REPORT
OF
The Second Meeting
of the National Onchocerciasis Task Forces (NOTFs) Representatives: sustainability indicators, assessment of projects and lessons learned

Abuja, Nigeria, June 17-22, 2002
CONTENTS

LIST OF ANNEXES ................................................................. ii
ACRONYMS .............................................................................. iii
ACKNOWLEDGEMENT ............................................................ v
EXECUTIVE SUMMARY ....................................................... vii -xiii

1. INTRODUCTION ........................................................................ 1
   1.1 Background ........................................................................ 1
   1.2 Objectives ........................................................................ 1

2. OPENING CEREMONY ...................................................... 2

3. OVERVIEW ON SUSTAINABILITY .................................. 2

4. SUMMARY OF REPORTS ON PROJECT SUSTAINABILITY EVALUATION OF PROJECTS .... 4
   4.1 Guidelines and instruments ............................................. 4
   4.2 Nigeria: Cross River ...................................................... 4
   4.3 Nigeria: Kaduna .............................................................. 5
   4.4 Nigeria: Taraba .............................................................. 5
   4.5 Malawi: Mwanza/Thyolo ............................................. 6
   4.6 Tanzania: Mahenge ...................................................... 7
   4.7 Uganda: Hoima ............................................................. 8
   4.8 Uganda: Kasese ............................................................. 8
   4.9 Uganda: Kisoro ............................................................. 9
   4.10 Uganda: Masindi .......................................................... 10
   4.11 General Comments on Project Presentations ......................... 10
   4.12 Main Findings And Recommendations On Evaluated Projects ....... 12

5. LESSONS FROM PROJECT SUSTAINABILITY EVALUATION BY INDICATORS ............ 13
   5.1 Coverage ..................................................................... 13
   5.2 Planning ...................................................................... 13
   5.3 Leadership .................................................................. 13
   5.4 Supervision and monitoring ......................................... 14
   5.5 Mectizan procurement and distribution ............................. 14
   5.6 Training ..................................................................... 14
   5.7 Sensitisation and Mobilisation ....................................... 15
   5.8 Finance and funding: .................................................... 15
   5.9 Transportation and Material Resources ............................ 16
   5.10 Human Resources ...................................................... 16

6. FRAMEWORK OF PROJECT SUSTAINABILITY PLANS ................................................. 17

7. CRITERIA FOR FURTHER APOC SUPPORT ................................................................. 17

8. CDTI IMPLEMENTATION IN CONFLICT AREAS ......................................................... 18

9. ADDITIONAL SUBJECTS CONSIDERED BY THE MEETING ..................................... 19
   9.1 MACROFIL ................................................................. 19
   9.2 The New Process of Reviewing Proposals ........................ 21
   9.3 CDTI Operational Research ........................................... 21
   9.4 Annual Treatment Objectives and Ultimate Treatment Goal .......... 21
   9.5 Experience of using CDTI as vehicle for sustaining Vit A supplementation in Nigeria 21

10. CONCLUSIONS AND WAY FORWARD ................................................................. 22

11. ANNEXES (1 - 7) ............................................................................. 25
ANNEXES

Annex A : Criteria for further APOC support xi
Annex B : Main findings and recommendations on evaluated projects xiii
Annex 1 : Annotated agenda 25
Annex 2 : Presentation on guidelines & instruments for sustainability evaluation 28
Annex 3 : Group report on problems & solutions by indicators 33
Annex 4 : Project sustainability plans (framework)
  4a - Taraba State CDTI project 39
  4b - KADUNA State CDTI project 41
  4c - MALAWI Phase 1 CDTI project 42
  4d - CROSS RIVER State CDTI project 44
  4e - CROSS RIVER State CDTI Project (LGA PLAN) 46
  4f - UGANDA CDTI projects 47
  4g - MAHENGE Project (Ulanga and Kilombero Districts) 49
Annex 5 : CDTI in conflict areas 51
Annex 6 : Members of the local organizing committee & Facilitators and rapporteurs of final report 53
Annex 7 : List of participants 54
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
</tr>
<tr>
<td>CDTI</td>
<td>Community Directed Treatment with Ivermectin</td>
</tr>
<tr>
<td>NGDO</td>
<td>Non Governmental Development Organization</td>
</tr>
<tr>
<td>TDR</td>
<td>Tropical Disease Research</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WR</td>
<td>World Health Organization Representative</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>HQ</td>
<td>Head Quarters</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>LGA</td>
<td>Local Government Authority</td>
</tr>
<tr>
<td>SOCT</td>
<td>State Onchocerciasis Control Team</td>
</tr>
<tr>
<td>LOCT</td>
<td>Local Government Onchocerciasis Control Team</td>
</tr>
<tr>
<td>NOTF</td>
<td>National Onchocerciasis Task Force</td>
</tr>
<tr>
<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
</tr>
<tr>
<td>CDDs</td>
<td>Community Directed Distributors</td>
</tr>
<tr>
<td>CSD</td>
<td>Chief of Sustainable Drug Distribution Unit</td>
</tr>
<tr>
<td>TA</td>
<td>Traditional Authority</td>
</tr>
<tr>
<td>SWAP</td>
<td>Sector Wide Approach</td>
</tr>
<tr>
<td>SSI</td>
<td>Sight Savers International</td>
</tr>
<tr>
<td>HKI</td>
<td>Helen Keller International</td>
</tr>
<tr>
<td>DOC</td>
<td>District Onchocerciasis Control</td>
</tr>
<tr>
<td>DMT</td>
<td>District Medical Team</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>LGDP</td>
<td>Local Government Development Programme</td>
</tr>
<tr>
<td>PAF</td>
<td>Poverty Alleviation Fund</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>MITOSATH</td>
<td>Mission to Save the Helpless</td>
</tr>
<tr>
<td>GOS</td>
<td>Government of Sudan</td>
</tr>
<tr>
<td>OLS</td>
<td>Operation Lifeline Sudan</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>OCP</td>
<td>Onchocerciasis Control Programme</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>VAS</td>
<td>Vitamin A Supplement</td>
</tr>
<tr>
<td>CME</td>
<td>Continued Medical Education</td>
</tr>
<tr>
<td>FMOH</td>
<td>Federal Ministry of Health</td>
</tr>
<tr>
<td>HAS</td>
<td>Health Surveillance Assistants</td>
</tr>
<tr>
<td>HCAC</td>
<td>Health Centre Area Committee</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENT

The forum is grateful to the Federal Ministry of Health (Nigeria), APOC management, UNICEF/Nigeria, WHO/Nigeria and the NGDO Coalition for Onchocerciasis Control for their support.

The National Onchocerciasis Control Task Force (Nigeria), the Nigeria National Onchocerciasis Control Programme Coordinator and his team, the Local Organizing Committee and the NGDO coalition/Nigeria (The Carter Center, ChristoffelBlinden Mission, Helen Keller International, Mission to Save the Helpless, Sight Savers International, UNICEF) are commended for their assistance in making the meeting a huge success.

The input of the CDTI Sustainability evaluation team, facilitators, rapporteurs, support staff and NOTF/Nigeria Workshop Organizing Committee is highly appreciated.
EXECUTIVE SUMMARY

The second meeting of National Onchocerciasis Task forces (NOTF) representatives of countries in the African Programme for Onchocerciasis Control (APOC) was held in Abuja, Nigeria from June 17th to 22nd 2002. Besides representatives of NOTF, other participants included: Representatives of UNICEF, WHO/Nigeria, APOC Management staff, APOC/ TCC members, Core group on sustainability of CDTI and evaluators who recently carried out assessments on sustainability of seven CDTI projects in nine (9) geographically distinct areas.

The main objective of the meeting was to create a common understanding of the meaning, importance, and measurement of sustainability of CDTI projects as well as practical implications of future work of countries and APOC support in this area. The focus of the meeting was on pooling and learning from results of the above CDTI assessments.

The meeting was opened by Dr. Suleman Sani, Director Hospital Services Federal Ministry of Health, on behalf of the State Minister of Health. Participants worked in plenary and group sessions to, analyze findings of evaluation of sustainability of individual CDTI projects; analyze findings related to groups of sustainability indicators across the nine projects and make relevant recommendations on how emerging issues should be addressed.

Evaluation of Projects for sustainability

Evaluation reports on the sustainability of the projects referred to above: Malawi (Mwanza/Thyolo), Uganda Phase I (Kasese, Kisoro, Masindi, Hoima), Nigeria (Taraba, Cross River, Kaduna), and Tanzania (Mahenge) were presented and discussed. Assessment of Kogi CDTI project in Nigeria will be undertaken by November, 2002. These assessments were carried out by teams of national and outside experts, over a period of 10 to 14 days using guidelines and instruments developed by the core group on sustainability and field tested in one project.

Indicators of sustainability

Assessments were based on nine groups of Indicators of sustainability grouped into the following three categories.

- **Indicators of Results (1 group):** Coverage- geographical and therapeutic
- **Indicators of CDTI support activities (5 groups):** Planning, Leadership, Monitoring and Supervision, Mectizan supply and distribution, Training and Mobilization/Sensitization;
- **Indicators of Resources provided (3 groups):** Finance and funding, Transport, other Material resources and Human resources.

Numerical grading was used to summarize assessment findings at community, sub-district, district, State/Region and national levels. Overall assessments of individual project also with numerical gradings were also carried out.

An important innovation in the process of evaluation was the convening of feedback/planning meetings involving the evaluators, policymakers (state/ district and sub-district authorities), planners and implementers. The meetings provided an opportunity to deliberate on findings and to develop plans to address identified problems.

Findings and Lessons from evaluation

A mixed picture emerges from the findings. The meeting was pleased to note that, on the whole, distribution of Mectizan® was being carried out satisfactorily in all the nine projects, reaching most communities under treatment in time including communities in very difficult-to-reach areas. National project coordinators in all projects are well trained and have adequate skills to effectively coordinate all CDTI activities. Communities everywhere were enthusiastic and willing to play
their part in CDTI and the programme were graded highly sustainable at the community level in seven projects. In few instances, projects have succeeded in forging an interesting network of collaboration with other indigenous NGOs and government organizations who have been involved with promotion of CDTI implementation. In six of the 9 projects evaluated, most key CDTI activities have become well integrated into the routine functioning of government health delivery systems at LGA/district and front line health facility levels.

Since the PHC system is poor and/or non-functional in most countries, inadequate human resources at the front line health facility level necessitated innovations: the use of supervisory staff paid by local NGOs in Cross Rivers state, Nigeria and educated community members as ‘volunteer’ supervisors in Uganda projects, but paid with APOC funds.

However, many problems, some of them critical, that stand in the way of sustainability were identified. For example, while geographic and therapeutic coverage rates are high in the majority of projects, unacceptable low levels were found in few villages. Planning in all projects is largely APOC / NGDO driven and related to funding request, resulting in a top-down process which often works against integration and excludes non-CDTI staff and other stakeholders. Though there exist clear budgetary provisions with CDTI well represented in the general budgets of most districts/LGAs, none of the projects has made serious plans on financial sustainability after APOC support ends.

Key political leaders and decision makers at different levels are not adequately sensitized and mobilized towards providing funds and other support to CDTI. In fact, programs in some districts were described as a “one-man-Show.” Lower levels of the system particularly the sub-district in several projects are not empowered to identify and solve problems. Front line health facilities were often written off as being poorly staffed and overworked. In these circumstances training and supervision of CDDs is carried out by staff at higher levels, bypassing health facility staff. However many projects recognizing the crucial role of sub-district and frontline health facilities have built their capacity to play an active role in CDTI within their limitations. The meeting agreed the use of remunerated ‘voluntary’ supervisors was necessary since the number of health personnel is not adequate to cope with the supervision needs of some communities but acknowledged the need to address the problem of remunerating supervisors in post-APOC period.

Another important lesson is that issues previously identified in monitoring progress of some projects had not been acted on, the same issues emerged from the evaluation. The major lesson from the evaluations is that most of what should be done is known, action is what needs to be intensified. On the nine projects, the meeting came to the conclusion that seven were making satisfactory Progress towards sustainability, two were not.

Building on lessons
The meeting spent considerable time examining different ways in which lessons emerging from the analysis of all the projects could be used to spearhead and intensify action on problems identified in individual projects. It was clear that those projects that had not made headway towards sustainability in five years needed a fundamental rethinking if sustainability objectives are to be achieved. The meeting’s view was that it couldn’t be “business as usual” for any project.

Using lessons from the pooled experiences the meeting elaborated sustainability plans to address shortcomings for each of the evaluated projects. The plans were referred to as Frameworks, recognizing the fact that suggestions and recommendations from the meeting will only become plans once they have been discussed, modified and agreed on by national teams. The framework indicates, problem identified in the evaluation, solution, who will do what, when and fund sources. It was recommended that a sustainability plan and budget be developed by all projects.
Evaluation findings presented a challenge not only to countries but also to APOC. How should APOC respond? Clearly the objective of APOC is that all CDTI projects should be sustainable, there is no question of abandoning any. It was felt strongly that APOC should intensify its advocacy role on CDTI to high level decision makers in countries. The meeting developed criteria for APOC support to projects in their fifth year (Annex A) and made specific recommendations on actions to be taken by APOC with respect to findings made by the evaluation teams. Annex B contains main findings and recommendations on action to be taken by countries and APOC on evaluated projects.

The meeting considered the planning meetings organised after evaluation of projects as being of great importance. APOC Management and senior decision makers in project countries should be encouraged to participate. The meeting also emphasised that sustainability assessment should be built into projects and start from the onset.

The meeting noted with satisfaction that some projects have started using CDTI as an entry point for implementing other programs (Helen Keller International and Vitamin A distribution in Nigeria). Participants observed that this experience confirms that CDTI provides a workable opportunity for integration of health programs. The meeting encouraged APOC to support integration of other drugs, such as Vitamin A supplement and praziquantel and other PHC activities into CDTI system.

**CDTI implementation in conflict areas**
Following the presentation and group discussions on CDTI implementation in conflict areas the meeting approved a framework of flexibility and promotion of CDTI through integration with activities of other humanitarian agencies working in conflict areas. APOC should respond by reaching technical agreements with these agencies. At country level the meeting advised projects to promote the use of CDDs in health and development emergency activities. It was recommended that APOC should continue to explore opportunities to reaching inaccessible areas including the use of high level advocacy for a cease-fire to administer treatments to affected communities.

**Drug development**
The meeting appreciated briefing provided on developments related to Moxidectin for the treatment of Onchocerciasis and noted with satisfaction the progress so far made. The meeting urged NOTF to participate actively in Phase III clinical studies on Moxidectin.

**Way-forward**
Discussions at the meeting were frank, focusing on needs of affected communities. Behind the approach taken by the meeting was the conviction that the best tool countries have to improve CDTI is learning from each other through pooling experiences, enabling individual countries to take action on pooled experiences. Collective pressure was seen as having great potentials for enhancing action in individual projects.

Innovation and operational research were seen as important strategies for finding solutions to difficult problems. A good example of innovation presented at the meeting was the deployment of non-health personnel as “volunteer” supervisors to CDDs. The volunteers include teachers who reside in communities and carry out tasks that would normally be carried out by health facilities. The volunteers receive some remuneration for the work done. Discussions are now under way to decrease their numbers to a level that can be financed by districts. Learning by doing of this nature should be encouraged and supported by APOC so that it is carried out in an organized way and results disseminated widely.
Concern was expressed by some participants that the evaluation instruments were too long. Some suggestions on how the number of indicators can be reduced were made at the meeting. It was also indicated in the meeting that the core group on sustainability plans to address this issue and that of manual.

Participants agreed that the Abuja meeting was a milestone in the effort of countries and APOC to enhance sustainability of CDTI. The meeting realized that many challenges lay ahead. For example, often only a portion of the population at the national or district levels is at risk of onchocerciasis. This makes the problem less “visible” to policy makers. Secondly a number of communities in APOC countries are in persistent conflict areas. In some project areas, because of poor terrain, no means of transportation is adequate except walking. The meeting called on all participants and partners to do whatever is in their power to augment and maintain the CDTI sustainability movement created at Abuja.
Annex A: CRITERIA FOR FURTHER APOC SUPPORT

The meeting developed the following criteria for use by APOC management in considering exceptional support to a project after its fifth year.

The Process:

- All projects should be monitored at end of the first year.
- A mid-term evaluation of sustainability should be carried out during the third year of CDTI implementation. The Midterm evaluation is very crucial to sustainability, APOC should use the results for determining areas of support to guide projects towards sustainability.
- For projects that have passed the third year without evaluation, APOC should use the report of external monitors as guide for initiating follow-up action.
- Fifth year evaluation of sustainability should be carried out on all projects that have passed through four years of APOC support and the findings used to determine the level and type of further assistance to be provided by APOC.
- Results of the Fifth year evaluations should be in classifying projects into three categories:
  - Fully sustainable
  - Making satisfactory progress towards sustainability
  - Not making satisfactory progress towards sustainability

For projects that are FULLY SUSTAINABLE, APOC should cease further support and continue to monitor its sustainability without such support.

For projects that are MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY, APOC should provide further support for the 6th to 8th year of CDTI implementation if the projects meet the following conditions:

- There should be a 3 year, post-APOC plan for sustainability
- All of previous year’s budget was released by government.
- Evidence that an effort has been made to address the issues raised during the Mid-term evaluation.
- Evidence that resources have been used for planned activities.
- Evidence that 100% geographic coverage and an acceptable (higher than 65%) therapeutic coverage has been attained.

For projects that are NOT MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY, APOC funding should cease until there is satisfactory evidence that critical issues raised in the evaluation report are being addressed by the government at all levels and changes made in project leadership.

APOC should support the following activities:

- Capacity building to strengthen project sustainability especially regarding:
  - Effective management of scarce resources
  - Advocacy and local resource mobilisation
  - Leadership
  - Data / information management
  - Advocacy for commitment of government to continue to support CDTI
- Capital equipment replacement
- External monitoring and evaluation
- Mapping (REMO)
- Operational research to improve implementation of sustainability of CDTI
**APOC should not support**

- Salary top ups
- Routine CDTI activities such as CDD training, monitoring and supervision and distribution of Mectizan
- Running cost for motor vehicles
- Cost of Consumables
- Internal procurement and transport of Mectizan
## Annex B: MAIN FINDINGS AND RECOMMENDATIONS ON EVALUATED PROJECTS

<table>
<thead>
<tr>
<th>#</th>
<th>PROJECT</th>
<th>STATUS</th>
<th>MAIN FINDINGS &amp; RECOMMENDATIONS</th>
</tr>
</thead>
</table>
| 1 | CROSS RIVER | - Coverages were satisfactory  
- There is integration into the health system  
- Strong networking and collaboration with indigenous NGOs  
- Routine supervision and training  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 2 | KADUNA | - Routine planning at the State level is made  
- State gives financial support.  
- LGA leadership is not fully sensitized  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Sensitize and involve LGA leadership  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 3 | TARABA | - Well integrated into the health system  
- Communities are well mobilized and involved  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 4 | MALAWI CDTI (MWANZA/THYOLO) | - Not integrated into the health system except at district level  
- Unsatisfactory geographical coverage  
- CDTI not in place  
- Heavily dependent on APOC funds | Project is not making satisfactory progress towards sustainability.  
- APOC funding should cease after the fifth year until satisfactory evidence that critical issues raised in the evaluation report are being addressed by the government at all levels, especially changes in leadership.  
- New leadership should prepare plan to establish a sustainable CDTI plan  
- Seek local dependable sources of post-APOC funding |
| 5 | MAHENCE | - CDTI is not understood by CDDs  
- Training of CDDs was done only once to a few in two years  
- Not integrated into health system  
- Communities are not involved  
- Heavily dependent on APOC funds | Project is not making satisfactory progress towards sustainability.  
- APOC funding should cease until satisfactory evidence that the government is addressing critical issues raised in the evaluation report at all levels, especially changes in leadership.  
- New leadership should prepare plan to establish a sustainable CDTI plan  
- Seek local dependable sources of post-APOC funding |
| 6 | UGANDA PHASE 1 CDTI (HOIMA) | - Geographical coverage is high  
- Integrated into the PHC at the district level  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 7 | UGANDA PHASE 1 CDTI (KASESE) | - Geographic and therapeutic coverages are high.  
- Well integrated into PHC at the district level  
- Heavily dependent on APOC | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors |
| 8 | UGANDA PHASE 1 CDTI (KISORO) | - There is budgetary allocation for CDTI at district level  
- Integrated into the PHC at the district level  
- Routine training and supervision  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors |
| 9 | UGANDA PHASE 1 CDTI (MASINDI) | - Integrated into the PHC system and supported from PAF  
- Political commitment is high  
- Staff are well trained and motivated  
- Inefficient use of resources  
- Low level of community ownership of CDTI  
- Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors  
- Intensify sensitization and mobilization of communities |
1. INTRODUCTION

1.1 Background
Mectizan®, the first drug suitable for large-scale treatment of onchocerciasis was donated by its manufacturers, Merck & Co. in 1987 for the control of onchocerciasis for all that need it, for as long as needed. Large-scale treatment programmes were subsequently developed in several countries in Africa with the assistance of Non Governmental Development Organisations (NGDOs). Studies supported by TDR/WHO between 1994 and 1995 established that higher coverage was achieved when communities played a major role in planning and directing treatment activities, than when they played a passive recipient role.

