Assessment of the Sustainability of the South West I CDTI Project, South West Province, Cameroon

June 2003

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## Abbreviations/Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
</tr>
<tr>
<td>CBCH</td>
<td>Chief of Bureau for Community Health</td>
</tr>
<tr>
<td>CBFA</td>
<td>Chief of Bureau for Finance and Administration</td>
</tr>
<tr>
<td>CBH</td>
<td>Chief of Bureau Health</td>
</tr>
<tr>
<td>CDD</td>
<td>Community Directed Distributor of Ivermectin</td>
</tr>
<tr>
<td>CDTI</td>
<td>Community Directed Treatment with Ivermectin</td>
</tr>
<tr>
<td>COP</td>
<td>Chief of Post</td>
</tr>
<tr>
<td>CSM</td>
<td>Community Self Monitoring</td>
</tr>
<tr>
<td>DHMC</td>
<td>District Health Management Committee</td>
</tr>
<tr>
<td>DMO</td>
<td>District Medical Officer</td>
</tr>
<tr>
<td>DO</td>
<td>District Officer</td>
</tr>
<tr>
<td>DTS</td>
<td>District Temporary Staff</td>
</tr>
<tr>
<td>FLHF</td>
<td>Front Line Health Facility</td>
</tr>
<tr>
<td>HA</td>
<td>Health Area</td>
</tr>
<tr>
<td>HAHC</td>
<td>Health Area Health Committee</td>
</tr>
<tr>
<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
</tr>
<tr>
<td>HSAM</td>
<td>Health Education Sensitization Advocacy and Mobilisation</td>
</tr>
<tr>
<td>MDP</td>
<td>Mectizan Donation Programme</td>
</tr>
<tr>
<td>MEDP</td>
<td>Manager Essential Drug Programme</td>
</tr>
<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>NGDO</td>
<td>Non-Governmental Development Organisation</td>
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<tr>
<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
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<tr>
<td>NOTF</td>
<td>National Onchocerciasis Task Force</td>
</tr>
<tr>
<td>PCSAF</td>
<td>Provincial Chief of Service Administration and Finance</td>
</tr>
<tr>
<td>PCSCH</td>
<td>Provincial Chief of Service for Community Health</td>
</tr>
<tr>
<td>PCSPh</td>
<td>Provincial Chief of Service for Pharmacy</td>
</tr>
<tr>
<td>PDPH</td>
<td>Provincial Delegation of Public Health</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMC</td>
<td>Provincial Management Committee</td>
</tr>
<tr>
<td>OPC</td>
<td>Provincial Onchocerciasis Coordinator</td>
</tr>
<tr>
<td>SAE</td>
<td>Serious Adverse Event</td>
</tr>
<tr>
<td>SWI</td>
<td>South West I</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WR</td>
<td>WHO Representative in Cameroon</td>
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</table>
Acknowledgement

The SWI Evaluation Team wishes to thank the Director, APOC for the opportunity given its members to participate in the evaluation of the project. We appreciate the travel and financial arrangements made by APOC management, NOCP Cameroon and the WHO country offices in Cameroon, Nigeria and Tanzania. Mr Akoa of the Airport Health Authority in Douala facilitated our immigration through the airport. The staff of the Provincial Delegate in Buea, under the direction of Dr Matilda Ayakonchong Akoharrey, was very cooperative and supportive of the mission. Without this assistance, we could not have carried out our duties as smoothly as we did. We acknowledge the input of NOTF Cameroon, Dr Rosa Befidi-Mengué, the Sight Savers International Country Representative for Cameroon, the District Medical Officers, Health Staff and the communities. Dr Andrew Atabe, the Sight Savers program officer went beyond the duties of a guide to participate in data collection.

Our appreciation goes to the Governor of South West Province, the District Officers and other government officials, who invariably made themselves available for courtesy calls, briefing and debriefing, even at very short notice.
Executive Summary

Introduction
The South West I Cameroon CDTI project was approved in 1998 and is therefore concluding its fifth year of APOC support. A team of evaluators from Cameroon, Nigeria and Tanzania carried out a fifth year evaluation of the sustainability of the project from 16-30 June 2003.

The terms of reference given to the evaluators were to:
- Evaluate the sustainability of the SWI project
- Discuss the findings in feedback/planning meetings with the provincial, district and country authorities and assist them to develop post-APOC sustainability plans
- To analyse the data collected and present a report to the project, NOTF and APOC management

Using the APOC guidelines for sample selection, the team worked at the provincial level as well as three districts, six health areas and twelve communities. The team carried out interviews of health personnel at these various levels and also met with community representatives at the district and community levels. Relevant documents were reviewed to give an insight into the routine functioning of the project. A representative of the NOTF was interviewed. The Country Representative of Sight Savers International, the supporting NGDO, and some of their staff were also interviewed.

Findings
Some of the communities in the project area are difficult to reach, and can only be accessed by walking for several hours as was the case in one community sampled, which the team could not reach because of time constraint. All communities requiring treatment are receiving it, giving 100% geographic coverage. Therapeutic coverage for the project has however been extremely low over the years, dropping from an average of 66.7% in the first year, to 42.7% in the second, 32.6% in the third and 30.2% in the fourth year. The perception of failure of the project that led to a campaign approach to Mectizan distribution in the fifth year, increased HSAM and abolition of cost recovery are believed to have contributed to the achievement of 70% therapeutic coverage rate at the fifth distribution in February/March 2003.

The project has been run essentially as a vertical programme and had been perceived at all health levels as an APOC/NGDO project, and in the community, it was perceived as a government project. Hence, ownership of the project is lacking both in the health care system and at the community level. The leadership of the programme and the initiative for various activities had been by the supporting NGDO, although steps are now being taken to devolve these to the Provincial Delegation of Health. The financial planning and control of APOC funds were also under the NGDO, and the APOC supported finance officer is based in the NGDO office in Yaounde. There is no justification for this situation in the fifth year of a project. The initiative for programme implementation at the district and health area levels was also that of the NGDO and directives from the
provincial level. The team recommends that staff at all levels should take over the leadership of the project.

The banking and accounting processes are extremely complex and tortuous, (Appendix XII) and the bank account from which project funds are finally withdrawn is based in another town. The evaluation team recommends that financial control should also devolve to the Provincial Delegation, the accounting procedure be simplified, a bank account be opened in Buea for ease of operation, and the APOC supported finance officer relocates to Buea with minimum delay.

There is a high-level of political commitment to the project as shown by the involvement of the District Officers, the Provincial Delegate and other Chiefs of Service in the CDTI campaign of 2003. This has however not been translated into financial support for the project. Over the years, Government financial contribution to the project has been minimal at all levels, consisting mainly of staff salaries and proceeds of cost recovery funds; the project being run almost entirely on APOC/SSI funds, contrary to the agreements signed with APOC. So far, APOC has contributed cash to the tune of CFA 215,808,974 and SSI has contributed CFA 98,543,104; in addition to capital equipment supplied by both partners. There is no clear indication of how much money government has contributed, although it has given a computer and some motorcycles. In the fifth year of the project, government financial input should have been in the region of 75% of overall cost of implementing core CDTI activities.

Even though integrated work-plans are available, CDTI has not been fully integrated into routine activities at all levels nor have the various levels and the community been empowered for the roles expected of them. HSAM has been weak leading to lack of understanding of the APOC and CDTI philosophies and lack of community ownership of the project. Staff attitude is however very good and there is enthusiasm to effect changes that will improve the project. NOTF and NGDO support will be needed to achieve these changes.

As far as Mectizan® ordering is concerned, calculation of tablets needed has been based on previous years treatment figures plus a 10% factor, rather than on the census figure and population growth rate times 3 (average number of tablets per person). The result was shortage of tablets when uptake increased. The Provincial pharmacy has not been the inventory holder for Mectizan® nor have they been involved in distribution to the lower levels, even though a very efficient drug distribution channel exists in the EDP. The team recommends that the correct method of calculating tablets be used and advantage be taken of the EDP to distribute tablets to the districts and health areas.

Feedback and planning meeting were held for the Provincial Delegation and Districts. The evaluation team facilitated the development of three-year sustainability plans for the province and all nine districts during these workshops. These plans are annexed to the report.
Conclusion

In evaluating the project against the *seven aspects and five critical elements*, the evaluation team concludes that the SWI Cameroon project *IS NOT MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY*. There are three aspects moderately blocking sustainability—integration, efficiency and simplicity. The three aspects severely blocking achievement of sustainability in this project are:

- **Resources**: There is no budget line for CDTI activities, no government counterpart funding for core CDTI activities and the project office is manned by only the OPC.
- **Community ownership**: There is no ownership of the project by the health care system or the communities, even though this is a fifth year project.
- **Effectiveness**: The geographic coverage has been low over the years, except the last distribution using the campaign method, which is unlikely to be sustainable.

The critical elements lacking are:

- **Money**: There is no counterpart funding from government. Though there are enough funds for the project, they come only from APOC and SSI
- **Mectizan® supply**: The supply system is not dependable. The provincial staff has not been trained on the Mectizan® ordering procedure and is not in charge of the inventory.
- **Political commitment** has not yet translated to tangible support for the project.

The feedback and planning workshops provided a good avenue for dialogue between the various partners and a readjustment to the role of each partner. The team believes that this process should continue till all the necessary changes are effected. Three-year District and Provincial sustainability plans now exist for 2004 to 2006. NOTF and APOC will need to monitor the implementation of these plans closely. It is the belief of the evaluation team, based on the experience and enthusiasm shown by staff, that the project has the potential for a quick turn around if given the necessary support.
1.0 INTRODUCTION
The South West Province is one of the ten provinces in Cameroon, and has two CDTI projects. The South West I project was approved by APOC in 1998, and the South West II project was approved in 2000. The supporting NGDO for the two projects is Sight Savers International. SWI includes 3 administrative divisions (Fako, Kupe Manengouba and Meme) made up of 10 administrative subdivisions. Buea is in the Fako Division and hosts the administrative headquarters of the SW Province. There are nine health districts in the SWI project area consisting of Buea, Limbe, Muyuka and Tiko in Fako division, Nguti, Tombel and Bafand in Kupe Manengouba division and Konye and Kumba in Meme division. In the project proposal, the estimated population of the whole South West I was 710,050 living in 465 communities, of which 388,514 were living in 294 hyper-endemic and 116,800 in 56 meso-endemic communities.

The health structure in Cameroon consists of a Ministry of Public Health with a Minister at the central level, responsible for defining policies, the Provincial Delegation headed by the Provincial Delegate for Health who converts policy to action, the District Medical Officers who execute the activities, and the Health Areas headed by the Chiefs of posts, which are the Front line health facilities taking care of communities. Health sector reforms are currently ongoing. There are also dialogue structures, consisting of the Provincial Health Management Committee, the District Health Management Committee and the Health Area Health Committee. The membership of these structures consists of community members, other stake holders and government health personnel and they have an input into decision-making and implementation of health activities at the various levels. The Provincial Health Management Committee is responsible for the South West Special Fund for Health, of which the Essential Drug Programme is one aspect.

The predominant vegetation of SWI is the equatorial rain forest but there is mangrove vegetation to the coast. The altitude ranges from 0 metre on the coast to 2200 metres in Buea with several small hills. Mount Cameroon, the highest peak in West Africa is in Buea. SWI has a very rich network of drainage systems flowing from high altitude and interrupted by numerous cascades, rapids and waterfalls. These streams provide breeding sites to Simulium vectors. The rainy season is from March to October, with its peak in July and August. The dry season is from mid-October to mid-March. Farming goes on all year round with maximal activities in March and April. The roads are mostly un-tarred and usually motorable, except for three months, July, August and September, when some areas are difficult to access.

1.1 Project background and history
Passive distribution of Mectizan® had been going on by various mission hospitals in the South West province for 8 years before the commencement of the SWI CDTI project. A research institution in Kumba was also involved in a WHO/TDR impact assessment study of ivermectin for which tablets were available for the five-year study. Although REMO exercise was said to have been carried out prior to commencement of the project, its refinement with REA was not done until 2001. At this time, 225 communities were classified as hyper-endemic with a population of 145,546 and 150 communities as meso-
endemic with a population of 128,454 (Total population 274,000). Two hundred and sixty four other communities were found to be hypo-endemic. In the first treatment year, 377,471 persons were registered, 444,197 in the 2nd, 251,575 in the 3rd, 277,337 in the 4th and 274,000 in the 5th treatment rounds respectively.

Using the CDTI approach, 251,778 persons were treated in the first year, 189,565 in the 2nd, 81,895 in the 3rd, 83,767 in the 4th and 194,636 in the 5th treatment cycle; for which overall average therapeutic coverage of 66.7%, 42.7%, 32.6%, 30.2% and 71% were achieved respectively. Hypo-endemic communities also receive clinic-based treatment. No figures are available for the first two years, but 50,589 persons from hypo-endemic communities received treatment in the 3rd year, 48,395 in the 4th year and 130,965 persons in the 5th year.

There is an Onchocerciasis Coordinator at the Provincial level, while the District Medical Officers are effectively the Onchocerciasis Coordinators at the District Level. Although the SWI project is in its fifth year, all the health levels visited from the provincial to the community level perceived the project as the supporting NGDO/APOC or government project, and even though they participated in various activities at times specified for them, they had no ownership of the project. A TDR/APOC workshop which took place in Limbe in 2002 and the recent evaluation of the SW2 project made the province aware of ‘failure’ of the project, what the provincial role should have been, and the need to rectify the situation.

This awareness led to a campaign approach for the fifth round of Mectizan® distribution in 2003. The campaign involved increased health education, advocacy, sensitization, mobilization, and recruitment of all health personnel, up to and including the Provincial Delegate of Health. Political figures were also involved at the highest level. The campaign led to increased participation of the communities, unusually high demand for Mectizan® and a high therapeutic coverage.

A total of CFA 215,808,974 has been received from APOC and spent on the SWI project from inception to date. SSI has also spent a total of CFA 121,843,448 consisting of CFA 98,543,104 cash and CFA 23,300,344 additional support for motorcycles etc. They have also budgeted a sum of CFA 30,190,108 for 2003, but expenditure will not be known till the end of the year.

1.2 Terms of reference
The Evaluation team was charged with the
- Evaluation of the sustainability of the CDTI Project in SWI in its 5th year
- Organization of feedback/planning meetings with the provincial, district and country authorities on integration of the CDTI, as well as post-APOC sustainability plan development with targets
- Analysis of data collected and production of a report
1.3 Team Composition (Appendix I)

Professor Adenike Abiose (Team Leader)
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Dr Kenneth Korve
Dr Edith Nnoruka
Dr Kayode Ogungbemi
Mr Daniel Ebah

2.0 METHODOLOGY

The South West I project of Cameroun qualifies for evaluation for sustainability in 2003 being in its fifth year of APOC funding. The team was sent to evaluate the South West I project using the recently developed instruments for the evaluation of Sustainability of CDTI Projects in their fifth year. A “Scout” was sent to the South West I project a week before the commencement of the exercise to:

- Plan the practical details with the project directors (MOH and NGDO)
- Introduce the instruments to the Project team
- Negotiate times and dates for all courtesy/ advocacy calls with government officials/Policy makers
- Sample sites for the evaluation
- Give advance information to all sites/ persons sampled of dates and times for interviews.
- Ask the District to make appointments for the FLHF
- Plan for the initial planning and feedback meetings with all relevant staff
- Inform all persons to be interviewed through a letter, the aim of the evaluation and broadly what would be discussed.
- Ensure that all necessary documentations are made available to the team
- Select local team members.
- Ensure that the necessary authorization was obtained for team members to move about and collect data at every site necessary.

2.1 Sampling:

Sampling was purposively done and the sample sites were chosen according to the stipulated guidelines. The primary criterion was the coverage rate (geographic and therapeutic coverage). This assessed the performance of the whole system; while the secondary criterion took into cognizance endemicity, geographic spread and accessability/convenience. Endemicity ensures that the sample contains both hyper- and meso-endemic areas in the same proportion as that of the REMO results for the project area. Geographic spread ensures that the sample contains areas which represent the different zones where the project operates, communities which are closer to towns and some which are more isolated. Accessability/convenience looks at the easiest areas to get to if you have two similar areas, bearing in mind the limited time frame to do field work.
Three Districts were selected out of the nine Districts of South West I project where CDTI activities are being carried out in accordance to the primary criterion (one with high coverage, another medium coverage and the third low coverage).

Secondarily, two health areas were selected for each district (one with high coverage and the other with low coverage) and two communities were selected for each health area chosen (one with high coverage, one with low coverage). The secondary criterion was satisfied in each case before coming up with the final choice. This resulted in the selection of the following samples reflected in table I below.

Table 1: Details of Sampled Sites: District, Health Areas and Communities for CDTI Sustainability Evaluation in South West I Province.

<table>
<thead>
<tr>
<th>S/N</th>
<th>Districts</th>
<th>(R_x) (Coverage Rate)</th>
<th>Health Areas</th>
<th>Communities (R_x) (Coverage Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tombel (Hyper/Meso)</td>
<td>High (60.7%)</td>
<td>Ndibenjock</td>
<td>1. Bangone (81.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Yorge (24.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>* Mbomekogid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ebonji</td>
<td>1. Etam (58.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Ebhul/Ehom (52.8%)</td>
</tr>
<tr>
<td>2</td>
<td>Muyuka (Hyper/Meso)</td>
<td>Medium (48.5%)</td>
<td>Meanja</td>
<td>1. Mile 29 (63%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. MeanjaCam (31.6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Muyuka</td>
<td>1. Makangal/II (68.7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Owa II (36.6%)</td>
</tr>
<tr>
<td>3</td>
<td>Kumba (Meso)</td>
<td>Low (36%)</td>
<td>Kumba Mbeng</td>
<td>1. Barombi Kang Long Island (76.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Baronmbi Kang Native (52.9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Kombone</td>
<td>1. Bole Dependa (26.9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Boa Bakundu (3.6%)</td>
</tr>
</tbody>
</table>

The evaluation team members were divided into sub teams to evaluate operations at the various levels according to the work plan (see Appendix II). The team met twice to familiarize themselves with the instruments and to agree on the tentative schedule. Initial meetings were also held with the State team members to acquaint them with the objectives and expected outcome of the evaluation.
2.2 Sources of Information

Basics
- **Research question**: How sustainable is the South West 1 CDTI project?
- **Design**: Cross-sectional, descriptive.
- **Population**: The NOTF, South West 1 project, including: its’ POCT (Provincial Oncho Team) with relevant MOH/MoPH officials; its’ NGDO (SSI) partner; its’ Districts with their District team members and policy makers; the project villages, their Leaders and CDDs.

**Instruments**:
- Questionnaire (see appendix: 'Detailed findings') structured as a series of indicators of self-sustainability. The indicators are grouped into 9 categories.
- These instrument guides the researcher to collect relevant information about each indicator, leading to judgments on sustainability at the 4 levels of operation.
- **Source of information**: Verbal reports from persons interviewed, supplemented by documentary evidence.

