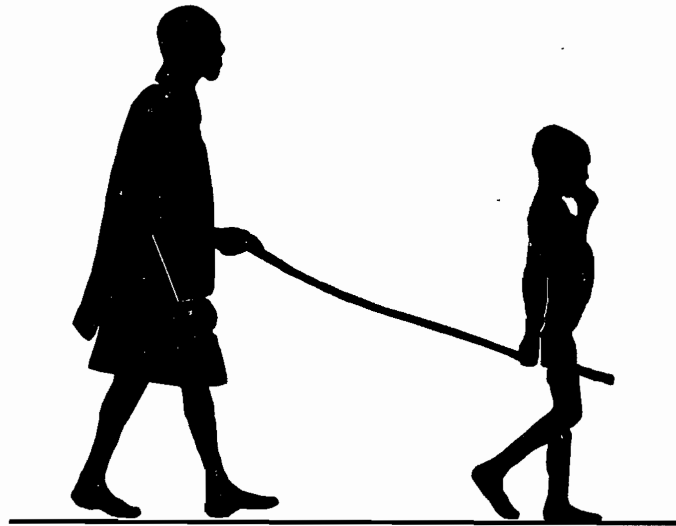
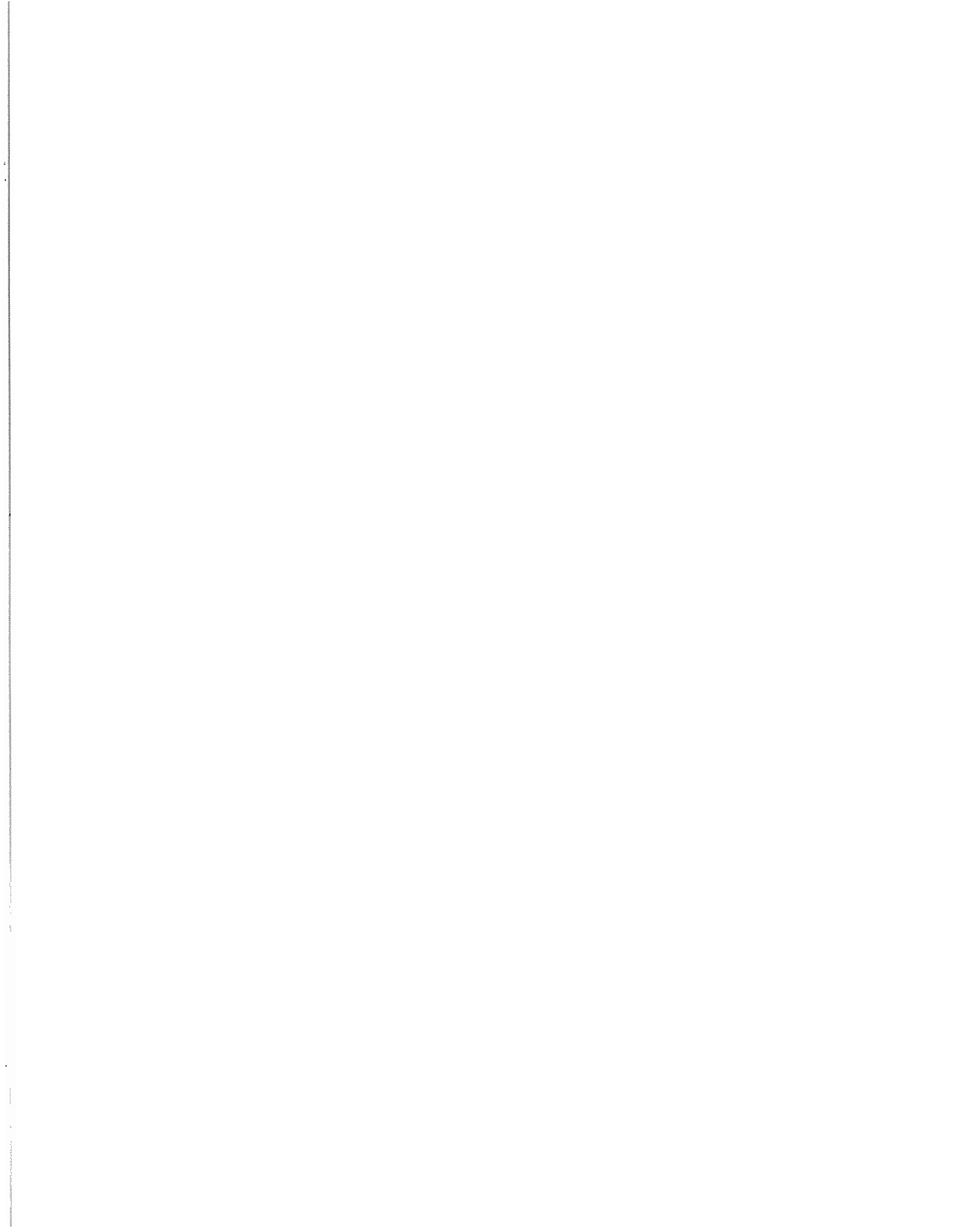


Summary
1996 Global 2000 River Blindness Program
Program Review for Nigeria, Cameroon, Uganda, and OEPA
9-11 December 1996
The Carter Center
Atlanta, GA