APOC was set up in 1995 to establish sustainable community directed systems for Mectizan® (Ivermectin) delivery to over 50 million people in 19 countries with the ultimate goal of eliminating onchocerciasis as a disease of public health importance. At present APOC is supporting 64 CDTI projects in 14 countries and more than 20 million people in about 50,000 communities are receiving treatment annually. APOC’s major concern is how to sustain current treatment coverage rates since treatment has to be continued as long as the adult worm remains productive, a period which is estimated to be up to 20 years. APOC, therefore, advocates and supports strategies that enhance sustainability of treatment activities in countries. These strategies include empowerment of communities, establishment of sustainable logistic support required for safe and timely delivery of Mectizan® and effective monitoring of the process of treatment. APOC’s sustainability strategy encourages the integration of onchocerciasis control to health care delivery systems. While countries have made considerable progress towards project ownership, competing demands and diminishing resources, social upheavals, natural disasters and multitude of pandemic diseases, have made it difficult for countries to meet their responsibilities in CDTI implementation.

A commissioned study on sustainability and a midterm evaluation of APOC, highlighted the need of developing plans for CDTI sustainability. APOC therefore formed a core group to develop guidelines and instruments for evaluating selected indicators of sustainability of CDTI projects. Seven CDTI projects in nine geographically distinct areas that are in their fifth year of CDTI implementation with APOC support have recently been evaluated using these guidelines and tool. In this report the word “project” shall be used for each geographic areas for sake of simplicity and clarity. The projects are in Nigeria (3), Malawi (1), Tanzania (1) and Uganda (4). The tenth project, (Nigeria: Kogi) is yet to be evaluated. The Abuja meeting provided an opportunity for discussing findings from the evaluations and making recommendations on the way forward for CDTI sustainability.

1.2 Objectives
Major Objective of the meeting was to create a common understanding of the meaning, importance and measurement of sustainability of CDTI projects as well as practical implications on the future work of countries and APOC support in this area.

Specific Objectives were to:
1. review and learn from findings and experiences of the evaluation on sustainability of the initial APOC supported projects, recently carried out.
2. Create awareness of non-sustainable systems and develop corrective plans.
3. Develop skills and instruments to carry out assessments of sustainability of CDTI Projects on a continuous basis.

4. Develop packages for assessing sustainability of CDTI Projects from their early stages.

5. Develop framework for country plans to promote sustainability.

6. Develop framework for plans of APOC HQ and its supporting bodies to provide support to countries to enhance/maintain sustainable projects.

7. Develop criteria for decisions on intervention support to projects, particularly after five years.

8. Reach agreement on the way forward for projects, particularly those in the final year, the support to be provided so that they achieve/maintain sustainability.

9. Address other relevant operational and management issues.

Participants worked in plenary and working groups to achieve the above objectives. The agenda for the meeting was agreed upon with minor modification (Annex 1).

2. OPENING CEREMONY

The Director of Public Health Services, Dr A.O. Asagba welcomed participants to the workshop. The Representative of the World Health Organisation in Nigeria (WR), Dr A. Moudi, in his address, stated that WHO now has offices in the 36 states of Nigeria and Abuja. Surveillance officers in each of these offices will assist in facilitating integrated disease control activities and monitoring (including CDTI). The UNICEF representative in Nigeria, represented by Chief of Water Environment and Sanitation, William Fellows, informed the gathering that onchocerciasis control is now part of core UNICEF activities in Nigeria. The Chair of NGDOs Coalition in Nigeria, Dr Elizabeth El-hassan reported that NGDOs in Nigeria have invested more than $20m in Nigeria for onchocerciasis control and will continue to support the projects. In his address, Director APOC, Dr A. Seketeli stressed the importance of policy makers in the success of CDTI and gave instances to demonstrate how policy makers can either “kill” or help sustain” CDTI. The take home message was that satisfactory progress towards sustainability would be the prerequisite for continued APOC funding. The Chairman of the occasion, Prof. Olikoye Ransome – Kuti in his remarks stated that he was delighted that CDTI emphasises integration into Primary Health Care and encouraged project managers to intensify efforts in this direction. Prof. Prozesky, one of the coordinators of the sustainability evaluation exercise, made a brief presentation on the nature and importance of sustainability. The Minister of State, Federal Ministry of Health who was represented by Director of Hospital Services Dr Suleiman Sani, formally declared the meeting open. The Chairman of the NGDO coalition in Nigeria Dr Elizabeth El-hassan gave a vote of thanks

3. OVERVIEW ON SUSTAINABILITY

In an overview on sustainability, Detlef Prozesky reviewed the past, present and future of CDTI. He traced the origin of the concern on sustainability of CDTI to the APOC midterm evaluation. The report of the evaluation revealed that though considerable input has gone into the implementation of CDTI, very little planning is in place for mobilization of resources for continuation of CDTI after funding by APOC ceases. In compliance with the recommendations of the mid-term evaluation team and in reaction to directives by JAF, APOC Management in 2001 set up a core team to develop indicators for monitoring sustainability in CDTI. Subsequently teams were commissioned to evaluate prospects of sustainability in 10 projects under the following terms of reference:

Short term
•To develop a framework with realistic and measurable indicators of sustainability
•To evaluate the current situation of fifth year projects regarding sustainability
• To assist local stakeholders to develop plans for sustaining these projects.

*Long term*

• To prepare a manual containing guidelines and instruments for sustainability evaluation

Detlef Prozesky presented the following definitions of *sustainability* based on lessons leant during the evaluation of Expanded Programme on Immunization (EPI).

An activity is considered *sustainable* if the necessary political decisions, administrative measures, resources (financial, human, material) are in place and can reasonably be expected to continue being so for the foreseeable future.

*Thus Self-sustainability* is the ability of a project to continue functioning effectively, using both its own resources and those provided from outside, provided the latter are dependable. He indicated that the core team identified *Effectiveness, Efficiency, Simplicity, Integration, Attitude and Resources* as the main aspects of sustainability.

*Indicators of sustainability* were subsequently developed by the sustainability core team and grouped into the following three categories.

Indicators of *results* achieved (1 group): Coverage

Indicators of CDTI *support* activities (5 groups): Training and mobilisation/sensitization, Supervision and monitoring, planning, leadership, and Mectizan supply

Indicators of *resources* provided (3 groups): Finance and funding, Transport and other material resources, and Human resources.

He recommended that *future plans for ensuring sustainability of CDTI should include* further refining of the instruments and manual, setting up of experienced evaluation teams, working out a way to help projects start moving towards sustainability early in the life of the projects, and working out how to help projects which are struggling to become sustainable. Finally, he observed that the workshop is a critically important step in the process of achieving sustainability for all CDTI projects.

In reaction to the presentation, the following concerns were raised:

- The instruments were too long.
- Difficulty in achieving project sustainability when various levels of CDTI implementation are taken into consideration.
- The definition of sustainability used for the evaluation is too dependent on attitudinal change.

In response, the presenter indicated that there were ongoing efforts to reduce the size of the instruments. He also stated that countries and independent evaluators can develop country-specific instruments for evaluating their own projects. On the second issue, he noted that though the communities are doing well, all the levels are interdependent and so their levels of sustainability should be integrated before deciding whether a project will be sustainable. However, the level of resources needed to achieve satisfactory levels of sustainability will vary, and it is possible that not much input will be required to achieve sustainability at the community level.
4. SUMMARY OF REPORTS ON PROJECT SUSTAINABILITY EVALUATION OF PROJECTS

4.1 Guidelines and instruments

Detailed presentation of the Sustainability Evaluation Guideline and Instruments was made by Joseph Okeibunor (Annex 2). At this point it was agreed that the term sustainability should replace self-Sustainability and that 65% therapeutic coverage be regarded as the minimum level to target. Therapeutic coverage should be calculated using the entire population as the denominator. It was recommended that the instrument be adapted for use in conflict areas and follow-up plans be made for monitoring implementation of activities in sustainability plans.

4.2 Nigeria: Cross River

The report on sustainability evaluation of Cross River CDTI project presented by Chukwu Okoronkwo, revealed that although Ivermectin distribution in the State started in 1995, CDTI was introduced in 1997. Fourteen (14) LGAs are under treatment. Geographic and therapeutic coverage rates are satisfactory. Commitment to, and planning for, sustainability of CDTI exists at all levels. Most key CDTI activities have become well integrated into the routine functioning of government health delivery system. There is integrated supervision and data is collected and reported entirely within the government system. The National Park staff paid by their Agency assist with supervision in difficult terrain where PHC is non-existent. Sufficient Mectizan tablets are collected and distributed in good time. Personnel are skilled, knowledgeable and fairly stable. Communities value Mectizan and are willing to contribute and in most cases have made arrangements to sustain local costs of distribution. The project has succeeded in forging an impressive network of collaboration with other indigenous NGOs and government organizations which promote CDTI.

However, routine supervision is done in communities without using supervisory checklists. Training is frequent and annual but does not address particular needs. Training and IEC materials are available but not in sufficient quantities for all the levels. The State and some LGAs had made financial contributions in the past but these are decreasing and in some cases non-existent. The project depends on APOC funding for routine activities such as training, collection and delivery of Mectizan and monitoring. Vehicles and other equipments are available but there are no dependable plans to effect major repairs or make replacements when they go bad.

Overall, the project has made satisfactory progress towards sustainability.

It is recommended that the project should prepare a comprehensive plan for post-APOC activities. Supervisory visits should be justified and checklists used. Training needs should be identified and only necessary training carried out. Project should make alternative but dependable arrangements for Mectizan collection from Lagos. There is need for high-powered advocacy visits from APOC to policy makers on the need for allocating adequate resources for CDTI activities.

The Nigeria National Onchocerciasis Control Coordinator agreed with the findings of the evaluation but observed that despite non-financial contribution from State Government the project has made tremendous strides towards sustainability with limited funds. The UNICEF representative, on the other hand, pointed out that there is no serious shortage of resources in Nigeria. What is required is advocacy to policy makers and general populace to use some of the available resources for CDTI. However, he will like to have data showing the impact of CDTI,
for use as a tool for advocacy. Director of APOC informed the meeting that APOC will soon embark on an impact analysis that will produce the 'impact' advocacy tools.

4.3 Nigeria: Kaduna

In presenting the Kaduna CDTI project sustainability evaluation report, Detlef Prozesky noted that the project was one of the first to receive APOC support.

Communities carry out their responsibility of registration, census and distribution effectively and CDTI activities of the most peripheral level (the village) appear to be sustainable, even now. The project is well integrated into the official health system. However supervision and monitoring is routinely done at all levels but not in a cost-efficient manner. Training, community mobilization and sensitisation are carried out routinely every year, without considering need. The planning at the State level does not address CDTI sustainability. Transport is sufficient at State but not available at the LGA level. In all cases transport is poorly managed and there are no plans for future replacements. There is guaranteed funding from the State for the future, but the amount is less than the funding requirement and there is no plan in place to tailor future activities to available funds. No budgetary allocations are made for onchocerciasis control at the LGA level, although in some, funds are released for CDTI activities as needs arise. There is commitment at State level but at the LGA level there is very little understanding of the programme and therefore little commitment, the LGA level particularly needs attention.

Overall, the project has made satisfactory progress towards sustainability

It was recommended that a sustainability plan and budget be developed within the resources of the State, for 2003 and subsequently drawn up annually. Training must be made specific to need, with particular attention given to new staff. The leadership at LGA level should be fully sensitised and involved in CDTI activities. Those LGAs, which are not yet allocating funds yearly for CDTI, must be strongly motivated to release some funds, however small. A system of strict control of the programme motorcycle needs to be instituted and a specific, realistic, dependable plan must be made for sourcing and using transport (vehicles, motorcycles, bicycles etc).

The Nigeria National onchocerciasis control Coordinator noted that onchocerciasis control programme in Kaduna is one of the oldest in the country and that APOC and NGDO support has further energised it. He is therefore not surprised that the project is sustainable. On funding, he noted that the LGAs are in a much better position to make financial contribution to CDTI activities than the State, if sensitisation is intensive and LG policy makers fully involved. The WR/Nigeria urged project implementers that are judged to be on the right direction not to rest on their oars but to move steadily towards full sustainability.

4.4 Nigeria: Taraba

Oladele Akogun presented the report of the sustainability evaluation of Taraba CDTI project. The meeting was informed that the Taraba CDTI project had just entered the 5th year of APOC support. The project is observed to be effective at all levels and actual treatment is on going. It is well integrated into the health system. Knowledge and acceptance of the programme by stakeholders is strong and CDTI activities at the community level are highly sustainable. Required routines are generally simple and easy to carry out (except the key area of community census).
However, many activities are not properly targeted, resulting in inefficient use of scarce resources. LGA and health facility level implementers are not yet fully empowered to carry out tasks at their level, and such tasks are often carried out by higher-level staff. The project still relies heavily on APOC. The key issues of planning, funding, transport, and delegation of responsibility need to be addressed for sustainability to be achieved.

**Overall, Taraba CDTI project has made satisfactory progress towards sustainability**

Evaluators recommended that the project plan its activities within limits of locally dependable resources. It was also recommended that training and supervision be targeted and LOCTs and district level staff be empowered to take full charge of activities at their levels. The project was advised to rationalise to achieve maximum efficiency in a creative manner rather than carry out activities in a routine manner.

Three feedback and sustainability planning workshops were held, one for the SOCT, and two for LOCT. Six LGAs attended each of the LOCT workshops. Although there is considerable agreement between the plans produced in this way and the recommendations that the evaluators made in this report, most of the plans still need to be refined. Finally, the plans need to be meticulously implemented, if the sustainability of the Taraba project is to be assured. APOC should consider follow-up training to ensure implementation.

The Nigeria National onchocerciasis control Coordinator agreed with the overall rating, which he attributed to the cordial relationship between the two NGDOs working in State and the MOH.

**4.5 Malawi: Mwanza/Thyolo**

Sustainability evaluation report on Malawi CDTI project in Mwanza and Thyolo Districts presented by Obinna Onwujekwe, showed that onchocerciasis is endemic in seven districts, five of which fall into other districts. Only Thyolo/Mwanza project, which is in its fifth year of APOC support was evaluated.

The government waives custom duties on all in-coming project items and actually pays handling charges arising from the clearing of ivermectin. At the Traditional Authority level (health centre level) health surveillance assistants routinely supervise CDTI activities in an integrated manner. A high level of integration of health care services was also found at the District level. However, CDTI is not in the national health care plan and there are no budgetary allocations for the programme. New Directors in the Ministry of Health are unaware of CDTI project activities in Malawi and have not considered any plans for sustaining the programme when APOC funding ceases.

Political leaders at the District level are not adequately sensitised and mobilized towards providing funds to support CDTI. Neither are health education and IEC materials readily available in the districts. In addition, there are no explicit plans to cover the recurrent costs of running existing transport or to replace them. At the Traditional Authority (TA) level, Chairmen of Health centre Area Committee (HCAC) and Medical Assistants are unaware of CDTI activities. Transport facilities are inadequate, affecting CDTI activities, especially in Mwanza. Political and traditional leadership in the communities are not properly mobilised for supporting CDTI activities at that level. Health Surveillance Assistants (HSA) deliver Mectizan to them. Registers and other CDTI records are poorly kept thus reflecting the weakness of training and supervision mechanisms. Community members are not adequately sensitised and mobilized to meet their
responsibilities. Geographic and therapeutic coverage was good in most communities but both political and traditional leadership were not part of the mainstream CDTI programme.

**Overall, the project is not making satisfactory progress towards sustainability.**

It was recommended that top level civil servants and politicians (Directors, Permanent Secretaries, Ministers and Parliamentarians) in the Ministry of Health should be sensitised and properly briefed about CDTI, and a participatory detailed implementation plan involving Districts should be developed. Implementers at the District, Health Center and community levels should be empowered to implement CDTI. Project should intensify sensitisation and mobilization as well as training of CDDs.

The Malawi National onchocerciasis control Coordinator complained that the method of evaluation influenced the responses received. He gave example of how a new Director of Health was asked about CDTI and being new on the job could not provide the required information. APOC Chief of Sustainable Distribution (CSD), Dr U. Amazigo informed that the findings of the evaluation agreed with both the World Bank and APOC monitoring reports, which were independently conducted.

4.6 Tanzania: Mahenge

Sebastian Baine presented the sustainability evaluation report on Tanzania CDTI Phase project in Mahenge district, which is the only APOC-supported project in Tanzania that has reached fifth year. The project was observed to be effective at the national and community levels but not at the regional and district levels. At the National level, the CDTI is integrated in the Annual Health Plan and has its budget, though release of funds is always untimely and inadequate.

Geographic and therapeutic coverage rates are low. Resources are not efficiently used at the district level while communities and wards are yet to be fully empowered to carry out their responsibilities within CDTI. Many CDDs had not been trained except a few personnel that received training once two years earlier and therefore had very little knowledge of CDTI concept. The project is not fully integrated into the district health system. Focal persons are not in the regions and general coordination between the national, regional and district is weak.

**Overall, the project is not making satisfactory progress towards sustainability.**

It is recommended that a detailed post-APOC implementation plan that is dependent on local resources be developed for the district. Community sensitisation and mobilisation should begin immediately. Empowerment of the communities should be given high priority. Regions and District Medical Officers should be involved in planning. Geographic and therapeutic coverage rates should be improved to acceptable levels. Advocacy to government for funding should be undertaken and other local sources of funding identified.

The National onchocerciasis control Coordinator informed the meeting that Ulanga district will be strengthened by the health reform going on in Tanzania but that Kilombero district will not benefit from the reforms until much later. The meeting was also informed that CDTI will benefit from the common pool income system referred to as Sector Wide Approach (SWAp) being introduced in Tanzania.
4.7 Uganda: Hoima

The report of the sustainability evaluation team presented by Joseph Okeibunor noted that the Hoima CDTI project, which is in its fifth year of APOC funding, is effectively implemented at all levels. Both geographic and therapeutic coverage rates were high. The project is well integrated into the health care system at the district level. Community members (non-health personnel) act as “volunteer” supervisors to CDDs in communities with inadequate personnel and non-functional peripheral health facility, but are paid by APOC Funds. The District Development Plan, formulated in a bottom-up participatory manner includes specific CDTI activities. Mectizan ordering system is effective and integrated with the government system at district level; its distribution is reliable at community level.

However, there is weak integration of CDTI into the health care systems at the sub-county health centre level. Resources are inefficiently managed as activities such as supervision, monitoring and training are routinely undertaken without reference to specific needs. The project relies heavily on APOC funding for the implementation of CDTI at all levels and depends heavily on the NGDO for initiating CDTI activities.