2.3 Analysis

Based on the information collected, each indicator is graded on a scale of 0-4, in terms of its contribution to sustainability.

The summary findings for each group of indicators were given at the end of each group.

The average 'sustainability score' for each group of indicators is calculated, for each level and a qualitative description of problem areas is given. Recommendations are made, prioritized, implementers specified and time frames given.

2.4 Limitations

- Some of the documentations required at the District and FLHF/Subdistrict level were not available despite prior information.
- Accessibility to Bangone, one of the communities in Tombel District was so poor that it had to be substituted with Ndise, which was the next community with similar characteristics (i.e same high therapeutic coverage) whilst in the field.

2.5 Advocacy Visits

Advocacy visits were paid to relevant persons at Provincial level, which include the Provincial Governor and the Provincial Delegation for Health, while at the District level, some Divisional officers were briefed before and also debriefed at the end of the field visits.

Finally, planning/feedback workshops were conducted for Provincial and District levels which involved relevant officers at those levels. During these planning workshops efforts were made to develop 3-year sustainability plans for 2004-2006.
EVALUATION FINDINGS

3.1 Sustainability at Provincial Level

FINDINGS:

PLANNING (1.8)

There are yearly plans for onchocerciasis control for 2001-2003 at the project office and Provincial delegate. The plans contained all CDTI activities and inputs were obtained from all partners at the various levels. There was some evidence of targeting plans to needs such as training for severe adverse events. The roles of each partner in planning and other CDTI activities were not clear; as the project had been perceived as an NGDO project right from the onset. Initiative or leadership role for planning had always been taken by NGDO.
Sustainability plans for both project and provincial level were not available, despite being in their fifth year of APOC funding. Specific plans for sustainability have been attempted by the NGDO partner and shown as a 6th year budget without any plans of action to support this.

MONITORING AND SUPERVISION (2.3)

Monitoring and Supervision are carried out yearly to the district and spot checks to FLHL and Communities, by the Provincial team. Problems identified such as refusals, are handled by OPC SWI and leadership at the Province occasionally helps in solving problems. Routine monitoring has been carried out most of the time and in some cases too many visits are carried out for a specific activity eg supervisory visits were as high as 2-3x per week for the periods of distribution and training; particularly in areas where there are no government hospitals. Supervisory visits are not integrated with other PHC programmes while in the field. Targeted monitoring and supervision to areas of weakness was only taken up recently and APOC funds are solely utilized for monitoring and supervision over the years. The NGDO also carries out supervision at all levels. In addition District Temporary Staff are supported by NGDO to help out with Monitoring, supervision and reporting at the district and other levels.

MECTIZAN PROCUREMENT AND DISTRIBUTION (1)

Mectizan ordering and procurement has been facilitated over the years by SSI. Mectizan is sent across to the districts once collected by the OPC SWI. A register of drugs received from SSI is maintained at project level and collected by district. However, the Manager of the Essential Drug programme at the Province has been involved with Mectizan custody only once in 2002, despite the fact that Merck now recognizes them as the official inventory holder for Mectizan for SW I project. Consequently, there is no Pharmacy inventory control at this level unlike other essential drugs. Collection and distribution of Mectizan by the Province is solely dependent on APOC funds and there are delays in ordering of Mectizan for the project.

TRAINING AND HSAM (1.3)

Provincial Staff train DMOs who in turn train the Chiefs of Posts at FLHF. Training had been routinely done yearly and not integrated with other PHC training. APOC and SSI funds have always been used for all levels of training. The NGDO partner (SSI) planned the training most of the time, while the Provincial staff served as facilitators but training material are not adequate. HSAM is planned for yearly at this level. A Joint briefing meeting is held at the Provincial Delegate which is presided over by the Governor for all Health Programmes yearly. The last one carried out early this year, as part of the Campaign led to a massive turn out of communities during distribution. Radio programmes are also carried out for sensitization as well as for mobilization. Advocacy is carried out yearly for commitment and ownership of the programme, yet therapeutic coverages have remained terribly low.
INTEGRATION OF SUPPORT ACTIVITIES (0)

CDTI Integration with other health (PHC) activities is non-existent at the Provincial level in spite of availability of annual overall integrated plans of action. All tasks carried out by staff are purely Oncho activities. Training, mebuzan delivery or returns of reports are solely done on their own.

FINANCE (1)

There are annual plans of action with costs to each CDTI activity for APOC, MoPH and SSI funds and the relative budgetary contributions of APOC and SSI for SW I project have been clearly spelt out for all the years. Core CDTI activities are funded almost entirely with APOC and NGDO money and the funds released, have a control system of reporting disbursements and retirements. However, movement of funds from the main NOTF/SWI Account in Yaounde to the joint APOC/SSI account in Limbe is very tortuous. This joint account has both APOC and SSI funds. (Annex XIII) The Province is not involved in budget preparation and MoPH(Provincial) is not aware of their own financial obligations, despite a column for them in the letters of agreement & financial reports. They are also unaware of any deficit. They feel the MoPH column referred to the Central or National level; as they at the provincial level have never been involved with the financial planning. The Government contribution to core CDTI activities is unclear. However government is responsible for the payment of salaries, the provision of office space, the recent plan to pay every CDD involved with CDTI 25 francs per person treated as well as the inclusion of CDTI to benefit from the HIPC scheme. In addition Government also donated a computer (which is in the NGDO office) to SW I. Despite financial technical support being given from inception of SWI project by APOC to staff at all levels (provincial right down to health areas), the issue of ownership still lingers till date.

TRANSPORT AND OTHER MATERIAL RESOURCES (1.8)

Provincial delegate is responsible for all transport at this level and authorizes trips and releases of funds for travels. Returns are made to APOC officer for funds disbursed for all movements for CDTI activities. Transport is used at this level to undertake support activities at the next level. Maintenance schedules and log books are in use for all transport at this level and maintenance of all transport, equipment and materials for SW I are dependent on APOC funds. Considering the amount of work ahead and because of the shared use of APOC vehicle (Land Cruiser & motorbikes) with other Public health programme, the functionality for the future is quite doubtful and yet there is no realistic plan for replacement.
HUMAN RESOURCES (2)

Staff at this level is stable and committed, and there is a system in place for orientation of new provincial Staff/project staff. Over the years the OPC SWI only with the guidance of the NGDO partner that has been running the project. The Provincial Oncho Task force team, consisting of 8 Chief's of posts that had not been actively involved in CDTI until the Mectizan Campaign this year. There is one temporary driver shared between the two projects SWI and SWII, who has not been formally employed and the Project Accountant for SWI who operates from the NGDO office in Yaounde.

COVERAGE (1)

Geographic coverage has been 100% for all districts in SWI project since inception, while the therapeutic overages for the 9 districts over the past 3 years, failed to achieve the recommended criteria of ≥ 65%; stable or increasing for all the districts of a project. In 2001 and 2002 the therapeutic coverages were 32.6% and 30.2% respectively. The Mectizan Campaign undertaken early this year resulted in an average therapeutic coverage of 70%. Some of the reasons for the poor therapeutic coverages were a) witchcraft (belief of the people b) fear of severe adverse effects c) Cost Recovery (which has currently been abolished), d) treatment carried out during unsuitable times for the communities. Hypo-endemic areas have received clinic-based treatment all the while (for the 5 years) even after the REA in 2001. In year 5 with 194,636 treatments in meso- and hypo-endemic areas, 130,965 treatments were given in hypo-endemic areas.
### RECOMMENDATIONS FOR THE PROVINCIAL LEVEL

<table>
<thead>
<tr>
<th>RECOMMENDATIONS</th>
<th>IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>‘Planning’</strong></td>
<td><strong>Priority: 1, 2, 3: HIGH</strong></td>
</tr>
<tr>
<td>1. The roles of each partner in planning and other CDTI activities should be</td>
<td><strong>Indicators of Success:</strong></td>
</tr>
<tr>
<td>clearly defined and adhered to based on their project proposal.</td>
<td>1. A schedule/document issued as a reminder to all partners on their roles and</td>
</tr>
<tr>
<td>2. All parties should be involved in the financial planning.</td>
<td>responsibility.</td>
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<tr>
<td>3. Specific 3 year plans for sustainability should be made and followed up</td>
<td>2. A detailed integrated Sustainability Health plan containing all CDTI activities</td>
</tr>
<tr>
<td>immediately by a 5 or 10 year plan.</td>
<td>should be available.</td>
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<tr>
<td></td>
<td><strong>Who to take action?</strong></td>
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<tr>
<td></td>
<td>Provincial Delegate</td>
</tr>
<tr>
<td></td>
<td><strong>Deadline for completion:</strong></td>
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<tr>
<td></td>
<td>End of August 2003</td>
</tr>
<tr>
<td><strong>‘Monitoring/Supervision’</strong></td>
<td><strong>Priority: 1, 2, 3: HIGH</strong></td>
</tr>
<tr>
<td>1. Supervisory visits should be planned, targeted and integrated with other PHC</td>
<td><strong>Indicators of Success:</strong></td>
</tr>
<tr>
<td>programmes.</td>
<td>Reports indicating planned &amp; targeted Monitoring/Supervision.</td>
</tr>
<tr>
<td>2. Supervisory check lists should be a ‘shared type’ or integrated checklist,</td>
<td>Improvement in performance at next treatment cycle.</td>
</tr>
<tr>
<td>so that it could be used for most PHC activities carried out at this level.</td>
<td>Availability of integrated checklists.</td>
</tr>
<tr>
<td>3. All Health programmes should be involved in CDTI activities.</td>
<td>Availability of government fund for activities.</td>
</tr>
<tr>
<td>4. Funds from dependable sources available for these activities, especially</td>
<td><strong>Who to take action?</strong></td>
</tr>
<tr>
<td>governments own.</td>
<td>Provincial Team (Delegate)</td>
</tr>
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<td></td>
<td><strong>Deadline for completion:</strong></td>
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<tr>
<td></td>
<td>Ending of June 2004</td>
</tr>
<tr>
<td><strong>‘Mectizan procurement and Distribution’</strong></td>
<td><strong>Priority: 1, 2, 3: HIGH</strong></td>
</tr>
<tr>
<td>1. Mectizan ordering, procurement and storage should entirely be the</td>
<td><strong>Indicators of Success:</strong></td>
</tr>
<tr>
<td>responsibility of the Province through the Essential Drug Programme.</td>
<td>Availability of Mectizan order/inventory forms at the Provincial Essential drug</td>
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<tr>
<td></td>
<td>Pharmacy.</td>
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<tr>
<td></td>
<td>Reports reflecting timely arrival and distribution of Mectizan.</td>
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</tbody>
</table>
| **2.** SSI should empower the province to enable them take up this task. | **Who to take action?**  
SSI, NOCP and Provincial Delegation.  
Manager EDP.  
**Deadline for completion:**  
Ending of November 2003. |
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<tbody>
<tr>
<td><strong>3.</strong> NOCP should ensure that the right quantity of mectizan gets to the projects well ahead of time for distribution to the communities</td>
<td></td>
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</tbody>
</table>
**Priority:** 1-3: HIGH  
**Indicators of Success:**  
Reports of integrated training.  
Improved commitment of the various stakeholders and ownership of programme |
| **"Training/HSAM"**  
1. Training should be more focused to needs.  
2. Training should be integrated with other PHC activities.  
3. HSAM activities should be properly planned and effectively implemented.  
Appropriate HSAM materials should be available for use. | **Who to take action?**  
Provincial Delegation, PCSCH, PCSHM, CBCH, OPC, SWI  
**Deadline for completion:**  
| **"Integration of support activities."**  
1. Integration of CDTI into other PHC activities like EPI, HIV-AIDs, etc at this level. | **Priority:** 1: HIGH  
**Indicators of Success:**  
Schedules of integrated support activities with CDTI |
| **"Finance"**  
1. Appropriate financial planning and budgeting of CDTI activities should be carried out at this level and should be reflected in the yearly Estimates of Recurrent expenditure for the delegation. | **Priority:** 1-5: HIGH  
**Indicators of Success:**  
Funds readily available and contributions of each partner clearly documented in financial reports.  
**Who to take action?**  
NOCP/NOTF, Provincial Delegation, PCSAF, SSI |
2. NOCP should ensure that Government commitment for all projects in Cameroun; towards CDTI sustainability is maintained.

3. Contributions of the various partners/stake holders at this level should be clearly spelt out.

4. The project accountant should move down to Beou from Yaounde, or the Provincial Chief of Service for Admin and Finance should take up the task of accounting for all aspects of CDTI at this level.

5. Delegate and SSI should put in place a process that is sustainable, more realistic and less complicated for fund management.

<table>
<thead>
<tr>
<th>'Transport/other Resources'</th>
<th>Priority: 1,3: HIGH; 2: MEDIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintenance and fueling of project vehicle/motorbikes should be properly planned with Provincial funding.</td>
<td>Indicators of Success: Well maintained transport.</td>
</tr>
<tr>
<td>2. Realistic plans for the replacement of vehicles should be made.</td>
<td>A realistic plan available for replacement of transport.</td>
</tr>
<tr>
<td>3. As the project is in its 5th year, and the fact that the vehicle has been efficiently managed even after the motor accident last year. Replacement by APOC is strongly recommended.</td>
<td>Who to take action? NOCP, Provincial Delegation-PDH, PCSAF, OPC.SWI; APOC</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>'Human Resources'</th>
<th>Priority: 1: HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Provincial Oncho Task force team should become more involved with CDTI activities as well as the operational running of the SWI project.</td>
<td>Indicators of Success: Schedule assigning each person their activities.</td>
</tr>
<tr>
<td></td>
<td>Who to take action? Provincial Delegate, OPC SWI.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Deadline for completion:</th>
<th>IMMEDIATELY</th>
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<tr>
<th>Deadline for completion:</th>
<th>December 2004</th>
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<tr>
<th>Deadline for completion:</th>
<th>IMMEDIATELY</th>
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</table>
Coverage
1. Therapeutic coverage should be improved upon.
2. The issue of treatment in Hypo-endemic areas should be addressed by NOCP/MoPH

Priority: 1,2: HIGH

Indicators of Success:
Increased therapeutic coverage.

Who to take action?
NOTF.

Deadline for completion:
ON GOING.

3.2 Sustainability at District Level

FINDINGS:

PLANNING (2.0)

The districts had CDTI plans of action which were integrated into the overall health plan. The plans were developed in a participatory manner involving the DMO, the CBH CBAF and the Chiefs of post. The budget contained in the plan was based on APOC and SSI funds and no funds were budgeted by the government. A campaign approach was used to mobilise the communities for treatment in year 2003. Community requirements
were not taken into consideration in the plan prepared e.g. time of distribution and mobilization

LEADERSHIP (2.0)

The District Medical Officers are in charge of CDTI activities as well as other health programmes, and with the CBH and CBAF constitute the district oncho team. They implement oncho activities and take full responsibility for CDTI at this level. The political leaders such as SDOs and DOs participated in HSAM. However, CDTI activities were initiated at the provincial level.

MONITORING AND SUPERVISION (2.0)

Reports are transmitted within the government system. The reports are generated by the CDDs and are collected by the DTS who takes them to the district from where they are sent to the provincial headquarters. Routine supervision by the DMOs and CBH usually ends at the health centre. However spot checks in communities are done when problems are identified by the COP. Transport for these activities is shared with other health programs. Monitoring reports are written. Supervision of CDTI activities was routine and not targeted (not based on need), especially in year 2003. Checklists are not being used and there are no specific plans/itineraries. The costs of supervision are borne by APOC/SSI in addition to DTS supported from funds provided by SSI.

MECTIZAN PROCUREMENT AND DISTRIBUTION (2.5)

In some cases, the provincial Oncho Coordinator for SWI supplies Mectizan to the District while in some cases the DMO collects from the Province. The Mectizan is shared by CBH, who then supplies the COP, who in turn delivers to the CDDs. Transport is paid by the government for Mectizan collection. Mectizan stock forms are completed when the drugs are collected. Quantity of Mectizan required was not based on census but on tablets used in the previous years plus 10%. There is an effective system of procurement which is effective although it bypasses the established essential drug program. Installmental supply of drugs to the district also created a problem.

TRAINING AND HSAM (1.3)

Health personnel are trained yearly. HSAM has led to increased awareness at the community level. HSAM was carried out when treatment coverage was discovered to be low in the previous years. HSAM was therefore carried out based on need. Social mobilization agents (dialogue structure) were used for sensitisation and advocacy. In year 2003, the district trained both COPs, CDDs and Social Mobilizers in a session at the district headquarters. Training was neither targeted nor integrated. Health education materials are available but inadequate.
FINANCE (0.8)

The districts have never budgeted and released funds for CDTI activities at this level. CDTI activities have been completely donor funded (APOC and NGDO) since the inception of the program apart from the 13% district retention from cost recovery funds.

TRANSPORT AND MATERIAL RESOURCES (1.8)

Most motorcycles provided by APOC, SSI and Government are functional and are suitable for supervision. HSAM materials are available but inadequate. Vehicles are maintained regularly using Government funds. The transport is combined as a pool to be used for all health programs. There is no plan to replace vehicles. Motorcycle log books are available but not used.

HUMAN RESOURCES (3.0)

The staff at this level are stable in post, skilled and knowledgeable with respect to implementation of CDTI. They spend between 4-5 years in post. All staff at this level expressed satisfaction with their job but there was inadequate commitment by some staff. Though salaries are paid regularly the rates are said to be poor.

