 pm to discuss important matters.
See report in Annex

Plenary report of groups' work

The plenary reconvened at 3 PM after the group work and the closed door RPRG members.
The report of the work group started with the English.
See report presentations in the Annexes

RPRG Final Recommendation (see Franca & Chukwu presentations)

Other Matters

Issue on confidentiality

Dr Onyeze informed the meeting on the confidentiality related to country data provided to members to enable proper review of country reports and requests in order to make appropriate recommendations to countries. He reminded the RPRG on the confidentiality agreement that is made for accepting to participate at the meeting and that the official signature will come with the letter of nomination signed by the WHO director and which is to come.

Meetings to come

Dr Tiendrebeogo informed participants on the coming meetings dates.
The next RPRG meeting will be held in November 18th to 22nd 2014. The venue will be communicated in due course.
The other meetings announced were:

- NTD master plan workshop for Anglophone countries in Zambia, Lusaka, 21-25 July, 2014 with training work shop for data manager
- The Francophone countries NTD Master Plan report and data manager workshop meeting will be held on 12-16 August, 2014. The venue will be communicated in due course.

AFRO NTD Programme's Video

A video was projected to participants

- On behalf of the 5 countries invited to attend the meeting, Dr Kirumbi expressed the gratitude to RPRG members.

- WHO HQ Representative, Dr King said that he was very enthusiastic to attend his first RPRG meeting. He had learnt a lot and that the HQ will continue to support such meetings.
- Partners: Dr Ottesen appreciated the fact that the meeting was organized after 3 years which in itself is a big accomplishment. He also said that partners ought to help ensure stability and hope that all the current partners will continue to be engaged and be involved in the meeting.
- Professor Moses Bockarie, on behalf of the RPRG members, thanked participants at the meeting. He expressed the hope that the human resource will be addressed timely.
- On behalf of colleagues, Dr Onyeze also thanked participants for attending the meeting. He was happy that it was a good beginning which in itself was a milestone going forward. There are more country engagement and scaling up intervention. Moreover, that the RPRG will help the decision making of countries moving. The RPRG is a great key to solve countries issues with regard to country NTD. He will be available to assist the NTD programme. Assured all for WHO AFRO engagement.
- The Vice chair (speaking in French) also thanked all the participants for attending the meeting which was very productive.

ANNEXES

1. Annex 1: Summary table of recommendations to countries from the LF-RPRG Sub-committee meeting in April 2014
2. Annex 2: Summary table of recommendations to English-speaking countries from the NTD-RPRG 1st meeting on PC in July 2014
3. Annex 3: Summary table of recommendations to French-speaking countries from the NTD-RPRG 1st meeting on PC in July 2014
4. List of participants at the NTD-RPRG meeting