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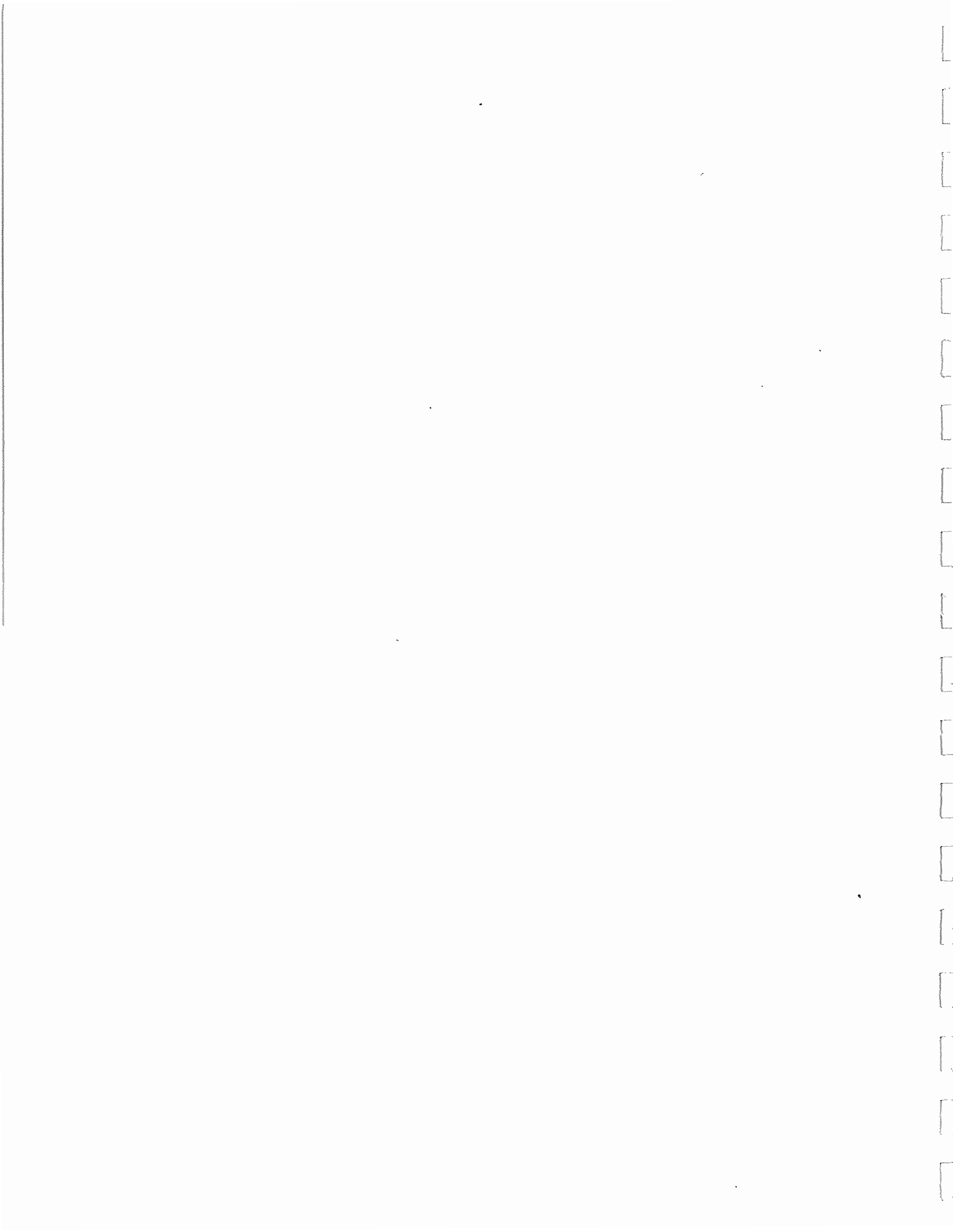
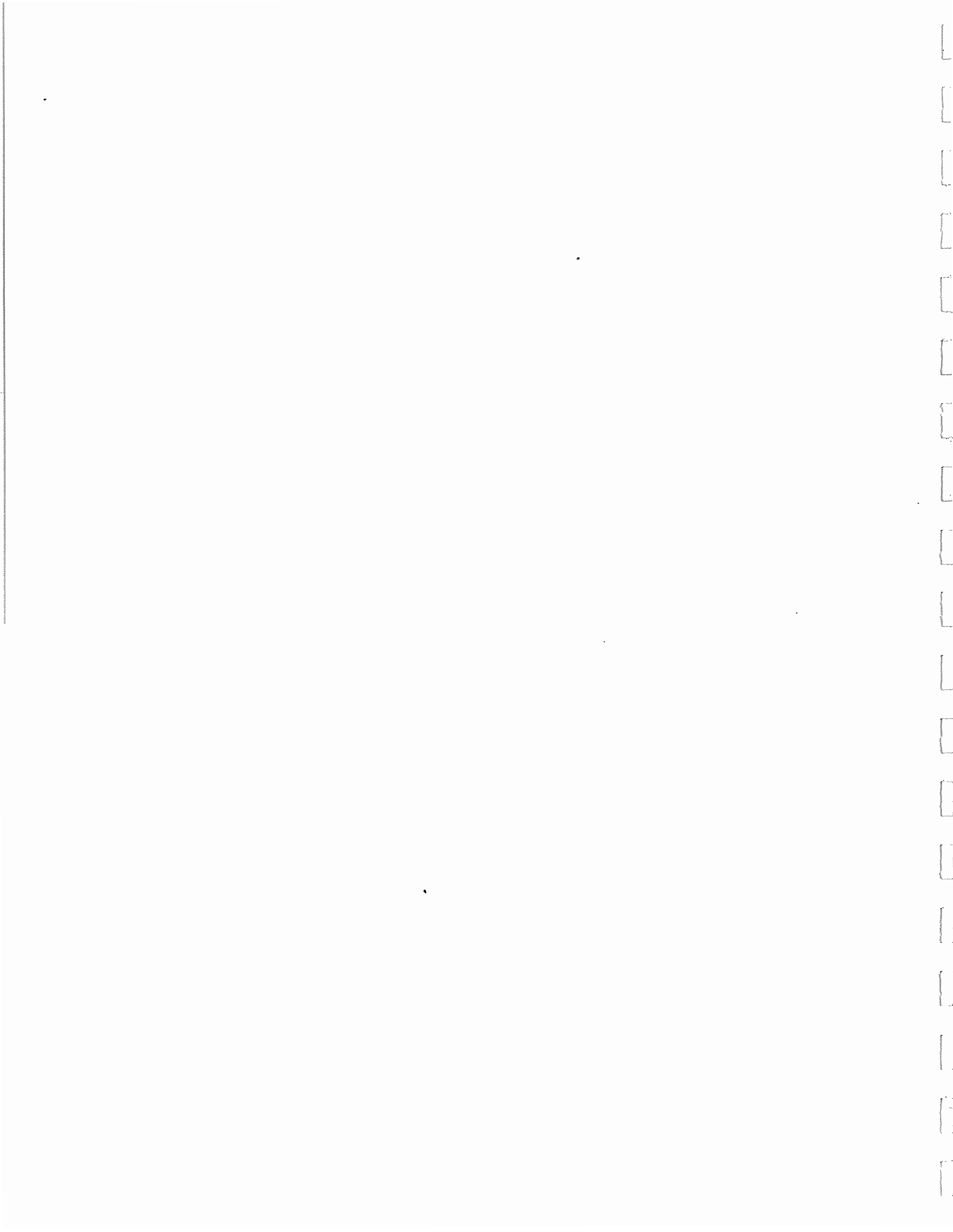


Acronyms

ATO	Annual Treatment Objective
APOC	African Program for Onchocerciasis Control
CDC	Centers for Disease Control and Prevention
GIS	Geographic Information System
GRBP	Global 2000 River Blindness Program of The Carter Center
IACO	InterAmerican Conference on Onchocerciasis
LCIF	Lions Clubs International Foundation
NGDO	Non-Governmental Development Organization
NOCP	National Onchocerciasis Control Program
NOTF	National Onchocerciasis Task Force
MDP	Mectizan® Donation Program
OEPA	Onchocerciasis Elimination Program of the Americas
PAHO	Pan American Health Organization
TCC	Technical Consultative Committee
RBF	River Blindness Foundation
REA	Rapid Epidemiological Assessment
REMO	Rapid Epidemiological Mapping of Onchocerciasis
UTG	Ultimate Treatment Goal
WHO	World Health Organization



EXECUTIVE SUMMARY

The Carter Center in Atlanta hosted its first annual Program Review of Global 2000 River Blindness Program-assisted activities on December 9-11, 1996. Each program (Nigeria, Latin America, Uganda, and Cameroon) reported on treatment activities, sustainability issues, status of Mectizan® stores, assessment, training and research, and administrative issues. The objectives of the program review were to 1) assess the status of each program, 2) assess impediments and problems in program implementation, 3) promote sharing and standardization of information, and 4) for the African programs, discuss plans for securing the support of the African Program for Onchocerciasis Control (APOC). Key aspects of the Program Review, supplemented by finalized treatment data provided since the meeting, are summarized in this report, as are recommendations for GRBP actions in 1997.