COVERAGE (2.0)

The geographical coverage is satisfactory at 100%. The therapeutic coverage is not satisfactory as only 67% of the communities have coverage of ≥ 65% in 2003. All the districts had a therapeutic coverage of less than 65% in years 2002 and 2001. The reasons for this low coverage were attributed to fear of adverse reactions, poor health education (witchcraft etc), and cost recovery system. The improvement in therapeutic coverage in year 2003 could be attributed to the abolition of the cost recovery system, better HSAM in campaign approach and the payment of CDDs by government, among others. Too many hypo endemic communities are under treatment.
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning</strong></td>
<td><strong>Priority</strong>: HIGH</td>
</tr>
<tr>
<td>• The campaign approach used to mobilize communities for treatment in year 2003 should be discontinued.</td>
<td></td>
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<tr>
<td>• Community requirements should be taken into consideration in planning for CDTI activities</td>
<td></td>
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<tr>
<td>• Development of integrated plans with government budget</td>
<td></td>
</tr>
<tr>
<td><strong>Indicators of success:</strong></td>
<td></td>
</tr>
<tr>
<td>• Availability of integrated work plan showing distribution, monitoring and supervision at different periods of the year</td>
<td></td>
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<tr>
<td>• Evidence of community involvement in overall CDTI planning.</td>
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<tr>
<td><strong>Who to take action</strong></td>
<td></td>
</tr>
<tr>
<td>• DMO &amp; CBH</td>
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<tr>
<td><strong>Deadline for completion</strong></td>
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<tr>
<td>• December 2003</td>
<td></td>
</tr>
<tr>
<td><strong>Leadership</strong></td>
<td><strong>Priority</strong>: MEDIUM</td>
</tr>
<tr>
<td>• The health staff at this level should initiate CDTI activities</td>
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<tr>
<td><strong>Indicator of Success:</strong></td>
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<tr>
<td>• Development of work plan of CDTI activities before distribution</td>
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<tr>
<td><strong>Who to take action</strong></td>
<td></td>
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<tr>
<td>• DMO and CBH</td>
<td></td>
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<tr>
<td><strong>Deadline</strong></td>
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<tr>
<td>• December 2003</td>
<td></td>
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<tr>
<td><strong>Monitoring and Supervision</strong></td>
<td><strong>Priority</strong>: HIGH</td>
</tr>
<tr>
<td>• Supervision of CDTI activities should be carried out more in areas/communities that have specific problems to be tackled such as refusals, non-compensation of CDDs etc.</td>
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<tr>
<td><strong>Indicator of Success:</strong></td>
<td></td>
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<tr>
<td>• Supervisory visit reports</td>
<td></td>
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<tr>
<td>• Checklists used for supervision</td>
<td></td>
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<tr>
<td>• Plans/itineraries</td>
<td></td>
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<tr>
<td>• Expenditures showing contribution of partners</td>
<td></td>
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<tr>
<td>Who to take action</td>
<td>Checklist should be used during supervision to enhance the tracking down of activities carried out and those pending</td>
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<tr>
<td></td>
<td>Use of SSI supported DTS to retrieve should be reviewed.</td>
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<td></td>
<td>- DMO, CBH</td>
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<tr>
<td>Deadline for completion</td>
<td>By end of next distribution</td>
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<tr>
<td></td>
<td>Plans/itineraries for supervision should be drawn before supervision is carried out</td>
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<td></td>
<td>The cost of supervision should be borne by government.</td>
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<td></td>
<td>Treatment data should be submitted to the COPs by CDDs who in turn submits to the district</td>
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<tr>
<td>Mectizan Procurement and Distribution</td>
<td>Priority: HIGH</td>
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</tr>
<tr>
<td><strong>Indicators for success:</strong></td>
<td></td>
</tr>
<tr>
<td>- Adequate Mectizan in established Essential Drug Programme (EDP)</td>
<td></td>
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<tr>
<td>- Mectizan supply forms</td>
<td></td>
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<tr>
<td><strong>Who to take action</strong></td>
<td></td>
</tr>
<tr>
<td>- DMO, Manager EDP and Provincial Delegate of Public Health</td>
<td></td>
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<tr>
<td><strong>Deadline for completion</strong></td>
<td></td>
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<tr>
<td>- July 2003</td>
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<tr>
<td>- During next distribution</td>
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</table>

| Quantity of Mectizan required should be based on updated census population and growth rate. (usually a factor 3 tablets per person, on average) |               |
| All tablets required for treatment for each district should be sent in bulk to the district before the commencement of treatment through established government system of supply of drugs |

<table>
<thead>
<tr>
<th>Training &amp; HSAM</th>
<th>Priority: MEDIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator of success:</strong></td>
<td></td>
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<tr>
<td>- Training report available</td>
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<td>- Training justifications</td>
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<tr>
<td><strong>Who to take action</strong></td>
<td></td>
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<tr>
<td>DMO and CBH</td>
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<tr>
<td><strong>Deadline for Completion</strong></td>
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<td>During next distribution</td>
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| District to empower COPs to train CDDs. |               |
| Training should be targeted to address the needs of the personnel involved |               |
| Training should be conducted in an integrated manner to include other health programs |

<table>
<thead>
<tr>
<th>Finance</th>
<th>Priority: HIGH</th>
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<tbody>
<tr>
<td><strong>Indicator for Success:</strong></td>
<td></td>
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<tr>
<td>- Budget availability</td>
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<tr>
<td>- Release of adequate funds for CDTI activities</td>
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<tr>
<td>- Seek for other dependable sources of funding.</td>
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<tr>
<td><strong>Who to take action</strong></td>
<td></td>
</tr>
<tr>
<td>DMO and CBH, PDPH.</td>
<td></td>
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<tr>
<td><strong>Deadline for completion</strong></td>
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<td>December 2003</td>
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</table>

| High powered advocacy visits should be paid to government policy makers to encourage them to budget and release funds for CDTI activities |               |
| Identify other sources of funding outside APOC and SSI |               |
**Transport and Material Resources**

- The available motorcycle log-books should be put to use. Where they are not available, efforts should be made to provide them.
- Produce additional Health Education materials

**Human Resources**

- There should be increased commitment by the staff
- Integrated training of additional nurses

**Coverage**

- Efforts should be made to obtain better estimate of the population in CDTI communities
- There should be conscious efforts to increase therapeutic coverage in subsequent years
- Policy on treatment of hypo endemic communities should be reviewed

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<tr>
<th>Priority: MEDIUM</th>
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<tbody>
<tr>
<td><strong>Indicator for success:</strong></td>
</tr>
<tr>
<td>- Routine use motorcycle log-books</td>
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<tr>
<td>- Adequate quantity of IEC material.</td>
</tr>
<tr>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td>DMO and CBH, NOTF</td>
</tr>
<tr>
<td><strong>Deadline for completion</strong></td>
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<tr>
<td>December 2003</td>
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<tr>
<th>Priority: MEDIUM</th>
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<tbody>
<tr>
<td><strong>Indicator for success:</strong></td>
</tr>
<tr>
<td>- Training reports</td>
</tr>
<tr>
<td>- Increased in number of trained nurses</td>
</tr>
<tr>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td>DMO and CBH</td>
</tr>
<tr>
<td><strong>Deadline for completion</strong></td>
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<tr>
<td>December 2003</td>
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</tbody>
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<thead>
<tr>
<th>Priority: HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator for success:</strong></td>
</tr>
<tr>
<td>- Community registers showing census update</td>
</tr>
<tr>
<td>- Increase in therapeutic coverage</td>
</tr>
<tr>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td>DMO, CBH and NOTF</td>
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<tr>
<td><strong>Deadline for completion</strong></td>
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<tr>
<td>Next treatment cycle</td>
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</tbody>
</table>
3.3 Sustainability at Health Area Level (FLHF)

**FINDINGS:**

**PLANNING (2.0)**

Health Appraisal meetings are held in the FLHF (health areas) to plan CDTI activities. The plans contain all CDTI activities, duration and cost. The CDDs and village chiefs participate in developing the plans. The implementation of the plan tagged Campaign approach method did not comply with the CDTI approach and may not be sustainable. There was no overall integrated year plan and no sustainability plan for the post APOC period had been developed.

**LEADERSHIP (3.0)**

The Chiefs of Post consider CDTI to be their programme and usually initiate and implement all CDTI activities at this level based on directives from DMOs. Chiefs, quarter heads, and health committee chairpersons, participate in mobilizing the communities. The village chiefs and quarter heads selected some CDDs while the
communities selected others. In some cases, COPs appoint and terminate the appointment of CDDs. However, implementation of CDTI was not integrated with other health activities at this level.

**MONITORING AND SUPERVISION (2.3)**

Reports of CDTI activities such as treatment summaries and supervision reports are produced and transmitted within government system. They are transmitted on time. Supervision was integrated in a few FLHF (health areas). In some communities, other nurses and the health committee chairperson assist the COP. Some problems such as non-use of measuring sticks and refusals were managed on the spot while others were referred to the district team for intervention. Supervision was not targeted as all the CDTI communities were visited many times. The district supervisors also supervised some communities. Other problems observed include lack of support for CDDs. Supervision is fully funded by the project (APOC and SSI). There is no reward system in place to encourage health workers and CDDs that show outstanding commitment to CDTI.

**MECTIZAN PROCUREMENT AND DISTRIBUTION (2.0)**

Mectizan is received in good time and is effectively distributed to the CDDs. Mectizan is stored separately from other drugs in the COPs office and issued out almost immediately. The quantity of drugs ordered was not adequate but remedial measures were taken to make up for the difference. There is a good Mectizan inventory of drugs received and balances returned. The drugs needed were however determined by adding 10% of the drugs used in the previous year. The ordering was done at the district level where COPs collect their drugs using APOC fund.

**TRAINING AND HSAM (1.5)**

Training and HSAM were done annually. Churches, town criers, and group meetings were used to sensitize the community. Training of COPs was done jointly with CDDs at the district level while the district team did the training of CDDs. Other health workers at the health facilities have poor knowledge of CDTI because the training for health workers is restricted to Chiefs of posts. HSAM activities were carried out as routine but not targeted at solving problems identified during monitoring. Problems such as lack of support for CDDs and sense of ownership of CDTI by the communities still persist. Health education materials such as posters and flip charts are provided by NOTF and are not adequate.

**FINANCE (0.5)**

Cost recovery system was used in the first four years, 10% of which was retained for Health area CDTI activities and 15% for other Health area activities. It was abolished in 2002 and government decided to pay 25 CFA per person treated to CDDs. It is however not clear, how government intends to fund the 15% of the cost recovery that used to be
retained in the Health areas. In some health areas, CDDs were paid from health centre funds pending re-imbursement from the central Government. There were no funds budgeted or released from government for CDTI activities at this level.

TRANSPORT AND MATERIAL RESOURCES (1.7)

Training/HSAM materials are produced by NOTF and have been distributed to the communities but are inadequate. The Chiefs of posts used health centre funds for fuelling and maintenance of motorcycles and could also pay for maintenance, replacement of parts and repairs if the project is perceived as their own. Motorcycles provided by APOC and SSI are also used for other health programmes. Motorcycles were not adequate for supervision and IEC materials such as posters were not provided on an annual basis. There are no plans for replacement of vehicles and materials. There is no guideline for movement or trips for CDTI. Logbook or travel authorization was not used at this level.

HUMAN RESOURCES (3.0)

The COPs are skilled, knowledgeable and committed to CDTI implementation and are stable in the job for at least five years. Other health staff at this level were however not trained and not actively involved in CDTI activities.

COVERAGE (4.0)

The geographical coverage is satisfactory at this level based on distribution reports. The treatment data for the hyper/meso and hypo endemic communities are not separated.
<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Planning</strong></td>
<td>Priority: HIGH</td>
</tr>
<tr>
<td>- A three year sustainability plan should be prepared and integrated into the health activities of FLHF</td>
<td><strong>Indicators of success:</strong></td>
</tr>
<tr>
<td>- The campaign approach used this year and already planned for year 2004 should be modified to conform with CDTI approach</td>
<td>- Availability of a 3 year integrated year 2004 CDTI sustainability work plan.</td>
</tr>
<tr>
<td>- The work plans for FLHF should incorporate the inputs from CDDs, Chiefs and quarter heads</td>
<td>- Evidence of inputs from CDDs, Chiefs and quarter heads</td>
</tr>
<tr>
<td><strong>Monitoring and Supervision</strong></td>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td>- Chief of post and other health personnel at FLHF should be trained on CDTI.</td>
<td>COPs</td>
</tr>
<tr>
<td>- More motorcycles should be made available for supervision at the FLHF level</td>
<td><strong>Deadline for completion</strong></td>
</tr>
<tr>
<td>- Supervision should be targeted at solving specific CDTI problems such as lack of support for CDDs and perception of CDTI as government project.</td>
<td>- December 2003</td>
</tr>
<tr>
<td>- An integrated supervisory checklist should be developed</td>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td><strong>Mectizan</strong></td>
<td><strong>Priority: HIGH</strong></td>
</tr>
<tr>
<td>- Training of FLHF and CDDs on how</td>
<td><strong>Indicators for success:</strong></td>
</tr>
<tr>
<td></td>
<td>- Training report</td>
</tr>
</tbody>
</table>

**Priority:** HIGH

**Indicators of success:**
- Availability of means of transportation
- Evidence of integrated supervisory visit/ checklists and reports
- Evidence that supervision is targeted at specific CDTI problems.
<table>
<thead>
<tr>
<th><strong>Training &amp; HSAM</strong></th>
<th><strong>Who to take action</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>− Training of COPs should be done by the District Team and should be based on needs.</td>
<td>• DMOs</td>
</tr>
<tr>
<td>− Training of CDDs should be done by the COPs at centers close to the community</td>
<td><strong>Deadline for completion</strong></td>
</tr>
<tr>
<td>− Other qualified health staff at the FLHF (health areas) should be trained on CDTI</td>
<td>• Before the commencement of next distribution</td>
</tr>
<tr>
<td>− HSAM activities should be targeted at solving identified CDTI problems.</td>
<td><strong>Priority: HIGH</strong></td>
</tr>
<tr>
<td>− Innovative and effective HSAM approach should be used to sensitise the communities to own the program and support their CDDs.</td>
<td><strong>Indicator of success:</strong></td>
</tr>
<tr>
<td>− Training manuals should be updated and provided to CDDs.</td>
<td>• Evidence that all health staff at the health centers have been trained</td>
</tr>
<tr>
<td>− Sufficient IEC materials should be produced by government and distributed to the communities</td>
<td>• The CDDs are trained by COPs</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>• Availability of updated training manuals</td>
</tr>
<tr>
<td>− FLHF should have a budget line for CDTI.</td>
<td>• Availability of IEC materials</td>
</tr>
<tr>
<td>− Operational Research should be conducted to compare the effects of cost recovery, payment of CDDs by government and support</td>
<td><strong>Deadline for completion</strong></td>
</tr>
<tr>
<td><strong>Priority: HIGH</strong></td>
<td>Before the commencement of next distribution</td>
</tr>
<tr>
<td><strong>Indicator for Success:</strong></td>
<td><strong>Who to take action</strong></td>
</tr>
<tr>
<td>• Availability of sufficient resources for CDTI at FLHF level.</td>
<td>DMOs and COPs</td>
</tr>
<tr>
<td>• Results of the operational research.</td>
<td><strong>Deadline for completion</strong></td>
</tr>
<tr>
<td>• CDDs motivation and satisfaction.</td>
<td>Before the commencement of next distribution</td>
</tr>
</tbody>
</table>
for CDDs by the communities on the effectiveness and sustainability of CDTI

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Who to take action</th>
<th>Priority: HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COPs, NOTF, Provincial Delgation of Health.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deadline for completion</td>
<td>End of next distribution period</td>
</tr>
<tr>
<td></td>
<td>Indicator for success:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Geographic coverage should be based on treatment in hyper/meso endemic communities only</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group of Indicators.</th>
</tr>
</thead>
</table>

3.4 Sustainability at the Community Level

South West I Project: Sustainability at Community Level.

- Planning: 2
- Leadership: 1.7
- Mon/Supervision: 2
- Medic: 1.5
- H&LM: 1
- Finance: 1
- Human R.: 2
- Coverage: 2

Average Weight (4)
FINDINGS:

PLANNING (2.0)

In most communities the community leaders and the CDDs jointly plan and take responsibility for the distribution of Mectizan. The leaders conduct regular consultations with the CDDs during the mectizan distribution season. However, it was discovered that, in most of the communities CDD do not involve their community leaders in critical issues such as refusals and low coverage in Mectizan distribution. Such issues are brought directly to the attention of the COP. This has been one of the factors which made community leaders to be less involved in CDTI. It was also found that, in most communities census and distribution are carried out at different times which is not cost effective.

LEADERSHIP (1.7)

The existence of the dialogue structure at this level provides an ideal structure from which, leadership for CDTI activities in the community could take off. However, in most of the communities, leadership has not played effective and proactive role in solving major problems such as refusals, low distribution coverage and has given inadequate support to CDDs. The communities are not directly involved in taking decisions on Mectizan distribution, but all decisions comes through the community leaders. In almost all communities the time of Mectizan distribution was decided by the health personnel, and in some communities even the appointment of CDDs was found to be done by the village heads, who also terminated the appointment in some areas.

MONITORING AND SUPERVISION (2.0)

It was found that, in most cases the health staff from the FLHF comes to collect the reports from the CDDs, instead of the CDD sending reports to the FLHF. Community treatment records were available at the communities, but some communities were keeping their registers at the FLHF. In all areas, no adequate transport was arranged by the community for the CDD to submit the reports to FLHF. There was also no system in place for community self monitoring.

MECTIZAN SUPPLY (1.5)

Mectizan is usually collected from the Health area (FLHF) after the officer in charge of the FLHF informs the community leadership about the availability of the drug. In the last round of treatment there was a shortage of Mectizan in some communities and as a consequence to this, not all eligible population were treated, and Mectizan drugs were not reserved for the treatment of absentees and temporary non-eligibles. The drug shortage was mainly due to non-rational calculation of amount of Mectizan ordered, which was determined by number of tablets distributed in the previous year plus 10%, instead of using population data as the base of ordering mectizan.
TRAINING AND MOBILIZATION (1.0)

CDTI training had been conducted for CDDs and health workers, and majority of these were found to be very conversant with the disease and the drug distribution. However, the community members are not well mobilized on CDTI and this is mainly due to the fact that the community leadership has not taken effective and proactive role in promoting acceptance and ownership of CDTI to the community members.

FINANCE (1.0)

Lack of sufficient funding was singled out to be the most serious hampering factor for CDTI activities in the communities. In the previous years CDDs used to be compensated (as motivation) by retention of 32% percentage of cost recovery funds from the community, but there were no funds for other CDTI activities apart from motivation of the CDDs. The community support to CDTI activities in terms of finances is almost non existence in most of the communities and this is mostly due to the fact that the communities see CDTI as a government owned programme, and the community members had played their part through cost recovery. Nevertheless, in most of the communities the CDDs are willing to continue with the distribution provided there is provision made to replace funds currently supporting CDTI activities.

HUMAN RESOURCES (2.0)

In most of the communities the ratio of CDDs to population was found to be inadequate (1 to 500 on average). Most CDDs do not travel far from their homes to distribute Mectizan. However, there were plans for training and replacement of CDDs on annually base. CDDs knowledge of CDTI is adequate, including knowledge of criteria for eligibility and that persons with severe adverse reactions have to be referred to the health centers. However, in some communities many of the CDDs have dropped out, and in others the CDDs have threatened to stop distribution if they are not compensated.

COVERAGE (2.0)

Geographic coverage was 100% as all the households and areas were treated. Therapeutic coverage however, was persistently low over the years, except for the fifth round of treatment carried out as a campaign, where 67% of the communities visited achieved coverage rates of 65% or higher.
The community leadership should take a proactive role in initiating CDTI activities in the community, and support CDDs activities. Community empowerment for decision on all issues of CDTI including, selection of CDDs, time and mode of distribution of mectizan.

### Monitoring and Supervision

- A reliable transportation for the CDD to submit reports at the FLHF to be arranged whenever necessary.
- Community self-monitoring system to be introduced.

### Priority: MEDIUM

**Indicators of success:**
- A reliable system of collection of reports in place
- Training of community self monitors (CSM).

**Who to take action**
- Community leaders, COP, NOTF/ PDPH, APOC

**Deadline for completion**
- Next treatment cycle.
### Mectizan

- The community should design a system of collecting mectizan from FLHF in each distribution season, and arrange a reliable transportation mechanism for the CDD.
- Reserve drugs should be kept within the community level for absentees and temporary non eligibles.
- Treatment records to be accurate and kept in the community.
- Training of all CDD to be conducted on how to determine quantity of mectizan to be ordered using the census figures as recommended by APOC.