ANNEX 1: RPRG APRIL 2014 MEETING SUMMARY RECOMMENDATION AND DECISION TABLE

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Angola	• PZQ	• AFRO needs to negotiate with Angola and Ghana, and with other key partners, how PZQ needs for Ghana could be met from approved consignments for Angola. • The RPRG recognized that it is important that the Mectizan needs to be secured to sustain MDA for the ongoing onchocerciasis interventions in the country.	• WHO AFRO should encourage the Angolan authorities to hold an all-encompassing stakeholders meeting to discuss the way forward on NTD implementation
Benin	• Report -6EUs (8IUs) for TAS1	• It was noted that TAS was implemented in 23 IUs in 2012.	• The RPRG approved the programme decision to have stopped the MDA in the 23 IUs. • The RPRG also requested the programme to share the results of the first post-MDA TAS conducted in 2014 for their review as soon as completed.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Burkina Faso	• Eligibility 4EUs (8IUs) for TAS2, 4EUs (11IUs) TAS 1	• The RPRG commended the programme for great progress that is being made to provide MDA for multiple rounds to all endemic areas and for good data and for an M&E plan. • TAS 2 is approved (for surveillance) but there is the need to ensure that TAS 2 is conducted at least 2 years after the previous TAS in the 4 EUs which are eligible for the first post MDA TAS. • To share with AFRO the results of the 8 EUs' TAS for RPRG review.	• RPRG approved TAS activities for the 4 EUs for which the TAS was requested to stop treatment. • RPRG also mentioned that justification on the 2 separate IUs in EU7 with only one spot-check site should be provided. • RPRG underscored the needed to ensure that the TAS target population for UE "Nord1" does not exceed 556 children filled in the eligibility form. • The RPRG approved all the new EUs for TAS 1 and added that the 2 separate IUs in EU 7 with only one shared sentinel site should be justified.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Cameroon	• Eligibility - 2EUs (9IUs) for TAS1	• The Review Group reiterated the need to conduct two additional rounds of PC in Muheza and Newala districts and then conduct an additional pre-TAS assessment. • RPRG noted with concern that many IUs have < 65% of coverage during the first 3 years. • The Review Group was also concerned that the WHO recommended protocol for the Pre TAS survey was not used. • RPRG emphasised importance of observing distance between the sampled villages in order to facilitate the interpretation of the validity of the results. • It was also noted that the coverage data did not support the implementation of the TAS (not 5 effective MDA coverage) • The Review Group questioned the selection of the sentinel survey sites. The national programme selected 5-6 neighbouring villages per EU, but each village had less than 300 people because they were unable to find villages that contained more than 300 people due to logistic problems. They used Mf prevalence for pre-TAS and all areas were 0%. Request for further clarification or justification about the methods of survey site selection would be required (e.g. distance between villages, population in those villages, how was baseline surveys conducted).	• RPRG mentioned the need to submit the drug request in line with the submission deadline in 2014 (August 2015). • The Review Group disapproved the programme request to conduct TAS because the Pre-TAS did not follow WHO guidelines. • Where feasible and resources exist, RPRG recommended integrating assessment of STH with the TAS surveys.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Comoros	• TAS Report	• The RPRG noted with thanks the TAS report submitted by Comoros, which highlighted that 1591 children were tested and 49 were ICT positive, exceeding the critical threshold of 18.	• Comoros to conduct two additional rounds of MDA across all three islands. If high coverage is achieved, sentinel sites and spot check surveys should be conducted to determine eligibility for a subsequent TAS.
Congo	• ALB, IVM, PZQ	• RPRG will continue to monitor the deadline set for Congo's drug supply.	• The RPRG approved requested to submit the drug request for ALB, IVM, PZQ in line with the submission deadline in 2014 (August 2015) for ALB, IVM, PZQ.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
DR Congo	• Coordinated Mapping for LF, Schisto and STH	• WHO/AFRO should consult CNTD regarding the validation support. • The RPRG encouraged data assessment for validity of mapping data. • During validation of data, baseline data collection should be done in appropriate transmission zones. • The validation of data should be performed by an independent person such as WHO/AFRO consultant. • The RPRG pointed out the need to assess the capacity of the DRC team to undertake MDAs for LF, Schisto and STH and the probability to build local capacity. • The RPRG raised questions regarding the accuracy and reliability of the mapping data due to some of the following: • Missing data, • Some survey villages much closer to each other than the recommended 50km distance apart, • There are numerous areas with '0' mf and these should be validated in particular and where necessary using more sensitive tests such as the serology antigen test' WB123' for LF. • The Review Group noted that the data on morbidity is limited hence it should be checked for completion.	• High Schisto risk communities should be included for MDAs where ever they exist • The RPRG pointed out that the Schisto MDA plan should show inclusion of non-enrolled SAC. • The Review Group also agreed that a map to indicate Schisto transmission foci by dot would be useful for reviewer. • It was agreed that for validation of the data, funding should be sought from the original Funder the CNTD. In case CNTD cannot fund the validation, then either WHO/AFRO, ENVISION or SCI could be approached.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Ethiopia	Ethiopia-LF mapped Woreda and Community 21.01.2014	• The RPRG acknowledges and congratulated Ethiopia on the rapid progress that has been made to map all Woredas for lymphatic filariasis. • The RPRG noted the difficulty in the decision to commit resources for implementing preventive chemotherapy for five years in woredas where the proportion of persons determined to be infected, defined as a positive immunochromatographic test (ICT) result, is about 1% which is threshold for indicating endemicity. • Currently, the protocol for such assessments is yet to be fully defined. Any strategy utilized would be considered as operational research.	• Ethiopia NTD programme needs additional data collection in more sites. • Advises AFRO/NTD programme to consider adopting a protocol for survey of low prevalence areas (prevalence of 1%). • AFRO is requested to work with relevant task force for NTDs to propose a protocol for review by the RPRG. • Following extensive deliberation, RPRG recommends that Ethiopia conducts additional investigative surveys in order to assess transmission in some areas with borderline results or where it could not be confirmed that the right procedures were followed.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Ghana	• Joint Request form for Selected Medicines for Preventive Chemotherapy (JRFSM) for the year 2014 • Joint Report Form (JRF) on Mass Drug Administration carried out in 2012 • Transmission Assessment Survey (TAS) eligibility Dossiers	• The national programme submitted the JRF 2012 and JRSM 2014 in April 2014. The national programme should submit the treatment data in 2012 and the drug request for 2015 in line with the submission deadline for 2015 (August 2014). • The national programme should provide reasons for the slow pace in scaling down PC interventions for LF as planned in the NTD Master Plan. The country is also requested to submit an updated scale-down plan for all relevant PC diseases in the country to WHO/RPRG for further guidance. • With regards to the conduct of TAS, the programme should: • Combine, where feasible and the total population of the joined EU is still within the recommended limits, EUs sharing borders and having similar programme progress to conserve resources. • Continue PC within the implementation units of EU 20, 21, and 23. This may include integrating the distribution with other public health campaigns. • Consider entomological studies to provide further information on current transmission risk.	• The drug request for Albendazole and Ivermectin is approved. Decision on the drug request for PZQ is pending, and will be communicated in due course. • Ghana is commended for the extensive pre-Transmission Assessment Survey (TAS) data collected in all Implementation Units prior to considering TAS. TAS in all Evaluation Units (EU), excepted EUs 20, 21 and 23, is approved to be conducted. • TAS is not approved for EUs 20, 21 and 23 since there was less than 4 rounds of effective coverage (>65%) in the concerned Implementation Units (IUs)
Madagascar	• Report - 1EU (1IU) for TAS1 and Eligibility - 1EU (3IU) for TAS 1	• The RPRG commended the well prepared presentation and the TAS plan submitted by the national programme by Madagascar. (The TAS protocol has been reviewed by the Task Force). TAS plan is well thought out and should be carried out. • The initial TAS carried out in Nosy Boraha was well conducted and the EU approved. TAS is now	• In light of the funding gap for the planned TAS and new resources available for STH, RPRG suggested that an integrated LF TAS with STH surveys should be considered.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
		planned for 3 IUs combined to form one EU.	
Malawi	• Pre-TAS Eligibility Form • Country Summaries, 2012 Annual Report and the 2014 Pre-TAS Sentinel Site Survey Proposal (Malawi and CNTD)	• RPRG congratulates the Programme for consistently achieving high coverage from 2008 to 2012 and the comprehensive development of the Pre-TAS plan. The Plan to conduct a Pre-TAS survey is approved.	• Submit the results of the Pre-TAS Survey and the completed TAS-Eligibility Form • Conduct/submit 2013 MDA coverage survey when available
Mali	• Eligibility 2 EUs (3 IU) for TAS 1	• The RPRG advised the programme to join the two districts namely Yorosso and Sikasso, for the EU1 and conduct TAS in Selingue as EU2. The delineation of the EU should be justified. • The RPRG pointed out the need to get additional information about the neighbouring areas, considering that the areas where TAS is planned are the cross-border districts with Guinea and Burkina Faso. Guinea is still mapping. • The RPRG commended the programme for the great progress that is being made to provide MDA for multiple rounds to all endemic areas.	• The RPRG gave a provisional approval to proceed with the TAS while awaiting the additional information on delineation of EU as well as the population movement across the borders with Burkina and Guinea which is still to start MDA for LF.
Niger	• Eligibility – 3 EUs (8IU) for	• The RPRG noted that TAS1 was planned in 7 EUs covering 14 IUs in Apr-Jun 2014, with support of FHI but RPRG has received only a request for 3 EUs.	• The RPRG requested for the final report of the results of the Implementation Units