The group concluded that in 1996, 3,828,180 people were treated in GRBP-assisted programs (92% of 1996 treatment objective); 2,516,191 (65%) were treated in partnership with the Lions Clubs International Foundation's SightFirst program. Difficulty with the importation of Mectizan® constrained program operations. GRBP will continue to focus on 1) monthly reporting of treatment and accomplishments, 2) improving Mectizan® distribution, 3) concise epidemiology and assessments used to determine how and where treatment is directed, 4) demonstrating sustainability of the programs, 4) application of the onchocerciasis/Mectizan® community-based distribution model to other disease areas, and 5) exploring the potential for eradicability, especially in Latin America.

INTRODUCTION

The Carter Center in Atlanta hosted its first annual Program Review of GRBP-assisted activities on December 9-11, 1996. In attendance were the country representatives of Global 2000 River Blindness Programs in Nigeria (Dr. Emmanuel Miri), Latin America (Dr. Edmundo Alvarez), Cameroon (acting, Mr. Jean Bangob),and Uganda (acting, Mr. Dominic Mutabazi), GRBP consultant Dr. Brian Duke, and GRBP headquarters staff. The main purposes of the review, which was co-chaired by Drs. Donald Hopkins and Frank Richards Jr., were to assess the status of each program, determine impediments and problems in program implementation, and for the African programs, to discuss plans for relating to the new African Program for Onchocerciasis Control (APOC). Each program reported on treatment activities, sustainability issues, status of Ivermectin, assessment, training and research, and administrative issues. One-half day was devoted to the presentation and discussion of each program. The review was modeled after similar reviews developed for national Guinea Worm Eradication Programs by Global 2000 and the Centers for Disease Control and Prevention (CDC), beginning with Pakistan in 1988.

Key aspects of the Program Review, supplemented by finalized treatment data provided since the meeting, are summarized in this report, as are recommendations for GRBP actions in 1997.

NIGERIA

GRBP in Nigeria is assisting distribution activities in seven states: Plateau, Abia, Anambra, Delta, Edo, Enugu and Imo States. The Lions Clubs International District 404 assists in mobilization and health education in the latter six states located in southeastern Nigeria, for which funding is provided by the Lions Clubs International Foundation's SightFirst program. RBF/GRBP assistance began in Plateau state in January 1992, in Abia and Imo states in September 1992, and in Edo, Delta, Anambra and Enugu states in January 1994.

The Global 2000 River Blindness Program (GRBP) in Nigeria helped provide Mectizan® to 3,030,679 persons, or 103 % of its Annual Treatment Objective (ATO) for 1996 (Table 1). The program also exceeded its ATO (6,016 out of 5,756 villages) for coverage of high-risk villages (hyperendemic villages in urgent need of treatment due to an estimated skin snip prevalence of ≥60% positive). In those states where GRBP and Lions are partners, 2,467,952 persons were treated (included in the 3,030,679 mentioned above).

Among the new states announced by the Federal Government of Nigeria in September 1996, Plateau State has been divided into Plateau and Nasarawa States, and Ebonyi State has been created from parts of Enugu and Abia States. GRBP will continue to work in the same geographic areas as before, including the new states Nasarawa and Ebonyi. Among the states assisted by GRBP, only Delta State is known to be *Loa loa* endemic. [Note: The filarial parasite *Loa loa* generally causes a benign systemic infection that rarely has been associated with encephalopathy after treatment with the microfilaricide diethylcarbamazine (DEC) in patients with heavy microfilarial (mf) infection (>10,000 mf/ml). The Mectizan® Donation Program recommends that health care workers be aware that patients treated for onchocerciasis with Mectizan® who have coincidental heavy microfilarial infection with *Loa loa* may be at risk for this rare event, and distribution programs in areas where high-density *Loa loa* exists should maintain enhanced surveillance for adverse reactions during the first 5 days after treatment.]

Epidemiological assessments have been completed in 9,272 communities so far in the GRBP-assisted states, with complete assessment coverage in Abia, Edo, Imo, and Plateau States. 3,654 (39%) of the assessed villages were classified as hyperendemic (estimated skin snip prevalence of ≥60% positive and so at high risk for severe onchocerciasis-related morbidity).

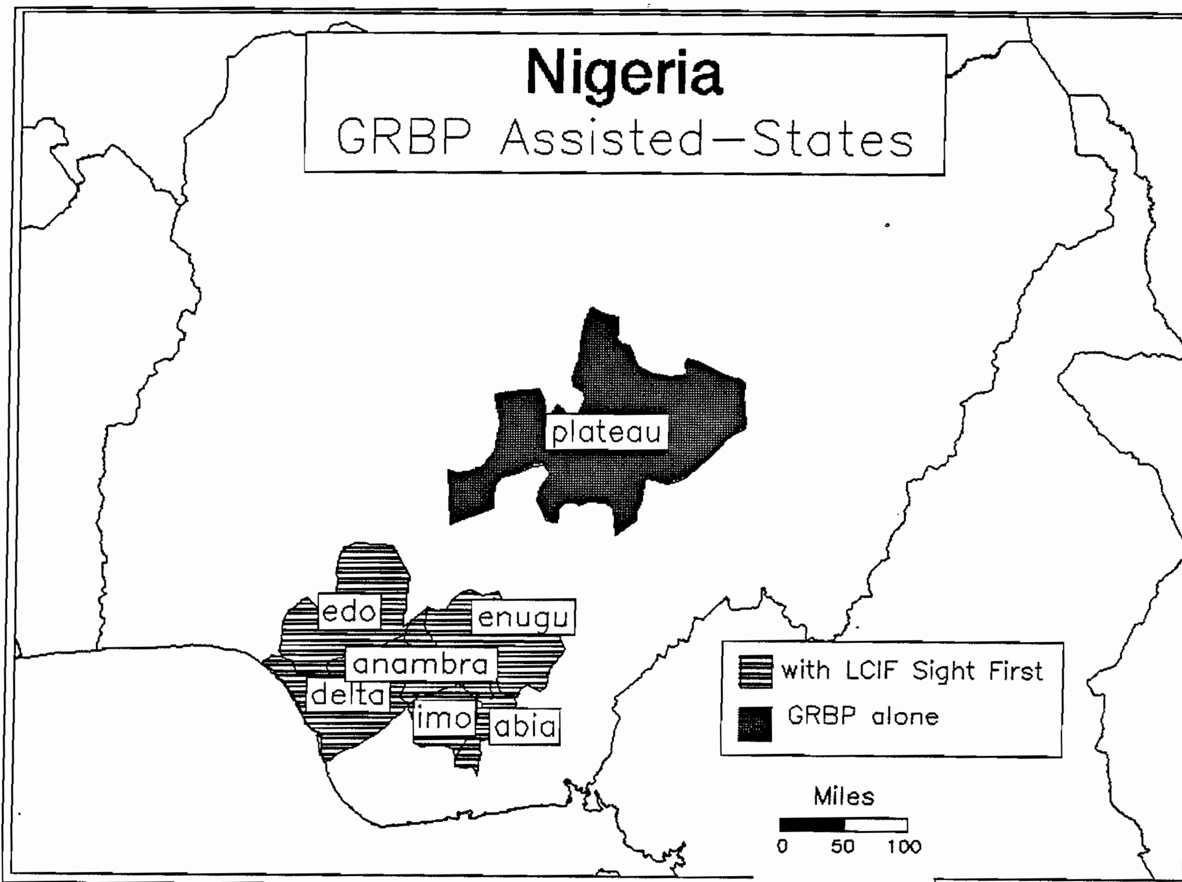
A central system of Mectizan® procurement was established using UNICEF's diplomatic status as the consignee for the drug which, after receipt, was then transferred to the Africare warehouse, then on to the various distribution programs, including GRBP. However, GRBP implementation during 1996 was constrained by significant delays in clearance and delivery of Mectizan® to Nigeria. The late arrival of Mectizan® during the year meant that more treatments had to be given during the rainy season, when only the larger villages near bigger roads were accessible. Many of the small and peripheral high-risk villages that were inaccessible during the rains had to be left untreated. After a lag in activities in November, GRBP Nigeria received 1.5 million tablets in December 1996. GRBP personnel worked over the holiday period to exceed their 1996 ATOs.