### Priority: HIGH

**Indicators for success:**
- A reliable system of collection of Mectizan
- Evidence of reservation for absentees and non eligibles to be put in place.

**Who to take action**
- COP, CDD

**Deadline for completion**
- End of next distribution.

### Training & HSAM

- Community leadership should take effective and proactive role in doing sensitization and in mobilizing community at large on CDTI issues.
- District and FLHL authority to intensify sensitization and mobilization of community leaders and members on CDTI
- Use of dialogue structures should be intensified for CDTI activities.

### Priority: HIGH

**Indicator of success:**
Change of perception of community towards ownership

**Who to take action**
Community leaders, CDDs, DMO, COP

**Deadline for Completion**
Before next distribution

### Finance

- The community to be sensitized on the need for them to support CDTI activities and motivate their CDDs.
- Central government to provide resources to substitute what accrued for CDTI activities from cost recovery funds.

### Priority: HIGH

**Indicator for Success:**
- Availability of support to CDDs.
- Availability of Central Government funds for CDDs.

**Who to take action**
NOTF, DMO, COP, and Community leaders.

**Deadline for completion**
December 2003
### Human resources
- Arrangement for replacement of CDDs who dropout and training of new CDDs.
- Adequate number of CDDs to be selected and trained.

### Coverage
- Community leadership should interact more with the district leaders to improve the advocacy and community mobilization.

### Priority: HIGH

<table>
<thead>
<tr>
<th>Indicator for success:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Number of new CDDs selected and trained.</td>
</tr>
<tr>
<td>- 2 CDDs per 250 persons in the community.</td>
</tr>
</tbody>
</table>

**Who take action**
COP, Community leaders

**Deadline for completion**
Before next distribution

<table>
<thead>
<tr>
<th>Indicator of success</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Improvement in HSAM to ensure high therapeutic coverage rate of ≥65% therapeutic coverage.</td>
</tr>
</tbody>
</table>

**Who take action**
DMO, COP, CDD

**Deadline for completion**
At next distribution.

#### 3.5 Findings of interest

The banking process for APOC funds is rather complicated. APOC funds are deposited from the WHO Country office into the NOTF bank account, from where they are transferred by NOPT into the SWI CDTI / NOTF account held with Standard Chartered Bank in Yaounde. Cash is withdrawn from here and paid into SCB Credit Lyonnaise Bank in Yaounde, which credits the money to the SWI/SSI Provincial CDTI account held with SCB Credit Lyonnaise Bank in Limbe, from where funds are withdrawn for field activities. The explanation the team received was that banking processes in Cameroon are slow, taking up to two weeks to clear a cheque from one bank to the other in Yaounde and much longer (more than one month) if the cheque were to be paid into an account in another town.

However, though the process enables speedy transfer of funds from Yaounde to Limbe, the joint account between SSI/SWI CDTI project does not allow for ease of understanding of the quantum of funds deposited from APOC and SSI respectively. Explanation received is that such a separation was no longer thought to be essential as all funds in the account were for the SWI project and were jointly approved for disbursement by both parties. (fig. 1).

The procedure for approval, release and accounting for APOC funds are even more complicated and tortuous. The OPC in Buea makes a request to the Provincial Delegate of Public Health for funds to implement an activity. The Provincial Delegate of Public
Health studies, approves and sends to SSI CR in Yaounde for approval. She studies same, approves and passes to the APOC account officer (operating from SSI office in Yaounde) to crosscheck, after which OPC Buea is given clearance to raise a cheque on the Yaounde Standard Chartered Bank account. This cheque is signed by the Provincial Delegate of Public Health (PDPH) who sends it to Yaounde for SSI CR to countersign, after which cash is withdrawn and paid into the Yaounde SCB Credit Lyonnaise Bank for immediate credit to the SWI/CDTI/APOC/SSI account held with the Limbe branch of the same bank. The OPC in Buea now raises a cheque for signature of the Provincial Delegate of Public Health, countersignature by SSI representative in Limbe, and subsequent collection of cash for CDTI activities.
When activities are concluded, the OPC or APOC accountant collects reports and justification from Districts, and the APOC account's officer in Yaounde classifies and reconciles the returns for the monthly reports to APOC through the WR in Yaounde. (figure 2.) We were informed that the monthly returns for SWI are currently up to date. This was not always so in the past. In fact, the APOC finance officer from Ouagadougou had to effect a "Cut-off" for funds for 1998 - 2001, due to lack of clarity of what had transpired; and the project accountant for that period was relieved of his post and the current one appointed in November 2001. A project account needs to be opened...
in Buea, the APOC supported accountant relocate to Buea and the financial/accounting procedure simplified as a matter of urgency.
PROCEDURE FOR APPROVAL, RELEASE, AND ACCOUNTING OF APOC FUNDS FOR CDTI ACTIVITIES

Fig 2: Accounting Procedures
4.0 CONCLUSION

4.1 Grading of the overall sustainability of SWI CDTI project

In making a judgment of the overall sustainability of the project, the evaluation team examined the seven aspects and six critical elements of sustainability.

a) The team made a judgment of the project, in terms of each of the seven ‘aspects’ of sustainability:

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Judgment: to what extent is this aspect helping or blocking sustainability in this project?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>Moderately blocking sustainability</td>
</tr>
<tr>
<td>Resources</td>
<td>Seriously blocking sustainability</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Moderately blocking sustainability</td>
</tr>
<tr>
<td>Simplicity</td>
<td>Moderately blocking sustainability</td>
</tr>
<tr>
<td>Attitude of Staff</td>
<td>Very much helping sustainability</td>
</tr>
<tr>
<td>Community Ownership</td>
<td>Seriously blocking sustainability</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Severely blocking sustainability</td>
</tr>
</tbody>
</table>

- **Integration**: Although comprehensive plans exist at all levels, there was no integration of CDTI activities into the health system, particularly at the Provincial level where the project was being managed as a vertical programme. Almost all core CDTI activities were carried out with APOC and SSI funds, with the exception of fueling of vehicles at district and health area levels.

- **Resources (human, financial and material)**: Trained personnel are available but not adequate at the provincial level where the project office is solely managed by the OPC SWI. There is no counterpart funding. Government financial input into the project has been only in the areas of salaries of personnel, provision of accommodation and occasional fueling of vehicles and stationery. Funds have never been budgeted for, or released for core CDTI activities since inception. APOC funds are not entirely managed within the government system.

- **Efficiency**: Although there is structural integration there is no evidence of functional integration. The implementation of core CDTI activities such as Training, HSAM, Supervision/ Monitoring were not targeted and therefore not based on needs. Existing government channels e.g. the Essential Drug Programme are not utilized for Mectizan distribution, and activities which could be carried out together e.g. census update and Mectizan distribution, are carried out separately.

- **Simplicity**: The process of running the core CDTI activities is simple. The banking process for APOC funds is rather complicated. The procedure for approval, release and accounting for APOC funds are even more complicated and tortuous.

- **Attitude of staff**: The staff at various levels are competent, highly motivated and willing to implement CDTI activities.
Community ownership: The communities have not yet accepted the project as their own, do not take responsibility for it and do not support their CDDs. The health care systems have also not taken ownership of the programme.

Effectiveness: Though the geographic coverage is 100%, the therapeutic coverage has been perpetually poor, except in 2003 when 70% of the districts achieved 65% or more therapeutic coverage due to the suspension of the cost recovery and improved HSAM with the campaign approach. It is however doubtful of the sustainability of the campaign approach in the future.

The evaluation team examined the ‘six critical elements’ of sustainability in the project. If these are not present, it is unlikely that the project will be sustainable.

<table>
<thead>
<tr>
<th>Money: Is there sufficient money available to undertake strictly necessary tasks, which have been carefully thought through and planned? (Absolute minimum essential activities.)</th>
<th>NO because funds are mainly APOC and SSI funds.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport: Has provision been made for the replacement and repair of vehicles? Is there a reasonable assurance that vehicles will continue to be available for the minimum essential activities?</td>
<td>YES for motorcycles NO for motor vehicle.</td>
</tr>
<tr>
<td>Supervision: Has provision been made for continued targeted supportive supervision? (the project will not be sustained without it)</td>
<td>YES.</td>
</tr>
<tr>
<td>Mectizan supply: Is the supply system dependable? (the bottom line is that enough drugs must arrive in the villages at time selected by the villagers).</td>
<td>NO</td>
</tr>
<tr>
<td>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.</td>
<td>NO</td>
</tr>
</tbody>
</table>

Therefore, in line with the guidelines for grading the whole project using the seven aspects and six critical elements of sustainability, the evaluation team concludes that the South West 1 CDTI project is NOT MAKING SATISFACTORY PROGRESS TOWARDS SUSTAINABILITY. This project has serious barriers to sustainability. It will require rethinking and mobilisation of high-level support to get it on the road again.

4.2 District Feedback Planning Meeting

The planning meeting was held on Tuesday 24th and Wednesday 25th June 2003. The full report with the agenda is given in Appendix VII. During the meeting, time was taken to administer questionnaires (see sample in Appendix VI) to the various Districts teams in districts that were not visited. This was to complement what was gathered from the
selected sample and enable the evaluators to have a better insight into the situation of sustainability of activities in the various Districts. District teams participated actively throughout, and prepared detailed 3-year sustainability plans of action.

Key issues addressed were lack of government funding for core CDTI activities, lack of community ownership and the problem with calculating Mectizan requirement. The districts sustainability plans now exist Appendix IX. All of them need more work to be done on them to be of practical use, and all need to be put into operation. This is primarily the responsibility of the DMOs, but they will need the support and encouragement of the Provincial Oncho Team and policy makers at the Provincial and District levels as well as the NGDO. The recommendations in this report should be taken seriously during CDTI implementation.

In future evaluations it will be ideal to administer the questionnaire before the start of the meeting. There is need for more time to be devoted to the making of the plans so that something more qualitative will come out of the workshop.

4.3 Provincial Feedback Planning Meeting

The Provincial feedback and planning meeting was held on Thursday 26th June 2003 at the Conference hall of South West Province. Special Fund for Health at the Delegation. Key issues discussed as arising from the findings at the provincial level included: treatment in hypoendemic areas, Mectizan procurement and delivery, Finances (no govt funding for core CDTI activities or counterpart funding) and financial management of project funds as well as the DTS employment. On the way forward on planning and making Sustainability plans for the provincial/project level, they were taken through a group work (SWOT) analysis and re-appraisal of their various roles post-APOC. Finally, they developed a 3 year Post- APOC Sustainability plan, identifying dependable sources of funding (as APOC will no longer be funding core CDTI activities after their 5th year). The full report with the agenda is given in Appendix VIII.

4.4 THE WAY FORWARD

The evaluation team found that the South West I project which is in its fifth year has major obstacles to sustainability. These have been described in detail in the report but the major obstacles of weak leadership at all levels, lack of community ownership of the programme, total dependence on APOC and SSI funds and lack of a dependable method of procuring and delivering Mectizan, need to be addressed urgently, if the project is to have a turn around.

The feedback and planning workshops provided a good avenue for dialogue between the various partners and a readjustment to the role of each partner. The team believes that this process will continue till all the necessary changes are effected. The provincial delegation now appreciates that they have to be in the driving seat, supported by SSI, and have shown willingness and a commitment to accept the responsibility. SSI was extremely supportive in the sustainability plan development process, and has commenced the process of devolution of powers to the province. The two partners should ensure that the plans are completed, while NOTF should monitor its implementation. The error of the
past, where the project was visited only once by NOTF staff in its five years of existence, should be avoided.

APOC will still have to monitor this project closely and give the necessary support for the implementation of the sustainability plans, as well as various recommended actions such as high level advocacy, provision of a vehicle, and training for community self monitoring. It is the belief of the evaluation team, based on the experience and enthusiasm shown by staff, that the project has the potential for a quick turn around if given the necessary support.
APPENDIX II

Evaluation WorkPlan

South West I Province: Buea, Cameroun; Evaluation Team Composition/Workplan.

Sub-Team One

Prof. A Abiose (Team Leader)
Dr E Nnoruka
POCT Member- Mah Cecilia/Joseph Kandem

Sub-Team Two

Dr Korve
Dr. Kirumbi
Dr Andrew Atabe

Sub-Team Three.

Dr Kayode Ogungbemi
Mr. Geoffrey Tukalebwa
POCT Member- Mr. George Besong

WORK PLAN

<table>
<thead>
<tr>
<th>Days</th>
<th>Sub-Team 1</th>
<th>Sub-Team 2</th>
<th>Sub-Team 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sat 14th June 2003.</td>
<td>All team members arrive and settle into hotels.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday 16th June 2003</td>
<td>Courtesy call to the Provincial Governor, Provincial Delegate of Public Health (PDPH), POCT SW 1 &amp; SSI (NGDO) by all team members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Later teams disperse for Data Collection on same Day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data collection from Provin Delegate for Public Health, Country Rep. of SSI, Prov.Chief of Serv for Hospital Medicine, Provincial Oncho Project co-ordinator SW L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub-teams 2&amp;3 travel to the Respective Districts for Data collection.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

47
<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data collection at District level (Tombel) &amp; one FLHF (Ndibenjock) with Two communities (Bangone &amp; Yorge) <em>Mbonokoigid</em></td>
</tr>
<tr>
<td><strong>Wednesday 18th June 2003</strong></td>
<td>Mop up data from Provincial Level/??? National/Central level</td>
</tr>
<tr>
<td></td>
<td>Data collection from Second FLHF (Ebonji) and two communities. (Etam &amp; Ebuhl/Ehont)</td>
</tr>
<tr>
<td><strong>Thursday 19th June 2003</strong></td>
<td>Data collection 3rd District (Muyuka)</td>
</tr>
<tr>
<td></td>
<td>Data collection from Ist FLHF (Muyuka) and two Comm. (Makanga I &amp; Owa II)</td>
</tr>
<tr>
<td><strong>Friday 20th June</strong></td>
<td>Mop up Data collection /Debriefing of Health facilities and reminder on feedback/planning Meeting. All teams Travel Back to base.</td>
</tr>
<tr>
<td><strong>Saturday - Sunday 21st &amp; 22nd June 2003.</strong></td>
<td>Collation of Data &amp; report writing. Preparation for debriefing of Provincial/Health District; Feedback/Planning meetings for workshops on 24th and 25th February.</td>
</tr>
<tr>
<td><strong>Monday 23rd June 2003.</strong></td>
<td>Summarizing Evaluation Findings and Finalizing Preparation of Feedback/Planning Work</td>
</tr>
<tr>
<td><strong>Tuesday 24th &amp; Wednesday 25th June 2003.</strong></td>
<td>Feed back/Planning workshop All Health District/Health areas</td>
</tr>
<tr>
<td><strong>Thursday 26th June 2003.</strong></td>
<td>Feedback/Planning workshop (Provincial)</td>
</tr>
<tr>
<td><strong>Friday 27th - Sunday 29th June 2003.</strong></td>
<td>Report writing</td>
</tr>
<tr>
<td><strong>Monday 30th June 2003.</strong></td>
<td>Final Feedback, Advocacy and Courtesy Call.</td>
</tr>
<tr>
<td><strong>July 1st 2003.</strong></td>
<td>Departure</td>
</tr>
</tbody>
</table>
REMINDER ON PERSONS TO BE INTERVIEWED

PROVINCIAL.
Provincial Chief of Service Administration and Finance, Provincial Delegate of Health,
Provincial Chief of Service Community Health, Provincial Chief of Service for
Pharmacy, Provincial Oncho Co-ordinator SW 1,
Provincial Chief of Service/Hospital Medicine.
Senior NGDO staff: SSI country director, SSI project manager, SSI/APOC accountant.
NOCP Staff: NOC accountant, field officers, drivers.
One or two other NOTF members.
WHO country representative, disease control programme officer in the WR’s office.
High ranking civil authorities at this level: State/Provincial governors.

DISTRICT
District Health management Team:
DMO
Chief of Bureau Health,
Chief of Bureau Administrator and Finance.
District Chairperson.

FLHF/SUB-DISTRICT LEVEL
Chief of Post
Health Committee Rep.

VILLAGE/COMMUNITY LEVEL
Village leaders and councilors. Village members, CDDs with their Registers and Stick.
# APPENDIX III

## LIST OF PERSONS MET

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles Ossongo Eken</td>
<td>I/C IEC</td>
</tr>
<tr>
<td></td>
<td>NOTF Secretariat</td>
</tr>
<tr>
<td>Mrs. Abunaw Ula</td>
<td>Provincial Chief of Service, Hospital Medicine</td>
</tr>
<tr>
<td>Mr. George Besong</td>
<td>Chief of Bureau for Primary Health Care</td>
</tr>
<tr>
<td>Mr. George Shafack Ndungbu</td>
<td>Provincial Chief of Service Administration and Finance</td>
</tr>
<tr>
<td>Ms Mah Cecilia</td>
<td>Provincial Oncho Co-ordinator, S.W.I</td>
</tr>
</tbody>
</table>

## PROVINCIAL

### Dr. Matilda Akoh Arrey
- Acting Provincial Delegate of Public Health and Provincial Chief of Services for Community Health

### Dr. Esther Nogbe
- Provincial Chief of Service Administration and Finance

### Mrs. Abunaw Ula
- Provincial Chief of Service Administration and Finance

### Mr. George Besong
- Chief of Bureau for Primary Health Care

### Mr. George Shafack Ndungbu
- Provincial Chief of Service Administration and Finance

### Ms Mah Cecilia
- Provincial Oncho Co-ordinator, S.W.I

## DISTRICT

### TOMBEL

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION</th>
</tr>
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<tbody>
<tr>
<td>Dr. Alexander Nkeng</td>
<td>DMO</td>
</tr>
<tr>
<td>Matze Pierce</td>
<td>CBH</td>
</tr>
<tr>
<td>Enonkaku Michael Tabe</td>
<td>CBAF</td>
</tr>
<tr>
<td>Christiana Ajang</td>
<td>COP</td>
</tr>
<tr>
<td>Enock Njako</td>
<td>CDD</td>
</tr>
<tr>
<td>Elong Samuel</td>
<td>Village Chief</td>
</tr>
<tr>
<td>Sune Mtuge</td>
<td>Councillor</td>
</tr>
<tr>
<td>Augustine Betanga</td>
<td>CDD</td>
</tr>
<tr>
<td>Ebong Francis Komensen</td>
<td>Village Chief</td>
</tr>
<tr>
<td>Binda Johnson</td>
<td>COP</td>
</tr>
<tr>
<td>Ebung Stanslaus</td>
<td>Health Committee Chairman</td>
</tr>
<tr>
<td>Ediage Wilfred</td>
<td>Village Chief</td>
</tr>
<tr>
<td>Nober Subenkone</td>
<td>CDD</td>
</tr>
<tr>
<td>James Mituge</td>
<td>Village Chief</td>
</tr>
<tr>
<td>Blasius Esambe</td>
<td>CDD</td>
</tr>
<tr>
<td></td>
<td>Community Members</td>
</tr>
</tbody>
</table>
MUYUKA

Dr. Bebetta Alexander
Felix Mfonya
Fombon Emmanuel
Lokendo Joseph
Martha Nkule
George Oyene
Brong Peter
Ewoujig Clement
Mandi Paul
Ester Akum
Nsea Peter
Tantoh
Jacob Bruno Mongidor

DMO
DO
CBH
CBAF
COP
CDD
Village Chief
Village Chief
CDD
COP
CDD
CDD
Chair Hosp.Magt. Committee
Community Members

KUMBA

Dr. Ndifochu
Esoe Emmanuel
Njikam Justine
Enaw Abunaw Pauline
Eringe
Obie George
Akama Adolf
Mbonge Josephine
Awunti Agnes
Motoh Philip
Bisingi David
Ekomba John Basiaka
Seranjauwalie

DMO
CBH
CBAF
COP
CDD
COP
Village Chief
CDD
Village Chief
CDD
Village Chief
CDD
Community Members
APPENDIX IV   DOCUMENTS SIGHTED.