Participants at the CDTI sustainability-planning workshop identified a number of opportunities for the sustainability of CDTI in Hoima, post-APOC. These included the existence of Poverty-Alleviation and PHC funds allocated to the District from the National to address specific problems, including elimination of onchocerciasis. Threats to sustainability of CDTI such as the weak PHC system, inadequate health personnel at the health centre levels as well as the use of ‘volunteer’ non-health system supervisors paid from APOC funds. The NGDO partner (SSI) indicated willingness to support control efforts as long as onchocerciasis remains a public health problem in Uganda.

*Overall, Hoima CDTI project has made satisfactory progress towards sustainability*

It was however, recommended that the use of ‘volunteer’ non-health system supervisors should be addressed especially how funds would be found to remunerate them when APOC funding ceases.

The National onchocerciasis control Coordinator agreed with the findings of the evaluators and promised that the plans for sustainability will be followed. The representative of the partner NGDO (SSI) indicated that SSI would encourage the district to take the lead in initiating activities. He also indicated that SSI would not provide all the post-APOC costs to the project.

4.8 Uganda: Kasese

The report of the Kasese District CDTI project sustainability evaluation presented by Joseph Okeibunor, shared that the project is well integrated into the health system at the District level. The project is effectively implemented at all levels with high therapeutic and geographic coverage rates. There is good political will and high commitment to sustainability of CDTI. Knowledge and acceptance of the programme by the district and community is strong and CDTI activities at the community level are highly sustainable.

Resources are inefficiently managed and CDTI activities such as supervision, monitoring and training are routinely implemented. Integration of the project at the health centre level is weak and sub-county implementers are yet to accept that the project will eventually be sustained with locally available resources. Mectizan is released at all levels in instalments because of fear of seizure of tablets by rebels during insurgence. The project still relies heavily on APOC funds for
the implementation of CDTI activities at all levels. Human resources at the health centre level are inadequate, necessitating the use of ‘volunteer’ supervisors, who are paid with APOC funds. The low level of awareness among some health personnel was also noted.

At the CDTI sustainability-planning workshop participants from the District identified some local partners whose input will enhance sustainability, namely:

- Belgium Technical Cooperation, which supports development of the agricultural-cum-health sector of the District.
- Kasese Cobalt Company Limited, which funds some development activities in the District.
- The National government allocates Poverty Alleviation and PHC funds (conditional funds) which the National government provides to the Districts for the elimination Onchocerciasis among other diseases
- The existing Continued Medical Education programme provides opportunity for introducing Onchocerciasis and CDTI to all the personnel in the entire health system.

**Overall, Kasese CDTI project has made satisfactory progress towards sustainability**

Some remedial actions, with respect to targeting CDTI activities such as supervision, monitoring and training were recommended. The use of ‘volunteer’ non-health system supervisors was also recommended as an issue to be addressed.

The Uganda National onchocerciasis control Coordinator agreed that training is not targeted and promised that NOTF will address the problem. He also stated that onchocerciasis control is part of the minimum health package in Uganda.

### 4.9 Uganda: Kisoro

The Kisoro CDTI project sustainability evaluation report presented by Richard Gibson revealed that CDTI activities are effectively implemented at the District level. Geographic and therapeutic treatment coverage rates are high at all levels of CDTI implementation. The supply and distribution of Mectizan is reliable and the control of the Mectizan distribution is efficient. The use of material resources is integrated. The District Onchocerciasis Control Coordinator (DOC) is knowledgeable, resourceful and involved in other health programmes. There is strong leadership and commitment from local leaders at the village level.

However, it was noted that at the District level, the CDTI programme is essentially a “one-man-show”. The DOC carries out training, supervision of supervisors and CDDs as well as Mectizan ordering, collection and distribution. It was also noted that government officials are not involved in planning for CDTI activities and that there is little commitment from politicians, many of who are from the onchocerciasis non-endemic area. Only three sub-counties, constituting about 8 % of the population of the District is at risk of onchocerciasis. This makes the problem less ‘visible’ to policy makers. Although there is budgetary allocation for CDTI at the District level, there is no evidence of increasing budgetary involvement. The health centre is not directly involved in CDTI except as conduit for Mectizan. The staff at this level is not involved in CDTI which is implemented solely only the supervisors and focal staff engaged in CDTI are involved.

Participants at the sustainability-planning meeting for Kisoro CDTI endorsed the findings of the evaluation team and listed steps for addressing them. They identified dependable alternative funding arrangements for the sustainability of CDTI post-APOC. These include the Local Government Development Programme (LGDP) and Poverty Alleviation Fund (PAF). The
stakeholders agreed on the proper targeting of CDTI activities for efficient management of resources.

**Overall, Kisoro CDTI project has made satisfactory progress towards sustainability**

It was recommended that the participation in CDTI activities should be widened and targeted activities should be planned within available budget.

The National onchocerciasis control Coordinator noted that training is really not targeted and agreed with the findings of the evaluators.

**4.10 Uganda: Masindi**

Richard Gibson presented the findings on sustainability evaluation of Masindi Uganda CDTI. He indicated that the project is supported by the Poverty Alleviation Funds and is an integral part of the Primary Health Care outreach in the district. The project has recorded high geographic and therapeutic coverage. Mectizan ordering system is effective and its distribution reliable. All levels of government accept responsibility for CDTI activities and focus on empowering the peripheral health facilities to meet their responsibilities.

Other members of the district health team besides the DOC are not involved in the CDTI activities besides the District Medical Team (DMT). Training, monitoring and supervision are not focused and resources are inefficiently used. Programme ownership has not yet been achieved at the community level. Non-health system personnel is used as paid volunteer supervisors of CDTI activities.

**Overall, Masindi CDTI project has made satisfactory progress towards sustainability**

It was recommended that a detailed post-APOC plan, that is dependable on local resources, be developed and the resources efficiently used.

The National Onchocerciasis Control Coordinator agreed that training and supervision have not been focused on need and promised that NOTF will address the issue. The use of remunerated “voluntary “ supervisors was necessary since the number of health personnel is not adequate to cope with the supervision needs of some communities. He, however acknowledged the need to address the problem of remunerating “volunteer supervisors” in post-APOC period

**4.11 General Comments on Project Presentations**

At the end of the presentations the following general comments were made:

- While collection of Mectizan from collection points should be carried out by CDDs, some flexibility is necessary. For example, for remote communities living at long distances from collection points, supervisors might provide drugs to CDDs at training sessions or when making supervisory visits.
- Non-integration of CDTI into the PHC system could be attributed, in some cases to lack of developed functional PHC system.
- The issue of drugs almost expiring before distribution in the Malawi project was considered as a problem by the project because the collection points are located within the communities and as such drugs should be collected and distributed early. In addition, communities and CDDs are not informed of the actual expiration dates.
• The recommendation to have a written document for Mectizan at the facility level was considered unnecessary. It was agreed that signed MOUs are adequate for importation and use of Mectizan. It is however the responsibility of the various NOTFs to ensure that this is followed through with the necessary regulating and registration bodies in country.
• Collection of Mectizan by CDDs immediately after training sessions does not contradict the CDTI strategy. However, projects should not misuse this, as it could mitigate against empowerment of communities.
• On the issue of Mectizan being on the essential drug list, participants felt the use of the word 'essential' for Mectizan is misleading. Rather it should be considered as an important drug.
• Mectizan supply to all the projects is adequate.
• Training and retraining should be well planned and targeted to address deficiencies in programme implementation.
• The low score for training in Kaduna project was attributed to restriction of training only to focal persons.
• The poor quality of training could be attributed to inadequate resources to train at all levels of implementation. The resource persons for this training need to be trained themselves to improve the quality of training.
• It was not clear if the content of the training, attrition rate of CDDs, and training of new CDDs by older CDDs are responsible for the poor record keeping and inability to calculate Mectizan requirement.
• It was observed that mobilisation and sensitization is intensified only at the community level. There should be concerted efforts to ensure all management staff (from National to District) of the programme are mobilised and sensitized on their roles in CDTI implementation.
• The evaluation tool did not assess how CDTI can be used as an entry point for other PHC activities.
• Integration of CDTI activities into the PHC system is part of sustainability meant to strengthen the system. It is an attitudinal issue.
• While the indicators for training were adequate, those for mobilisation and sensitization were difficult to assess.
• Participants felt some evaluators did not study the health systems in the various countries as well as the proposals sent by the projects to enable them appreciate the various implementation procedures in place. This is probably why they were not flexible in their assessment of the projects. If evaluators are not properly oriented they would arrive at conclusions and recommendations that are not realistic.
• Since the PHC system is poor in most countries, emphasis should be on how to strengthen supervision in weak projects. For example Uganda has a good supervisory system but the question is how sustainable it would be post-APOC? The project feels it could be sustained if the number of supervisors is reduced to cover a group of communities as against one supervisor per community.
### 4.12 Main Findings And Recommendations On Evaluated Projects

<table>
<thead>
<tr>
<th>#</th>
<th>PROJECT</th>
<th>STATUS</th>
<th>MAIN FINDINGS &amp; RECOMMENDATIONS</th>
</tr>
</thead>
</table>
| 1 | CROSS RIVER | • Coverages were satisfactory  
• There is integration into the health system  
• Strong networking and collaboration with indigenous NGOs  
• Routine supervision and training  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 2 | KADUNA | • Routine planning at the State level is made  
• State gives financial support.  
• LGA leadership is not fully sensitized  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Sensitize and involve LGA leadership  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 3 | TARABA | • Well integrated into the health system  
• Communities are well mobilized and involved  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 4 | MALAWI CDTI (MWANZA/THYOLO) | • Not integrated into the health system except at district level  
• Unsatisfactory geographical coverage  
• CDTI not in place  
• Heavily dependent on APOC funds | Project is not making satisfactory progress towards sustainability.  
- APOC funding should cease after the fifth year until satisfactory evidence that critical issues raised in the evaluation report are being addressed by the government at all levels, especially changes in leadership.  
- New leadership should prepare plan to establish a sustainable CDTI plan  
- Seek local dependable sources of post-APOC funding |
| 5 | MAHENGE | • CDTI is not understood by CDDs  
• Training of CDDs was done only once to a few in two years  
• Not integrated into health system  
• Communities are not involved  
• Heavily dependent on APOC funds | Project is not making satisfactory progress towards sustainability.  
- APOC funding should cease until satisfactory evidence that the government is addressing critical issues raised in the evaluation report at all levels, especially changes in leadership.  
- New leadership should prepare plan to establish a sustainable CDTI plan  
- Seek local dependable sources of post-APOC funding |
| 6 | UGANDA PHASE I CDTI (HOIMA) | • Geographical coverage is high  
• Integrated into the PHC at the district level  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding |
| 7 | UGANDA PHASE I CDTI (KASESE) | • Geographic and therapeutic coverages are high.  
• Well integrated into PHC at the district level  
• Heavily dependent on APOC | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors |
| 8 | UGANDA PHASE I CDTI (KISORO) | • There is budgetary allocation for CDTI at district level  
• Integrated into the PHC at the district level  
• Routine training and supervision  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors |
| 9 | UGANDA PHASE I CDTI (MASINDI) | • Integrated into the PHC system and supported from PAF  
• Political commitment is high  
• Staff are well trained and motivated  
• Inefficient use of resources  
• Low level of community ownership of CDTI  
• Heavily dependent on APOC funds | Project has made satisfactory progress towards sustainability.  
- Prepare sustainability plan  
- Seek local dependable sources of post-APOC funding  
- Address the sustainability of using paid ‘voluntary’ supervisors  
- Intensify sensitization and mobilization of communities |
5. LESSONS FROM PROJECT SUSTAINABILITY EVALUATION BY INDICATORS

Deliberations on sustainability lessons across the nine projects, by indicators were introduced by Chukwu Okoronkwo, Joseph Okeibunor, Richard Gibson, Obinna Onwujekwe, Johnson Ngorok and Sebastine Baine. Deliberations and recommendations are summarised below.

5.1 Coverage

Generally geographic and therapeutic coverage rates are high. However coverage rates are adversely affected in conflict areas, areas without adequate health care infrastructure, and areas with community perception problems. There are reporting errors due to wrong calculation, report falsification and failure to apply the correct denominator in calculating therapeutic coverage.

It was recommended that:
- there should be targeted support supervision,
- community mobilisation and sensitisation should be intensified
- records should be kept at each level and copies sent to the higher level for collation
- total population should be used as a denominator for calculating coverage
- treatment should be rapidly extended to communities not yet treated

5.2 Planning

Planning is largely APOC / NGDO driven and related to funding request, resulting in a top-down process which does not allow for integration and excludes non-CDTI staff and other stakeholders. Planning is usually not a routine activity at the peripheral (health centre) level, resulting in failure to incorporate activities at this level in the regional and national plans. Only one project has planned for the post-APOC period. Three projects have considered it while the other five projects have done nothing in this regard.

It was recommended that
- planning should be participatory and the bottom-up approach adopted taking available funds into consideration
- planning should be integrated into routine health activities
- all projects irrespective of year of implementation, should immediately begin planning for the post-APOC period
- APOC should support capacity building for planning and planning meetings.
- from the onset, projects should provide detailed and integrated plans indicating how the projects will be sustained

5.3 Leadership

At the national level, all the projects have a designated officer. Generally, there is a lot of political commitment but this is usually not translated into practical and financial support. Even though the projects were in the 5th year, responsibility for initiation of CDTI activities occurred at the peripheral level (community, health centre) in only 4 projects while 5 projects responded to the demands of the higher level.
It was recommended that:
- APOC conducts high level advocacy for political commitment
- advocacy with policy makers and politicians be innovative
- political and administrative leaders be included in CDTI activities
- management at all levels be empowered to carry out activities assigned to them

5.4 Supervision and monitoring

Generally treatment registers are fairly well kept, and treatment records and reports are transmitted using government system. In many projects, problems identified during supervision were addressed and lower levels empowered to identify and solve problems during supervision. In Uganda, where non-health personnel are recruited as supervisors the initiative was commended but it was noted that the sustainability of their present number and remuneration would need to be addressed.

Supervision is done in frequent and non-targeted fashion without the use of supervisory checklist or the reporting of such visits. In some projects, the national and / or the districts level sometimes supervised the community by passing the health facility level. In district with difficult terrain supervision was lacking due to lack of transportation. Supervision is motivated by the availability of APOC funds. Data collected is not used as a management tool but to satisfy the requirements of funding bodies.

It was recommended that:
- guidelines for identifying areas with special supervisory needs be developed and circulated by the NOTFs
- more health personnel particularly those at the health facility level be involved in CDTI
- NOTF should develop and use checklists for supervision
- Community self-monitoring should be up scaled in all projects
- the health facility level should be empowered to supervise the community and supervision to be stepped down and targeted
- data collected should be used as a management tool

5.5 Mectizan procurement and distribution

Following the signing of the memorandum of understanding between APOC and the respective governments, Mectizan clearance and free importation is assured in all countries. In many communities, Mectizan is received at convenient and acceptable periods and Mectizan management functions within the existing drug delivery system. However, the collection and distribution from the central sources currently relies on APOC / NGDO funds. The required quantity of Mectizan is not estimated at the community level. Some CDDs cannot estimate required quantities. Timing of distribution is dependent on the availability of drugs, funds or health personnel in most projects.

It was recommended that:
- Mectizan procurement, distribution and reporting be integrated into the existing drug distribution / health care systems
- Mectizan required by each level be made available in one instalment
- amount of drugs required be calculated using updated census figures from CDD registers
- peripheral health facility (health centre) staff be empowered to collect, store and allocate Mectizan to communities
- period of distribution should be determined by the community

5.6 Training

Training is routine and does not address problems identified during monitoring and supervision. Training is carried out when APOC funds are available. In places where there is Continued Medical Education programme for workers, CDTI training is not incorporated. In few cases training of CDDs is sometimes carried out by higher level staff instead of the health facility level personnel.

It was recommended that:
- trainers of trainees should be well trained at all levels
- re-training should be targeted and should deal with specific issues raised from evaluation
- CDTI training should be integrated into other training programmes of the health care system
- all health personnel in the health facilities within the endemic communities should be trained on CDTI

5.7 Sensitisation and Mobilisation

Mobilisation and sensitisation strategies are generally poor particularly at the health facility levels. Mobilisation and sensitisation are vertical and not targeted.

It was recommended that:
- mobilisation and sensitisation should be targeted to address specific issues and persons/groups
- the projects should develop mobilisation / sensitisation strategies relevant to their peculiar needs
- mobilisation and sensitisation should be integrated into existing health care programmes
- concerted effort should be made in ensuring that all management staff at all levels of the program are mobilised and sensitised on their roles in CDTI implementation

5.8 Finance and funding:

Communities have ways of supporting CDTI activities like provision of financial incentives to CDDs. In some projects, budgets are excessive and financial control system inefficient. In many projects, government pays staff salaries while NGDO partners provide financial support for specific activities. None of the projects has made any serious plans on financial sustainability post-APOC, the health facility level being the weakest in this respect.

It was recommended that:
- all projects develop short, medium and long-term financial sustainability plans and intensively mobilise additional / alternative funds
- APOC funds capacity building for key NOTF project staff on cost accounting, analysis and financial management
- NOTF and projects should identify dependable sources of local funding, e.g. national budgets, user fee, local NGOs, social health insurance scheme
- Projects should plan within available budgets
- Funds should be managed at the level at which an activity is taking place
5.9 Transportation and Material Resources

There is a degree of integration in the use of transport facilities available at health facility, Sub-District and LGA/county levels. Supervisors in some health facilities travel short distances, which do not require use of transport facilities. Usually, movements by the CDDs are within the communities where they live. The running cost of vehicles in almost all projects is totally dependent on APOC funds even though these vehicles are used in an integrated manner. There is very little control in the use of the vehicles, logbooks are not well kept and proper procedures for requisition and authorisation are not followed. No plans have been made for the replacement of project vehicles and other equipments by the end of the project. In some project areas, because of poor terrain, no means of transportation is adequate except walking.

It was recommended that:

- APOC meets some pressing needs in replacing capital equipment.
- NOTF should institute a system of strict control of transport. Every trip and expenditure (fuel, tyres and repairs) should be authorised, the use of logbooks should be mandatory and these logbooks entries should be reconciled against trip authorisations
- integrated use of CDTI transport for other health activities should be promoted
- Governments and other partners should be involved in the maintenance, fuelling and replacement of vehicles as well as other capital equipment used for CDTI activities

5.10 Human Resources

The national project coordinators are well trained and have adequate skills to effectively coordinate all CDTI activities. Staff situation has been stable over the years especially in Uganda and Malawi where DOCs have been at their postings for more than five years because of the decentralization policy implemented in these countries. There are adequate and skilled personnel at the LGA/district level. CDDs have sufficient knowledge on CDTI and are willing to continue serving communities. Communities are willing to continue treatment with Mectizan for as long as it is necessary because the drug is perceived to be a very important drug for improving vision, suppressing itching and curing skin rashes.

The health facility level is poorly staffed in most project areas and there are very few health personnel with special training, especially in health education. In some projects, salaries are inadequate and sometimes delayed, leading to low morale.

It was recommended that

- adequate IEC materials be provided to the communities;
- personnel with special training from other sectors be used in CDTI activities whenever necessary.

Report on Group Activity

After the presentations, participants went into group sessions and came out with the problems and solutions as identified for the projects. Reports of the working groups as presented at the plenary sessions are attached (Annex 3). In discussing the group presentations, participants stressed the need for preparation of realistic action plans that meet priority needs of the projects based on the resources that will be available. They also advocated capacity building at the national and project
levels. In view of the low level of government funding for CDTI implementation, projects were urged to adopt more pragmatic measures to mobilize funds from alternative sources. The meeting noted that financial sustainability of a project could not be measured effectively until APOC funding ceases. It also stressed that guidelines should be laid down for the replacement of worn-out capital equipment by APOC given the bureaucracy in the government system for procurement of capital items.