APOC: GRBP assisted in writing a proposal to APOC for 1997 funding in Kwara, Ondo, Kogi and Taraba states. GRBP also assisted the National Onchocerciasis Control Program (NOCP) in its launching of the onchocerciasis trust fund. The NGDO Coalition further helped the NOCP by supplying office equipment and helping with the national Rapid Epidemiological Mapping of Onchocerciasis (REMO) exercise.

Jos Training Center: The GRBP Training Center in Jos conducted its first in-country middle level management training for 20 participants drawn from eleven states in Nigeria. This training program was developed in collaboration with the U.S. Centers for Disease Control and Prevention (CDC) and the Rollins School of Public Health of Emory University. The training began with a nine-day workshop in August 1996, after which participants identified problem areas in their own projects, developed and applied solutions to those problems using the Total Quality Management (TQM) method, then returned for a December reunion workshop and presented their findings. Most participants had effected dramatic improvements in the problem areas chosen. Two members of the GRBP field staff in Nigeria (Dr. Abel Eigege and Ms. Ifeoma Umolu) completed a six-week long training course in management and leadership skills in Atlanta in late 1996. The latter course prepared them to become trainers of trainers for teaching similar courses at the Training Center in Jos.

Progress towards sustainability: In an effort to monitor progress towards achieving sustainability of community-based distribution of Mectizan® in the assisted states, the GRBP in Nigeria has started tracking certain indices. In all of the at-risk communities slated for treatment in 1996 in Nigeria, the community members themselves had selected the community-based distributors (CBDs), each of whom had to meet the standard requirements set by GRBP and the Ministry of Health. Also, all of the CBDs are supervised by Primary Health Care workers who are a part of Nigeria's national health care system. Communities were not otherwise involved in the *design* of the treatment program in the GRBP-assisted states. A study conducted by the GRBP in collaboration with consultants from the University of Jos to evaluate community participation and ownership in regard to Mectizan® distribution in Plateau State (where GRBP and before it, RBF, have been assisting for five years) concluded that establishment of community health committees was vital to ensuring sustainability.

Map Nigeria



1996 Treatment Figures in LCIF/GRBP-assisted states-Nigeria

STATE	TX(earp)	TX(arv)	TX(hrv)
Abia	453,182	942	942
Anambra	287,239	890	871
Delta	367,603	185	184
Edo	442,571	576	576
Enugu	354,535	1,150	1,148
Imo	562,822	1,494	1,458
Plateau*	562,727	888	837
TOTAL	3,030,679	6,125	6,016

TX=treated
eligible at-risk population (earp)
at-risk villages (arv)
high-risk villages (hrv)
***Plateau State is assisted only by GRBP**

NIGERIA RECOMMENDATIONS:

- The 1997 Mectizan® supplies **must** be received in a timely manner through UNICEF in order not to interrupt distribution. This involves resolution of Mectizan® shipment issues with the Mectizan® Donation Program (MDP), UNICEF, and the Government of Nigeria.
- Seek more financial and material support for the program from the Nigerian government.
- Prepare APOC proposals by July 1997 for Plateau State and Nasarawa State.
- Build the relationship with Lions through additional publicity, and by facilitating participation by local Lions.
- Encourage those who have the Nigerian REMO data to share that data with GRBP and other NGDOs in both digital and printed formats so that it may be used operationally.
- Seek to publish a report of the Plateau State experience focused on sustainability.
- Determine prevalence of *Loa loa* in Delta State. Close monitoring for secondary reactions in accordance to MDP recommendations needs to be established given the existence of *Loa loa* there.
- Draft a summary for WHO's Weekly Epidemiological Record of Nigerian treatments by all programs in that country in 1996.
- The Jos Training Center needs to take a more regional approach (not just Nigerian participants, but representatives from other countries' onchocerciasis programs), be more oriented toward sustainability by using fee-for-service rather than grant money, establish francophone skills, and seek APOC support in the coming year.