A. PROVINCIAL LEVEL

3. REA/ REMO listing of all endemic communities with their population figures
4. South West I Proposal for CDTI (July 1997)
7. Cash book - APOCH funds
8. Applications for release of funds and approvals for expenditures
11. Reports of routine supervision
12. Reports of HSAM meetings
13. Mectizan Stock registers
14. Mectizan distribution schedules to districts.
15. Report of advocacy and community mobilizations
16. Reports of trainings conducted, 2000, 2001
17. Attendance list at DMO trainings for 2000 and 2001
19. Schedule for Mectizan Campaign February-March 2003
20. Training materials seen include, CDD training manual, LOCT training guide, Flip charts on CDTI, training materials on Severe Adverse Events.
B. DISTRICT LEVEL (TOMBEL, MUYUKA AND KUMBA)

- Detailed CDI work plan and Budget
- Integrated work plan
- Transport summary reports
- Ledgers
- Monitoring reports
- Reports of Appraisal meetings.
- Financial retirements/returns
- Mectizan inventory forms.

C. FLIF LEVEL (KUMBA MBENG, KOMBONE, MEANJA CAMP, EBONJI, NDIBENJOCK & MUYUKA)

- The coverage reports for the past three years.
- 2002, 2003, and 2004 years plans for CDI
- Financial documents showing retirement of allowances for CDI activities.
- CDI supervision reports
- Mectizan inventory forms
- Training reports
- Treatment registers for communities
- Integrated work plan
- Detailed CDI work plan

D. COMMUNITY LEVEL (ETAM I, EBU/EBIHOM, YORGE, NDISE, OWE II, MAKANGA II, BAROMBI KANG LONG STREET, BAROMBI KANG NATIVE, BOLE DEPENDA, BOA BAKUNDU, MILE 29 AND MEANJA CAMP.

1. Community registers
2. Measuring sticks
**APPENDIX V**  ANALYSIS OF QUESTIONNAIRES FROM SIX DISTRICTS NOT VISITED.

This sustainability questionnaire was filled out by participants (DMOs, CBFs, CBAFs, COPs) from the six Districts that were not visited by the evaluation team. The participants filled the questionnaire during the workshop on feed back and planning organised on the 24th and 25th for Health Area and District staff at the conference hall of the Delegation of Public Health, Buea.

A total of 40 questionnaires were distributed and retrieved from the participants as indicated below:

- Bangem 9
- Buea 2
- Limbe 5
- Nguti 10
- Tiko 4
- Konye 10

In general, most of the responses given by the respondents to the questionnaire correspond with and confirmed our observations in the field.

However, the team noted some of the observations made by the respondents in the areas of leadership, monitoring, Mectizan supply and distribution, and training of HSAM. These responses are presented below.

**LEADERSHIP**

As strengths and in addition to what is already written in the instrument, the participants indicated that the administrative authorities and political leadership were involved in HSAM activity at all levels.

**MONITORING**

In the area of weaknesses and as addition to those found in the instrument, the respondents reported that in some cases, the Provincial coordinators for SW1 project supplied Mectizan to the District while in some the District Medical Officer collected from the Province.

**TRAINING AND HSAM**

As strength under this indicator and in additions to those cited in the instrument, the respondents indicated that social mobilisation agents and dialogue structures are used for sensitisation and advocacy.

In conclusion, the responses from both the districts visited and those that filled the questionnaire are similar even though reported in varying degrees.
APPENDIX VI: CONSOLIDATED INSTRUMENTS (REFER TO ANOTHER DISKETTE)
APPENDIX VII

Minutes of the Planning Workshop for District/Health Areas held on the 24th to 26th of June 2003 at the Provincial Delegation in Buea

ATTENDANCE
DMOs, CBHs, CHAFs and COPs from the nine Districts namely, Muyuka, Tombel, Kumba, Buea, Limbe, Tiko, Konye, Bangem and Nguti

INTRODUCTION
The meeting started at 9:30 am with a prayer after which an introduction of the evaluators was made. The participants were also introduced. Then a welcome address was delivered by Dr. Matilda Akoharrey after which the leader of the evaluation team stated the objective of the evaluation and highlighted some key elements of sustainability. These include a background information on APOC philosophy and also aspects which must be present in a project for it to be judged as being sustainable, such as:

a) Effectiveness
b) Efficiency
c) Simplicity
d) Integration
e) Attitude, and
f) Resources

She noted that a lot of work has been done at all the levels visited but there is need to take an in depth look at sustainability of current level of operations. She pointed out further that the objective of the evaluation was to look at how well the project has fared over the years and also to assist the project to plan for sustainability.

METHODOLOGY & LIMITATIONS
The team explained to the participants the process by which the sample size was selected taking into cognizance the overall coverage, endemicity and geographical spread. The major consideration however was coverage. At the end of the selection process they pointed out that 3 Districts, 6 Health Areas and 12 communities were selected. Some limitations the team encountered:

1. The difficulty in accessing some of the communities selected.
2. The unavailability of some documents needed

FINDINGS
The team presented a summary of their findings at each level highlighting strengths and weaknesses for each of the nine indicators, namely: Planning, Leadership, Monitoring & supervision, Mectizan procurement, Training/HSAM, Finance, Transport and material resources, Human resources and Treatment coverage (both geographic and therapeutic).
The critically deficient areas were in finance, community participation and training and HSAM.

Summary of findings presented at each Level are given below:

At the community level

Dr. Edward Kirumbi did the presentation of finding at this level. The presentation stressed the fact that community leaders and CDDs were jointly taking responsibility for the distribution of Mectizan within their communities and community members also know the benefits of Mectizan. They mentioned that the drug helps in eradication of skin rashes, itching, expels worms from their body and improves their vision. They also expressed the interest in taking the drug annually for as long as is required. The CDDs knowledge of CDTI was found to be adequate and most importantly they expressed their willingness to continue with the distribution in most of the communities visited. In fact some CDDs feel that the health of their people is more important than the financial support they will get from their community.

The presentation however stressed some of the weaknesses of this level. It was found that the community members see CDTI as a government owned programme. In fact in all communities the health staff was the one that decided on the time of distribution. In most villages, the leadership has not played effective and proactive role in solving major problems such as refusals and inadequate support to CDDs. The therapeutic coverage of this level was also very poor as only 67% of the communities visited had a coverage rate of more than 65% at the last distribution and it was much lower in previous years.

At the health facility level

Dr. Kayode Ogungbemi presented the findings of this level. Some of the strengths he mentioned included the fact that Health center funds are used for fueling and maintenance of motorcycles by the Chiefs of Post (COP), as well these Chiefs of post being skilled, knowledgeable and committed to CDTI implementation. He however mentioned some weaknesses, which included that supervision of CDTI by the COPs, and these visits had been fully funded by APOC; and that the implementation of CDTI was not integrated with other health activities at this level.

At the District level

Dr. Kenneth Korve presented findings of this level. He first mentioned the strengths identified at this level, which included the existence of integrated plans, the staff at this level was also found to be skilled and knowledgeable with respect to the implementation of CDTI and they also expressed satisfaction with their job. Dr. Korve also enumerated weaknesses at this level and these were the fact that the districts have never budgeted and released funds for CDTI activities. The activities are completely donor funded (APOC and SSI) since the inception of the programme. Training was not targeted and was not integrated.
At the Provincial Level

Dr Edith Nnoruka presented findings at this level. She enumerated the strengths of the CDTI programme at this level, which included existence of plans for onchocerciasis control for 2001-2003, targeted training, the involvement of the leadership at the Provincial delegation in solving problems. There were however more weakness at this level. Key amongst them were that: Only SSI has been responsible for the financial planning for CDTI activities, the non-existence of specific plans for counterpart funding from government, collection and distribution of Mectizan by the province was found to be solely dependent on APOC funds, the movement of funds from the main NOTF/SWI account in Yaounde to the joint APOC/SSI account in Limbe is very tortous and finally that the project accountant for SWI is based at the NGDO office in Yaounde and not at the province.

General Discussions

Participants acknowledged lack of financial support from government. This was mainly because government has not been properly sensitized. The issue of the CDTI program being a vertical program was also discussed. It was mentioned that the lifting of the cost recovery has also helped to improve treatment coverage. The District/Health Area personnel for each district were tasked to ensure that work plans for activities are carefully written taking into consideration the financial implication for such activities.

Four group sessions were held as follows:

First group session: Situation regarding sustainability of our project
Group 1. The Community
Group 2. The Health Areas
Group 3. The District Level

Second group session: Solutions to the weaknesses regarding sustainability of our project
Group 1. The Community
Group 2. The Health Areas
Group 3. The District Level

Third group session: Resources likely to be available at different levels of the programme for the next three years
Group 1. Money and Human resources
Group 2. Transport and Equipment/Material resources

Presentations & general discussions were made after each group work. Copies of those presentations are attached as Appendices:
Completion of Questionnaires

Districts that were not visited were provided with questionnaires to enrich the findings already made.

*Fourth group session: Making of sustainability plans for the next three years*

Information was received at this point that communities are represented at the planning meeting through DMOs who are Secretaries of the District Health Committee. Participants were then divided into 9 groups, one for each district. Each group comprised of DMO, CBH, CBAF and COPs with the tasks of developing sustainability plans for the next three years, taking into consideration the findings of the team, their own recommendations and the elements of sustainability. The plans are attached as Appendix IX

The workshop was brought to an end on Thursday 26th June 2003.

**AGENDA FOR THE DISTRICT/HEALTH AREA WORKSHOP**

**Day 1: 24th June 2003**

<table>
<thead>
<tr>
<th>Item</th>
<th>Activity</th>
<th>Time</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Registration of Participants</td>
<td>8.30 – 9.00am</td>
<td>POCT Members</td>
</tr>
<tr>
<td>2.</td>
<td>Opening prayers</td>
<td>9.05 – 9.10</td>
<td>To be appointed</td>
</tr>
<tr>
<td>3</td>
<td>Welcome Address/Introduction of Participants</td>
<td>9.15 – 9.30</td>
<td>OCP SWI Mah Cecilia</td>
</tr>
</tbody>
</table>
| 4    | Introduction to the workshop Programme.  
- Evaluation objectives  
| 5    | Evaluation Methodology | 10.00 – 10.15 | Dr. E Nnoruka.                    |
| 6    | Coffee Break | 10.15 – 10.40 |                                      |
| 7    | “Feedback” on achievements, issues and lessons from the South West I evaluation on sustainability of CDTI  
- Findings at Community level.  
- Findings at Health Areas (FLHF).  
- Findings at District Level  
- Findings at the Provincial level | 10.40 – 10.45  
10.45- 10.50  
10.55 – 11.00  
11.00- 11.05 | Dr. Kurumbi  
Dr K Ogungbemi  
Dr K. Korve  
Dr E Nnoruka |
<p>| 8    | Open discussion/clarifications on findings. | 11.05-12.00 | Prof. A Abiose.                  |
| 9    | LUNCH BREAK | 12.00 – 13.00 |                                      |</p>
<table>
<thead>
<tr>
<th></th>
<th>What is the situation regarding Sustainability in our Project? Group Work: Swot analysis in 3 groups. Group 1: The Community. Group 2: The Health areas. Group 3: The District Level.</th>
<th>13:00 - 14:00</th>
<th>Dr. E. Nnoruka</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Presentation of Group Work, followed by plenary discussion.</td>
<td>14:00 - 14:30</td>
<td>Dr. Kurumbi.</td>
</tr>
<tr>
<td>11</td>
<td>What could be the solutions to the weaknesses regarding sustainability on our project? Group work Group 1: Planning, Monitoring &amp; Super. Group 2: Finances, Training &amp; HSAM. Group 3: Transport, Mectizan.</td>
<td>14:30 - 15:15</td>
<td>Dr. K. Korve</td>
</tr>
<tr>
<td>12</td>
<td>Feedback from Group work</td>
<td>15:15 - 16:15</td>
<td>Dr. Ogungbemi.</td>
</tr>
<tr>
<td>13</td>
<td>Summary of Previous Days work (To be appointed from the participants).</td>
<td>16:15 - 16:30</td>
<td>Prof. A. Abiose.</td>
</tr>
</tbody>
</table>

**Day 2: 25th June 2003**

<table>
<thead>
<tr>
<th></th>
<th>Welcome</th>
<th>9.00-9.05 am</th>
<th>Mah Cecilia</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Summary of previous Days work. The Present Day's programme.</td>
<td>9.05 - 9.15</td>
<td>Mr. Kenneth Ebah</td>
</tr>
<tr>
<td>16</td>
<td>Group Work: What resources are we likely to have at the different levels of the programme, for the next 3 years. Group 1. Money and Human resources Group 2. Transport and Equip./ Material.</td>
<td>9.15 - 10.15</td>
<td>Dr. Ogungbemi</td>
</tr>
<tr>
<td>17</td>
<td>Presentation of Group work/Plenary Discussion.</td>
<td>10.15 - 11.00</td>
<td>Prof. Abiose</td>
</tr>
<tr>
<td>18</td>
<td>Coffee Break</td>
<td>11.00 - 11.30</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Group work: Making a Sustainable plan for the coming year. 2 groups Each to compile a tabulated plan with the available resources.</td>
<td>11.30 - 13.00</td>
<td>Dr. E. Nnoruka.</td>
</tr>
<tr>
<td>20</td>
<td>LUNCH</td>
<td>13.00 - 14.00</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Presentation of group work, followed by Plenary Session.</td>
<td>14.00 - 14.45</td>
<td>Dr. Korve.</td>
</tr>
<tr>
<td>22</td>
<td>Plenary Discussion: Making a master &quot;Sustainable Plan&quot; for the coming year.</td>
<td>14.45 - 15.30</td>
<td>Dr. Kurumbi/Dr Nnoruka.</td>
</tr>
<tr>
<td>23</td>
<td></td>
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<tr>
<td></td>
<td>Practical steps to implement the required in the ‘Sustainable Plan’.</td>
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<td>---------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>24</td>
<td>Closing Ceremony</td>
<td></td>
<td></td>
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</tbody>
</table>
APPENDIX VIII
Provincial Feedback/ Planning Workshop Report.

Provincial level
This workshop was held on Thursday 26th June 2003 at the Conference hall of South West Province Special Fund for Health. This took off at 10:45 am.
In attendance were: the evaluation team, the Provincial Oncho Task force team comprising of Dr M Akoharrey (the Acting Provincial Delegate of Health), Dr. E Nogbe (PCSHM), Mr G Shafack (PCSAF), Abunaw Ula (Ag Manager Essential Drug Programme), Besong George (CBPHC), Mr J Kandem (POCT member), Mah Cecilia (OPC SWI), Oponde Peter (OPC SWII); others also present were Mr C Ossongo (NOTF representative) and Dr. R Befidi (SSI Country Representative).
Dr. M Akoharrey declared the workshop open with a short welcome address and an opening prayer was said by Prof. Abiose.

OVERVIEW
Prof. Abiose started by expressing appreciation for the co-operation of the Provincial Officers in making the work of the evaluators run smoothly. Next she introduced the Workshop by giving an overview of APOC philosophy and the essence of the evaluation exercise for projects in their 5th year. It was expected that by the 5th year that community ownership of the programme was fully and projects were expected to be sustainable. Prof Abiose took participants through the following elements of project sustainability which include attitude, resources, effectiveness, efficiency, simplicity, and integration. She also explained the critical elements of Sustainability that must be present for a project to be sustainable. These were Money, Transport, Supervision, Mebectizan supply and Political commitment.

METHODOLOGY & LIMITATIONS
Dr Nnoruka next explained the methodology undertaken by the evaluation team for the selection of sampled sites. Participants were told that a total of 12 communities were visited in 3 Districts out of the nine that CDTI activities were being carried out, for the South West I project. The other six Districts had to fill out questionnaires.
She enumerated the criteria the team used in sample selection to include coverage (primary selection criteria) then endemicity, geographical spread and accessibility (as secondary selection criteria). She noted that the team made efforts to go into areas that were not easily accessible in order to have a good view of the situation on ground. Information on the instruments used at the 4 levels and the scoring system for each of the indicators was also mentioned. The following factors were mentioned as being limitations of the exercise: unavailability of documentations required at some of the District and FLHF/Health area level, and the inaccessibility of one of the communities, Bangone in Tombel District. This she said resulted in the selection of another community Ndise.
SUMMARY OF FINDINGS
The team of evaluators went through a summary of their findings at the various levels provincial, district, health areas and communities. This was followed by a general discussion on the findings. The critical issues raised were on:
Transport at District level: the question was raised since Govt. funds are being utilized for maintenance of motorcycles why then was Govt. input said to be zero. The response was so because it was the government contribution to core activities that was looked out for.
On the aspect of District Temporary Staff employed by SSI, the Country Rep. for SSI explained that, these DTS were government employees who were funded by SSI and not SSI employees per se.
Replacement of motorcycles and inadequacy in the health areas, the province felt the motorbikes were adequate since not only APOC motorbikes were in the field. They also went on to say that those in the health areas were in no position to know if replacements were being requested for; because the Province was the one to make this request. It was also stated that Government had given some motorbikes and was going to distribute some more for the HIV/AIDS programme.
The Campaign approach for Mectizan distribution. This was raised because the APOC guidelines were not adhered to for the 2003 distribution. DMOs visited many communities and even trained CDDs. The evaluators also felt it was not going to be a sustainable means for Mectizan distribution in the future. It was seen as a salvage process or rescue approach.