6. FRAMEWORK OF PROJECT SUSTAINABILITY PLANS

Participants worked in four groups to consider problems identified in each project and develop a framework of project sustainability plans (Annex 4a to 4g). Following the presentations of plans for the different projects, APOC Director requested clarification on how long supporting NGDOs are committed to assisting the CDTI projects. The SSI representative in Nigeria responded that SSI would remain ‘for as long as onchocerciasis remains a disease of public health importance’. The representative of CBM at the meeting stated that his organization is awaiting the outcome of the evaluation in order to know the next thing to do. The MITOSATH representative expressed her organization’s commitment to the programme.

Meanwhile, it was agreed that project sustainability plans be further reviewed and adapted at the project level and that NOTF be responsible for monitoring follow-up of the plans.

7. CRITERIA FOR FURTHER APOC SUPPORT

One of the working groups developed the following criteria for use by APOC management in considering exceptional support to a project after its fifth year

The Process:

- All projects should be monitored at end of the first year
- A mid-term evaluation should be carried out during the third year of CDTI implementation. The Midterm evaluation is very crucial to sustainability, APOC should use the results for determining areas of support to guide projects towards sustainability.
- For projects that have passed the third year without evaluation, APOC should use the report of external monitors as guide for initiating follow-up action.
- Fifth year evaluation should be carried out on all projects that have passed through four years of APOC support and the findings used to determine the level and type of further assistance to be provided by APOC.
- Results of the Fifth year evaluations should be in classifying projects into three categories
  - Fully sustainable
  - Making satisfactory progress towards sustainability
  - Not making satisfactory progress towards sustainability

For projects that are FULLY SUSTAINABLE, APOC should cease further support and continue to monitor its sustainability without such support.

For projects that are MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY, APOC should provide further support for the 6th to 8th year of CDTI implementation if the projects meet the following conditions:
- There should be a 3 year, post-APOC plan for sustainability
• All of previous year’s budget was released by government.
• Evidence that an effort has been made to address the issues raised during the Mid-term evaluation
• Evidence that resources have been used for planned activities
• Evidence that 100% geographic coverage and an acceptable (higher than 65%) therapeutic coverage has been attained

For projects that are **NOT MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY**, APOC funding should cease until there is satisfactory evidence that critical issues raised in the evaluation report are being addressed by the government at all levels and changes made in project leadership.

**APOC should support the following activities**
- Capacity building to strengthen project sustainability especially regarding
  - Effective management of scarce resources
  - Advocacy and local resource mobilisation
  - Targeted Retraining of health personnel and ivermectin distributors
    - Leadership
    - Data / information management
    - Advocacy for commitment of government to continue to support CDTI
- Capital equipment replacement
- External monitoring and evaluation
- Mapping (REMO)
- Operational research to improve implementation of sustainability of CDTI

**APOC should not support**
- Salary top ups
- Routine CDTI activities such as CDD training, monitoring and supervision and distribution of Mectizan
- Running cost for motor vehicles
- Cost of consumables
- Internal procurement and transport of Mectizan

The meeting endorsed the recommendations.

**8. CDTI IMPLEMENTATION IN CONFLICT AREAS**

Irene Mueller made a background presentation on CDTI implementation in conflict areas. She observed that majority of APOC – supported projects are in countries that are in conflict, post conflict, in fragile environments that could lead to conflict and countries affected by bordering conflict countries. The consequences of this include the destruction of infrastructure, disruption of civil society, population displacement, immeasurable human suffering and disruption of CDTI. The presenter showed the photograph of southern sector task force coordination office destroyed last year.

The Sudan Programme has one national plan and one NOTF. Under NOTF Sudan, there are two separately run projects, the Government of Sudan (GOS) project and the Operation Lifeline Sudan (OLS) project. A Consortium of NGOs and UN Agencies that has been providing assistance under
the UN since 1989 implement the OLS project. Majority of the communities that are endemic for onchocerciasis are in the South where conflict exists (OLS project).

Following the presentation, a group was given the task to discuss CDTI implementation in conflict areas and report to the plenary. The group came out with a framework, which was presented at plenary. (Annex 5)

9. ADDITIONAL SUBJECTS CONSIDERED BY THE MEETING

9.1 MACROFIL

Dr. Janis Lazdins informed the gathering that the search for a macrofilaricidal drug was informed by the need for a drug that could achieve elimination of onchocerciasis in a shorter period of time allowing for longer intervals between treatment, would be extremely safe and can be given at the community level by communities. Furthermore, if a curative drug would be available this would resolve the difficult issue of sustainability.

The target profile for such a drug will require that it can be administered not only to individuals with proven infection but also to those with presumed infection. It should be macrofilaricidal and able to permanently eliminate microfilariae from the skin so that these are undetectable 12 or 18 months after a single treatment. In addition, it should be safe (less than one drug related serious adverse effects /1000 treatments), and finally it should be safe for administration to children under 5 years (ideally > 2 years).

He informed the meeting that in TDR there is a group that addresses the product research and development of new or improved tools. This is done at 3 levels:

- Discovery and development of new products for public health management of selected neglected communicable diseases.
- Capacity building and technology transfer for research and development to disease endemic communities.
- Enhancement of private sector participation including development of public/private partnership.

This is implemented through:

- “Principal investigator” – initiated research, funded after peer review by steering committee.
- Development through “virtual” teams, in partnership with academic, public, non-for profit and pharmaceutical institutions.
- Registration/production/commercialisation, if possible with pharmaceutical partner, this way guaranteeing, “access”.

Moxidectin is one of the general microcyclic lactones, which have been used to treat hundreds of millions of food animals without reproductive toxicity or intrinsic mechanism–based toxicity. *In vitro* and *in vivo* animal models have shown superior microfilaricidal and macrofilaricidal effects when compared to Ivermectin. There is slow death: 1 year after single dose. Furthermore, the half-life of moxidectin in the blood is 18 days compared to two days for Ivermectin is 2 days.

He explained the 3 phases in the clinical development plan for moxidectin.

The first in–man clinical trial (phase 1) has been carried out with healthy non-infected volunteers. The drug appears to be safe and well-tolerated providing blood levels compatible with antifilarial activity.
Phase 2 clinical study will be carried out in the Clinical Research Center in Hohoe, Ghana. This study will establish how safe and tolerable the drug will be in patients with mild, moderate and severe *Onchocerca volvulus* infection and will establish the dose that will be used in the next large clinical study.

Phase 3 study will include large number of patients (approximately 1500) in meso and hyper endemic areas of different geographic zones and will require both patient that have been treated and those not treated with Ivermectin. The study will compare the effect of Ivermectin against moxidectin on reduction of skin microfilaria and assess the effect on adult worms.

Dr. Lazdins presented a timetable for the entire study and estimated that the drug will be available for use by 2008, if all planned activities are successfully implemented.

The following questions and comments came up after the presentation:

- Has the drug any antagonistic effect in patients treated with a combination of moxidectin and Ivermectin.
- It will be important to know if the drug will be affordable to the target group?
- What is the ethical implication of not treating some group before they are ‘reserved’ for research?
- The targeted group of infected people are still available and reachable. One only needs to know for how long they will be needed and where. However, care should be taken in moving people from their local environment.
- Can the target patients be drawn from any country?
- What is the ethical implication of administering Moxidectin in areas where lymphatic filariasis and loa loa are co-endemic?
- Are there medical infrastructure available in the sites where this research will be carried out, and if not is the research team providing one?
- It was recommended that NOTFs be fully informed and involved in the studies.

In his response, Dr. Lazdins said the research is still ongoing. After the registration of the product there will be an effectiveness study (phase 4) where *Loa loa* and other diseases issues will be addressed.

Director APOC explained that the research group will not build new health centers as TDR and APOC do not have funding for this, but will provide functional facilities where necessary. In addition he stressed that the discussions are not to promote Moxidectin against Ivermectin and added that there is assurance of collaboration between the pharmaceutical companies producing the two drugs. He also said they made it clear that APOC will definitely not be able to pay for the drug and hoped for support from other sources. He noted that Ivermectin naïve patients can be found in projects in conflict areas such as Sudan, DRC, Ethiopia, Burundi and Liberia. Concluding, Dr. Lazdins said nothing will be done without the full knowledge and approval of the governments of the countries where the studies will be conducted.
9.2 The New Process of Reviewing Proposals

The forum was informed that APOC Management has been mandated by JAF to review guidelines to be used by implementers as guides for submission of proposals to TCC which meets twice a year. The next TCC meeting will hold in September 2002, and deadline for submissions is July 2002. In addition, copies of the proposed format for country presentations to JAF8 meeting in Ouagadougou was made available to participants.

9.3 CDTI Operational Research

Clarification was provided for operations and operational research. The proposal for the former could be approved by Director APOC if under $5,000 while the later has to be approved by TCC. It was reported that insufficient number of proposals is received from APOC countries, particularly francophone countries. APOC would provide support to countries to develop proposal-writing skills.

9.4 Annual Treatment Objectives and Ultimate Treatment Goal

The definition of Ultimate Treatment Goal (UTG) was given as the maximum number of people to be treated annually in meso/hyper endemic areas within the project area, ultimately to be reached when the project has reached full geographic coverage.

Annual Treatment Objective was defined as the estimated number of persons living in meso/hyper-endemic areas that a CDTI project intends to treat with Ivermectin in a given year. Copies of an extract from TCC14 containing definitions on total population, eligible population, ATO, UTG, calculation of therapeutic and geographic coverage rates were distributed to participants.

9.5 Experience of using CDTI as a vehicle for sustaining Vitamin A supplementation in Nigeria

Musa Obadiah of Helen Keller International (HKI) made a presentation on the experience of using CDTI as a vehicle for sustainable Vitamin A supplementation in Borno, Adamawa and Taraba States. Vitamin A was distributed by CDDs twice a year to children under five years and pregnant mothers. Modified MIS forms were used for data collection and analysis, and distribution was monitored within existing health care structures. A total of 116,131 (95.3%) out of 121,789 children targeted and 32,933 (98%) out of 33,484 women targeted have been covered within the one – year period of the exercise.

The weaknesses observed were increased duration of CDDs’ and health workers’ training period and possible overload of the PHC system. There were also threats arising from overload of CDDs, demand for incentives by CDDs and overload of an already weak PHC system. Furthermore, the vitamin A supplement (VAS) is twice a year as against the single annual dose of Mectizan.

The strengths observed include the use of the CDTI structure to deliver Mectizan and VAS at the same time. VAS supply system is in place like that for the Mectizan tablets. Adequate political will is in place. The health benefits include normal growth and cognitive skills development in children; as well as reduction in morbidity and mortality rates in post partum mothers.
Participants observed that this experience confirms that CDTI provides a workable opportunity for integration of health programmes.

10. CONCLUSIONS AND WAY FORWARD

1. The meeting noted that only 9 of the 10 projects entering their fifth year were evaluated before the meeting and Kogi State CDTI project will be evaluated later.

2. The forum agreed that the Abuja meeting is a milestone in the effort of countries and APOC to enhance sustainability of CDTI.

3. Discussions at the meeting were frank focusing on needs of affected communities. Behind the approach taken by the meeting was the conviction that the best tool countries have to improve CDTI is learning from each other through pooling experiences, enabling individual countries to take action on pooled experiences.

4. The forum was pleased to note that, on the whole, distribution of Mectizan® was being carried out satisfactory reaching all communities under treatment. However, many problems, some of them critical, standing in the way of sustainability were identified.

5. Recommendations made by the meeting to address problems identified, pose a challenge to projects evaluated, other projects, governments, APOC and the Core Group on sustainability.

6. The meeting recognized the need for the development of a sustainability checklist for monitoring progress towards sustainability.

7. The forum agreed that APOC should continue supporting operations and operational research to improve the implementation and sustainability of CDTI projects.

8. The meeting considered the organization of planning meetings with stakeholders after evaluation as being of critical importance.

9. The meeting recommended that mid-term evaluation be carried out on all projects in their third year and a final year evaluation be conducted in the fifth year by APOC.

10. The Core Group on sustainability should review available guidelines and instruments on indicators to incorporate suggestions and recommendations from the meeting.

11. In order to increase political and financial commitment to CDTI activities, within an environment competing for resources, APOC was encouraged to continue studies on the impact of CDTI and share results of this study with policy makers as an advocacy tool.

12. In planning for the next NOTF meeting, groups should be given specific tasks to handle thoroughly to enable discussions to be more productive; relevant documents should be sent to participants in good time; and that agenda be worked out by the host country with contribution from other NOTFs and circulated in advance with APOC playing a facilitating role.

13. APOC should consider continuing with the approach of this meeting where exchange of experience was across countries, both English and French-speaking.
14. The meeting noted with satisfaction that some projects have started using CDTI as an entry point for implementing other programmes (Helen Keller International and Vitamin A distribution in Nigeria). The meeting encouraged APOC to support integration of other drugs into CDTI distribution system such as Vitamin A supplement and praziquantel.

15. Projects should build in sustainability monitoring from the onset.

16. APOC should continue monitoring the sustainability of projects after the 5th year.

17. The meeting acknowledged the presentation on the development of Moxidectin for the treatment of Onchocerciasis and noted with satisfaction the progress so far made. Participants urged that NOTF participate in Phase III clinical studies on Moxidectin.

18. The meeting expressed appreciation to NOTF/Nigeria for hosting the meeting and thanked the rapporteurs and NOTF/Nigeria organizing committee (Annex 6).
11. ANNEXES (1 - 7)

Annex 1 : ANNOTATED AGENDA / ORDRE DU JOUR ANNTE

Monday 17 June

08:00 – 08:45  Registration
08:45  Meeting commences

Chair: Dr. E. Tarimo
Co-chair: Prof. O Kale
Rapporteurs: Akogun, Baine, Onwujekwe

08:45 – 10:00  First Technical Session
Approval of Agenda and Objectives – Dr. Tarimo
Overview of Self Sustainability – Prof. D. Prozesky

10:00 – 11:00  Official Opening
Chair: Prof. Ransome Kuti
Welcome Address: Dr. A. O. Asagba, Director, Public Health
Dr. E. Elhassan, Chair, NGDO Coalition/Nigeria
Dr. A. Moudi, WR Nigeria
Dr. A. Seketeli, Director APOC
Prof. D. Prozesky, Joint Chair Self Sustainability Evaluation
Prof. O. Kuti, Executive Chair, NPHDA
Dr. A. Ndalolo, Hon. Minister of State for Health
Vote of Thanks: Dr. E. Elhassan, Chair NGDO Coalition, Nigeria

11:00 – 11:30  Tea
11:30 – 13:00  Project Presentations  Nigeria: Taraba (Akogun)
Nigeria: Cross River (Okoronkwo)
Nigeria: Kaduna (Prozesky)

13:00 – 14:00  Lunch
14:00 – 15:30  Project Presentations  Malawi: Mwanza/Thyolo (Onwujekwe)
Tanzania: Mahenge (Baine)
Uganda: Hoima (Okeibunor)

15:30 – 16:00  Tea
16:00 – 17:30  Project Presentations  Uganda: Kasese (Okeibunor)
Uganda: Kisoro (Gibson)
Uganda: Masindi (Gibson)
**Tuesday 18 June**
Chair: Dr. Bodzongo
Co-chair: Dr. Ntep
Rapporteurs: Emuka, Okeibunor, Presenters

08:30 – 09:00  Issues from day one and house keeping
09:00 – 10:30  Presentation on Evaluation Guidelines & Instruments (Okeibunor)
Presentation of Group One indicators (Gibson, Okoronkwo)
Planning, Leadership, Coverage
Supervision / Monitoring
10:30 – 11:00  Tea
11:00 – 13:00  Introduction to Group activity
Group activity
13:00 – 14:00  Lunch
14:00 – 15:00  Group activity
15:00 – 15:30  Tea
15:30 – 17:30  Feedback plenary

**Wednesday 19 June**
Chair: Dr. J. Jiya
Co-chair: Ms I. Mueller
Rapporteurs: Isiyaku Sunday, Gibson, Okoronkwo, Presenters

08:30 – 09:00  Issues from day two and house keeping
09:00 – 10:30  Presentation of Group two indicators (Okeibunor/Ngorok/Ally)
Training / Mobilization / Sensitization
Mectizan distribution
10:30 – 11:00  Introduction to Group activity
11:00 – 11:30  Tea
11:30 – 13:00  Group activity
13:00 – 14:00  Lunch
14:00 – 15:00  Group activity
15:00 – 15:30  Tea
15:30 – 17:30  Feedback plenary

**Thursday 20 June**
Chair: Prof. A. Abiose
Co-chair: Dr. S. Katenga
Rapporteurs: Ukam, Ally, Maduka, Presenters

08:30 – 09:00  Issues arising from day three and house keeping
09:00 – 11:00  Presentation of Group three indicators (Onwujekwe / Baine)
Finance / Funding
Transport / Material Resources / Human resources
11:00 – 11:30  Tea
11:30 – 13:00  Introduction to Group activity
Group activity
13:00 – 14:00  Lunch
14:00 – 15:00  Group activity
15:00 – 15:30  Tea
15:30 – 17:30  Feedback plenary
Friday 21 June
Chair: Dr. Ndoyo
Co-chair: Dr. Tarimo
Rapporteurs: Franca, Obinna, Okoronkwo, Presenters

08:30 – 09:00  Issues arising from day four and house keeping
09:00 – 10:00  MACROFIL: Research on Moxidectin (Dr. Lazdins)
  Countries with special needs: Conflict areas (Ms Mueller)
  The way forward: recommendations relating to projects
10:00 – 11:00  Criteria for additional support (Gibson)

11:00 – 11:30  Tea
11:30 – 13:00  Introduction to group activity – Planning framework for countries and
  APOC HQs and supporting bodies
  Group activity
13:00 – 14:00  Lunch
14:00 – 15:00  Group activity
15:00 – 15:30  Tea
15:30 – 17:30  Feedback
19:00  Cocktail

Saturday 22 June
Chair: Dr. Ndyomugyenyi
Co-chair: Dr. Tambala
Rapporteurs: Okeibunor, Elhassan, Baine, Presenters

08:30 – 09:00  Issues arising from day five and house keeping
09:00 – end  Preparation for 8th session of Joint Action Forum (JAF8):
  Country Presentations
  The new process of reviewing proposals to APOC
  Research in CDTI (operations and operational research)
  Mectizan forecasting: Ultimate Treatment Goal (UTG) and Annual
  Treatment Objective (ATO)
  Experience of using CDTI as a vehicle for sustainable Vitamin A
  supplementation in Nigeria

Review and approval of report
Closing
Annex 2: PRESENTATION ON GUIDELINES, INDICATORS & INSTRUMENTS FOR SUSTAINABILITY EVALUATION

Background
The beginning
- Study on sustainability - Dr Tarimo
- Report of mid-term external reviewers
- Phase II and Phasing out Period

APOC needs to ensure that participating governments are fully aware of the cost of sustaining CDTI and the added benefits for other health programmes.

Terms of reference
Short-term
- To develop a simple framework with realistic and measurable indicators of sustainability, taking into consideration options available to countries for filling resource gaps
- Evaluate the current situation of 7 CDTI projects in 10 geographically distinct sites which will be completing their 5th year of APOC support by December 2002
- Assist NOTFs to develop a plan for these ten projects, based on careful prioritising, and more careful use of Trust Funds

Long term
- Prepare a short manual using the framework developed.