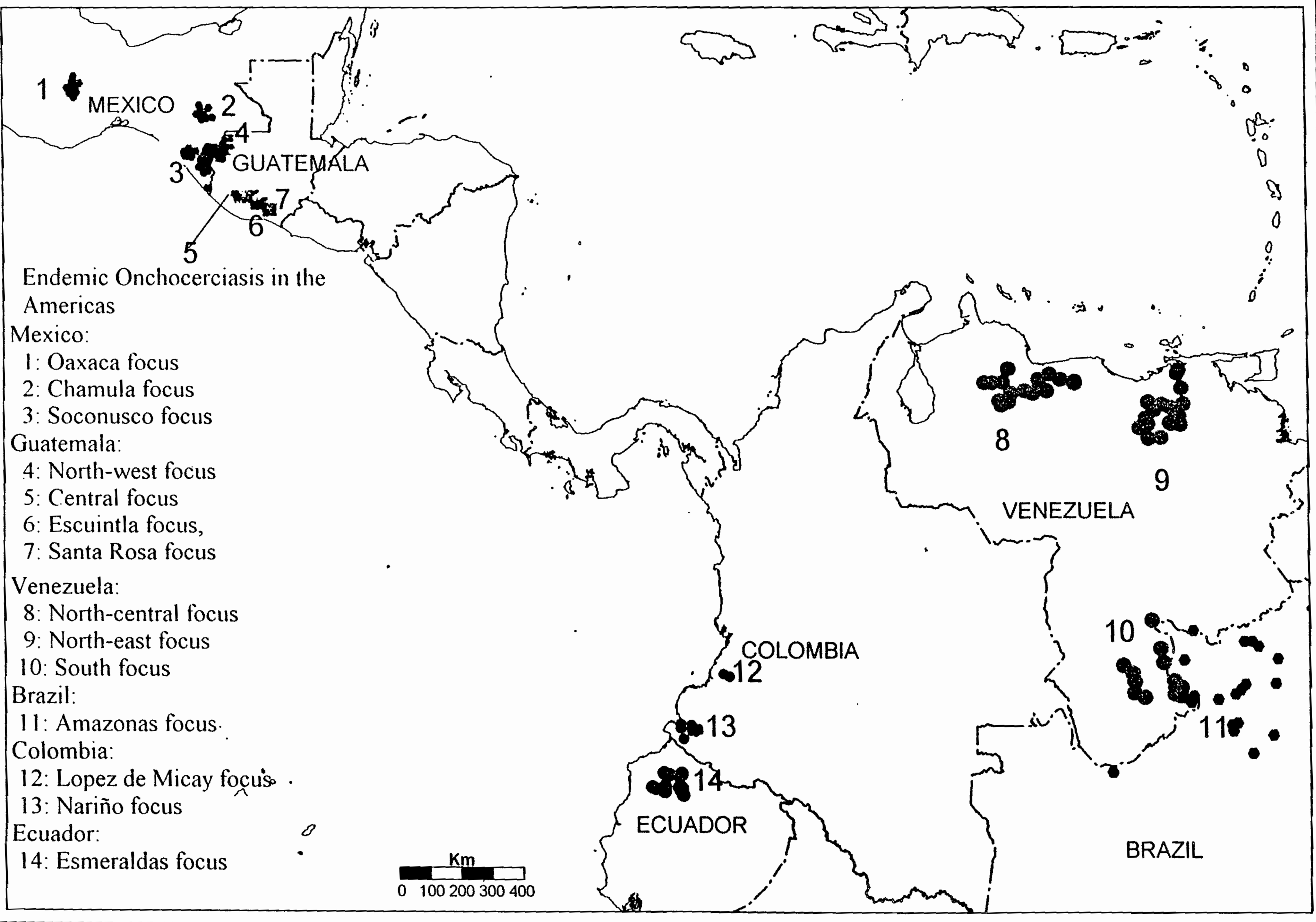
ONCHOCERCIASIS ELIMINATION PROGRAM FOR THE AMERICAS (OEPA)

The six endemic countries (Guatemala, Mexico, Venezuela, Brazil, Ecuador, Colombia) have collectively treated 197,571 eligible at risk persons, or 60% of their Annual Treatment Objective (ATO) for the year (328,576). However, the percentages of ATO achieved in each country varied from 32% in Guatemala to 97% in Ecuador. The program in Guatemala was restarted in 1996 after an interruption in 1994 that resulted from the decentralization of health services. Although only one treatment round has been provided to about 51,265 persons at risk in Guatemala this year, more persons treated with two treatments at six monthly intervals (as before) are planned in 1997. Mexico treated 87% of its 1996 ATO for persons at risk to be treated, and, as usual for the past few years, provided Mectizan® in 100% of its at-risk communities. Ecuador has reached 99% of its communities at risk and 97% of its ATO for persons at risk. The newest national Onchocerciasis Elimination Programs in Brazil, Colombia, and Venezuela all carried out first-round treatments in 1996, including, for the first time, treatments in both the northern and southern foci in Venezuela, the first mass treatments ever in Brazil, and treatment of the single known endemic community in Colombia. Notably, 98% of all known high-risk communities in the Americas are under Mectizan® treatment.

Representatives of all six endemic countries of the Americas met on November 19-21 at the sixth annual Inter American Conference on Onchocerciasis (IACO), in Oaxaca, Mexico, where they reported on activities in their programs. Also attending were representatives from the regional office of the Onchocerciasis Elimination Program of the Americas (OEPA) and GRBP, Pan American Health Organization (PAHO), CDC, USAID, MDP, and the Inter-American Development Bank. Participants adopted norms developed for surveillance at a meeting held in Ecuador earlier this year, and recommended the prompt development of a process for international certification of onchocerciasis elimination for the Americas.

Progress towards sustainability: In each of the six endemic countries, delivery of Mectizan® is considered to be primarily the responsibility of the government concerned. All of the country programs work within a primary health care approach, and in all countries, the onchocerciasis activities are implemented as an integrated program in conjunction with other health activities. In Ecuador, there is 100% community involvement in the design and implementation of interventions. However, Ecuador is the only endemic country in the Americas where a budgetary line item for onchocerciasis does not exist.

Geographical distribution of endemic onchocerciasis in the Americas



OEPA

Reported National Treatment Activities for 1996

Endemic Focus (Country)	Population treated: Cumulative for 1996	Population treated: Objective for 1996	Population treated: Percent of objective for 1996	High risk villages treated Cumulative for 1996	High risk villages: Treatment objective for 1996	High risk villages treated: Percent of objective for 1996	At risk villages treated Cumulative for 1996	At risk villages: Treatment objective for 1996	At risk villages: Percent of objective for 1996
BRAZIL	897	971	92%	34	34	100%	34	34	100%
COLOMBIA	230	335	69%	1	1	100%	1	1	100%
ECUADOR	17,392	17,910	97%	43	43	100%	119	120	99%
GUATEMALA	51,265	162,088	32%	10	17*	59%	318	517	62%
MEXICO	126,446	144,672	87%	242	242	100%	947	947	100%
VENEZUELA	1,341	2,600	52%	15	16	94%	24	40	60%
T O T A L	**197571**	**328576**	**60%**	**345**	**353**	**98%**	**1443**	**1,659**	**87%**

OEPA RECOMMENDATIONS

- Provide support to the Venezuelan program for epidemiological assessment of the northern foci.
- Help PAHO to establish criteria for certification of onchocerciasis elimination.
- Document the interruption of transmission in the Americas.
- Determine if there is substantial negative impact to changing from biannual to annual treatments in areas where transmission is or can be interrupted.
- Adjust OEPA ATO figures to be consistent with those on Mectizan® applications. This process will also be helpful in consolidating figures for the six countries, and help both MDP and OEPA maintain accurate records.
- Complete a Weekly Epidemiological Record summary highlighting what OEPA has done in 1996.
- Analyze the strengths and weaknesses of the six different health systems' ability to sustain Mectizan® delivery.
- Focus data analysis on documenting that all high-risk villages in the Region are under treatment.
- Keep the coalition (represented by PAHO; the governments; and the Program Coordinating Committee, including GRBP) engaged in the regional initiative.

UGANDA

Despite various complications related to insecurity in some areas, GRBP Uganda attained 77% of its 1996 ATO for eligible at-risk population (498,501 persons treated), and has reached 87% of at-risk villages (1,230). However, recent rebel activity and movements of refugees from Zaire have increased insecurity in several of the other districts where GRBP is assisting the Ministry of Health in distribution of Mectizan®. Treatments were resumed (after delays associated with the influx of refugees) in the latter part of the year in Kabale and Rukungiri Districts. No treatments have been undertaken at all in Gulu District this year due to insecurity, and the program has never operated in Kitgum District, as intended, for the same reason. Disruptions of one kind or another have also recently affected activities in parts of Moyo, Nebbi and Kasese Districts.