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
	TAS1	In all of the 3 EUs presented for TAS, the individual village pre-TAS results were not presented, only the aggregate district results. • Additionally, in Keita district, the MDA coverage was low for multiple rounds of MDA; the RPRG questioned whether enough rounds of effective coverage had been achieved. However, the eligibility was already approved for the 3 EUs and that TAS was conducted in 3EUs of which 2 seems to have failed. The results should be sent to the RPRG. • They commended the programme to continue conducting high-quality pre-TAS assessments in each district that has completed 5 effective rounds of MDA to avoid the implementation of TAS in EUs that have not yet met the elimination target. • It was noted that Baseline, mid-term and pre-TAS conducted with all the result of the pre-TAS< 2 (0 to 0.8%) ICT test. • Pre-TAS data was presented by village as a mean per IU. But some individual villages had >1% prevalence in spot check surveys and it was not clear which IUs these villages belong to.	surveyed. • The RPRG commended the great progress that is being made to provide MDA for multiple rounds to nearly all endemic areas.
Senegal	• TAS eligibility	• RPRG highlighted the need to conduct coverage survey to assess the overall programme performance • RPRG also recommended a required two additional MDA. • RPRG advocated to conduct mf surveys in additional spot-check sites with sufficient sample size following the WHO guidelines.	• It was observed that the treatment coverage data for 2010, 2011, and 2012 are missing. • Mention was made to the fact that Pre-TAS sample size was small in some sites. • The request for a TAS was not approved because of insufficient data