Expected outcome
The framework will help the countries to:
- follow a strategic plan during the Phase II and Phasing-out Period of APOC
- analyse cost implications for sustaining CDTI projects
- monitor progress

Update on activities so far
- Preliminary (planning) meeting in Geneva
- Meeting in Ouaga to develop instruments
- Pre-testing of instruments, plus evaluation of Kaduna State CDTI project
- Assessments of 9 out of 10 projects mentioned above

Composition of core group
Coordinators: Tarimo and Prozesky
- Health Economists: Rumuni, Baine, Ally, Onwujekwe
- Medical doctors with experience in district health management and financing: Kale, Gibson, Tarimo, Prozesky, Ilunga, Rumuni, Onwujekwe
- Social scientists: Ekejuba
- NOTF members: Ndyomugyenyi, Okoronkwo, Homeida
- TCC representative: Homeida

Concepts
Two concepts under sustainability
Self-sufficiency: The ability of a project to continue functioning effectively, using only resources generated within the country itself.
Sustainability: The ability of a project to continue functioning effectively, using both its own resources and those provided from outside - provided the latter are dependable.
**Accepted As Guiding Concept**

Characteristics/aspects of sustainability

- Effectiveness: projects that are functioning effectively are more likely to be sustainable.
- Efficiency: projects that are run cost-effectively are more likely to be sustainable.
- Simplicity: projects that use simple, uncomplicated routines and procedures are more likely to be sustainable.
- Integration: projects which have become integrated into the routine running of the health services are more likely to be sustainable.
- Attitude: projects are more likely to be sustainable if staff have accepted CDTI as a routine, which they will continue to do even in the absence of additional material reward.

**Indicators of Sustainability**

The indicators are grouped into nine categories. These relate to:

1. The results achieved in the project: 1 group of indicators
2. The routine activities which produce the results: 5 groups of indicators
3. The resources provided for these activities to take place: 3 groups of indicators

**METHODOLOGY**

**Methodology 1**

- Design question:
- How sustainable is the CDTI project?
- Design: cross-sectional, descriptive
- Population: the Projects, including project management teams at all levels -
  - NC, senior civil servants, politicians
  - SOCT, its NGDO partner
  - LGA and the LOCTs
  - Communities/villages, their leaders and CDDs

**Methodology 2**

- Sampling
- Duration of visit 10 -14 days
- Data collection and analysis
  - Source of information: interviews and document study
- Feedback/Planning meetings at:
  - State/ regional level
  - LGA/ district level
- Report writing

**Sampling**

The primary criterion is coverage (geographical and therapeutic). This is because it is a measure of the performance of the whole system – and it is the sustainability of that system that we are evaluating.

**Sampling**

The following secondary criteria are also taken into consideration:

- Endemicity: ensuring that, as far as possible, the sample contains both hyper-endemic and meso-endemic areas (more or less in the same proportion as that of the REMO results for the project area).
- Geographical spread: ensuring that, as far as possible, the sample contains areas which represent the different zones where the project operates, and communities which are closer to towns and some which are more isolated.

**Sampling**
For projects containing many districts/ LGAs (e.g. Nigeria)

❖ For each project, you sample at least three districts (one with good coverage; one with medium coverage; one with poor coverage).
❖ For each district/ LGA, you sample two sub-districts (one with good coverage, one with poor coverage)
❖ For each sub-district, you sample two villages (one with good coverage; one with poor coverage).

For projects containing 1-2 districts (e.g. Uganda). For each project, we sampled one or two districts.

- If there is only one district:
  - We sampled four sub-districts (one with good coverage, two with medium coverage and one with poor coverage).
  - For each sub-district we sampled two villages (one with good coverage and one with poor coverage)

**Grading**

**Grading a whole project**
When grading the project as a whole, it is important to bear in mind that there are a number of critical elements of sustainability, without any of which it is unlikely that any project will be sustainable:

❖ Money – there should be sufficient funds available to undertake strictly necessary tasks which have been carefully thought through and planned (absolute minimum residual activities).

❖ Transport – provision must be made for the replacement and repair of vehicles. There must be a reasonable assurance that a vehicle will be available for minimum essential activities. Note that ‘vehicle’ does not necessarily imply ‘4x4’ or even ‘car’.

❖ Supervision – the project will not be sustained without continuous mobilization and targeted supportive supervision.

❖ Mectizan supply – the supply system must be dependable. The bottom line is that enough drugs must arrive in villages at the time selected by the villagers.

❖ Political commitment – effectively demonstrated by awareness of the CDTI process among policy makers (resulting in tangible support); and a sense of community ownership of the programme.

❖ Other indicators remain important and should be taken into account together with the more critical elements listed above.

**Mistakes we tried to avoid in the analysis**

❖ The following problem areas were noted in the analysis of the first two projects:
❖ The analysis (and recommendations) could focus on the functioning of the project, rather than its sustainability.
❖ The analysis could be incomplete, not taking significant pieces of field data into account.
The recommendations could be superficial, non-specific and unrealistic.
Sometimes findings at one level were not consistent with those of another level.

Making recommendations
Finally the group has to make recommendations, about steps that projects and countries need to take to achieve sustainability. These recommendations are made for each of the four levels, and should have the following characteristics:

- They must be strictly based on the findings of the field work. They address the areas of poor sustainability that the research has uncovered.
- They must be practical and achievable:
  - For each recommendation a suggestion must be made, about who should be responsible for carrying it out.
  - For each recommendation a deadline or time line should be suggested.
  - One or more indicators of achievement must be given for each recommendation.

Making recommendations
Recommendations should be prioritised, as follows:

- **HIGH**: this recommendation is critically important. If it is not carried out the project will not be sustained.
- **MEDIUM**: this recommendation is important but not critical. Carrying it out will enhance the sustainability of the project though.
- There should not be any LOW priority recommendations.

INSTRUMENT
There are 4 separate instruments that are not attached to this report. However the instrument for assessing national headquarter/region/state was presented to the meeting.

Levels which should be sustainable
Evaluation takes place at four levels:
- National headquarters of MoH; Province/region/State - a group of districts
- Health district/ LGA
- Health sub-district/ first line health facility
- Village/ community

Defining indicators
District level: 'Supervision and monitoring'

- **Indicator**: The relevant person at the LGA/ district level is routinely and efficiently supervising the CDTI activity of the sub-districts on site
- **Definition**:
  - There should be evidence that each sub-district is visited at least once around the time of distribution.
  - There should not be unnecessarily many visits - there should be clear justification for each one.
  - Only the sub-district should be routinely visited, not the villages.

<table>
<thead>
<tr>
<th>All villages identified by REMO are under treatment</th>
<th>Findings: All endemic villages are under treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm records with the REMO list</td>
<td></td>
</tr>
<tr>
<td>Is this good for sustainability</td>
<td>Fully</td>
</tr>
</tbody>
</table>

Note: Coverage has two sub indicators. Add and divide by two to get Score for coverage
ANALYSIS

Grading each indicator
The team makes a joint decision: ‘Is this good for sustainability?’

<table>
<thead>
<tr>
<th>Grading</th>
<th>Meaning</th>
<th>Numerical value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully</td>
<td>The criterion is fully satisfied/ met.</td>
<td>4</td>
</tr>
<tr>
<td>Highly</td>
<td>The criterion is almost fully met - there is a small deficit.</td>
<td>3</td>
</tr>
<tr>
<td>Moderately</td>
<td>The criterion is about halfway fulfilled.</td>
<td>2</td>
</tr>
<tr>
<td>Slightly</td>
<td>The criterion is marginally fulfilled.</td>
<td>1</td>
</tr>
<tr>
<td>Not at all</td>
<td>The criterion is not fulfilled at all.</td>
<td>0</td>
</tr>
<tr>
<td>Not applicable</td>
<td>This criterion is not relevant to this particular case.</td>
<td></td>
</tr>
</tbody>
</table>

Grading the project overall

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>This project is completely sustainable.</td>
</tr>
<tr>
<td>2</td>
<td>This project is not far from being sustainable - project staff themselves should be able to undertake the required remedial action.</td>
</tr>
<tr>
<td>3</td>
<td>This project is potentially sustainable, but will require expert guidance from outside to get it on the road to sustainability.</td>
</tr>
<tr>
<td>4</td>
<td>This project is seriously unsustainable - there is some doubt as to whether it ever will be. It needs a lot of immediate expert guidance from outside.</td>
</tr>
</tbody>
</table>

Making recommendations

- *Areas of low sustainability will be identified and need to be remedied.*
- *Recommendations made will have to be prioritised.*
- *Deadlines and targets will have to be set for each recommendation.*
- *Someone will have to work with the local teams to plan remedial action.*

Limitations and problems

- Inconsistencies and duplications in the instrument were identified in the pre-testing, and corrected
- The sample needs to be adjusted: more districts, fewer health centres and villages per district. This was corrected following pre-testing of instruments in Kaduna state.
- The documentation required at different levels was not ready - respondents did not receive advance notice
- Having project staff with the evaluation team was initially problematical - they had to be educated about the methodology
### Annex 3: GROUP REPORT ON PROBLEMS & SOLUTIONS BY INDICATORS

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>SOLUTIONS</th>
<th>Action by Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>• Maintain flexibility during treatment in conflict areas.</td>
<td>NOTF and supervisors at all levels</td>
</tr>
<tr>
<td>• Conflict areas</td>
<td>• Sensitise and advocate for the provision of infrastructure like Communication, transport, Storage facility at all levels.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Infrastructure</td>
<td>• Targeted mobilisation and sensitisation should be intensified.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Perception Problems</td>
<td>• Communities should be encouraged to select more CDDs adequate to cover the population (at least 2 CDDs for 250 Persons)</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Education on therapeutic and geographic coverage rates should be given at all levels.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Calculation Errors</td>
<td>• Targeted supervision using checklist as well as spot check at all levels is highly recommended.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Falsifying reports.</td>
<td>• Incentives should come from communities in the form that is decided by them (cash or kind)</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• CDD Incentives</td>
<td>• National government should formulate Policies that encourage sustainability.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Cost Recovery</td>
<td>• Caution should be taken to introducing cost recovery system, community should be adequately mobilised on the responsibilities of other partners in the cost recovery arrangement.</td>
<td>Communities and supervisors at all levels</td>
</tr>
<tr>
<td>• Calculations of therapeutic coverage rate not based on correct denominator (i.e. total population)</td>
<td>• Re-emphasise use of total population as the denominator in calculations/reporting therapeutic coverage rate</td>
<td>NOTF</td>
</tr>
<tr>
<td>• Slow progress in geographical and therapeutic coverage over the years, some Projects not seen as concerned about low coverage figures</td>
<td>• Reorient programme staff at all levels to value coverage figures bearing in mind the ultimate goal of eliminating onchocerciasis as a public health problem (UTG).</td>
<td>NOTF/APOC</td>
</tr>
<tr>
<td>• Difficulty in raising therapeutic coverage, including continuing problems of negative perception of the drug in some projects</td>
<td>• To Use coverage figures, ATO and UTG as a management tools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Innovative Health education campaign with IEC materials developed by participatory approach.</td>
<td></td>
</tr>
<tr>
<td>PROBLEMS</td>
<td>SOLUTIONS</td>
<td>Action by Who?</td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>PLANNING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Planning usually a top bottom process.</td>
<td>• Provide training to update skills.</td>
<td>NOTF/APOC</td>
</tr>
<tr>
<td>• The lower levels of implementation not usually involved in formulation of plans.</td>
<td>• Workload at the lower level should be put into consideration during planning.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>• Often denies possibility of integration. Excludes non-CDTI staff.</td>
<td>• Plans should be integrated into the PHC system.</td>
<td></td>
</tr>
<tr>
<td>• Major role players outside project may be unaware of CDTI activities.</td>
<td>• Planning should be participatory with the involvement at all stakeholders.</td>
<td>NOTF and supervisors at all levels</td>
</tr>
<tr>
<td>• Lack of planning culture at lower levels</td>
<td>• Plan within available funds.</td>
<td></td>
</tr>
<tr>
<td>• Plans developed by national level not participatory</td>
<td>• Managers at higher levels to ensure that lower-level managers have annual plans</td>
<td></td>
</tr>
<tr>
<td>• Poor quality of plans (some really being only ‘budgets’)</td>
<td>• Adopt bottom-up approach and involve all stakeholders in developing plans</td>
<td></td>
</tr>
<tr>
<td>• Lack of planning capacity especially at lower levels</td>
<td>• CDTI plans to be shared with other departments included in national/district health plans</td>
<td>NOTF and supervisory at all levels</td>
</tr>
<tr>
<td>• Adherence to plans made by communities e.g. treatment times</td>
<td>• Targeted Training – on formulation of action plans</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Order required Mectizan well in time and make funds release for implementation according to plan</td>
<td>NOTF and supervisors at all levels</td>
</tr>
<tr>
<td><strong>LEADERSHIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Incompetence staff, in leadership position</td>
<td>• High-level policy makers should be involved in advocacy and problem solving where this problem exists.</td>
<td>NOTF</td>
</tr>
<tr>
<td></td>
<td>• All partners should be involved in the evaluation of the leadership where such problem exists.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At the end of the evaluation all partners should participate in discussion on the way forward. This will give partners opportunity to review leadership at all levels.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recognition of good leadership should be encouraged and rewarded at all levels.</td>
<td></td>
</tr>
<tr>
<td>• Lot of moral support, little or no resource.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

34
<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>SOLUTIONS</th>
<th>Action by Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous turn-over of important policy/decision makers</td>
<td>Need for continuous and innovative advocacy targeting important policy/decision-makers</td>
<td>NOTF</td>
</tr>
<tr>
<td>Limited follow up on political commitment</td>
<td>Use of beneficiaries in sensitisation</td>
<td>NOTF/APOC supervisors at all levels</td>
</tr>
<tr>
<td>Poor leadership skills among national/district programme managers/coordinators e.g. in delegation of task</td>
<td>Increased Participatory IEC</td>
<td>NOTF/APOC</td>
</tr>
<tr>
<td>Limited downward empowerment/delegation of authority</td>
<td>Reorientation of attitude</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Lack of innovation</td>
<td>Targeted training on management skills</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPERVISION AND MONITORING</th>
<th>SOLUTIONS</th>
<th>Action by Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate and untargeted supervision</td>
<td>Supervision should be targeted and CDTI checklist used.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Lack of supervision checklists</td>
<td>Make written plans for regular supervisory visits; use supervision check lists</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Lack of supervision reports/checklist (CDTI specific) in most places not available, in a few places where they were available they were not used all the time.</td>
<td>Reports of targeted supervisory visits should be made at all levels</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>The use of non-health paid volunteers for supervision.</td>
<td>Arrange training for community self-monitoring using existing tools and encourage community self monitoring</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Supervision not integrated into the PHC system</td>
<td>Organise CSM/stakeholders meetings at community level</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Lack of / inadequate supervisory systems (lack of tools, skills, manpower)</td>
<td>Discourage payment of volunteers from APOC/NGDO funds.</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>Higher levels overstepping and supervising much lower levels</td>
<td>Community, LGA should be encouraged to take up supervisory role</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td></td>
<td>Integrate supervision into on-going health programmes activities, share personnel and logistics in supervision and monitoring</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td></td>
<td>Empower lower levels to take on supervisory task</td>
<td>Supervisors at all levels</td>
</tr>
<tr>
<td>PROBLEMS</td>
<td>SOLUTIONS</td>
<td>Action by Who?</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| MECTIZAN PROCUREMENT AND DISTRIBUTION        | • Potential risk of non-commitment to duty free tax agreement for Mectizan import  
• Inappropriate storage of Mectizan  
• Parallel distribution of Mectizan.  
• Inappropriate planning of Mectizan need  
• Non-integration of Mectizan into the existing national drug distribution system  
• Insufficient/lack of management tools for Mectizan supply  
• Collection and transportation of mectizan using APOC & NGDO funds (National, State & LGA)  
• Storage and stock control independent of government system but is considered dependable.  
• Release of drugs in instalments – concern for drug loss verses cost of collection.  
• Poor record keeping and lack of population update by some communities  
• Leakage of Mectizan | • Adherence to MOUs by National Governments and involvement of key government agencies as stakeholders.  
• Where there exists a dependable procurement and distribution system in the PHC, this should be used for Mectizan. Where is non-existence, a parallel system should be set up, as much as possible as  
• Integrate stock and storage control in existing Government facilities if functioning well  
• Specific budget lines must be made and release effected for transportation of Mectizan.  
• To institute adequate Mectizan inventory mechanism  
• Drug should be made available at all levels in one instalment.  
• Adequate monitoring of Mectizan use | NOTF/APOC  
NOTF and supervisors at all levels  
NOTF and supervision at all levels  
Supervisors at District/State and sub-District LGA levels  
NOTF/APOC  
NOTF and supervisors at all levels |
<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>SOLUTIONS</th>
<th>Action by Who?</th>
</tr>
</thead>
</table>
| **TRAINING AND SENSITIZATION** | • Targeted mobilization sensitisation of stakeholders at all levels on CDTI intensified.  
• Integrate CDTI into the mainstream of other health programme.  
• Tools for targeted training/sensitisation based on need should be designed and used.  
• Need assessment of training be carried out  
• Develop and use checklist for training and sensitisation  
• Advocate for update of training curricula to include CDTI  
• Project to utilise training manual developed by APOC  
• Training to be conducted for all health staff | Supervisors at all levels  
NOTF and supervisor at all levels  
NOTF/APOC  
Supervisors at all levels  
NOTF/APOC  
Supervisors at all levels |
| Key decision makers not being aware of CDTI  
Non-integration of CDTI in other health training  
Programme staff lacking sufficient sensitisation/advocacy skills  
Inappropriate content of training  
Insufficient/lack of checklist for training and sensitisation  
Non-integration of oncho control activities in training curriculae of health workers  
Lack of training manuals for different levels  
Other health staff in general not fully conversant with CDTI | | |
| **FINANCE AND FUNDING** | • All projects in their 4th year should provide APOC with specific financial plans for sustainability in post APOC.  
• Budgets should be prepared in a realistic manner with detail justification.  
• APOC management should undertake annual external auditing of the projects.  
• Projects to ensure full integration of CDTI into the existing health and development activities.  
• Innovative approaches should be adopted to source for alternative sources of funding from local NGOs, private sector and government agencies  
• Adopt innovative advocacy strategy to sensitive high level policy makers to ensure timely release of adequate funds at all levels. APOC and NGDOs to support high-powered advocacy.  
• In the early stages of APOC support, financial plans for matching of funds by other partners more especially governments must be made. | NOTF/APOC  
NOTF/ Projects  
NOTF/APOC  
Supervisors at all levels  
NOTF and supervisors at all levels  
NOTF/APOC  
NOTF/APOC |
| Financial dependence on APOC for CDTI activities at all levels  
Inadequate release of funds by Governments at all levels.  
Poor budget estimates in financial plans | | |
<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>SOLUTIONS</th>
<th>Action by Who?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSPORT AND OTHER MATERIAL RESOURCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Project vehicles depend on APOC funds for running and maintenance cost.</td>
<td>• Adopt measures to Integrate and control vehicle use within the health department.</td>
<td>Supervisors at all levels NOTF/APOC</td>
</tr>
<tr>
<td>• In some projects cost of maintaining old vehicle is high.</td>
<td>• Plans should be put in place for the replacement of obsolete vehicles and equipment by government at all levels.</td>
<td>NOTF/APOC</td>
</tr>
<tr>
<td>• Project vehicles are poorly controlled.</td>
<td>• APOC to replace worn-out vehicles and equipment in the 4\textsuperscript{th} and 5\textsuperscript{th} year, and phasing out period if such request are adequately justified.</td>
<td>NOTF/APOC</td>
</tr>
<tr>
<td>• There are no plans for replacement of obsolete vehicles and equipments.</td>
<td>• Plans should be put in place for the maintenance of vehicles and equipment donated by APOC in the early stages of projects.</td>
<td>NOTF</td>
</tr>
<tr>
<td>• Examine logbooks in relation to planned activities at all levels.</td>
<td>• Responsibilities of CDTI implementers should be matched with the skills of the coordinators at all, and stakeholders should set minimum criteria for such positions at all levels.</td>
<td>NOTF and supervisors at all levels</td>
</tr>
<tr>
<td><strong>HUMAN RESOURCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low and untimely staff salaries.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inadequate skill of some project coordinators.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Annex 4a: Project Sustainability Plans (Framework): TARABA State CDTI Project