Consideration was given to GRBP Uganda taking over onchocerciasis control activities in Mbale, based on a request to GRBP by both the Ministry of Health and World Vision International. GRBP's (RBF) past role in performing initial Rapid Epidemiological Assessment (REA) in Mbale, is a significant factor in the request.

APOC: GRBP has approval for 1997 APOC support for Kisoro and Kasese Districts. GRBP HQ will be following the 1997 experience in these districts very closely. With the advent of APOC, REMO has become an increasingly important exercise in Uganda. At the December 1996 APOC meeting in Cotonou, it was indicated that REMO/GIS for Uganda is expected by the first half of 1997, and that the TCC now requests that REMO be completed nationwide prior to any further review of Ugandan applications for APOC funding.

Progress towards sustainability: Except for Moyo and Gulu Districts, where village leaders selected the community-based distributors (CBD), in all other districts where GRBP/RBF has worked in Uganda for the past five years, the CBDs are selected by both village leaders and members of the community. All of the CBDs are volunteers; they are not paid any remuneration by the program or the community. In most of the GRBP-assisted districts, the program delivers Mectizan® to the Ministry of Health's district headquarters by public bus, except in Gulu, where it is delivered by GRBP vehicle, and Moyo and Nebbi, where it is delivered by air because of insecurity. (District Medical Officers now collect other drugs from the Central stores.) The estimated average cost per person treated in the GRBP-assisted districts is US$0.51.

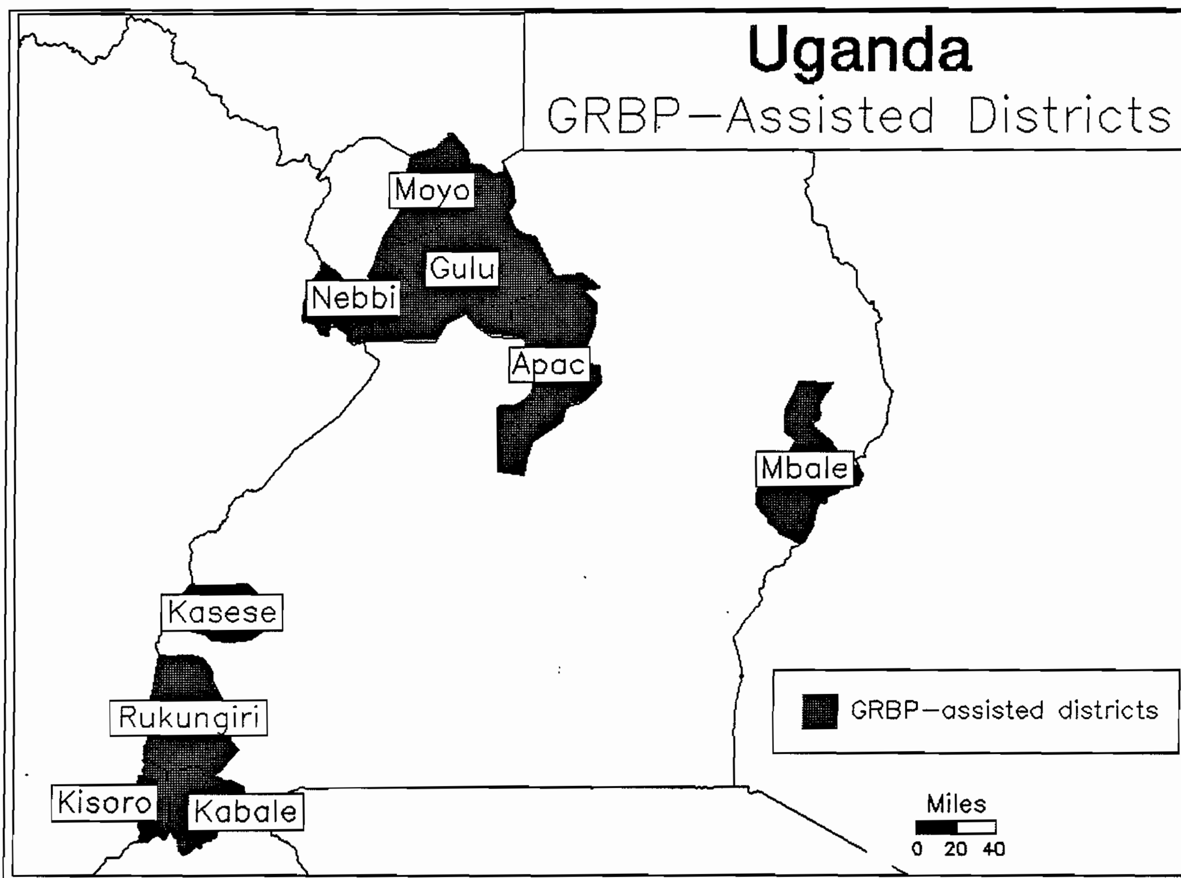


Table - 1996 Uganda treatment figures

Month/District	Kasese	Rukungiri	Kisoro	Kabale	Moyo	Gulu	Nebbi	Apac	TOTAL
January	-	-	-	-	-	-	-	-	-
February	20,757	-	10,966	-	-	-	-	-	31,723
March	28,211	-	400	-	-	-	49,407	-	78,018
April	-	-	-	-	66,513	-	24,132	-	90,645
May	-	-	-	-	89,308	-	60,000	-	149,308
June	-	-	-	-	60,551	-	22,100	4,488	87,139
July	-	-	-	-	16,589	-	1,905	-	18,494
August	-	-	-	-	-	-	-	-	-
September	-	-	-	-	-	-	-	-	-
October	-	18,756		9,456	3,231	-	-	-	31,443
November	-	6,600		1,908	2,287	-	-	-	10,795
December	-	936	-	-	-	-	-	-	936
TOTAL	48,968	26,292	11,366	11,364	238,479	-	157,544	4,488	498,501

UGANDA RECOMMENDATIONS

- GRBP headquarters will closely follow the 1997 financial and administrative experience in APOC-supported Kisoro and Kasese Districts. APOC applications should be prepared for Mbale and Kabale in time for the October 1997 TCC meeting.

- The decision was made that GRBP would support activities in Mbale in 1997.