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
		• RPRG declined the request for TAS because of insufficient data	
Sierra Leone	• WHO TAS eligibility Forms • Pre TAS and LF Treatment Trend 2008-2012 • Defining the Evaluation Unit	• While the RPRG acknowledges the great progress made to provide multiple rounds of MDA to all endemic districts the programme should conduct 2 more rounds of MDA in Bombali, Koinadugu and Kailahun districts and achieve effective coverage. • The RPRG acknowledged the great progress that is being made to provide MDA for multiple rounds to all endemic areas in the country. According to the data reported, the programme defined the EU successfully. Reported MDA coverage since programme inception in the targeted EU met the effective coverage target of ≥65% of the total population for at least 5 years in most districts. In both EU1 and 6, at least one of the districts contained a sentinel or spot check site with a microfilaremia prevalence of above >1%, thus not meeting the criteria to be eligible for TAS. • Sierra Leone has made great progress in NTD preventive chemotherapy and should sustain the momentum of providing good PC coverage in all areas. The programme should ensure resources are allocated for implementing TAS according to WHO guidelines. The continued control of soil-transmitted helminthiasis must also be considered in areas that may pass TAS and stop MDA for LF.	• Proceed with TAS in EU2-5 • Proceed with TAS in only Kenema district in EU6 if the programme desires. • For EU2-5, the epidemiological assessments conducted in the sentinel and spot-check sites met the criteria of <1% microfilaremia prevalence. Therefore, EU2-5 are eligible for TAS according to WHO guidelines. In EU1, TAS is not advised as the epidemiological data in the sentinel/spot check village did not meet the criteria. In EU6, if Kailahun district is excluded, then TAS could be done for just the district of Kenema. • Where feasible and resources are available, the programme should consider integrating the TAS with assessment of STH •
Tanzania	• Joint Request	• Re-map LF in the areas where MDA has not been	• The drug request for Albendazole,

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
	form for Selected Medicines (JRFSM) 2014 for Preventive Chemotherapy • Transmission Assessment Survey (TAS) Dossier	started in consultation with the secretariat. • Submit the drug request in line with the submission deadline in 2014 (August 2014). • Conduct two additional rounds of PC in Muheza and Newala districts and then conduct an additional pre-TAS assessment • Where feasible and resources exist, integrate assessment of STH with the TAS surveys	Ivermectin and Praziquantel is approved. • Mass drug administration (MDA) in Loshoto and Mkuranga districts can be stopped. • Surveillance by TAS in Tandahimba district can be initiated.
Togo	• Eligibility – 4EUs (8IUs) for TAS3	• The RPRG commended the excellent progress made by the NTD team in Togo to eliminate LF, and added that the LF program in Togo is a model for other countries in the region. • The RPRG congratulated the PM for the program achievements. • The RPRG encourage the program to work with partners to accelerate planned efforts to validate new surveillance tools and strategies for LF. • The RPRG commended the well thought out TAS Plan • The Review Group suggested that the NPELF should consider supporting operational research to assess the potential role of new antibody tests for assessing LF transmission	Approved the planned TAS 3 to be carried out.
Uganda	• TAS Eligibility Forms for 6 EUs • Joint Request	• The review process of the TAS eligibility form would have benefited from information on other interventions e.g. Oncho/STH deworming and use of	• TAS eligibility for all six EUs approved. However, it is recommended that ways of combining the EU, Abim (95,291) with