GROUP WORK.
After the tea break, Dr Korve facilitated the SWOT analysis for the Provincial level. Here they looked at the situation regarding Sustainability at the provincial level and took it up as a group work that was presented back after an hour. Some of the opportunities and threats that were raised included:
The opportunity of DTS being integrated into the District System and used for other programmes. The threat here was that some of the DMOs may be reluctant to give financial support if SSI stops paying them.
For Mectizan procurement: the opportunities mentioned here were that their Essential Drug Programme should now take over mectizan procurement and distribution to the communities. Threat: was that late reporting of CDTI activities on distribution from the districts could delay Mectizan orders.
Training: opportunity here is that the province could integrate CDTI training with other health programme training. The threat was that they felt extra funds would be required to run large training sessions, and this may be lacking.
Financial: Opportunities mentioned here were that the province has structures that can manage financial affairs. There is also the possibility of separating the APOC CDTI SWI account from the SSI account in the province.
Human Resources: Opportunities: The provincial task force team could be used for all CDTI activities at this level. There was also an opportunity to employ 2 drivers, one for SWI and the other for SWII.
The other Group work was on the: 'Planning for Sustainability at Provincial / project level'. The Group had the task of coming up with a 3 year sustainability plan Post APOC,
making a plan for 2004-2006, and identifying resources for their Post APOC Era. This was done immediately after, being briefed by Dr. Nnoruka on the guidelines for preparing a Post APOC sustainability plan. They were also informed on items APOC would no longer support after their 5th year.

OUTCOME
The ‘South West I Sustainability plan’ now exists - but it clearly still needs to be put into practice. This is primarily the responsibility of the Province and assisted by SSI and NOCP. They need to be actively encouraged by the NOCP. In particular, the project leaders need to look critically at the evaluation team’s recommendations as they appear in this report.

Provincial level workshop Programme
26th June 2003

Sustainability of CDTI in South West I: “Feedback” Workshop
AGENDA

<table>
<thead>
<tr>
<th>Item</th>
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</tr>
<tr>
<td>5</td>
<td>Evaluation Methodology</td>
<td>10.00 – 10.15</td>
<td>Dr. E Nnoruka.</td>
</tr>
<tr>
<td>6</td>
<td>Coffee Break</td>
<td>10.15 – 10.40</td>
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<tr>
<td>7</td>
<td>“Feedback” on achievements, issues and lessons from the South West I evaluation on sustainability of CDTI Findings at Community level. Findings at Health Areas (FLHF). Findings at District Level Finding at the Provincial level</td>
<td>10.40 -10.45</td>
<td>Dr M. Akoharrey</td>
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<tr>
<td></td>
<td></td>
<td>10.45- 10.50</td>
<td>Dr K Ogungbemi</td>
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<td></td>
<td></td>
<td>10.55 – 11.00</td>
<td>Dr K. Korve</td>
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<tr>
<td></td>
<td></td>
<td>11.00- 11.05</td>
<td>Dr E Nnoruka</td>
</tr>
<tr>
<td>8</td>
<td>Open discussion/clarifications on findings.</td>
<td>11.05-12.00</td>
<td>Prof. A Abiose.</td>
</tr>
<tr>
<td>9</td>
<td>LUNCH BREAK</td>
<td>12.00- 13.00</td>
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</tr>
<tr>
<td>10</td>
<td>What is the situation regarding Sustainability in our Project?</td>
<td>13:00-13.45</td>
<td>Dr M. Akoharrey, Dr. Korve</td>
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<tr>
<td></td>
<td>Group Work: Swot analysis Provinical level</td>
<td></td>
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<tr>
<td>11</td>
<td>Presentation of Group Work, followed by plenary discussion.</td>
<td>13.45-14.20</td>
<td>Dr. Kurumbi/Ogungbemi/</td>
</tr>
<tr>
<td>12</td>
<td>The way forward – How do we develop our own Sustainability plans?</td>
<td>14:20-15.00</td>
<td>Dr M Akoharrey/Dr E Nnoruka</td>
</tr>
<tr>
<td>13</td>
<td>Group work: Making a Sustainable plan for the coming year at Provinical level. (A tabulated plan with the available resources.)</td>
<td>15.00-16.00</td>
<td>Dr. M Akoharrey/Dr. E Nnoruka</td>
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<tr>
<td>14</td>
<td>Feedback presentation of group work, followed by Plenary Session.</td>
<td>16.00-16.45</td>
<td>Dr Akoharrey/Dr. Korve/Dr. Ogungbemi</td>
</tr>
<tr>
<td>15</td>
<td>Closing Ceremony</td>
<td></td>
<td>Prof A. Abiose/Dr M. Akoharrey</td>
</tr>
</tbody>
</table>

To be appointed from amongst participants:
Rappateur for Morning Sessions-
Rappateur for Afternoon Sessions-
Presenter of Summary-
APPENDIX IX

REPORT ON ADVOCACY VISITS

A) **First advocacy meeting to Governor's Office**

On 16th June, the evaluation team for SW I CDTI project paid a courtesy call visit to the office of the Governor of South West Province, Buea His Excellency EJAKE BONDA THOMAS. The Acting Provincial Delegate of Public Health introduced the members of the evaluation team, then Professor Adenike Abiose gave a brief introduction of APOCs philosophy for the control of onchocerciasis. She informed the governor that, the CDTI project was at its fifth year and APOC support was coming to an end, and so the Government of Cameroon needs to prepare to take over in supporting all the Onchocerciasis control activities in the Country.

Professor Abiose further explained that the evaluation will be conducted in three Districts:

- Kumba
- Tombel
- Muyuka,

and that, at the end of the evaluation, findings will be made available to the Provincial Delegate of Public Health.

In his response, His Excellency the Governor of South west Province expressed his appreciation for the evaluation team for having travelled all way to Cameroon to assist Cameroonian. He further said that he will be very glad to get a feedback of the evaluation work at the end.

B) **Second visit to Governor’s office**

On Friday, 27th June 2003 an evaluation team for SW I CDTI project paid a second visit to Governors office and then to the Divisional Officer.

The main objective of the visit was to give a brief feedback on the evaluation work which has started since 16th June, and also to do advocacy on issues pertaining to post APOC sustainability of the SW I CDTI project.

The Provincial Delegate introduced the evaluation team to the Governor, and then Professor A. Abiose, the head of the evaluation team gave a summary report of the evaluation work conducted.

She mentioned that three Districts were visited namely: Kumba, Tombel and Muyuka, and a total of 12 communities and 6 Health facilities in the three districts were visited.

Professor Abiose further elaborated that the onchocerciasis programme has made a good progress in the Province, however she mentioned that, there are two critical issues which need immediate attention. The issues are:

a) The Government must ensure that it allocates and release sufficient funds for the onchocerciasis programme, especially as APOC is pulling out at the end of the 5th year.

b) There is need to intensify advocacy and mobilization of community leaders, and the community at large so that they take ownership of the programme. She
indicated that a copy of the final report will be given to the Provincial Delegate of Health.

His Excellency the Governor responded that, it is a great pleasure to him to hear about the good work done by the evaluation team, and the report which have revealed important issues to be brought to the attention of his office.

He indicated that he will make sure all the issues raised in the final evaluation report which will be made available soon, will be addressed effectively including resource allocation.

C). Visit to Divisional office.

The Divisional Officer MR. DINY NGOE after getting a brief report and the main evaluation findings from Professor Abiose, he welcomed the evaluation team warmly. He indicated that he had been fully involved in CDTI and in fact he had acted as a CDD at the launching of the last distribution. He promised to do intensive advocacy and sensitisation to communities so that they will take the ownership of the programme, and also provide any necessary support after seeing the evaluation report.

The Divisional officer concluded by saying that “For some one to be Wealthy the first thing is to be Health”
APPENDIX X, XI AND XII (EXIST AS HARD COPIES.)
APPENDIX VI

COMPLETED CONSOLIDATED INSTRUMENTS

FOR

PROVINCIAL DISTRICT HEALTH AREAS AND COMMUNITIES
Instrument 1: national/ State level

NOTE:
- This instrument is for national level which coordinates programme implementation in the country. It could also be used (modified slightly if necessary) for another level of support other than the main implementation level (district/ LGA). An example of this level is the 'State' in Nigeria.

The focus of this level's activities in CDTI
The main function of this level is to develop, revise as necessary, and oversee implementation of CDTI Policy. This level also provides support to the level below it:
- Providing targeted training, HSAM and monitoring/ supervision.
- Arranging for an adequate supply of Mectizan.

| Country: | [ ] |
| Researcher: | [ ] |
| Date: | [ ] |

Abbreviations/ acronyms
- CDD: community directed distributor
- CDTI: community directed treatment with ivermectin
- FLHF: first line health facility
- HSAM: health education, sensitisation, advocacy, mobilisation – i.e. activities which are aimed at getting all the key players to participate wholeheartedly in the programme
- NGDO: non-governmental development organisation
- NOTF: national onchocerciasis task force

Sustainability evaluation instrument no.1 – national level – March 2003 version
1.1 Check whether there is a year plan for onchocerciasis control, appearing as part of an overall written plan for the health service at this level.

This indicator assesses whether the programme has become integrated into the health service, and whether management is accepting ownership of the programme – both good for sustainability.

### Characteristics of the indicator

a. Onchocerciasis control should be integrated into the overall written year plan of the health service at this level. Note that this plan is usually not very detailed.

### Sources of information

- Examination of:
  - Written plans: yearly, quarterly, monthly etc.
  - Minutes of planning meetings.
  - Interview with senior health service staff at this level.

### Findings

Describe the present situation:

There were yearly written microplans for onchocerciasis control containing all CDTI activities at the project office. Inputs are obtained from all partners at the various levels. Workplans seen were mainly for the period of 2001-2003. Similarly at the Provincial Delegation of Public Health for South West 1, an integrated overall plan of Action for 2002 – 2003 were seen. The 2003 integrated workplan was more detailed for all CDTI related activities.

If planning and implementation of CDTI is not part of the overall year plan:

- Why is this?

- Which steps are being taken to improve the situation?

Mectizan distribution for 2003 was organized as a campaign in February to March to try to salvage the image of SW1 project.

### Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no. 1 – national level – March 2003 version
1.2 Check whether there is a year plan containing details of all activities needed for CDTI at this level.

This indicator assesses whether the project is functioning effectively, and whether management accepts ownership of the programme – both good for sustainability.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
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<tbody>
<tr>
<td>a. This more detailed plan should make provision for all key elements of onchocerciasis control: Mectizan supply; targeted training; targeted HSAM; targeted monitoring/supervision. (Note that in the case of a country which contains many projects, the NOTF plan will be less detailed).</td>
<td>▪ Examination of written plans: yearly, quarterly, monthly etc. ▪ Interview with senior health service and project staff at this level.</td>
</tr>
<tr>
<td>b. The plan varies from year to year, showing that it is targeted to the specific needs of each year.</td>
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</table>

Findings

Describe the plan for the present year:

*The project office had a detailed CDTI plan which outlined key activities, timeframe and persons responsible for carrying out these activities. Provincial plans were more on*

Describe the plan for the previous year:

*The detailed year plans at the project for 2001-2002 showed some evidence of targeting particularly in the area of training for severe adverse effects.*

If the plan is incomplete, or simply a re-write of previous plans:

▪ Why is this?

Planning for CDTI activities was not taken seriously from inception of the project because it had been perceived as an NGDO project initially; up until November 2002 when they were told they had failed to qualify for inclusion into a recent Multi-Country study by TDR/WHO because of their poor performance. *The plans were specific and not re-written for each year.*

▪ Which steps are being taken to improve the situation?

Analysis

▪ When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

▪ Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
1.3 Check whether all partners (government, UN agencies, NGDOs etc.) are meaningfully involved in the overall planning process.

This indicator assesses whether the programme is functioning effectively – if each partner is clear about its role, this is good for sustainability.

**Characteristics of the indicator**

| a. All partners should contribute to the routine planning of a project. |
| b. Partners should be clear about their own roles, and those of the other partners. |

**Sources of Information**

- Examination of:
  - Plans: yearly, quarterly, monthly etc.
  - Minutes of NOTF meetings.
- Interview with senior staff at this level (project, government, relevant UN agencies, NGDOs etc.)

**Findings**

Describe the present situation:

Planning is done from bottom upwards and starts at the end of each year during the appraisal meetings of the various levels e.g for the Health Areas- CDDs, Village health committee members are involved; at the district level- 2 CDDs for each Health area, one Chief representing each Health area, Health area Health committee member and SSI country rep. are involved. Inputs from these levels are sent upwards onto the next level.

For the provincial meeting, the following are involved, District Medical Officers, Chief BAF, POC SW1, Provincial delegate members, the National Onchocerciasis Co-ordinator and SSI the NGDO partner. Planning is participatory. However not all partners are meaningfully involved in the financial planning for CDTI which has been done by SSI from inception till date. The role of each partner has only recently been appreciated by most levels.

If partners are not meaningfully involved in planning:

- Why is this?
  
  * Provincial partner all the while believed it was an SSI project.
  
- Which steps are being taken to improve the situation?

  * Meeting at the provincial Delegate level after the Limbe TDR/WHO workshop, led to the Mectizan Campaign which created a better understanding for ownership and commitment to the programme.

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
1.4 Check whether specific planning for sustainability has taken place, for the period after APOC funding is withdrawn.

This assesses whether the programme is functioning effectively, and that management has begun to take ownership of it and can mobilise the resources it needs.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
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<tbody>
<tr>
<td>a. Members of NOTF have made plans for this period, which will enhance programme sustainability. This planning should include: identifying resource gaps; strategies to cut expenditure; and strategies to find dependable sources of resources.</td>
<td>- Examination of the written sustainability plans.</td>
</tr>
<tr>
<td>b. There should be written evidence that such planning has taken place.</td>
<td>- Interviews with senior staff at this level (government, NGDO, NOTF etc.).</td>
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<tr>
<td>c. There should be evidence that the plans are being successfully implemented.</td>
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</table>

Findings

Describe the present situation:

There are no Sustainability plans yet at project office nor at the provincial level; despite being in their fifth year. Provincial delegate for Health has no specific plans for counterpart funding from Government, but hopes to explore avenues for accessing Government credits for running general services, for sustainability at some point in time. Specific plans for sustainability have been attempted by the NGDO partner but no Sustainability plan has been put up for Post APOC period. There is however a 6th year budget that is not supported by any action plan produced by SSI.

If there has been little or no planning for sustainability:

- Why is this?

Only recently understanding their roles, but is hoping the South west I evaluation team shall help them plan for sustainability.

- Which steps are being taken to improve the situation?

None.

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

| Fully | Highly | Moderately | Slightly | Not applicable |

Sustainability evaluation instrument no.1 – national level – March 2003 version
2. Indicators of activities and processes: monitoring/supervision

2.1 Check whether staff at this level is being used appropriately for monitoring/supervision.

This indicator assesses whether the programme is functioning efficiently.

### Characteristics of the indicator

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
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<tbody>
<tr>
<td>a. Staff members at this level should routinely only supervise the level immediately below them. Staff should not supervise the FLHF or community levels. ‘Spot checks’ may however be done from time to time.</td>
<td>Examination of:</td>
</tr>
<tr>
<td>b. Staff members at this level should have empowered staff members at the level below them to supervise activities at their own level, as well as levels further down.</td>
<td>* Supervisory checklists, plans and reports.</td>
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<td></td>
<td>* Visitor's books at all the levels below this one.</td>
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<td></td>
<td>* Trip authorisations.</td>
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<td>Interviews with:</td>
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<td></td>
<td>* Staff at this level.</td>
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<td></td>
<td>* Staff at levels below this one.</td>
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</table>

### Findings

Describe the present situation:

During this year's special Mectizan campaign, 8 'Service Chiefs' from the province were involved with this year's Monitoring and was carried out for 8 days. DMOs were supervised and some spot checks were carried to the FLHF.

For the first and second years, Oncho project co-ordinator and SSI (NGDO partner) carried out routine monitoring and supervision at all levels. By 3rd and 4th year monitoring and supervision became targeted to areas of weakness. Spot checks were carried to the FLHF and communities.

If staff members are not being used appropriately for monitoring/supervision:

- Why is this?

  There is no functional Provincial onchoTeam.

- Which steps are being taken to improve the situation?

  So far DTS were employed by NGDO in 2002 to help out with Monitoring, supervision and reporting.

  Planning for targeted quarterly supervision carried out to districts to integrate CDTI Monitoring into it. Currently have checklists for this.

### Analysis

- When writing the report you have to summarise:
  
  * The evidence about how well this indicator is being achieved.
  
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
2.2 Check whether monitoring/supervision is being planned and carried out in an efficient and integrated manner.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the Indicator</th>
<th>Sources of information</th>
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</thead>
<tbody>
<tr>
<td>a. One routine supervision visit per year must be done to each project (as a separate entity, or as a district).</td>
<td>- Examination of:</td>
</tr>
<tr>
<td>b. Supervision visits for CDTI should be integrated where appropriate with supervision of other programmes.</td>
<td>* Supervisory checklists, plans and reports.</td>
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<tr>
<td>c. Resources for supervision (human, transport etc.) should be efficiently used:</td>
<td>* Visitor's books at the level immediately below this one.</td>
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<tr>
<td>* Using as few staff members as possible.</td>
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<td>* Planning trips to cut down on distance travelled.</td>
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<td>* Not spending unnecessarily many nights out etc.</td>
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<tr>
<td>d. Supervision visits should be thorough, using a checklist.</td>
<td>- Interviews with:</td>
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<td>* Staff at this level.</td>
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<td>* Staff at the level. immediately below this one.</td>
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</table>

**Findings**

Describe the present situation:

Supervision is Not integrated. Checklists are used. Supervisory visits are planned. It is routinely done. All supervisory visits were dependent on APOC funds.

Describe the situation the previous year:

Not integrated. Monitoring and supervisory visits were up to 3x yearly. The initial one was to monitor/supervise training, second was for distribution and the third one was for the District evaluation meetings. In cases where there are no government hospitals in the health areas e.g Missionary Hospital; supervisory visits are even as high as 2-3x per week for the periods of distribution and training.

If monitoring/supervision is not being done efficiently:

- Why is this?  
  No previous understanding of exact provincial role.  
  No Provincial tasks Team non existent.

- Which steps are being taken to improve the situation?

**Analysis**

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in monitoring/supervision activity: is it becoming more efficient?

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
### Characteristics of the indicator

<table>
<thead>
<tr>
<th></th>
<th>Sources of information</th>
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<tbody>
<tr>
<td>a.</td>
<td>Examination of the following documents:</td>
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<td>* Plans: yearly, quarterly, monthly etc.</td>
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<td></td>
<td>* Minutes of staff/planning meetings.</td>
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<td>* Reports of previous monitoring exercises.</td>
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<td>* Letters of commendation.</td>
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<td>* Letters with information and feedback.</td>
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<tr>
<td>b.</td>
<td>Interviews with:</td>
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<td></td>
<td>* Staff at this level.</td>
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<td></td>
<td>* Staff at the levels below this one.</td>
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<tr>
<td>c.</td>
<td>As soon as problems are identified as a result of supervision visits, or from coverage data (i.e. areas with low coverage) the appropriate manager should deal with them.</td>
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<tr>
<td>d.</td>
<td>Such problems should usually be passed on to the appropriate managers at the next level below to deal with, with the necessary support – thus empowering these persons.</td>
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<td></td>
<td>Successes should be noted and reported, and appropriate feedback given.</td>
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<tr>
<td>d.</td>
<td>There should be evidence of action taken based on recommendations in the reports of previous monitoring exercises.</td>
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### Findings

**Describe the present situation:**
When a problem such as refusals and low coverage is identified, measures are taken by the Oncho project Co-ordinator to tackle this in the field and this is even extended to lower levels if she is called upon. The Provincial Delegation of Health occasionally helps out in solving problems if their attentions are required.