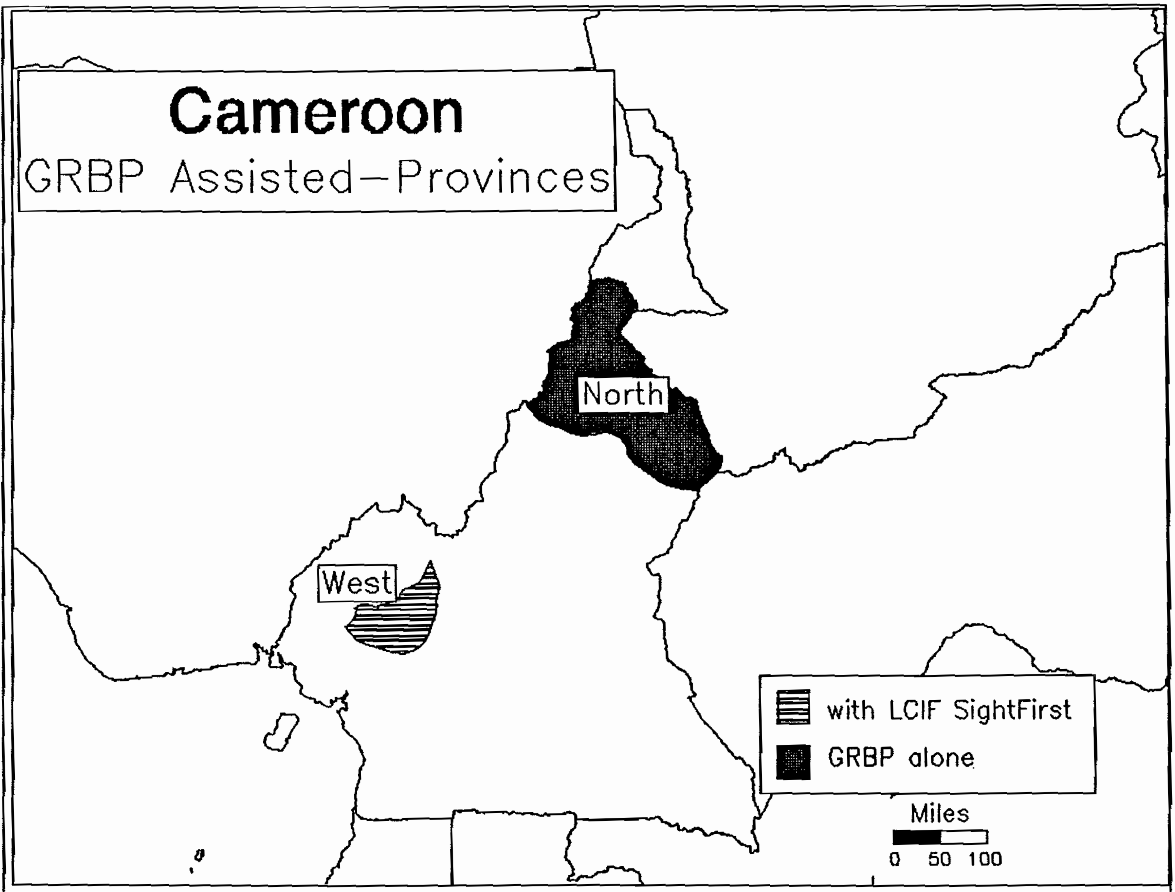
- REMO: Uganda should make a case to APOC that its first priority is to deal with onchocerciasis in highly endemic areas where assessments have already been made. In the meantime, when prioritizing districts for APOC applications in Uganda, consideration should be given to the status of REMO in those areas.

- Seek to publish a report on the sustainability aspects of the Uganda program.

CAMEROON

The new West Province Mectizan® distribution program, which was launched in September 1996 with the assistance of GRBP and Lions Clubs International Foundation's SightFirst program, treated 48,239 persons in 1996 in five health districts. In the North Province, where GRBP/RBF assistance began in 1992, 59% of the 1996 ATO for the eligible at risk population has been reached (53,190), in 93% of the targeted endemic villages (353). The ministry of public health took over the North Province program administration completely in 1996, with GRBP only providing financial assistance for the past year. The low coverage rate for persons treated in North Province results in part from the Government of Cameroon's cost recovery requirement, which follows the directives of the Bamako Initiative. All GRBP-assisted programs in Cameroon are in keeping with the ministry of public health policy of distributing Mectizan® as part of an outreach effort from local health centers, whose nursing personnel take the drug to the villages and distribute it with assistance by community-based health workers appointed by village health committees.

Distribution dynamics in the two Cameroonian provinces vary greatly due to differences in community acceptance of the drug and the cost recovery system. High rates of community acceptance occur in the West Province, but coverage is relatively low due to the fact that adults spend their available money to treat themselves, but not their children. Thus, most treatments are provided there to adults. In contrast, in the North, treatment is not popular among adults, and the 100 CFA charge for Mectizan® results in many adults refusing treatment. However, since children are treated free, coverage is usually best among younger age groups; re-treatment campaigns often require teams to return to villages for a second time to encourage the adults to (pay and) take the drug.


Cameroon
GRBP Assisted-Provinces
North
West
with LCIF SightFirst
GRBP alone
Miles
0 50 100

CAMEROON RECOMMENDATIONS

- Continue efforts to recruit a senior GRBP country representative with capacity for management and technical experience related to Mectizan® distribution.

- Given its national health policy of outreach distribution, Cameroon should test the flexibility of a different orientation of APOC policy (that of community-based distribution) with its revised National Plan. Dr. Brian Duke will offer his assistance in the writing of that Plan.

- Given that blinding onchocerciasis exists in North Province, GRBP should ensure that the treatment program is sustained there. Develop the North Province APOC proposal for the August 1997 TCC deadline. Dr. Brian Duke will assist with writing that proposal. Also, develop a strategy for improving coverage in the North (Brian suggests pushing to reduce cost to 100 CFA per family rather than per individual).

- Expand treatments in West Province to a total of 10 health districts, in accordance to the LCIF action plan. GRBP noted that this expansion will result in projected treatment of more than 400,000 people in 1997, the most ambitious expansion of any GRBP program. Conduct additional REA in the West Province in 1997, and establish better geographic and population data. Closer monitoring for secondary reactions needs to be established given the existence of *Loa loa* in the West Province.

- Improve communications with LCIF and other NGDOs in the coalition. Push for monthly treatment reporting by all NGDOs, and seek to resolve budgetary issues. An external review of the NGDO Coalition should be considered. Experiences between Nigeria and Cameroon with regard to LCIF should be shared. Build the relationship with Lions through additional publicity.

- Seek to publish a report of the cost recovery and sustainability aspects of the Cameroonian GRBP/RBF experience in the North Province.

HEADQUARTERS RECOMMENDATIONS

Help programs to ensure that Mectizan® applications are submitted to MDP in a timely manner to minimize shipment difficulties and delays in receipt.

Get the most thorough endemicity information possible on all villages under treatment possible. The ability to distinguish high risk villages (communities or those with nodule rates $\geq$ 40% or microfilaria rates $\geq$ 60%) is particularly lacking in Uganda and Cameroon. REMO exercises alone do not provide these data; REA at each village does.

APOC: Review all APOC proposal drafts developed by the program offices at least three weeks before they are due to be sent to the APOC Technical Consultative Committee (TCC). Follow the Uganda/APOC administration experience with their districts.

Define Ultimate Treatment Goals (UTG) for each program. The UTG is the figure that indicates that complete Mectizan® coverage has been achieved in the program area of the eligible at-risk population and at-risk villages. When the ATO is established the goal is to try and get closer to the UTG for each country.