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Objective</th>
<th>To be carried out by whom</th>
<th>Indicator of success</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High level advocacy to His Excellency</td>
<td>To create greater awareness and financial support</td>
<td>APOC, NOCP, zonal office and NGDOs</td>
<td>Vouchers showing release of funds; signing of visitors book; attitude change; itinerary plan</td>
<td>Nov.-Dec. 2002</td>
</tr>
<tr>
<td>2</td>
<td>Advocacy to LGA executive and paramount chiefs</td>
<td>To solicit for political will and support to CDTI</td>
<td>Hon. Commissioner, Perm.Sec., DPHC, SOC,</td>
<td>Full participation of communities in CDTI; prompt release of counterpart funds by LGAs</td>
<td>Nov.-Dec. 2002</td>
</tr>
<tr>
<td>3</td>
<td>Targeted Mobilisation of endemic communities</td>
<td>To enhance full participation of communities in CDTI activities</td>
<td>LOCTs, SOCTs, drivers</td>
<td>Community acceptability and participation</td>
<td>Dec. 2002</td>
</tr>
<tr>
<td>4</td>
<td>Training of LOCTs on proper calculation of coverage rates; guideline on problem identification &amp; management; planning for sustainability; usage of supervisory checklist; attitudinal issues</td>
<td>To empower health workers with appropriate knowledge and skills create more awareness and participation in CDTI</td>
<td>ZOC, NGDOs; SOCTs,</td>
<td>Availability of training schedule and attendance lists</td>
<td>Jan. – Feb. 2003</td>
</tr>
<tr>
<td>5</td>
<td>Targeted supervision at LGAs with problems of low coverage using existing checklist</td>
<td>To identify LGAs with low coverage and to empower personnel to deal with such</td>
<td>LOCTs, SOCTs, NGDOs</td>
<td>Availability of reports/checklists</td>
<td>March – June 2003</td>
</tr>
<tr>
<td>6</td>
<td>Collection/collation of reports</td>
<td>Report to appropriate level and have records</td>
<td>SOCTs, LOCTs, health workers, CDDs,</td>
<td>Availability of correct treatment results</td>
<td>April-May 2003</td>
</tr>
<tr>
<td>7</td>
<td>Mop-up &amp; Coverage of conflict areas</td>
<td>Treat defaulters/ cover areas with conflicts; retrieve outstanding reports</td>
<td>SOCTs, LOCTs, CDDs</td>
<td>All eligible community members are treated including those in conflict areas</td>
<td>Jun. 2003</td>
</tr>
<tr>
<td>8</td>
<td>Identification of possible sources of funding locally (e.g. CBOs, NGOs)</td>
<td>To raise funds for planned activities</td>
<td>MOH policy makers</td>
<td>Written commitments; report of meetings/advocacy visits with NGOs</td>
<td>June – August</td>
</tr>
<tr>
<td>9</td>
<td>Review of logistic needs; identification &amp; communication with possible sources of replacement</td>
<td>To ensure that replacements are made for sustaining key activities</td>
<td>MOH policy makers; ZOC; NGDOs</td>
<td>Written commitments</td>
<td>June – August</td>
</tr>
<tr>
<td>10</td>
<td>Fuelling and maintenance of vehicles</td>
<td>Keep vehicles roadworthy, move staff to field</td>
<td>MoH</td>
<td>Vehicles in good functioning condition</td>
<td>Dec. 2002</td>
</tr>
<tr>
<td>11</td>
<td>Procurement of IEC materials</td>
<td>To sensitise communities</td>
<td>MoH</td>
<td>Enough IEC materials are obtained</td>
<td>Dec. 2002</td>
</tr>
<tr>
<td>12</td>
<td>Procurement of summary forms, office consumables, annual report writing</td>
<td>To collate treatment records; to keep appropriate records; to transfer same to appropriate levels</td>
<td>MoH</td>
<td>Adequate materials are obtained</td>
<td>Dec. 2002</td>
</tr>
<tr>
<td>13</td>
<td>Training materials</td>
<td>To facilitate training and learning</td>
<td>MoH</td>
<td>Sufficient materials are procured</td>
<td>Dec. 2002</td>
</tr>
<tr>
<td>14</td>
<td>Procurement of Mectizan</td>
<td>To have required Mectizan for disbursement to endemic communities</td>
<td>MoH, NGDOs</td>
<td>Available quantity of Mectizan</td>
<td>Nov.-Dec. 2002</td>
</tr>
<tr>
<td>15</td>
<td>Communication/electricity bill</td>
<td>Keep abreast with partners and NOCP</td>
<td>MoH</td>
<td>No disruption of communication at any level, due to non-payment</td>
<td>Jan.-Dec. 2003</td>
</tr>
<tr>
<td>16</td>
<td>Review meetings with LOCT</td>
<td>Appraise performance</td>
<td>MoH, NGDOs</td>
<td>Improved performance based on new concepts learned</td>
<td>Aug.-Sept.2003</td>
</tr>
<tr>
<td>17</td>
<td>Oncho Day celebration</td>
<td>Enlighten the public on the socio-economic burden caused by oncho</td>
<td>MoH officials, NGDOs, Press, SOCTs, LOCTs</td>
<td>Public are enlightened, hence increase in acceptability and participation</td>
<td>12 Feb. 2003</td>
</tr>
<tr>
<td>18</td>
<td>ZOTF meeting</td>
<td>To share experiences on CDTI implementation from other States within the zone</td>
<td>SOC, two SOCTs, NGDOs</td>
<td>Agenda and minutes of ZOTF meeting</td>
<td>June-Dec. 2003</td>
</tr>
<tr>
<td>19</td>
<td>Review meeting (APOC assisted States)</td>
<td>To ensure that all States are implementing CDTI in accordance with APOC philosophy</td>
<td>SOC, two SOCTs, NGDO partners</td>
<td>Report of review meeting; planned programme for the following year</td>
<td>Oct. 2003</td>
</tr>
<tr>
<td>20</td>
<td>Review meeting (CBM assisted States)</td>
<td>To apprise work done in CBM assisted States</td>
<td>NOC, two SOCTs</td>
<td>Report of review meeting; planned programme for the following year</td>
<td>July-Aug. 2003</td>
</tr>
<tr>
<td>21</td>
<td>Develop Year 2004 plans at State and LGA levels in a participatory manner</td>
<td>To specify key activities that will be carried out for 2004</td>
<td>SOCTs; LOCTs; LGA/MOH policy makers; NGDOs; ZOC</td>
<td>Detailed and specific plans of action for 2004 exist at LGA and State levels</td>
<td>Oct. Nov. 2003</td>
</tr>
</tbody>
</table>
### Annex 4b: Project Sustainability Plans (Framework): KADUNA State CDTI Project

<table>
<thead>
<tr>
<th>S/N</th>
<th>ACTIVITIES</th>
<th>OBJECTIVES</th>
<th>WHO TO TAKE ACTION</th>
<th>WHEN</th>
<th>WHERE</th>
<th>INDICATOR OF SUCCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Planning &amp; Budgeting</td>
<td>To identify activities that help sustain CDTI</td>
<td>NOCP; NGDO; SOCT</td>
<td>Ready by Oct. 2002</td>
<td>State Level</td>
<td>A document of plan and budget 2003</td>
</tr>
<tr>
<td>2</td>
<td>Advocacy/ Health Education/Mobilization</td>
<td>To create awareness and mobilize resources and political commitment</td>
<td>NOCP; NGDO; SOCT</td>
<td>Continuous exercise</td>
<td>State Level</td>
<td>Release of funds; Release of material support</td>
</tr>
<tr>
<td>3</td>
<td>Training</td>
<td>To update and strengthen technical capacity of implementers in weak areas that need improvement to attain sustainability</td>
<td>NOCP; NGDO; SOCT; LOCT</td>
<td>Preparation for next round of Mectizan distribution</td>
<td>State Level</td>
<td>Improved output of CDTI implementers</td>
</tr>
<tr>
<td>4</td>
<td>Resource Mobilization</td>
<td>To source for alternative and aim for additional financing of CDTI for purpose of sustainability</td>
<td>NOCP; NGDO; SOCT; LOCT</td>
<td>Should be on a continuous basis</td>
<td>State Level</td>
<td>Availability of resources for CDTI implementation</td>
</tr>
<tr>
<td>5</td>
<td>Monitoring &amp; Supervision</td>
<td>To ensure efficiency with emphasis on poorly performing LGAs in CDTI activities</td>
<td>NOCP; SOCT; LOCT</td>
<td>Quarterly</td>
<td>State Level</td>
<td>Improvement in Ivermectin coverage; Improvement in data collection</td>
</tr>
<tr>
<td>6</td>
<td>Transport Management</td>
<td>To set up a transport control and maintenance system</td>
<td>NOCP</td>
<td>August 2002</td>
<td>State Level</td>
<td>Checking log books and trip and maintenance, authorization</td>
</tr>
</tbody>
</table>
### Annex 4c: Project Sustainability Plans (Framework): MALAWI Phase 1 CDTI Project

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOTF based in district/ regional area in an NDGO office not in the federal capital MOH office</td>
<td>The NOTF should be relocated do the federal level from Blantyre. Leaving the NOTF in Lilongwe.</td>
<td>December 31, 2002</td>
<td>Lilongwe</td>
<td>Director of Preventive health services, officer in charge community health services</td>
</tr>
<tr>
<td>Low level of awareness amongst policy makers</td>
<td>Sensitization of all policy makers at the federal level</td>
<td>August 31, 2002</td>
<td>National Level</td>
<td>The national coordinator, MP’s from Oncho Areas</td>
</tr>
<tr>
<td>No Post APOC plan at any level</td>
<td>All</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The NOTF national plan is not incorporated into the MOH plan</td>
<td>The national coordinator must ensure that this year the plan in incorporated (this plan should assume No APOC funding shortages)</td>
<td>February 2003</td>
<td>The national level</td>
<td>The National Coordinator</td>
</tr>
<tr>
<td>DOTF does not have a detailed plan</td>
<td>DOTF must develop a detailed annual plan incorporating needs from the lower levels</td>
<td>August 31, 2003</td>
<td>District level</td>
<td>District level</td>
</tr>
<tr>
<td>DOTF plan is not incorporated into the district plan</td>
<td>Submit a detailed plan to the DHO</td>
<td>September 31, 2003</td>
<td>District level</td>
<td>District Oncho coordinator.</td>
</tr>
<tr>
<td>No national budget lines, which makes it difficult for GOV to allocating fund.</td>
<td>National plans must have budget lines</td>
<td>February 2003</td>
<td>National level</td>
<td>National Oncho coordinator.</td>
</tr>
<tr>
<td>District (DHO)level has not allocated funding for Oncho activities</td>
<td>A substantial effort must be made to advocate for making Oncho a funding priority at the district level</td>
<td>July 1, 2002</td>
<td>The district Level</td>
<td>District Oncho coordinator.</td>
</tr>
<tr>
<td>The MOH does not monitor or audit APOC funding</td>
<td>NOTF should initiate discussions with the MOH to establish an internal for NOTF funds</td>
<td>August 31, 2002</td>
<td>National level</td>
<td>Chairman NOTF</td>
</tr>
<tr>
<td>HQ and district funds are not separate budget lines</td>
<td>NOTF coordinator should develop separate budgets</td>
<td>August 31, 2002</td>
<td>National Level</td>
<td>Chairman NOTF</td>
</tr>
<tr>
<td>Distribution Only in 6 out of 7 districts</td>
<td>NOTF to Conduct REA in Chiradzulu to determine actual need for mass TX. IF need confirmed mass TX to begin early September</td>
<td>September 15, 2002-Prior to TCC</td>
<td>District Level</td>
<td>District Level Staff</td>
</tr>
</tbody>
</table>

Not all problems are listed here due to the table format.
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
<th>WHEN</th>
<th>WHERE</th>
<th>WHO</th>
</tr>
</thead>
</table>
| High perceived refusal rate for Mectizan                              | Intensify sensitization activities, develop IEC strategy                 | July 31, 2002 | Community           | DHA, DOC  
Responsible person: National coordinator |
| High CDD attrition rate                                               | Train additional CDD                                                     | July 31, 2002 | Community           | DHA, DOC  
Responsible person: National coordinator |
| Misconceptions regarding side effects Mectizan                        | Intensify sensitization activities, develop IEC strategy                 | July 31, 2002 | Community           | DHA, DOC  
Responsible person: National coordinator |
| Lack of transport                                                     | Additional 14 motorcycles                                                | November 31, 2002 | National level | APOC |
| Minimal political commitment at all levels                            | Initiate stake holder Meetings                                           | August 31, 2002 | ALL levels          | TF Stake Holders  
DHA, DOC  
Responsible person: National coordinator |
| Inadequate frequency, duration, and structure of CDD and supervisor training. | Reevaluate/redesign/strength training program                            | July 31, 2002 | District and health center level | DHA and training manager  
Responsible person: National coordinator |
| Inadequate quality and frequency of supervision at all levels         | Implement and enforce hierarchical supervision                           | July 31, 2002 | All levels          | All levels  
Responsible person: National coordinator |
| NO ACTIVE NGDO                                                       | Approach SSI                                                             | August 31, 2002 | National level | MOH |
### Annex 4d: Project Sustainability Plans (Framework): CROSS RIVER State CDTI Project

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
<th>WHO</th>
<th>WHEN</th>
<th>FUNDING SOURCE</th>
<th>WHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low coverage</td>
<td>Conduct intensive Heath Education and supervision</td>
<td>SOCT; LOCT Health facilities staff communities</td>
<td>June to December 2002</td>
<td>LGA State Stakeholders</td>
<td>Biase, Odukpani, Yala, Ogoja, Ikom, and Obudu LGAs</td>
</tr>
<tr>
<td>CDTI not integrated into PHC plan</td>
<td>Awareness and action by Directors PHC, planning, permanent secretary Commissionner, planning commission and budget department to create a budget line and release fund for CDTI</td>
<td>State Zonal Coordinator Chair NOTF UNICEF</td>
<td>August 2002 (before budget preparation)</td>
<td>GOVT; NGDO</td>
<td>State &amp; LGA Ministry of Health</td>
</tr>
<tr>
<td>Lack of comprehensive State Post APOC Plan</td>
<td>To elaborate costed, realistic &amp; sustainable post APOC plan including budget as part of the Government 5 year rolling plan</td>
<td>State &amp; LGA programme managers Zonal Coordinator Planning commision, Budget Department Chair NOTF UNICEF</td>
<td>August 2002</td>
<td>GOVT. APOC</td>
<td>State</td>
</tr>
<tr>
<td>Mectizan collection dependent heavily on APOC</td>
<td>Line item in State budget</td>
<td>State &amp; LGA programme managers Zonal Coordinator Planning commision, Budget Department Chair NOTF UNICEF</td>
<td>August 2002</td>
<td>GOVT</td>
<td>State</td>
</tr>
<tr>
<td>Excessive Supervisory visits to the field</td>
<td>Supervisory visits to be targeted based on needs Using checklist</td>
<td>Zonal Coordinator SOCT LOCT HFS</td>
<td>June – Dec.</td>
<td>GOVT</td>
<td>State LGA Community</td>
</tr>
<tr>
<td>Training needs not identified and targeted</td>
<td>Identify and target training needs</td>
<td>Zonal Coordinator SOCT LOCT HFS</td>
<td>June – Dec.</td>
<td>GOVT; NGDO</td>
<td>State LOCT HFS</td>
</tr>
<tr>
<td>PROBLEM</td>
<td>SOLUTION</td>
<td>WHO</td>
<td>WHEN</td>
<td>FUNDING SOURCE</td>
<td>WHERE</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>----------------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| Inadequate funding of the Project                | • Advocacy and sensitization of stakeholders  
  • Identification of more partners  
  • Opening account and Fund raising | State coordinator  
  MOH  
  Zonal coordinator  
  Unicef  
  NOTF  
  Other stakeholders | Oct – Dec. annually | GOVT. | State |
| Uncertain support from leading supporting agency | comittment, plans, and budget, for project support | APOC  
  FMOH  
  Zonal coordinator | July – Dec. | GOVT; APOC; NGDO | Abuja; Lagos; Enugu |
| Replacement of old vehicle                       | Provision of new items                                                   |                          | APOC; NGDO          |                |        |
## Annex 4e: Project Sustainability Plans (Framework) : CROSS RIVER State CDTI Project (LGA PLAN)

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SOLUTION</th>
<th>WHO</th>
<th>WHEN</th>
<th>FUNDING SOURCE</th>
<th>WHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of alternative Mectizan collection points</td>
<td>Agreeing on alternative collection points with community leaders</td>
<td>LOCT; HFS</td>
<td>July – Dec. 2002</td>
<td>GOVT</td>
<td>LGA community</td>
</tr>
<tr>
<td>Lack of comprehensive LGA CDTI post APOC plan</td>
<td>To elaborate costed, realistic &amp; sustainable post APOC plan including budget as part of the LGA integrated PHC plan</td>
<td>LOCT PHC Coordinators</td>
<td>August 2002</td>
<td>GOVT</td>
<td>LGAs</td>
</tr>
<tr>
<td></td>
<td>To plan &amp; organize 3 day planning workshop for LOCT &amp; PHC</td>
<td></td>
<td></td>
<td>APOC</td>
<td></td>
</tr>
<tr>
<td>Training not targeted</td>
<td>Identify and target training needs</td>
<td>LGA Coordinators DOS</td>
<td>July – Dec. 2002</td>
<td>GOVT</td>
<td>Communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health facilities</td>
</tr>
<tr>
<td>Excessive supervisory visits to the field Supervisory check list not used</td>
<td>Supervisory visits to be targeted based on needs Using checklist</td>
<td>LOCT; DOS</td>
<td>July – Dec. 2002</td>
<td>GOVT</td>
<td>Communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health facilities</td>
</tr>
<tr>
<td>Mectizan collection dependent heavily on APOC</td>
<td>Integration into PHC drug delivery system</td>
<td>Heads of Units of health facilities LOCT</td>
<td>MONTHLY</td>
<td>GOVT</td>
<td>LGA HQs</td>
</tr>
</tbody>
</table>
| Inadequate funding of the project & costing to guide budgeting and expenditure | • Advocacy and sensitization of stakeholders  
• Identification of more partners opening account and Fund raising | PHC Coordinators LOCT ; SOCT | July – Dec. 2002 | GOVT; NGDO     | LGA           |
| Refusals/absentees Side effects              | Intensive mobilization & health education                                | LOCT Communities        | July – Dec. 2002 | GOVT           | Communities |
| Inadequate support to CDDs                   | Sensitization and mobilization to reorient communities                  | LOCT                    | July – Dec. 2002 | Communities    | Communities |
## Annex 4f: Project Sustainability Plans (Framework): UGANDA CDTI Projects