**Successes are just reported back and individuals encouraged for their performance.** There are no commendation prizes but SSI has initiated programmes such as Eye care (integrated with CDTI) which uses CDDs of outstanding performance as a means of encouraging other CDDs to continue with their role within the communities.

**If the system of managing problems/successes is weak:**
- Why is this?
- Which steps are being taken to improve the situation?

### Analysis

- **When writing the report you have to summarise:**
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Your overall judgement: is this indicator for sustainability being achieved?**

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Sustainability evaluation instrument no. 1 – national level – March 2003 version
3. Indicators of activities and processes: Mectizan® procurement and distribution

3.1 Check whether sufficient Mectizan is being ordered, stored and distributed within the government system at this level, in good time.

This indicator assesses whether the programme is functioning efficiently, its processes are simple, and it is becoming more integrated into the government system.

### Characteristics of the indicator
- The Mectizan supply should be controlled within a government system. This does not have to be the system routinely used for the supply of other drugs.
- The system should be effective, uncomplicated and efficient.
- This system should use dependable, sustainable resources for its operation. It is desirable that these resources should be supplied by the government.
- The system should supply sufficient Mectizan for the needs of all the projects concerned, in good time.

### Sources of information
- Examination of all Mectizan ordering and stock control documentation at this level.
- Interviews with staff at this level (government, NGDO etc.).

### Findings
Describe the situation the previous year:
Treatment data at the end of each year is used to make estimates for Mectizan required by the project for the subsequent year through SSI. An application is written to Mectizan Donation Programme (MDP) by SSI. Merck informs SSI when the Mectizan supply is ready for shipment, WHO facilitates the clearing. Up until 2002, SSI delivered to OPC SWI, till when the Provincial pharmacy at Buea was given the responsibility of Mectizan inventory holder. So far the Provincial pharmacy has been involved with Mectizan custody only once in 2002, despite the fact that Merck recognizes them as the official custodians for Mectizan for SW I. There is no pharmacy inventory control at this level unlike other essential drugs.
Mectizan is next sent across to the districts once collected by the OPC. A register is maintained at project level of drugs received from SSI and collected the districts. APOC funds are utilized for this purpose.

Describe the situation the year before that:
Same as above.

If the government system is not fully responsible for all steps of the Mectizan supply system:
- Why is this?
To ensure returns and reduce delays in ordering of Mectizan, SSI has remained the recipient and accountant officer for Mectizan for the projects in the South West Province.

- Which steps are being taken to improve the situation?
Attempts at empowering SW I project to ensure early returns of treatment data has been taken up.

### Analysis
- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What has been the trend in Mectizan supply?

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level -- March 2003 version
4. Indicators of activities and processes: training and HSAM

4.1 Check whether staff members at this level are being used appropriately as trainers.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the Indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. Staff at this level should routinely only train staff at the level immediately below it. | • Examination of training materials, plans/programmes, reports:  
  * At this level.  
  * At the levels below this one. |
| b. Staff members at this level should have empowered the level immediately below them to train lower levels. | • Interviews with:  
  * Staff at this level (the trainers).  
  * Staff at the very next level below (the trainees).  
  * Staff at the district/ LGA level.  
  * Staff at the FLHF level. |

Findings

Describe the present situation:

_Provincial Staff train DMOs in 2003. Training was routinely done. Only APOC and SSI funds have always been used for training._

Describe the situation the year before:

_The Nurses at FLHF were trained jointly with the DMOs at provincial level in 2002. Routine training was carried out, but in 2001 it was focused and the DMOs assigned topics for presentation._

If staff members are not being used efficiently as trainers:

- Why is this?

_Because SSI planned and carried out the training, while the Provincial staff served as facilitators, from onset of the project. They never clearly understood their roles._

- Which steps are being taken to improve the situation?

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in the way in which staff are being used as trainers:

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Moderately</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4.2 Check whether **training is being planned and carried out in an efficient and integrated manner.**

*This indicator assesses whether the programme is functioning efficiently and in an integrated manner.*

### Characteristics of the indicator

| a. | There should be an objective need for each episode of training. This means there should be evidence that staff to be trained lack knowledge and skills to perform the job, and the training should then focus on this deficiency only. Repeat training of already skilled staff should not happen. |
| b. | If circumstances permit training for CDTI should be integrated with other training, e.g. in in-service training programmes. |
| c. | Resources for training (human, transport etc.) should be efficiently used: |
|     | * Using as few staff members as possible. |
|     | * Using as little time as possible (without sacrificing quality) |
|     | * Choosing the most cost-effective site etc. |

### Sources of information

- Examination of training materials, plans/programmes, reports:
  - At this level.
  - At the levels below this one.
- Interviews with:
  - Staff at this level (the trainers).
  - Staff at the very next level below (the trainees).
  - Staff at the district/ LGA level.
  - Staff at the FLHF level.

### Findings

Describe the present situation:

*No training was carried out this year it was a briefing refresher carried out just before campaign for the eight Chiefs of Post at the provincial level.*

*Last training was carried out in 2001. Training had been routinely done once every year. Training reports and programmes were available for 2001-2003. Only APOC funds are utilized for all forms of training.*

Describe the situation the year before:

*Last training was carried out in 2001. DMOs were assigned topics to themselves for this training. Training was routinely done. Training had not been targeted up until last year Nov/December 2002.*

If training is not being carried out in an efficient and integrated manner:

- Why is this?
  * Lack of understanding of role of province in the project.
- Which steps are being taken to improve the situation?

Following the campaign a better understanding of the project is occurring. Plans shall be complied from henceforth.

### Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Examine the trend in training activities – is it becoming more efficient and integrated?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Moderately</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4.3 Check whether staff at this level is planning and carrying out HSAM activities in an efficient manner.

This indicator assesses whether the programme is functioning efficiently and effectively, and whether managers are taking ownership of the programme.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Staff members identify situations where decision makers lack information about commitment to CDTI, and undertake activities to inform and persuade these persons.</td>
<td>• Examination of HSAM plans/programmes and reports.</td>
</tr>
<tr>
<td>b. HSAM activities are properly planned. They are only carried out where there is an objective need for them, and not as a matter of routine.</td>
<td>• Interviews with:</td>
</tr>
<tr>
<td>c. Such activities should only be carried out at the national level, and at times at the level immediately below (but only when staff at that level asks for help).</td>
<td>* Staff (programme and management) at this level.</td>
</tr>
<tr>
<td>d. There is evidence that these HSAM activities have been effective and have led to action.</td>
<td>* Civil authorities at this level.</td>
</tr>
<tr>
<td></td>
<td>* Staff and civil authorities at the next level down.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation (in relation to efficiency and outcome):

HSAM is planned for at this level. Advocacy is carried out yearly for commitment and not for ownership of the programme. There is a joint meeting at the Provincial Delegate presided over by the Governor for all Health Programmes yearly. Advocacy is then carried out jointly by all public health programmes and also involves the, Religious, Political and other opinion leaders of South west Province. (Information is then passed on to them by the various units, Oncho is also involved. The last one carried out early this year, as part of the Campaign led to a massive turn out of communities during distribution. Radio programmes are also carried out for sensitisation as well as for mobilization.

Describe the situation the year before (in relation to efficiency and outcome):

HSAM was carried out routinely yet therapeutic coverages were low.

If HSAM activities are not being carried out efficiently:

- Why is this?
  
  Were not completely aware of the roles in relation to ownership of the programme.

- Which steps are being taken to improve the situation?
  
  Content of Advocacy, Health education, Sensitization and Mobilization shall now become more targeted.

Analysis

- When writing the report you have to summarise:
  
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in HSAM activities – is it becoming more efficient and effective?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
5. Indicators of activities and processes: integration of support activities

5.1 Check whether the various programme support activities are being planned and carried out in an integrated manner.

This indicator assesses whether the programme is functioning efficiently and in an integrated manner.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Staff combines two or more tasks on a single trip:</td>
<td>* Examination of documents: trip authorisations, log books, trip reports etc.</td>
</tr>
<tr>
<td>* Monitoring / supervision for CDTI (and other projects, if staff is responsible for them as well).</td>
<td>* Interviews with:</td>
</tr>
<tr>
<td>* Training for CDTI (and other projects, if staff is responsible for them as well).</td>
<td>* Staff from this level (managers, administrators, drivers etc.).</td>
</tr>
<tr>
<td>* HSAM.</td>
<td>* Staff from the next level below.</td>
</tr>
<tr>
<td>* Fetching records.</td>
<td></td>
</tr>
<tr>
<td>* Delivering Mectizan.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

CDTI integration with other PHC activities is non existent at the Provincial level. All tasks carried out by staff are purely Oncho activities. Training, mectizan delivery or returns of reports are solely done on its own.

Describe the situation the year before:

Same as above.

If integration between support activities is poor:

* Why is this?

This was because of the poor perception of the programme.

* Which steps are being taken to improve the situation?

Nothing

Analysis

* When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

* Examine the trend in the integration of activities – is it becoming more common?

* Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6. Indicators of resources: financial

6.1 Check whether appropriate amounts are budgeted for planned onchocerciasis control activities at this level

This indicator assesses whether the programme is functioning efficiently.

**Characteristics of the indicator**

<table>
<thead>
<tr>
<th>Description</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The costs for each onchocerciasis control activity in the year plan at this level should be clearly spelt out in a budget.</td>
<td>- Examination of the budget documents.</td>
</tr>
<tr>
<td>b. There is evidence of a const reduction/containment strategy (e.g. targeted training, HMAS and monitoring/supervision; training conducted at the next level below etc).</td>
<td>- Interviews with the health service managers at this level.</td>
</tr>
<tr>
<td>c. Project managers should have a clear estimate of the funds that will be available to them for onchocerciasis control in the coming year, and should be able to justify this belief.</td>
<td></td>
</tr>
<tr>
<td>d. The total amount budgeted for in the year plan should fall within this estimated income.</td>
<td></td>
</tr>
</tbody>
</table>

**Findings**

The budget and estimated income:

- For this year:
  
  There are plans of action with costs to each CDTI activity for APOC, MoPH and SSI funds. Even though there exists a column for MoPH (which should be provincial contribution), they are not aware of their own contributions and feels it is the Central or National role as they were not part of the financial planning.

  According to the Provincial Chief of Service for Administration and Finance, budgeted plans of action for Health at Provincial level does not usually tally with releases; the Center actually determines what is given to them irrespective of the budget. Also, usually there is a general credit line for Health activities at all levels and so it is difficult to know how much each programme spends. However, it is then the prerogative of the vote holder at each level to apportion to each programme accordingly.

  OPC SWI not too clear on how much it would cost oncho activities in the coming year. There are no evidence of cost containment.

- For the previous year:
  
  Same as above.

- For the previous year:
  
  Same as above.

If budgeting has been inappropriate:

- Why is this?
  
  Province is not involved in budget preparation.

- Which steps are being taken to improve the situation?
  
  Future participatory plan to include budgeting.

**Analysis**

- When writing the report you have to summarise:
  
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in the budgeted amount and the expected income:

- Your overall judgement: is this indicator for sustainability being achieved?

  Fully  | Highly  | Moderately  | Slightly  | Not applicable

Sustainability evaluation instrument no.1 – national level – March 2003 version
6.2 Check whether the government is budgeting and disbursing sufficient amounts for onchocerciasis control yearly, and in good time.

This indicator assesses whether the programme is becoming integrated, and whether the government is accepting ownership of the programme and can mobilise the resources it needs.

### Characteristics of the indicator

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>The relative budgetary contributions of the government and other partners to onchocerciasis control should be clearly spelled out.</td>
</tr>
<tr>
<td>b.</td>
<td>The amount that the government has budgeted in one or more specific onchocerciasis control budget lines (e.g. current and capital) should be increasing yearly, as a proportion of total expenses. By the end of Year 5 of APOC funding the bulk of onchocerciasis control expenses at this level should be met from government funds; by the end of Year 3 at least half of it.</td>
</tr>
<tr>
<td>c.</td>
<td>The amounts actually disbursed from such budget lines should be increasing yearly, as a proportion of total expenses. (Note that actual disbursement is more important than budgeting, and is a real sign of political commitment).</td>
</tr>
</tbody>
</table>

### Sources of information

<p>| |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>• Examination of:</td>
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<td></td>
</tr>
</tbody>
</table>

### Findings

The budget and disbursements:

- For this year:

  The relative budgetary contributions of APOC and SSI for SW I project have been clearly spelled out. Government contribution has not been clearly spelled out apart from the payment of salaries, the provision of office space, and donation of a computer to SW I and the recent plan to pay CDDs 25 francs per person treated. However, we were told by the NOTF accountant that Government financing of NOCP, started in 2001/2002 when it released 95,000,000 F CFA. This was for the purchase of some equipment (a desk top for South west I). And that Government had promised to include CDTI into the HIPC fund estimated at 454,000,000 F CFA.

APOC released the sum of $136,861 (68,430,745 million CFA)

SSI has budgeted $31,062 (15,531,062 million CFA) in addition they also donated 11 more motor cycles (costing 40,902,108 CFA). 6 of these motorbikes were sent to SW I and 5 to SW II.

APOC has got a separate accountant at the NGDO office.

- For the previous year:

  APOC released the sum of $82,540 (41,207,065 million CFA)

SSI released $29,809 (14,904,942 CFA)

Provincial (Government) contributions were not quantifiable apart from the salaries.

- For the year before that:

  APOC released $71,337 (35,668,911 million CFA)

SSI released $22,507 (11,253,997 million CFA)

Provincial releases were not quantifiable.

If the government proportion of expenditure is not increasing proportionately:

- Why is this?

  Government proportion of expenditure has not reflected any pattern yet. So far APOC has put in a total of 215,756,389 CFA plus funds for REA and Evaluation. SSI however has stated that their support will still continue at the same level and will not go higher Post-APOC. They will continue to support Supervision, mobilization, Mectizan ordering and Transportation to the Province, Health Education and Appraisals.

- Which steps are being taken to improve the situation?

  No steps have been taken at provincial level for this.

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to
Examine the trend in government budgeting and disbursements:

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Not applicable</th>
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</table>

affect sustainability.
6.3 Check whether in case of a deficit between estimated costs and the amount provided by the government, dependable provision is being made to meet it.

This indicator assesses whether the government is able to mobilise the resources it needs, as well as its commitment to ownership.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Project management at this level should be aware of the shortfall, if one exists, and of its size.</td>
<td>• Inspection of:</td>
</tr>
<tr>
<td>b. Project management should have specific and realistic plans to bridge the shortfall.</td>
<td>* The budget documents.</td>
</tr>
<tr>
<td>c. If it is planned that non-government sources of funding are to be used after APOC funding ends, written commitment for this should have been obtained at the highest level in these donor organisations. Projects in Year 3 of APOC funding should also be well on the way to achieving such commitment.</td>
<td>* Records of expenditure (ledgers, orders, approvals for expenditure etc.).</td>
</tr>
<tr>
<td></td>
<td>* Letters of agreement.</td>
</tr>
<tr>
<td></td>
<td>* Interviews with managers at this level (government, NGDO etc.).</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

Unaware of deficit and nothing has been done yet.

Describe the situation the previous year:

Same as above.

If the shortfall cannot be met:

- Why is this?
- Which steps are being taken to improve the situation?

Nothing.

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Examine the trend in shortfall and how it is to be supplemented:

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6.4 Check whether funds disbursed for onchocerciasis control from the budget at this level are efficiently managed

This indicator assesses whether the programme is functioning efficiently.

Characteristics of the indicator

| a. The budget holder should be using a control system with the following elements: |
| - Approval of each item of expenditure. |
| - Allocation of expenditure against specific budget headings. |
| - Regular calculation of residual amounts under budget headings. |
| b. All the funds released yearly should be spent as budgeted. |

Sources of information

- Inspection of:
  - The budget documents (government, NGDO etc.).
  - Financial control records (ledgers, orders, approvals for expenditure etc.).
- Interviews with managers at this level (government, NGDO etc.).

Findings

Describe the present situation:
- Approval of expenditure:

There is a control system that is efficiently run by the OPC SWI for managing funds at the project office. Budget documents were sighted reflecting releases against approved specific budgeted activities. Withdrawals made and bank balances were also seen. There is however a tortuous movement of APOC funds from Yaounde to the project office. APOC funds for SWI move from WHO Yaounde to NOTF/NOCP account then to project account in Yaounde. Cash is withdrawn and moved to another Yaounde bank similar to the Limbe one for easy transfer of funds to the SWI account in Limbe. At Limbe the account is joint for both APOC and SSI. From here funds for approved CDTI activities are cashed by the OPC for SWI. The Approving officers for this account are both SSI and the Provincial Delegate, this is also the same for the similar bank in Yaounde. But for the NOTF/NOCP account, SSI and NOTF are the approving officers. However SSI is actually the budget holder for SWI project.
- Allocation of expenditure:

- Regular insight into budget line balances:

If the funds are not being well managed:
- Why is this?

- Which steps are being taken to improve the situation?

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Moderately</th>
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<th>Not applicable</th>
</tr>
</thead>
</table>
7. **Indicators of resources: transport and other material resources**

7.1 Check if adequate and appropriate transport and other material resources are available for necessary CDTI activities at this level.

*This indicator assesses whether the programme is functioning **effectively**, and whether it is able to mobilise the **resources** it needs.*

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. There are adequate numbers of functional vehicles available for necessary CDTI activities. | * Inspection of:  
  * Each vehicle in the pool, each piece of equipment: its source; its functional status.  
  * Training materials and stationery stocks.  
  * Interviews with managers at this level (government, NGDO etc.). |
| b. The vehicles are appropriate for the purpose they are intended to fulfil – tough but not luxurious. | |
| c. There is sufficient office equipment available, in working order: computers, printers, photocopiers – also stationery and materials for training and HSAM. | |
| d. The running costs for these vehicles and equipment are met from dependable, sustainable sources. | |

**Findings**

Describe the present situation:

<table>
<thead>
<tr>
<th>Type of vehicle</th>
<th>No.</th>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land Cruiser</td>
<td>1</td>
<td>APOC</td>
<td>Is working, suitable for the work ahead.</td>
</tr>
<tr>
<td>Motorbikes</td>
<td>38</td>
<td>APOC</td>
<td>All in good order, 2 stolen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of equipment</th>
<th>No.</th>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer</td>
<td>2</td>
<td>1APOC 1Govt</td>
<td>Is Working</td>
</tr>
<tr>
<td>Overhead project.</td>
<td>1</td>
<td>APOC</td>
<td>Is working</td>
</tr>
<tr>
<td>Telephone/ Fax</td>
<td>1</td>
<td>APOC</td>
<td>Working</td>
</tr>
<tr>
<td>Training/ HSAM material</td>
<td>No.</td>
<td>SSI/ MOH</td>
<td>Inadequate.</td>
</tr>
</tbody>
</table>

* APOC, MoH, NGDO, other (specify)  ** Is it working? Is there enough of it for the job? Is it suitable for the job?