Annual Treatment Objective: Headquarters will request a detailed rationale whenever the ATOs change in a monthly report. Similarly, each program is requested to hold the individual district, region, state or country reporting units accountable by keeping a running total of the cumulative figures and querying the regions when their figures do not match.

Headquarters will request monthly reporting on sustainability indices and related issues in 1997.

Headquarters will request information from MDP related to the shipment of Mectizan® for the programs and packaging of Mectizan® in bottles of 3 mg tablets. Information on new distribution procedures needs to be disseminated to the programs on new dosing for children and pregnant women, shelf life, packaging, life span of drug in opened bottles, etc.

GRBP headquarters will continue to emphasize and research the potential for eradicability, and investigate use of the Mectizan® community-based distribution systems for other drugs.

1996 data															
Country/Tx Category		***January***	***February***	***March***	***April***	***May***	***June***	***July***	***August***	***September***	***October***	***November***	***December***	***TOTAL***	***% of ATO***
NIGERIA	ATO(earp)	2,947,000		ATO(arv)	7,014		ATO(hrv)=	5,756							
TX(earp)		16,237	130,052	307,216	375,304	541,215	48,007	50,068	326,764	334,601	19,024	21,803	860,388	3,030,679	103%
TX(arv)			107	1,024	790	1,218	66	80	450	620	83	51	1,636	6,125	87%
TX(hrv)			107	1,024	789	1,203	66	80	448	615	77	46	1,561	6,016	105%
UGANDA	ATO(earp)	648,514		ATO(arv)	1,418		ATO(hrv)=	1,418							
TX(earp)		0	31,723	78,018	90,645	149,308	87,139	18,494	0	0	31,443	10,795	936	498,501	77%
TX(arv)		0	81	291	219	298	138	71	0	0	50	51	31	1,230	87%
TX(hrv)		0	81	291	219	298	138	71	0	0	50	51	31	1,230	87%
CAMEROON	ATO(earp)	207,021		ATO(arv)	620		ATO(hrv)=	620							
TX(earp)					23,836	12,115	8,846	19,372	1,930	1,897	7,866	22,676	2,891	101,429	49%
TX(arv)					132	121	63	34	3			31	17	401	65%
TX(hrv)					132	121	63	34	3			31	15	399	64%
OEPA*	ATO(earp)	328,576		ATO(arv)	1,659		ATO(hrv)=	353							
TX(earp)														197,571	60%
TX(arv)														1,443	87%
TX(hrv)														345	98%
Cumulative totals	ATO(earp)	4,131,111		ATO(arv)=	10,711		ATO(hrv)=	8,147							
TX(earp)	0	16,237	161,775	385,234	489,785	702,638	143,992	87,934	328,694	336,498	58,333	55,274	864,215	3,828,180	93%
TX(arv)	0	0	188	1,315	1,141	1,637	267	185	453	620	133	133	1,684	9,199	86%
TX(hrv)	0	0	188	1,315	1,140	1,622	267	185	451	615	127	128	1,607	7,990	98%

ATO: Annual Treatment Objective TX: Number Treated earp: Eligible At Risk Population arv: At Risk Villages hrv: High Risk Villages (nodule prevalence >39%)

*OEPA figures in November column are cumulative Jan.-Nov. 1996

LIST OF PARTICIPANTS

GRBP Headquarters

Mr. Andy Agle
Ms. Nwando Diallo
Dr. Brian Duke
Dr. Donald Hopkins
Ms. Joni Lawrence
Ms. Wanjira Mathai
Dr. Frank Richards
Mr. Rick Robinson
Mr. Craig Withers

Country Representatives of GRBP Programs

Dr. Edmundo Alvarez - OEPA/Guatemala
Mr. Jean Bangob (Acting)- Cameroon
Dr. Emmanuel Miri - Nigeria
Mr. Dominic Mutabazi (Acting)- Uganda

Centers for Disease Control and Prevention

Mr. Mike Malison
Ms. Sheri-Nouane Johnson

AGENDA

First Meeting of the Country Representatives of the Global 2000 River Blindness Program
The Carter Center
December 9-11, 1996
The Cecil B. Day Chapel

Monday, December 9

Introduction and purpose

8:00 a.m.- 8:15 a.m.	Welcome and introductory remarks	Dr. Donald Hopkins
8:15 a.m.- 8:30 a.m.	Objectives of the Program Review	Dr. Frank Richards

Nigeria

Program reports (continued)

8:30 a.m. - 9:30 a.m.	Nigeria GRBP Presentation	Dr. Emmanuel Miri
9:30 a.m. - 10:30 a.m.	Discussion	Dr. Emmanuel Miri
10:30 a.m. - 10:45 a.m.	Break	
10:45 a.m. - 12:30 p.m.	Discussion/recommendations	Dr. Donald Hopkins
12:30 p.m. - 1:30 p.m.	Lunch in the Copenhill Cafe	

OEPA

Program reports (continued)

1:30 p.m. - 2:30 p.m.	OEPA Presentation	Dr. Edmundo Alvarez
2:30 p.m. - 3:30 p.m.	Discussion	Dr. Edmundo Alvarez
3:30 p.m. - 3:45 p.m.	Break	
3:45 p.m. - 5:15 p.m.	Discussion/recommendations	Dr. Frank Richards

Tuesday, December 10

Uganda

Program reports (continued)

8:00 a.m. - 9:00 a.m.	Uganda GRBP Presentation	Mr. Dominic Mutabazi
9:00 a.m. - 10:00 a.m.	Discussion	Mr. Dominic Mutabazi
10:00 a.m.- 10:15 a.m.	Break	
10:15 a.m. - 12:00 p.m.	Discussion/recommendations	Dr. Donald Hopkins
12:00 p.m. - 1:00 p.m.	Lunch in the Copenhill Cafe	

Cameroon

Program reports (continued)

1:00 p.m. - 2:00 p.m.	Cameroon GRBP Presentation	Mr. Jean Bangob
2:00 p.m. - 3:00 p.m.	Discussion	Mr. Jean Bangob
3:00 p.m. - 3:15 p.m.	Break	
3:15 p.m. - 4:45 p.m.	Discussion/recommendations	Dr. Frank Richards
6:00 p.m. -	Dinner at Vickery's 1106 Crescent Avenue	

Wednesday, December 11

Discussion of 1997 Annual Treatment Objectives, Mectizan® needs, and Sustainability issues

8:00 a.m. - 10:00 a.m.	Nigeria	Dr. Emmanuel Miri
10:00 a.m. - 10:15 a.m.	Break	
10:15 a.m.- 12:00 p.m.	OEPA	Dr. Edmundo Alvarez
12:00 p.m. - 1:00 p.m.	Lunch in the Copenhill Cafe	
1:00 p.m. - 3:00 p.m.	Uganda	Mr. Dominic Mutabazi
3:00 p.m. - 3:15 p.m.	Break*	
3:15 p.m. - 5:00 p.m.	Cameroon	Mr. Jean Bangob
5:00 p.m. - 5:30 p.m.	Conclusion and closing remarks	Dr. Frank Richards