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
	Form for Selected Medicines (JRFSM) 2014 for Preventive chemotherapy	ITNs. • The national programme should provide information on the number of Praziquantel tablets donated/procured from other sources too in the JRSM so that the secretariat and the RPRG can have overall picture of the national drug needs and PC plan. • The LF annual report and drug request for 2014 were submitted very late (April 2014). The national programme should submit its drug application in line with the submission deadline (15 August each year for the next year MDA).	other neighbouring EUs be explored. • The medicines' request for 2014 for LF, Oncho and STH interventions is approved.
Zambia	• Mapping LF	• The RPRG acknowledged the national programme's desire to implement a validation survey before initiating MDA.	

ANNEX 2: RPRG JUNE-JULY 2014 MEETING SUMMARY RECOMMENDATION AND DECISION TABLE

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Ethiopia	• National Master Plan for Neglected Tropical Diseases, 2013 – 2015, Ethiopia • Zonal level NTD Maps • Scale up and scale down plan	• The NTD-RPRG commended the rapid progress towards completing NTD mapping Ethiopia in the past year. The national programme should consider presenting separate scale-up plans for Oromyia, Amhara, SNNPR and Tigray and then jointly for the smaller Regional States (BG, Afar, Somali, Gambella). • The deadline for submission of 2015 joint application package to WHO is August 15, 2014. The national programme is encouraged to complete and submit all forms within the package, including the PC Epidemiological Data Reporting Form and the Annual Work Plan. This data provides the basis upon which requests for donated medicine in 2015 will be reviewed. • LF: Operational research could be considered in districts where there was only one positive or no evidence of malaria transmission. • SCH/STH: Plan for scale-up of preventive chemotherapy with Praziquantel according to WHO guidelines based on district-level prevalence of SCH	LF: • Conduct MDA in all districts in which the threshold of 1 positive ICT in at least one of mapped communities was reached or exceeded. • Submit TAS eligibility forms to WHO, including the coverage data for 5 woredas that may qualify for TAS in 2015. SCH/STH: • To support the 2015 request for donated medicine, the methods, sample size and results of SCH/STH mapping should be submitted to WHO for RPRG review Trachoma • The methods, sample size and mapping results of trachoma mapping should be presented to WHO for review by the NTD-RPRG. • The scale up and scale down plan for trachoma MDA should

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
		• SCH/STH: There should be clarification as to whether the scale up plan is based on both *S. haematobium* and *S. mansoni*	be resubmitted to WHO for review by RPRG once the new plan has been developed by the NTTF Onchocerciasis: • Data from the delineation mapping in hypo-endemic areas should be presented to WHO for review by RPRG • MDA should continue in all endemic areas as applicable.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Kenya	• National Multi-Year Strategic Plan for Control of Neglected Tropical Diseases, 2011 – 2015 • 2014 Drug Application Form • Proposal for funding of Mass Drug Administration (MDA) in the Programme to Eliminate LF in November 2013	• The NTD-RPRG expressed their concerns about the expiration of PZQ and noted that NTD programme have an obligation to manage donated products effectively. The Review Group provided conditional approval for the application for the requested quantities of DEC and ALB and for 3.5 million PZQ. • RPRG urged Kenya to review their 2011-2015 Master Plan and develop a new Master Plan for 2016-2020 in a timely fashion.	• Before any further shipment of medicines, the MoH/Kenya should provide written plan to prevent the expiration of PZQ tablets in the future. • Conduct at least 5 annual rounds of MDA in all LF endemic districts. Assessments of microfilaria (mf) should be conducted in sentinel and spot-check sites in districts targeted for scaling down to determine the impact of MDA and ascertain whether these districts are eligible for transmission assessment surveys (TAS). The national programme should complete and submit TAS Eligibility Forms to WHO for RPRG review prior to initiating TAS.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Malawi	• 2014 Pre-TAS Sentinel Site Survey Report for the Lymphatic Filariasis Programme in Malawi • Report for sentinel site surveys in 26 LF prevalent districts in Malawi March 2014 • TAS Eligibility form for 11 Evaluation units.	• Concerning the request for review of a proposed LF TAS plan to inform the decision on whether to stop MDA, 11 separate EUs comprising of 26 IUs are to be surveyed. The plan is well aligned with the estimated scale-down of MDA in the country. All EUs selected were justified, including population size. The last LF MDA was in 2013 September; hence timing was appropriate (since TAS should be done at least 6 months after last MDA). All the results in the sentinel and spot-check sites found no microfilaria in any of the tested persons. Given that: i. Drugs have been shipped to Malawi for September 2014 MDA and; ii. TAS is due and all EUs are eligible • RPRG commended the country for the progress made to date towards eliminating LF and submission of a very good sentinel and spot-check site report and TAS plan	• Conduct MDA in 2014 as planned with donated drugs currently in storage • RPRG approved the country request for TAS in the 11 EUs 6 months after the MDA in September 2014