<table>
<thead>
<tr>
<th>Issues</th>
<th>Solution (What?)</th>
<th>Responsible (Who)</th>
<th>Time Completed (When?)</th>
<th>Level (Where?)</th>
<th>Applicable Districts</th>
<th>Resources (Source)</th>
</tr>
</thead>
</table>
| 1. NGDO initiates program activities | - Empower DOC to initiate and take leadership in program implementation  
- Urge NGDO partner to take the “back seat” | NGDO partner (SSI) | By Dec. 02 | District | Hoima | N/A |
| 2. Delivery of Mectizan to periphery level dependent on APOC funds | Integration of drug delivery into district delivery system (essential drugs) | DMO  
DOC  
NOC | By Dec. 02 | District | Hoima  
Masindi | Transport,  
Funds (District) |
| 3. Training is not targeted | - targeted training  
- Produce IEC materials | DOC | Ongoing | All levels | Hoima  
Masindi  
Kisoro | Funding  
(District/MOH) |
| 4. No funds released for CDTI activities by district, although it was budgeted | - advocacy to release funds from government  
- joint planning meetings with district staff, NOC, NGDO | District  
NOC  
NGDO | As needed | District | Hoima  
Masindi  
Kasese | Transport  
(APOC,  
NOTF) |
| 5. Poor management of vehicles | - improve management of motorcycles by bringing to the attention DMO | DMO | As needed | District | Hoima  
Masindi | (NOC, NGDO) |
| 6. Lack of capital equipment (computers, printers, photocopiers, peripherals) | - purchase of capital equipment  
- computer training | APOC | By Dec. 02 | District | Hoima  
Masindi  
Kasese  
Kisoro | Funding  
(APOC) |
| 7. Low therapeutic coverage (< 65%) | - carry out operations research to determine reasons for low coverage and address them | District | By Dec. 02 | Communit y | Hoima  
Kasese | Funds  
(APOC) |
| 8. “Volunteer” supervisors are too many (1 per community) | - reduce number of supervisors  
- purchase bicycles for each supervisors | DOC/APOC | By Dec. 02 | Sub-county | Hoima  
Kasese  
Kisoro  
Masindi | Bicycles  
(APOC) |
| 9. Inadequate fuel (US $15 for 6 days per month of supervising CDTI activities) | - integrate supervisory activities | DDHS | By Dec. 02 | District | Hoima  
Masindi | Funds  
(District) |
<table>
<thead>
<tr>
<th>Issues</th>
<th>Solution (What?)</th>
<th>Responsible (Who)</th>
<th>Time Completed (When?)</th>
<th>Level (Where?)</th>
<th>Applicable Districts</th>
<th>Resources (Source)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Poor record keeping</td>
<td>- targeted training for supervisors and CDDs (focus on record keeping)</td>
<td>NGDO, DOC</td>
<td>By Dec. 02</td>
<td>District</td>
<td>Hoima</td>
<td>Funds, training materials (District)</td>
</tr>
<tr>
<td>11. There is no participatory planning and integration into the district health plan</td>
<td>- involve all stakeholders in planning and integrate the plans at all levels</td>
<td>All DOC NGDO NOC</td>
<td>March 03</td>
<td>District</td>
<td>Masindi, Kisoro</td>
<td>Funds (APOC, NGDO)</td>
</tr>
<tr>
<td>12. Weak involvement of political leaders in CDTI activities</td>
<td>- prompt and adequate sensitization of political leaders</td>
<td>DMO DOC NOC</td>
<td>As needed</td>
<td>District</td>
<td>Masindi, Kisoro</td>
<td>Funds (APOC)</td>
</tr>
<tr>
<td>13. Supervisory visits routine (not targeted)</td>
<td>- ensure that supervision is targeted and integrated within the district supervisory system</td>
<td>DOC</td>
<td>Ongoing</td>
<td>Sub-county</td>
<td>Kasese, Kisoro</td>
<td>Funds (District)</td>
</tr>
<tr>
<td>14. Lack of commitment of health center staff trained for CDTI activities</td>
<td>- sensitzation of health center staff</td>
<td>DDHS DOC NOC</td>
<td>By Dec. 02</td>
<td>District</td>
<td>Kasese</td>
<td>Funds (APOC, NGDO)</td>
</tr>
<tr>
<td>15. Release of Mectizan tablets in instalments</td>
<td>consider the release of all drugs at once and ensure immediate distribution to reduce threat of theft by rebels</td>
<td>DOC NOTF NGDO</td>
<td>By March 03</td>
<td>District</td>
<td>Kasese</td>
<td>N/A</td>
</tr>
<tr>
<td>16. There is a need to incorporate relevant issues raised here into already developed each district plans</td>
<td>- incorporate the documents</td>
<td>NGDO NOC</td>
<td>By Aug 02</td>
<td>National NGDO</td>
<td>Hoima, Masindi, Kasese, Kisoro</td>
<td>N/A</td>
</tr>
</tbody>
</table>
# Annex 4g: Project Sustainability Plans (Framework): MAHENGE Project (Ulanga and Kilombero Districts)

<table>
<thead>
<tr>
<th>Indicator Problems</th>
<th>Recommendation</th>
<th>Actor</th>
<th>Time Frame</th>
<th>Source of fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Therapeutic coverage was low</td>
<td>Assess process indicators for coverage to use these indicators as advocacy tool</td>
<td>NOTF</td>
<td>By July 2003</td>
<td>GOVT &amp; NGDOs</td>
</tr>
<tr>
<td>Planning Stakeholders are not involved in planning process(top down)</td>
<td>Planning should involve all stakeholders (bottom up)</td>
<td>NOTF</td>
<td>End of August 2002</td>
<td>GOVT &amp; NGDOs</td>
</tr>
<tr>
<td>Leadership Coordinator is an NGDO employee hence it has been hard to coordinate and integrate project activities into the district health system</td>
<td>Devolve more power of decision to the District Coordinators and phase out the current coordinating office</td>
<td>NOCP</td>
<td>Dec-03</td>
<td></td>
</tr>
<tr>
<td>District leadership has not yet owned the CDTI project in Kilombero District</td>
<td>Include CDTI activities under the Kilombero DMO to be more responsibility for the CDTI project</td>
<td>NOTF</td>
<td>Dec-02</td>
<td></td>
</tr>
<tr>
<td>Supervision/Monitoring The Region has been by passed in the monitoring and supervision activities</td>
<td>The National office should involve the region in the monitoring and supervision</td>
<td>NOC</td>
<td>Dec-02</td>
<td>GOVT &amp; NGDOs</td>
</tr>
<tr>
<td>Mectizan distribution CDDs walk long distances up to 15 kms to collect drugs (mectizan)</td>
<td>Provide 150 bicycles to 150 communities out of the 300</td>
<td>NOTF</td>
<td>Aug-02</td>
<td>APOC</td>
</tr>
<tr>
<td>Indicator</td>
<td>Problems</td>
<td>Recommendation</td>
<td>Actor</td>
<td>Time Frame</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Training/Sensitisation/Mobilisation</td>
<td>CDDs not fully conversant with CDTI principals</td>
<td>Targeted training</td>
<td>NOTF</td>
<td>Aug-02</td>
</tr>
<tr>
<td>Lack of IEC materials</td>
<td></td>
<td>Develop and produce appropriate IEC materials</td>
<td>NOTF/Districts</td>
<td>Dec-02</td>
</tr>
<tr>
<td>Finance/Funding</td>
<td>Inadequate funding</td>
<td>Mobilise/fundraise resources from diversified sources (e.g. UNICEF, MSF)</td>
<td>NOTF</td>
<td>Dec-03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Determine the funding requirements for each level</td>
<td>NOTF/DMOs</td>
<td>Dec-02</td>
</tr>
<tr>
<td>No financial contribution from the Government</td>
<td></td>
<td>Put in place innovative and professional advocacy (e.g. DALYs, QALYs)</td>
<td>NOTF&amp; APOC</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Kilombero DMO by passed in the approval of payments</td>
<td></td>
<td>Make sure DMOS approve all payments</td>
<td>NOC</td>
<td>Dec-02</td>
</tr>
<tr>
<td>Transport and material resources</td>
<td>Vehicles and motorcycles are completely worn out (&gt;7 years old)</td>
<td>Replacement (2 vehicles) one for each district and (4 motorcycles) 2 per district</td>
<td>APOC</td>
<td>Aug-02</td>
</tr>
<tr>
<td>Human resources</td>
<td>Inadequate number of health staff</td>
<td>Advocate to increase number of health workers and innovative use of other non health workers</td>
<td>NOTF</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Annex 5: CDTI IN CONFLICT AREAS

PROBLEMS
- Movement of populations
- Infrastructures are destroyed
- Geographical inaccessibility
- Insecurity/instability of staff
- Administration problem
  - paralysis
- Disruption in the planning
  - programme
  - finance (use of several currencies, exchange rate, budget)
- Provision in materials and products
  - material stolen
  - lack of control
- Excessive cost
- Amplification of the problems
- New priorities arise for communities

RECOMMANDATIONS
- Continue with Mectizan distribution
  - Movement from endemic area toward non-endemic area: distribution within the existing health system.
  - Movement from non-endemic area toward endemic area: distribution using CDTI.
  - As much as possible, use mobile CDDs that will be moving with the populations.
- Make advocacy with the authorities for the rebuilding.
- Advocacy with authorities for a cease-fire and quietude days
  - Seize all opportunities and assets to reach inaccessible areas.
- Follow the instructions from the United-Nations and have distinctive dresses for the CDTI staff.
- APOC should give more flexibility in the achievement of programme and allow subdivision of the projects
  - suspension of activities
- Minimize losses of Mectizan
  - give to each CDD the number of Mectizan tablets required
  - distribute Mectizan during the period of lull.
  - Provide appropriate to the stock managers
  - sensitize the military authorities
- The projects should well justify their budgets
  - give details
  - flexibility at the APOC level
- Integrate CDTI in the other health programmes
- Make advocacy with the other health programmes which pay perdiems to also use the CDDs

FRAMEWORK
- At APOC level
  - Reach agreements with the humanitarian agencies so that they integrate CDTI in their activities.
  - Continue giving support to zones which have already implemented CDTI.
  - Make advocacy for the mobilisation of resources.
- At the country/field level
  √ Seize all the opportunities to implement CDTI activities.
  √ Mobilize local resources to support CDTI.
  √ Use CDDs in health emergency activities conducted in the field.
  √ Implicate parties in conflict in the support to CDTI.
Annex 6

MEMBERS OF THE LOCAL ORGANIZING COMMITTEE

1. Dr. K. Korve Chair
2. Mr. C. Ogoshi Member
3. Dr. M. Obadiah Member
4. Mr. O. Fasina Member
5. Princess P. Ogba – Pearce Member
6. Mrs. F. Olamiju Member
7. Dr. Y. Fayomi Member
8. Mr. A. O. Jaiyeoba Member
9. Dr. Y. A. Saka Member

FACILITATORS AND RAPPORTEURS OF FINAL REPORT

1. Dr. E. Tarimo
2. Prof. D. Prozesky.
3. Ms P. Drameh
4. Prof. E. Braide
5. Dr. E. Elhassan
6. Dr. R. Befidi-Mengue
7. Mrs T. Subayi-Cuppen
8. Prof. O. Akogun
9. Dr. U. Amazigo
10. Dr. M. Noma
11. Mrs V. Matovu
12. Mr. H. Zoure
13. Dr J. Okeibunor
14. Mr U. Oyene
15. Mr C. Okoronkwo
16. Mr. Sunday Isiyaku
Annex 7: LIST OF PARTICIPANTS

SECOND MEETING OF THE NATIONAL ONCHOCERCIASIS TASK FORCES (NOTFs) REPRESENTATIVES OF THE AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL (APOC) COUNTRIES

ABUJA, 17th to 22nd JUNE 2002

CAMEROON

Dr. Marcelline NTEP
National Coordinator, National Onchocerciasis Control Programme, Ministry of Public Health, c/o WHO, B. P. 155 Yaounde, Cameroon – Tel/Fax: (237) 222.69.10 – E-mail: sgoa@camnet.cm or mangamar2001@yahoo.fr

Dr. Rosa BEFIDI-MENGUE
Country Representative, Sight Savers International (SSI) Cameroon Office & Chairperson of the NGDO Coalition, P. O. Box 4794 Yaounde, Cameroon – Tel: (237) 221.12.33 – Fax: (237) 221.79.43 – E-mail: sssicam@iccnet.cm

CHAD

Dr. Kimingar NAMANGUE
National Coordinator, National Onchocerciasis Control Programme, Ministry of Health, BP 5467 N’Djamena, Chad – Tel/Fax: (235) (235) 52.48.38 or (235) 52.08.19

Mrs. Nsimire Denise NDAGANO
Health Coordinator, Africare, BP 689 N’Djamena, Chad – Tel: (235) 52.47.14 – Fax: (235) 52.35.45 – E-mail: africare.tchad@intnet.td

CENTRAL AFRICAN REPUBLIC

Dr. Justin N’DOYO
Director of Preventive Medicine and Disease Control, National Coordinator of Onchocerciasis Control Programme, Ministry of Health, BP 783 Bangui, Central African Republic – Tel: (236) 61.76.65 or (236) 50.90.70– Fax: (236) 61.61.17 or (236) 61.01.37 – E-mail: cbmi@intnet.cf

Mr. Helmut SCHRADER
Country Representative, Christoffel-Blindenmission (CBM) and Chairman of the NGDO Coalition, BP 1722, Bangui, Central African Republic – Tel/Fax: (236) 61.61.17 – E-mail: hrschrader@ad.com
**CONGO BRAZZAVILLE**

Dr. François MISSAMOU  
Medecin – Chef du Programme National de Lutte contre l’Onchocercose (PNLO), Direction de la Lutte contre la Maladie, B. P. 236 Brazzaville, Congo – Tel: (242) 68.05.63 – E-mail: opc_congo@yahoo.fr

Dr. Damase BODZONGO  
Directeur General de la Sante, BP 78 Brazzaville, Congo – Tel: (242) 81.57.46 – Fax: (242) 81.04.81 – E-mail: bozos@congo.net

**DEMOCRATIC REPUBLIC OF CONGO**

Dr. Kupa MUKENGESHAY  
National Coordinator, National Onchocerciasis Task Force (NOTF) Secretariat, B. P. 8081, 36, Avenue de la Justice, Kinshasa/Gombe, Democratic Republic of Congo – Tel: (243) 33.247

Mr. David LAW  
Program Administrator, Christoffel-Blindenmission (CBM), c/o Task Force (NOTF) Secretariat, B. P. 8081, 36, Avenue de la Justice, Kinshasa/Gombe, Democratic Republic of Congo – Tel: (243) 8801976 – E-mail: Dlaw@maf.org

**ETHIOPIA**

Mr. Teshome GEBRE  
Country Representative, The Carter Center, Global 2000 River Blindness Program & Chairman of the NGDO Coalition, P. O. Box 13373 Addis-Ababa, Ethiopia – Tel: (251) 1 61.59.80 – Fax: (251) 1 62 45 62 – E-mail: global2000@telecom.net.et

**EQUATORIAL GUINEA**

Dr. Anacleto SIMA  
National Director for Onchocerciasis Control and other Filariasis, Ministry of Health and social welfare, Malabo, Equatorial Guinea – Tel/Fax: (240) 9.05.79

**LIBERIA**

Dr. Zolu D. TRAUB  
National Coordinator, National Onchocerciasis Task Force (NOTF) Secretariat, Ministry of Health & Social Welfare, P. O. Box 10-9009 Monrovia 10, Liberia – Cellular phone: (231) 512898

Mrs. Verda TARPEH  
Project Officer, Liberia/Regional Initiatives, Sight Savers International (SSI), 10 Nortei Ababio Street, P. O. Box 18190 Airport Residential, Accra, Ghana – Tel: (233) 21.77.42.10 – Fax: (233) 21. 77.42.09- E-mail: vtarpeh@sightsavers.org
MALAWI

Mr. Phillimon TAMBALA
National Coordinator, National Onchocerciasis Task Force (NOTF) Secretariat, Ministry of Health & Population, c/o International Eye Foundation (IEF), P. O. Box 2273, Blantyre, Malawi – Tel: (265) 624-603 – Fax: (265) 624-526 – E-mail: notfmalawi@globemw.net or tambalapaj@globemw.net

Mr. Fedson Budala NKHOMA
Training & Supervision Manager, International Eye Foundation (IEF). P. O. Box 2273 Blantyre, Malawi – Tel: (265) 624-448 – Fax: (265) 624-526 – E-mail: ief@malawi.net

NIGERIA

Prof. Olikoye RANSOME KUTI
Chairman, National Primary Health Care Development Agency, 681-682 Port Harcourt, Crescent Off Gimbibya Street, Garki Area II, Abuja, Nigeria – Tel: (234) 9 3143631 – Fax: (234) 9 3143629

Prof. Oladele B. AKOGUN
Parasite and Tropical Health, Department of Biological Sciences, Federal University of Technology, Yola, Nigeria – Tel/Fax: (234) 75 626467 – E-mail: akogunb@skannet.com

Mrs. Sheri ABARI
Assistant Director NCD, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 8023076883

Mr. Abbas Mustapha ABDULLAHI
State Onchocerciasis Coordinating Team, Senior Officer – Tel: (234) 09 2341772 or (234) 08 044100414

Dr. Abimbola ASAGBA
Director, Public Health, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 9 5238150

Mrs. Adebimpe ADEBIYI
Assistant Director/Principal Dental Officer, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 9 6702169 or (234) 9 23179994

ALH Abbas DALHATOU
Federal Capital Territory Onchocerciasis Coordinator, Health Department, Ministry of Federal Capital Territory, Abuja, Nigeria – Tel: (234) 9 2341772

Dr. Odu BAMGBOSE

Dr. Waziri DOGO-MUHAMMAD B.
Consultant Special Grade II, Federal Ministry of Health, Inspectorate Division, Department of Hospital Services, Federal Secretariat, Abuja, Nigeria - Tel
Prof. Luke EDUNGBOLA  
Chairman, Steering Commitment, NOCP (Nigeria), Faculty of Health Sciences, University of Ilorin, Ilorin, Kwara State, Nigeria – Tel/Fax: (234) 31 220416

Dr. Abel EIGEGE  
Director, Plateau - Nassarawa Program, Carter Center, Jos, Plateau State, Nigeria

Dr. Emmanuel C. EMUKAH  
Project Administrator, IMO/ABIA Project, The Carter Center, Global 2000 River Blindness, IMO/ABIA Projet Plot R/60 GRA Off High Court Road Owerri, Nigeria – Tel: (234) 83 231090–Fax: (234) 83 231883 – E-mail: grbpimab@infoweb.abs.net

Mr. Olakunle FASINA  
Project Accountant, Federal Ministry of Health, Federal Secretariat, Ikoyi – Lagos, Nigeria – Tel/Fax: (234) 1 2696013

Dr. Yemi FAYOMI  
Zonal Onchocerciasis Coordinator, NOCP Kaduna, 1 Golf Course Road, Kaduna State, Nigeria – Tel: (234) 62 242533 - Fax: (234) 62 242533

Mr. A. JAIYEBOA  
Zonal Onchocerciasis Coordinator, Federal Ministry of Heal B-Zone, 2 Oladejo Adigun Road Jericho, Ibadan, Nigeria – Tel: (234) 2 2411350

Mr. Godwin Onehireme IHIMEKPEN  
Chief Medical Lab. Scientist, Department of Hospital Services, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 5234589 – E-mail: ihimekpen@jonigpost.com

Mr. Edward O. JABOLUWA  
Federal Ministry of Health, Abuja, Nigeria – Tel (234) 80 3 774 7874

Dr. Yewande JINADU  
Deputy Director, (Oncho/Schisto), Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 9 2611721 or (234) 9 296013 – Fax: (234) 9 2694096 – E-mail: myjinadu@yahoo.com

Dr. Jonathan Y. JIYA  
National Coordinator, National Onchocerciasis Control Programme, Federal Ministry of Health, Ikoyi – Lagos, Nigeria – Tel/Fax: (234) 1 2696013

Dr. David MALGWI  
Deputy Director, National Programme on Immunization (NPI) – Tel: (234) 9 314 1287/8

Mr. Ahmed Shu’aibu MOHAMMED  
Scientific Officer II, Public Health, Area 2 Section 2 Abuja, Nigeria – Tel: (234) 9 2341772

Mr. Gabriel Audu MOSES  
Chief Internal Auditor, Ministry of Education, Kaduna State, Nigeria
Prof. Obioma NWAORU
Researcher, Enugu State University of Technology, P.M.B. 01660, Enugu State, Nigeria – Tel: (234) 42 258078 or (234) 42 256128 – Fax: (234) 42 250836 – E-mail: obnwaorgu@yahoo.com or onwaorgu@infoweb.abs.net

Mrs. Patricia OGBU-PEARCE
Zonal Onchocerciasis Coordinator, NOCP Zonal Office Jahun Road, Bauchi State, Nigeria – Tel: (234) 77 540091 – Fax: (234) 77 540091