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Nigeria	• The mapping results for lymphatic filariasis (LF) in the two states of Benue and Oyo. • The mapping results for schistosomiasis (SCH) and soil-transmitted helminthiasis (STH) in 17 states in Nigeria • The 2015 Joint Drug Request for Albendazole for lymphatic filariasis and STH, and Praziquantel for schistosomiasis. • A table listing 15 LGAs by state (4 in Benue and 11 in Oyo State) and the results for the LF mapping • A table indicating SCH and STH mapping results of the five schools per LGA in the 17 states surveyed	• Collects baseline data of microfilaremia (mf) in at least 1 sentinel site per 1 million population according to WHO guidelines before MDA • Implement the provisional strategy of twice-yearly Albendazole plus intensified vector control in any LGA co-endemic for Loa loa where ivermectin is not co-administered for onchocerciasis elimination • Improve coverage during MDA by intensifying social mobilization before and during the distribution, expand beyond CDTI areas to the entire LGA and develop a specific strategy for urban areas • Conduct coverage surveys to assess quality of reported data and identify reasons for low coverage • Consider triple drug administration (IVM, ALB, PZQ) according to WHO guidelines to avoid multiple MDAs	RPRG gave approval for the drug application: • For the two new states (Oyo and Benue) where funding is certain • Continuation of treatment for states where funding is certain • Albendazole 2 times/year for LF elimination in *Loa loa* areas non-eligible for CDTI in the south-eastern states • The LF mapping results and recommended that the programme implement mass drug administration according to WHO guidelines for those LGAs where prevalence of circulating filarial antigenemia was 1% and above (≥1% ICT+). • The SCH and STH mapping results and recommended that the programme implement targeted preventive chemotherapy according to WHO guidelines applying the required treatment regimen for each LGA as per the mapping results.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
Tanzania	• Power Point Presentation on Country's Progress in NTD Control and Elimination • NTD Master Plan • 2013 LF MDA Coverage • Scaling up and down plan 2012-2020	• LF MDA in the 5 regions where scale up is planned and resources committed. • Where the national programme suspects inconsistent LF infection data, additional assessment should be conducted using the WHO recommended methodology for mapping, preferably by revisiting the villages with the highest ICT result from baseline mapping. These assessments could also serve as baseline sentinel sites where needed if microfilaria can be assessed on all positive ICT. Where needed for additional evidence, operational research using a modified mapping protocol could be implemented in a subset of these areas with inconsistent data. • The national programme complete and submit the PC Epidemiological Data Reporting Form including the most recent assessment data to WHO in order to update the population requiring preventive chemotherapy in the country. • Completed TAS Eligibility Forms should be submitted to WHO for RPRG	• The deadline for submission of 2015 joint application package to WHO is August 15, 2014. The national programme is encouraged to complete and submit all forms within the package, including the PC Epidemiological Data Reporting Form and the Annual Work Plan. This data provides the basis upon which requests for donated medicine in 2015 will be reviewed.

Country	Type of Dossier	Recommendation/ Comments	Decision Taken
		review. • As the country scales down LF MDA, a decision on whether MDA should be stopped should take into consideration the co-endemicity of onchocerciasis and STH. • Regarding the scale-up of preventive chemotherapy for schistosomiasis and Trachoma, continue scale-up in endemic areas as planned according to WHO guidelines. • The national programme coordinates with all stakeholders to review and complete together the joint application package for 2015. The deadline for submission to WHO is 15 August.	

TABLEAU RESUME DES RECOMMANDATIONS DE LA REUNION DU GRRP MTN JUIN-JUILLET 2014

Pays	Type de Dossiers	Recommandations/ Commentaires	Décisions prises
ANGOLA	- Formulaire de requête conjointe pour des médicaments sélectionnés de la CP - Formulaire de rapport conjoint sur la DMM	La conclusion générale et les recommandations au programme national de lutte contre les MTN sont les suivantes : • La demande pour 1,5 million de comprimés d'Albendazole pour les HTS a été approuvée afin que ce médicament puisse être combiné avec les 3 millions de comprimés de Praziquantel disponibles dans le pays pour le traitement de masse combiné contre la schistosomiase et les HTS • Toutes les données de cartographie réalisées sur les MTN en Angola doivent être saisies sur le formulaire de rapport des données épidémiologiques des MTN-CTP et soumises à l'OMS en même temps que les formulaires de rapports conjoints sur les DMM de 2013, le formulaire de requête conjointe de médicaments sélectionnés pour la chimiothérapie préventive pour l'année 2015 et le plan de travail annuel pour 2015, pour revue et avis du groupe NTD-RPRG • Un Plan directeur national et un plan de mise en œuvre clair pour couvrir tous les districts endémiques dans le pays doit être partager avec l'OMS pour examen avant la prochaine réunion de NTD-RPRG en novembre 2014.	• Les données de cartographie doivent être rapportées à l'OMS pour revue • Un plan directeur national pour la mise à l'échelle de la chimiothérapie préventive, avec une indication claire du soutien et de la coordination des partenaires, devrait être élaboré pour la période 2014-2020

Pays	Type de Dossiers	Recommandations/ Commentaires	Décisions prises
BENIN	Rapports de l'enquête d'appréciation de la transmission (TAS) de la filariose lymphatique	Le groupe de revue recommande de : • Poursuivre les DMM dans les 27 autres Communes endémiques et envisager la mise en œuvre des enquêtes d'appréciation de la transmission (TAS) de la filariose lymphatique dès que les critères d'éligibilités seront remplis. • Soumettre le formulaire de requête conjointe de médicaments sélectionnés (FRCMS) de la chimiothérapie préventive pour l'année 2015, le formulaire de rapport conjoint (FRC) sur les DMM de 2013 ainsi que le plan de travail annuel 2015 avant le 15 Août 2014. Le formulaire de rapport sur les données épidémiologiques (FREPID) des MTN de la chimiothérapie préventive doit également être soumis afin que les données de cartographie (ou de suivi-évaluation) soient présentées de façon standardisée.	• Continuer les activités de surveillance y compris le 3ème TAS selon le guide de l'OMS dans les 23 communes où les premières évaluations de la transmission de la filariose lymphatique ont été réalisées.

Pays	Type de Dossiers	Recommandations/ Commentaires	Décisions prises
COTE D'IVOIRE	- Le plan de la mise à échelle - Les résultats de la cartographie - Demande de médicaments.	- Le groupe de travail a estimé que les données épidémiologiques actuellement disponibles en Côte d'Ivoire permettent une mise en œuvre progressive et soutenue du plan de lutte contre les MTN. - Le calendrier est apparu raisonnable et réaliste. - A court terme, les ressources sont suffisantes. Pour le long terme, le groupe de travail encourage le programme national à poursuivre ses activités pour la mobilisation de ressources - Il a été relevé que deux lots de Mectizan® sont en voie de péremption (2 million en Août 2014 et 8,6 million au mois d'Octobre 2014). Il a été envisagé avec l'aide des partenaires de réaliser une campagne anticipée de distribution de médicaments au niveau de 7 districts afin d'absorber ces médicaments - Le comité apprécie l'effort de mise à échelle des activités de lutte contre les MTN. La commande de médicaments reflète les besoins en termes de population à couvrir. **Toutefois le comité recommande de gérer rigoureusement les médicaments pour éviter des situations de péremption.**	1. Le groupe recommande que dès 2015, la coordination et l'intégration des PC-MTN soit effective en Côte d'Ivoire. 2. Il recommande la mise en œuvre de toutes les mesures du plan directeur national de lutte contre les MTN. 3. Assurer une coordination effective des programmes en vue d'une distribution intégrée des médicaments 4. Utiliser le nouveau formulaire de commande commune de médicament pour 2015, accompagné du plan de travail annuel 2015, du rapport de traitement de 2014, et du formulaire OMS pour la déclaration des données épidémiologiques, afin que les données disponibles soient présentées de façon standardisée.