Prof. Martin G. OGBE
President of Nigerian Society for Parasitology, Delta State University, Abaraka, Nigeria – Tel: (234) 9 2342733 – GSM: (234) 9 8033013825 – E-mail: ogbegbemi@yahoo.co.uk

Dr. Ololade Olusola OJO
Deputy Director, Federal Ministry of Health, Abuja, Nigeria – Tel/Fax: (234) 9 5238928 – E-mail: drlolaoyo@msn.com

Dr. Joseph OKEIBUNOR
Senior Lecturer, Department of Sociology/Anthropology, University of Nigeria, Nsukka, Enugu State, Nigeria – Tel: (234) 42771169 – E-mail: EPSEELON@aol.com or onwaorgu@infoweb.abs.net

Dr. Cyril Chidebe OKEKE
Assistant Director, Department of Hospital Services, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 5237416 or (234) 8037869570 – E-mail: cyrilchidebe@yahoo.com

Dr. (Mrs.) Omobolane Rose Mary OLOMU
Assistant Director, Federal Ministry of Health, Abuja, Nigeria – Tel: (234) 9 5232023

Mr. Ukam Ebe OYENE
State CDTI Project Coordinator, Onchocerciasis Control Programme School of Health Technology, Calabar, Cross River State, Nigeria – Tel/Fax: (234) 87 236517 – E-mail: onyeneue@justice.com or onchocal@skannet.com

Dr. Y. A. SAKA
Assistant to the National Coordinator, National Onchocerciasis Control Programme, Federal Ministry of Health, Ikoyi – Lagos, Nigeria – Tel/Fax: (234) 1 2696013

Dr. Suleiman SANI
Director, Hospital Services, Department of Hospital Services, Federal Ministry of Health, Abuja, Nigeria

Dr. U. UDOFA
Zonal Onchocerciasis Coordinator, Zone A Office c/o National Onchocerciasis Control Programme, Federal Ministry of Health, Ikoyi – Lagos, Nigeria – Tel/Fax: (234) 1 2696013

Mr. John Ado UMARU
Project Administrator, The Carter Center, Global 2000 River Blindenmission, Jos – Plateau State, Nigeria – Fax: (234) 73 460097 – E-mail: g2000@hsen.org
Mr. YA’U Hassan  
State Onchocerciasis Coordinator Team, Department of Health Services, Federal Capital Territory, Abuja, Nigeria – Fax: (234) 09 234 1772

Dr. Yewande THORPE  
Deputy Director, Federal Ministry of Health, Abuja, Nigeria

Mr. Victor Garba ZARAFI  
Administrative Officer, National Onchocerciasis Control Programme (NOCP), Federal Ministry of Health, Abuja – Nigeria – Tel: (234) 8033115864

SUDAN

Dr. Nazar Abdel Rahim MOHAMMED  
Deputy National Coordinator for Onchocerciasis and Trachoma Control Programmes Sudan, c/o P.O. Box 12810 Khartoum, Sudan – Tel: (249-11) 235502– Fax: (249-11) 235502 - E-mail: nazarmohamed@hotmail.com or amst33@hotmail.com

Mr. Mark PELLETIER  
Country Representative, The Carter Center, Global 2000 River Blindness Program & Chairman of the NGDO Coalition, c/o Acropole Hotel, P. O. Box 48 Khartoum, Sudan - Tel: (249-11) 79.26.58 or (249-11) 77.17.45 – Fax: (249-11) 78.55.36 – E-mail: global@sudanmail.net

Mrs. Irene MUELLER  
Program Manager, Southern Sudan Onchocerciasis Control Program, HealthNet International, P. O. Box 76133 Nairobi, 00508 Kenya – Tel: (254-2) 573-704 – Fax: (254-2) 574-452 – E-mail: hnetnbo@nbnet.coke

Dr. Samson Paul BABA  
National Coordinator for the Southern Sudan Onchocerciasis Control Program, c/o HealthNet International, P. O. Box 76133 Nairobi, 00508 Kenya – Tel: (254-2) 573-704 – Fax: (254-2) 574-452 – E-mail: hnetnbo@nbnet.coke

Dr. Tong Chor MALEK  
Senior Field Officer, Academy of Medical Sciences & Technology, P. O. Box 12810 Khartoum, Sudan – Tel: (249-11) 22.67.99 or (249-11) 23.55.02 – Fax: (249-11) 23.55.03 – E-mail: tong-schewitaak@hotmail.com

TANZANIA

Dr. Simon KATENGA  
National Coordinator, Eye Care & Onchocerciasis Control Programme, Ministry of Health, P. O. Box 9083 Dar-es-Salaam, Tanzania – Tel: (255) 222 130025 – Fax: (255) 222 130009 – E-mail: katenga@raha.com

Mr. Pius MABUBA  
Country Representative, Sight Savers International (SSI) & Acting Chairman of the NGDO Coalition, P. O. Box 2513 Dar-es-Salaam, Tanzania – Tel: (255) 222 2701098 – Fax: (255) 222 27011097 – E-mail: c/o sightsaverstz@raha.com
UGANDA

Dr. Richard NDYOMUGYENYI
National Coordinator, National Onchocerciasis Control Programme Secretariat, 15 Bombo Road, P. O. Box 1661 Kampala, Uganda – Tel: (256-41) 348-332 – Fax: (256-41) 348-339 – E-mail: notf@imul.com

Dr. Johnson NGOROK
Country Representative, Sight Savers International (SSI) & Chairman of the NGDO Coalition, Uganda Country Office, P. O. Box 21249, Colline House, Pilkington Road, 3rd Floor, Kampala, Uganda – Tel: (256-41) 230299 – Fax: (256-41) 230338 – E-mail: ingorok@sightsavers.or.ug

NON GOVERNMENTAL DEVELOPMENT ORGANIZATIONS (NGDOs)

Mr. John EGUAGIE
Project Administrator, The Carter Center, Global 2000, Edo/Delta State – Tel: (234) 052 256919/252719

Dr. Elizabeth O. EL-HASSAN
Country Representative, Sight Savers International (SSI) & Chairperson of the NGDO Coalition, 1 Golf Course Road, Kaduna State, Nigeria – Tel/Fax: (234) 62 248360 or (234) 62 248973 – E-mail: ssing@infoweb.abs.net

Engr. William FELLOWS
SNR Program Officer (UNICEF), WES SECTION CHIEF, 30 A Onyinkan Abayomi Drive Ikoyi, Lagos, Nigeria – Tel: (234) 1 2690276-80

Dr. Emmanuel I. GEMADE
Project Officer Health, UNICEF, 30 A Onyinkan Abayomi Drive, Ikoyi - Lagos, Nigeria – Tel: (234) 1 2690276 – Fax: (234) 1 2690726 – E-mail: egemade@unicef.org

Mr. Christopher IBEKWE
Senior Program Assistant, 30A Onyinkan Abayomi Drive, Ikoyi (UNICEF), Lagos – Nigeria – Tel: (234) 1 2690276-80 – cibekwe@unicef.org

Mr. Sunday ISIYAKU
Project Officer, Sight Savers International (SSI), 1 Golf Course Road, Kaduna State, Nigeria – Tel/Fax: (234) 62 248360 or (234) 62 248973 – E-mail: ssing@infoweb.abs.net

Dr. Kenneth KORVE
Director, Southeast Programs, The Carter Center Global 2000 National Office, No. 1 Jeka Kadima Street, P. O. 7772 Jos – Plateau State, Nigeria – Tel: (234) 73 461861 or (234) 73 460097 – Fax: (234) 73 460097 - E-mail: g2000@hisen.org or cartercenterng@yahoo.com
Mrs. Chinyere Uzoamaka MADUKA  
Project Administrator for Enugu/Anambra/Ebonyi States, Nigeria, Global 2000, The Carter Center, South East, No 8th First Avenue Independence Lay Out Enugu – Tel: (234) 42 452333/(234) 42 456836 – Fax: (234) 42 450460 - grbpmab@infoweb.abs.net

Ms. Wanjira MATHAI  
Sr. Program Officer, One Copenhill, Atlanta, GA 30307, USA – Tel: (770) 488 4511 – Fax: (770) 488 4521 – Wgm6@cdc.gov

Dr. Emmanuel Samson MIRI  
Country Representative, The Carter Center, Global 2000 National Office, No. 1 Jeka Kadima Street, P. O. Box 7772 Jos – Plateau State, Nigeria – Tel: (234) 73 463870 – Fax: (234) 73 460097 – E-mail: g2000@hisen.org

Mr. Muyiwa OLAMIYI  
Programme Associate, United Nations Development Programme, Cooperative Bank Building, Maitaima, Federal Capital Territory – Tel: (234) 9 4132109

Dr. Musa A. Z. OBADIAH  
Country Director, Helen Keller International (HKI), No.1, Akila W. Machunga Road, Opp. National Library, Jos. P. O. Box 6661, Jos - Plateau State, Nigeria – Tel: (234) 73462672 – Fax: (234) 73 462672 – E-mail: hkwj@hisen.org

Mr. Christopher Sunday OGOSHI  
Deputy Onchocerciasis Coordinator, Christoffel-Blindenmission (CBM), 3 A Gomwalk Close, P. O. Box 8426, Jos – Plateau State, Nigeria – Tel: (234) 73 456578 – Fax: (234) 73 454230 – E-mail: cbmjos@hisen.org

Mrs. Francisca Onyeka OLAMIJU  
Executive Director, Mission to Save the Helpless (MITOSATH) Riverblindness Control Program, No. 6 Noad Avenue, Tekan Headquarters, behind Central Bank, Box 205, Jos – Plateau State, Nigeria – Tel/Fax: (234) 73 450153 or Tel: (234) 73 454044 – E-mail: mitosath@hotmail.com

CORE GROUP MEMBERS

Ms. Mariam ALLY  
Health Economist, Ministry of Health P. O. Box 9083, Dar-es-Salaam, Tanzania – Tel: (255) 744 436472 - Fax: (255) 222 130009 - E-mail: mariam_mwakobe@yahoo.com

Dr. Sebastian OLIKIRA BAINE  
Medical Doctor, Institute of Public Health, Makerere University, P. O. Box 7072 Kampala, Uganda – Tel: (256) 71 925861 – Fax: (256-41) 531-807 – E-mail: Sbaine@iph.ac.ug or Sobaine@yahoo.co.uk

Dr. Richard Allan GIBSON  
Medical Doctor, P. O. Box 52482Wienda Park 0149 Johannesburg, South Africa – Tel: 27-12 3541147 (work) – Fax: +27-12 3541758 – E-mail: rgibson@medic.up.ac.za
Prof Oladele Olusiji KALE  
Department of Preventive and Social Medicine, University College Hospital, Ibadan, Nigeria –  
Tel: (234) 2 8100397 or (234) 2 8103563 – Fax: (234) 2 8100319 – E-mail: ookale@skannt.com  
or ookale@yahoo.com

Dr. KEBELA ILLUNGA Benoît  
Directeur, Direction Epidémiologie et Président du GTNO, Ministère de la Santé, Directeur de  
l’Epidémiologie, 39, avenue de la Justice, Gombe/Kinshasa, République Démocratique du Congo  
– Tel: (243) 33333 ou (243) 9972691 – E-mail: minisante4d@ic.cd ou kebelailunga@yahoo.fr

Mr. Chukwu OKORONKWO  
National Onchocerciasis Control Programme, Federal Ministry of Health, Ikoyi – Lagos, Nigeria  
– Tel/Fax: (234) 1 2696013 – E-mail: chukoro_Christ@yahoo.co.uk

Dr. Obinna Emmanuel ONWUJEKWE  
Department of Pharmacology and Therapeutics, University of Nigeria, Teaching Hospital, P. M.  
B. 01129 Enugu, Nigeria – Tel: (234) 42 457188 – Fax: (234) 42 259569 – E-mail: onwujekwe@yahoo.co.uk

Prof. Detlef PROZESKY  
Team Coordinator, 90, 22nd Street, Menlo Park, Pretoria 0081, South Africa – Tel: +27-12—354-  
1148 (office) - +27-12-346-1875 – Fax: +27-12-354-1758 – E-mail: dprozesky@medic.up.ac.za

Dr. Eleuther TARIMO  
Team Coordinator, c/o WHO Office, P. O. Box 9292 Dar-es-Salaam, Tanzania – Tel: (255) 222  
73505 or (255) 222 73568 – Fax: (255) 222 71720 – E-mail: eleurther@ud.co.tz

TCC MEMBERS

Prof. Adenike ABIOSE  
Medical Director, TCC Member of APOC, Steering Committee NOCP, Sightcare International, P.  
O. Box 10392, Kaduna, Nigeria – Tel: (234) 62 417373 or (234) 62 248684 – Fax: (234) 62  
410873 or c/o SSI/Kaduna (234) 62 248973 – E-mail: abiose@infoweb.abs.net

Prof. Ekanem Ikpi BRAIDE  
Parasitologist, Department of Biological Sciences, University of Calabar, P. O. 3679 Calabar,  
Cross River State, Nigeria – Tel: (234) 87 230452 – Fax: (234) 87 236298 or (234) 87 230929 –  
E-mail: ekanem-b@hotmail.com

WORLD BANK

Mrs. Tshiya SUBAYI-CUPPEN  
World Bank – Oncho Focal Point, 1818 H Street N. W., MSN J 901, Washington, DC 20433 –  
USA – Tel : (202) 473-5018 – Fax : (202) 473-8216 – E-mail : tsubavi@worldbank.org  
Or  
Mrs. Tshiya SUBAYI-CUPPEN  
c/o The World Bank Resident Mission. B. P. 03-2112, Cotonou, Benin – Tel: (229) 31.21.24
WORLD HEALTH ORGANIZATION

GENEVA

Ms. Pamela S. DRAMEH
NGDO Coordinator for Onchocerciasis Control, Prevention of Blindness and Deafness, World Health Organization (WHO), 20, Avenue Appia, CH-1211 Geneva 27, Switzerland – Tel: (+41 22) 791-3211 – Fax: (+41 22) 791-47 – E-mail: dramehp@who.ch

Dr. Janis LAZDINS
Manager, Filariasis R & D (Macrofil), World Health Organization (WHO), 20, Avenue Appia, CH-1211 Geneva 27, Switzerland – Tel: (+41 22) 791-3818 – Fax: (+41 22) 791-4854 – E-mail: lazdinsj@who.int

NIGERIA

Dr. Abdou MOUDI
Country Representative, World Health Organization (WHO), 443 Herbert Macaulay Street, Yaba, Nigeria – Tel: (234) 1 7741718 or (234) 8034020825 – Fax: (234) 1 5452179 – E-mail: moudiabdou@who-nigeria.org

Dr. Henry EDEGHERE
Surveillance Supervisor, World Health Organization (WHO), 1, Golf Course Road, Kaduna – Tel: (234) 62 244101 – Fax: (234) 62 244102 – E-mail: edegehreh@yahoo.co.uk

APOC MANAGEMENT

Dr. Azodoga SEKETELI
Director, African Programme for Onchocerciasis Control (APOC), 01 BP’ 549 Ouagadougou 01, Burkina Faso – Tel: (226) 30.24.56 – Fax: (226) 34.28.75 or (226) 34.36.47 – E-mail: seketelia@oncho.oms.bf

Dr. Uche AMAZIGO
Chief of the Sustainable Drug Distribution Unit, African Programme for Onchocerciasis Control (APOC), 01 BP 549 Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 – E-mail: amazigouv@oncho.oms.bf

Dr. Mounkaïla NOMA
Chief of Epidemiological Unit and Vector Control, African Programme for Onchocerciasis Control (APOC), 01 BP 549 Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 – E-mail: nomam@oncho.oms.bf

Mrs. Victoria MATOVU
Community Ownership and Partnership Officer, African Programme for Onchocerciasis Control (APOC), 01 BP 549 Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 – E-mail: matovuv@oncho.oms.bf

63
Mr. Honorat ZOURE  
Biostatistic and Mapping, African Programme for Onchocerciasis Control (APOCH), 01 BP 549  
Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 –  
E-mail: zoureh@oncho.oms.bf

Mr. Yaovi AHOLOU  
Administrative Officer, African Programme for Onchocerciasis Control (APOCH), 01 BP 549  
Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 –  
E-mail: aholouy@oncho.oms.bf

SECRETARIAT

Mr. Gideon AHIABA  
Administrative Officer, World Health Organization (WHO), 443 Herbert Macaulay Street, Yaba,  
Nigeria – Tel : (234) 1 7741718 or (234) 8034020825 – Fax : (234) 1 5452179 – E-mail :

Ms. Rakiya MAMMAN  
World Health Organization (WHO), 443 Herbert Macaulay Street, Yaba, Nigeria – Tel : (234) 1  
7741718 or (234) 8034020825 – Fax : (234) 1 5452179 – E-mail: mamanr@who-nigeria.org

Ms. Betty I. EZOMO  
NOCP Zone C, 1, Golf Course Road, P. O. Box 503 Kaduna, Nigeria – Tel : (234) 62 242533

Mrs. G. A. EHUHU  
NOCP Headquarters, Federal Ministry of Health, Federal Secretariat, Room 915, Ikoyi – Lagos,  
Nigeria – Tel/Fax: (234) 2696013

Mr. S. AGORO  
NOCP Headquarters, Federal Ministry of Health, Federal Secretariat, Room 915, Ikoyi – Lagos,  
Nigeria – Tel/Fax: (234) 2696013

Ms. Esther MUSA  
Secretary, Christoffel-Blindenmission (CBM), 3 A Gomwalk Close, P. O. Box 8426, Jos –  
Plateau State, Nigeria – Tel: (234) 73 454230 – Fax: (234) 73 456578

Mr. A. SAMANDE  
NOCP Zonal Office Jahun Road, Bauchi State, Nigeria – Tel: (234) 77 540091 – Fax: (234) 77  
540091

Mr. E. B. BAHAGO  
National Onchocerciasis Control Programme (NOCP), Federal Ministry of Health, P. M. B. 083,  
CSG 1 (PH) Room 4A 302, Abuja, Nigeria

Ms. Letty NWAFOR  
NOCP Zone C, 1, Golf Course Road, P. O. Box 503 Kaduna, Nigeria – Tel : (234) 62 242533
Mr. Gideon ZEPHANIAH
Administrative Secretary, Helen Keller International (HKI), No.1, Akila W. Machunga Road,
Opp. National Library, P.O. Box 6661, Jos - Plateau State, Nigeria– Tel: (234) 73462672 – Fax: (234) 73 462672 – E-mail: hkwj@hisen.org

Mrs. Edith KABORE
Secretary, African Programme for Onchocerciasis Control (APOC), 01 BP 549 Ouagadougou 01,
Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 – E-mail: kaboree@oncho.oms.bf

Ms. Patricia MENSAH
Bilingual Secretary, African Programme for Onchocerciasis Control (APOC), 01 BP 549
Ouagadougou 01, Burkina Faso – Tel: (226) 34.29.59 or (226) 34.29.53 – Fax: (226) 34.28.75 – E-mail: mensahp@oncho.oms.bf

INTERPRETERS

Mr. Edmond JOHNSON
Conference Interpreter, 26 Ogunlana Drive Suru-Lere, Lagos, Nigeria – Tel: (234) 8044101501 – Fax: (234) 1 4920110 – E-mail: lingualink2001@yahoo.com

Mr. Taiwo DAVID
Conference Interpreter, P. O. Box 14, Ikeja – Lagos, Nigeria – Tel: (234) 8023366888 – E-mail: tawodavid@yahoo.com

Ms. Bomi ROSIJI
Conference Interpreter, 833 Marine Road, Appapa – Lagos, Nigeria – Tel: (234) 1 5877321 or (234) 1 4728125 or (234) 8033031262 – Fax: (234) 1 587732 – E-mail: BROSIJI@AOL.COM

Prince Eviano ACHAKOBE
Conference Interpreter, C.A.7, TBS, Lagos – Nigeria – Tel: (234) 8033228101 or (234) 8023049377 – Fax: (234) 1 2634570 – E-mail: eviano2@yahoo.co.uk