Pays	Type de Dossiers	Recommandations/ Commentaires	Décisions prises
NIGER	1. Rapport d'enquête d'appréciation de la transmission (TAS) de la filariose lymphatique et de l'impact de la DMM avec l'Ivermectine et l'Albendazole conduite de 2007 à 2012 dans trois unités d'évaluation des Régions de Tahoua et Tillaberi au Niger 2. Fiche d'éligibilité pour la mise en œuvre du TAS dans 5 UE (districts de Aguie, Dakoro Guidan Roumdji, Madaoua, Boboye, et Tillaberi).	Rapport d'évaluation du TAS dans trois UE - Le protocole de mise en place du TAS a été respecté. Deux des trois UE n'ont pas passé le TAS car le nombre d'enfants avec ICT positifs était supérieur à la valeur critique. - UE1 (districts de Tahoua, Illela, et Konni): 98 ICT positifs (valeur critique 20) - UE2 (districts de Kollo, Say et Tera) : 23 ICT positifs (valeur critique 20) - Le nombre d'ICT positifs (19) dans la 3ème UE (districts de Bouza et Keita) était en dessous de la valeur critique de 20. Par conséquent cette unité d'évaluation passe le TAS. Eligibilité de cinq UE pour mener le TAS - Les critères d'éligibilité pour les cinq UE sont remplis. L'inclusion de deux districts dans une UE est appropriée. Il est à noter que les résultats des enquêtes dans les sites sentinelles et de contrôle ponctuel ont d'abord été présentés de façon agrégée. - Les résultats désagrégés ont été envoyés aux membres du RPRG afin de permettre d'évaluer de façon définitive si les critères d'évaluation pour la mise en œuvre des TAS étaient remplis.	Rapport d'évaluation du TAS dans trois UE • Le RPRG recommande de continuer les traitements de masse pendant deux années supplémentaires dans les deux UE qui n'ont pas passé le TAS. • Le NTD-RPRG recommande également d'évaluer les raisons de l'échec des TAS dans les districts inclus dans ces deux UE. • Le NTD-RPRG recommande d'arrêter les TDM dans la troisième UE, mais également d'enquêter et de traiter les cas d'ICT positifs (enquête de voisinage). Eligibilité de cinq UE • Le RPRG approuve la mise en œuvre des TAS dans les 5 UE.

Pays	Type de Dossiers	Recommandations/ Commentaires	Décisions prises
RDC	Formulaire de demande commune de médicaments pour la chimiothérapie	Il s'agit d'une demande déjà approuvée et dont l'envoi des médicaments est en cours. Les membres du RPRG félicitent le pays pour avoir réalisé la cartographie dans 9 des 11 provinces du pays et l'encourage à compléter la cartographie dans les 2 provinces restantes. Le groupe constate également que la demande a été soumise à temps pour la campagne de distribution de masse de 2014. Le groupe recommande : - que le traitement de masse soit effectif dans les zones de santé pour lesquelles la demande a été effectuée ; - d'étendre le traitement dans les autres provinces dès 2015. Pour cela, la commande devrait être envoyée au plus tard le 15 Aout 2014, accompagnée du plan de distribution 2015 et du rapport de la distribution de masse de 2013 (au moins pour l'onchocercose); - de soumettre le formulaire de commande commune de médicament pour 2015, accompagné du plan de travail annuel 2015, et du formulaire OMS pour la déclaration des données épidémiologiques, afin que les données disponibles soient présentées de façon standardisée.	Compléter la cartographie dans les deux provinces restantes et soumettre tous les résultats pour revue par le Groupe

Annex 4: List of participants of the 2 RPRG meetings in April and July 2014

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