Describe the availability/ suitability/ functionality of the present vehicles, equipment and materials, considering the work still to be done in the coming 5-10 years:

*Considering the amount of work ahead and because of the shared use of APOC vehicle (Land Cruiser & motorbikes) with other Public Health programmes at this level, the adequacy of these vehicles is quite doubtful for the work available.*

If transport, equipment and materials are inadequate and/or funded from sources which are not dependable:

- **Why is this?**
  * Maintenance of all vehicles, equipment and purchase of materials for SW I are dependent on APOC funds and this is not dependable for sustainability.
  * Which steps are being taken to improve the situation?  
  **Nothing!**

**Analysis**

- **When writing the report you have to summarise:**
  * The evidence about how well this indicator is being achieved.  
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Your overall judgement: is this indicator for sustainability being achieved?**
  * Fully  **Highly**  Slightly  Not at all  Not applicable

Sustainability evaluation instrument no. 1 – national level – March 2003 version
7.2 Check if transport and other material resources in use at this level are adequately and appropriately maintained.

This indicator assesses whether the programme is functioning effectively and efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There is a routine maintenance schedule for each vehicle, which is adhered to and recorded. This includes weekly driver maintenance, scheduled garage servicing, and replacement of worn tyres.</td>
<td>Inspection of:</td>
</tr>
<tr>
<td>b. Equipment such as photocopiers and generators is regularly maintained according to a schedule, and this is recorded.</td>
<td>* Vehicle and equipment maintenance schedules.</td>
</tr>
<tr>
<td>c. Staff members have ways of coping when vehicles break down or are not available, so that CDTI activities are not disrupted.</td>
<td>* Vehicle and equipment maintenance records.</td>
</tr>
<tr>
<td>d. The costs for vehicle and equipment maintenance and repair are met by from dependable/sustainable sources.</td>
<td>* Interviews with managers at this level (government, NGDO etc.), drivers.</td>
</tr>
<tr>
<td>e. Repairs to vehicles and equipment are rapidly and efficiently done.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

Has a maintenance schedule and log books are in use for all transport at this level. Provincial delegate is responsible for all transports at this level and authorises trips and releases of funds for travels. Returns are made to APOC officer for funds disbursed for APOC activities. SW I has no photocopier but depends on SWII photocopier which has been bad from inception of that project. APOC funds are utilized for all maintenance and fuelling.

If the vehicles and equipment are not being well maintained, and/or funded from sources which are not dependable:

- Why is this?

  - Which steps are being taken to improve the situation?

  Nothing!

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
7.3 Check if the transport available at this level is appropriately managed and used.
This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Transport is used at this level, and to undertake support activities at the next level. It should not be used for CDTI implementation activities at lower levels.</td>
<td>• Inspection of vehicle control documents:</td>
</tr>
<tr>
<td>b. The use of transport is properly controlled:</td>
<td>* Copies of trip authorities (also noting destination and purpose).</td>
</tr>
<tr>
<td>* Trips made for CDTI purposes should be properly authorised in writing by the relevant official.</td>
<td>* Log books.</td>
</tr>
<tr>
<td>* Each trip undertaken for CDTI purposes should be recorded in a log book.</td>
<td>* Interviews with managers at this level (government, NGDO etc.).</td>
</tr>
<tr>
<td>* Trip authorities and log book entries and regularly reconciled, and action taken if there are discrepancies.</td>
<td></td>
</tr>
</tbody>
</table>

Findings
Describe the present situation:
Transport is used at this level and to undertake support activities at the next level. Log books are in use for all transport at this level. Use of transport is well controlled. One temporary driver is shared between the two projects SWI and SWII, but has not been formally employed yet.

If the transport is not being well managed:
- Why is this?

Transport is well managed by the Province.

- Which steps are being taken to improve the situation?

Analysis
- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Slightly</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately</td>
<td>Not at all</td>
<td></td>
</tr>
</tbody>
</table>
7.4 Check if there are appropriate and realistic plans for the replacement of transport and other material resources, when APOC support comes to an end. This indicator assesses whether the programme managers are taking ownership of the programme, and are able to find resources for it.

**Characteristics of the indicator**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
<td>Management should know that replacements will be needed before the end of the programme, and have specific, realistic plans to meet the need at that time.</td>
</tr>
<tr>
<td><strong>b.</strong></td>
<td>It should be planned that the government will:</td>
</tr>
<tr>
<td></td>
<td>* Provide replacements for vehicles and equipment.</td>
</tr>
<tr>
<td></td>
<td>* Maintain existing vehicles and equipment.</td>
</tr>
<tr>
<td></td>
<td>* Provide stationery and materials for training and HSAM.</td>
</tr>
<tr>
<td><strong>c.</strong></td>
<td>If it is planned that replacement will be from non-government sources, written commitment for this should have been obtained at the highest level in these donor organisations (end of Year 5), or negotiations should have started (end of Year 3).</td>
</tr>
</tbody>
</table>

**Sources of information**

- Inspection of letters of agreement.
- Interviews with:
  - Programme managers at this level (government, NGDO etc.).
  - High-ranking Ministry officials and other decision makers at this level.

**Findings**

Describe the present situation:

*Nothing has been done.*

If the plans for replacing vehicles, equipment and materials are unsatisfactory:

- Why is this?

*Unaware of extent ownership of the project.*

- Which steps are being taken to improve the situation?

*Nothing yet.*

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: Is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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<th>Slightly</th>
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</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
8. Indicators of resources: human resources

8.1 Check whether staff at this level is skilled, knowledgeable and committed, regarding the implementation of CDTI in its area of operation.

This indicator assesses whether the programme has been able to develop sufficient resources for itself.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. The number of staff members in the government health service at this level should be appropriate to the task in hand: not too many or too few. | - Inspection of:  
* Staff files.  
* Training reports and timetables.  
* Interviews with  
* Managers and other staff at this level (government, NGDO etc.).  
* Staff at the next level below. |
| b. Team members should have enough knowledge and skill to undertake all the key CDTI activities themselves, without help:  
* Planning  
* Report writing  
* Training and HSAM  
* Monitoring/ supervision | |
| c. There should be evidence that the team is committed to the success of the programme (from the evidence of the partners, as well as workers at the next level below; from written reports and timetables). | |

Résultats

Describe the present situation:

- Particulars of current staff

<table>
<thead>
<tr>
<th>Area of skill</th>
<th>No. of persons qualified in this area</th>
<th>No. of persons competent enough to perform the job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Report writing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Training and HSAM</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Monitoring/ supervision</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Data management</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Computer skills</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mectizan ordering/ distribution</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- Number of persons who show that they are committed to their work, and perform it well:

<table>
<thead>
<tr>
<th>Very committed</th>
<th>Moderately committed</th>
<th>Little evidence of commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

If the staff at this level lack skills and commitment:

- Why is this? There is no provincial Oncho Task force team per se. Only this year were 8 Chief's of services actively involved in CDTI for the Mectizan Campaign in a bid to rectify the poor outcome of CDTI activity for SWI. Over the years it has been only the Oncho Provincial Cordi SWI who has been running the project, with the guidance of the NGDO partner. There are no drivers for SWI and SWL. However recommendation has been made for recruitment of Drivers. There is no Project Accountant at the Province.

- Which steps are being taken to improve the situation? Shall go by Plan of action and recommendations of the evaluation team.

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
8.2 Check whether staff at this level is stable, and whether provision is made for passing on CDTI skills when a trained person moves away.

This indicator assesses whether the programme has been able to maintain its resources.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Staff at this level should remain in one post for at least five years.</td>
<td>- Inspection of staff files.</td>
</tr>
<tr>
<td>b. There should be immediate orientation (in CDTI) of new, unskilled project staff members.</td>
<td>- The table in 8.1.</td>
</tr>
<tr>
<td></td>
<td>- Interviews with managers and other staff at this level.</td>
</tr>
</tbody>
</table>

**Findings**

Describe the present situation:

Staff at this level are stable. The OPC for SWI has been there since the inception of the CDTI programme. The Provincial Chief of Service for Community Health has been in place for 2-3 years now.

There is in place facility for orientation of new provincial Staff/project staff.

Describe the situation two years ago:

If the staff is not stable, and new staff is not being trained:

- Why is this?
- Which steps are being taken to improve the situation?

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- What is the trend in the number and quality of staff?
- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
9. Indicators of output: coverage

9.1 Check whether all projects in the country (or districts in the project) have a satisfactory therapeutic coverage rate.

This indicator assesses whether the programme is effective – if the rates are poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. All projects in the country (or districts/ LGAs in a project) should have a therapeutic coverage rate of 65% or higher (the denominator being the total population).</td>
<td>• Inspection of distribution reports and statistics at project level, for the past 3 years.</td>
</tr>
<tr>
<td>b. These rates should be stable or increasing.</td>
<td>• Interviews with staff at:</td>
</tr>
<tr>
<td></td>
<td>* This level.</td>
</tr>
<tr>
<td></td>
<td>* The next level below.</td>
</tr>
</tbody>
</table>

Findings

The therapeutic coverage situation in the projects (or districts/ LGAs):

- At the last distribution:

  Geographical coverage was 100% for all districts in SWI project. However the therapeutic coverage varied significantly. For 2003 the average therapeutic coverage for all districts for SWI was 70%.

- The year before:

  In 2002 the therapeutic coverage was 80.2%.

- The year before that:

  While in 2001 the therapeutic coverage was 32.6%

If the therapeutic coverage rates are poor:

- Why is this?

  Some of the reasons for the poor therapeutic coverages were a) witchcraft (the belief of the people) b) Severe Adverse effects c) Cost Recovery d) treatment carried out during unsuitable times for the communities and e) the coexistence of Loa loa in some communities.

  It was also noted that hypo-endemic areas have been treated all the while (for the 5 years) even after the REA in 2001.

- Which steps are being taken to improve the situation? (if such steps are already being taken that is good for sustainability)

  The Mectizan Campaign was taken up early this year to try to salvage this perpetual poor coverage.

Analysis

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in therapeutic coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

| Fully (100% of projects have a therapeutic coverage rate ≥65% - stable or increasing) | Highly (90-99% of projects) | Moderately (80-89% of projects) | Negligibly(<70% of projects) |

Sustainability evaluation instrument no.1 – national level – March 2003 version
Instrument 2: district/ LGA level

NOTE:
- This instrument evaluates the level, which actually takes responsibility for implementing CDTI in its area of operations. It is that level where health services are planned and provided. We are going to refer to it as the district/ LGA level.
- The level below this one is the one where the health centres/ clinics/ dispensaries are located. We are going to refer to this level as the ‘FLHF’ (front line health facility) level.

<table>
<thead>
<tr>
<th>The focus of this level’s activities in CDTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>The main function of this level is to <strong>take responsibility for the implementation</strong> of CDTI in its area of operation.</td>
</tr>
<tr>
<td>However its function is still largely one of <strong>support of the FLHF level</strong>.</td>
</tr>
<tr>
<td>* Providing targeted training, HSAM and monitoring/supervision.</td>
</tr>
<tr>
<td>* Arranging for an adequate supply of Mectizan.</td>
</tr>
<tr>
<td>The FLHF level is the one that is finally responsible for working with the CDDs in the communities.</td>
</tr>
</tbody>
</table>

Geographical name of this district/ LGA:  

Project:  

Researcher: PROF. A. ABOSE, DR E NNORUKA, DR K KORVE, DR K OGUNGBEMI, DR E KIRUMBI, MR D EBAH  

Date: JUNE 16-19, 2003  

Respondents: DISTRICT MEDICAL OFFICERS (DMOs), CHIEFS OF BUREAU HEALTH (CBHs), AND CHIEFS OF BUREAU ADMINISTRATION AND FINANCE (CBAFs)  

Abbreviations/ acronyms  

CDD: community directed distributor  
CDTI: community directed treatment with ivermectin  
FLHF: first line health facility  
HSAM: health education, sensitisation, advocacy, mobilisation – i.e. activities which are aimed at getting all the key players to participate wholeheartedly in the programme  
NGDO: non-governmental development organisation  

Sustainability evaluation instrument no.1 – national level – March 2003 version
1. Indicators of activities and processes: planning

1.5 Check whether the year plan for CDTI appears as part of an overall written plan for the activities of the district/ LGA.

This indicator assesses whether the programme has become integrated into the health service, and whether management is beginning to accept ownership of the programme – both good for sustainability.

**Characteristics of the indicator**

| a. CDTI should be integrated into the overall written plan (showing that staff at this level consider CDTI to be part of their yearly routine, like any other programme). |
| b. The plan should make provision for all key activities: Mectizan supply; targeted training; targeted HSAM, targeted monitoring/ supervision. |
| c. Year plans should be drawn up in a participatory way. |
| d. Year plans must take into account community requirements for the timing of distribution. |

**Sources of information**

- Inspection of:
  * The written year plans.
  * Minutes of planning meetings.
- Interviews with:
  * Staff at this level: managers and others (pharmacist, transport officer etc.).
  * Staff at FLHF level.

**Findings**

Describe the present situation:

Plan for CDTI is integrated into the overall health plan. There is also a separate CDTI plan, which has all the key activities for oncho. The plan is developed in a participatory manner involving the DMO, the CBH CBAF and the Chiefs of post. Appraisal meetings are held during which planning is carried out. Plan of action and minutes of appraisal meetings are available.

Community requirements were not taken into consideration in the plan prepared e.g. time of distribution and mobilization.

If planning and implementation of CDTI is not part of the overall year plan:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

**Analysis**

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
2. **Indicators of activities and processes: leadership**

2.1 Check whether the district/ LGA health management team is taking full responsibility for the implementation of CDTI at this level.

*This indicator assesses whether management is taking ownership of the programme.*

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. It should be the management team at this level, and not higher levels/ NGDO leadership, which is initiating the key CDTI activities: planning, targeted monitoring/ supervision, targeted training and HSAM, Mectizan ordering/ distribution. | - Inspection of year plans.  
- Interviews with:  
  * Management team at this level.  
  * Person responsible for CDTI at this level.  
  * Staff at the project level  
  * NGDO leadership.  
  * Staff at FLHF level. |
| b. There should be a focal person for CDTI activities. | |

**Findings**

Describe the present situation:

*Oncho activities are initiated at the provincial level. The staff at the district level, however take full responsibility of implementing CDTI. The DMO is the focal person at this level*

If leadership at this level is not taking the initiative in implementing CDTI:

- Why is this?

Oncho activities are tied to the availability of Mectizan which can only be known at the provincial level

- Which steps are being taken to improve the situation?

None

**Analysis**

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
3. **Indicators of activities and processes: monitoring/supervision**

3.1 Check whether routine data concerning CDTI activities are being transmitted from this level, entirely within the government system.

*This indicator assesses whether the programme has become more integrated into the government system, and is functioning effectively.*

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The reporting process should take place within the government system, not using other resources. Data being transmitted includes: coverage reports; Mectizan statistics; training reports; distribution reports; financial reports.</td>
<td>• Examination of reports and report forms.</td>
</tr>
<tr>
<td></td>
<td>• Interviews with:</td>
</tr>
<tr>
<td></td>
<td>* Managers and staff at this level.</td>
</tr>
<tr>
<td></td>
<td>* Staff at the project level.</td>
</tr>
</tbody>
</table>

**Findings**

Describe the present situation:

There were delays in reporting until the introduction of DTS who are supported by SSI. These were introduced in year 2001 to facilitate monitoring, supervision within the government system. The reports are generated by the CDDs and these are collated by DTS who sends them to the district. Reports are still transmitted within Government system. The costs are borne by both APOC/SSI.

If data are not being transmitted within a government system:

- Why is this?

They are used temporarily to address the issue of delays in reporting.

- Which steps are being taken to improve the situation?

Nothing

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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<tr>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
3.2 Check whether the responsible persons at the district/LGA level are efficiently supervising CDTI activity at the FLHF level in an integrated manner.

This indicator assesses whether the programme is functioning **efficiently** and in an **integrated manner**.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. Staff at this level should routinely only supervise the FLHF, and not the community level. ‘Spot checks’ may however be done from time to time. | * Examination of:  
  * Supervisory checklists, plans, itineraries and reports.  
  * Visitor’s books at FLHF level. |
| b. Although one routine supervision visit per FLHF per year is necessary, supervision visits should focus more on FLHFs where there are proven problems – each supervision visit must be justified. | * Interviews with:  
  * Staff at this level.  
  * Staff at the FLHF level. |
| c. Supervision visits for CDTI should be integrated with supervision of other programmes (e.g. through a shared checklist). Transport for supervisory visits should be shared with other programmes. | |

**Findings**

Describe the present situation:

Routine supervision ends at the health centre. However spot checks in communities are done when problems are identified by the COP. During distribution, supervision is done based on proven problems such as low treatment coverage in the communities. Normally, supervision is integrated with EPI, Leprosy, Hygiene and Sanitation etc. Transport for these activities is shared with other health programs. No information on plans and itinerary. Checklist is not being used.

If supervision is not being done in an integrated and efficient manner:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

**Analysis**

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
3.3 Check whether there is a routine process of management of problems and successes, which are indicated by the monitoring system.

This indicator assesses whether the programme is running efficiently and effectively, and whether management is beginning to accept ownership of the programme.

### Characteristics of the Indicator

<table>
<thead>
<tr>
<th>a. As soon as problems are identified as a result of supervision visits, or from coverage data (i.e. areas with low coverage) the appropriate manager should deal with them.</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Where relevant such problems should be passed on to the appropriate FLHF staff to deal with, with the necessary support – thus empowering these persons.</td>
<td></td>
</tr>
<tr>
<td>c. Successes should be noted and reported, and appropriate feedback given.</td>
<td></td>
</tr>
<tr>
<td>d. There should be evidence of action taken based on recommendations in previous monitoring exercises.</td>
<td></td>
</tr>
</tbody>
</table>

### Sources of information

- Examination of the following documents:
  - Year plans and annual reports.
  - Minutes of staff/ planning meetings.
  - Reports of previous monitoring exercises.
  - Letters of commendation.
  - Memos.
- Interviews with:
  - Staff at this level.
  - Staff at the FLHF level.

### Findings

**Describe the present situation:**

The managers deal with problems (e.g. non use of measuring sticks and refusals) identified from supervision or from treatment on the spot. They have appraisal meetings to address problems (minutes available). Monitoring reports are written (a sample was seen in some places). The communities that were doing well were also commended.

If the system of managing problems/ successes is weak:

- **Why is this?**

Not Applicable

- **Which steps are being taken to improve the situation?**

Not Applicable

### Analysis

- **When writing the report you have to summarise:**
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Your overall judgement: is this indicator for sustainability being achieved?**

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Moderately</th>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4. Indicators of activities and processes: Mectizan® procurement and distribution

4.1 Check whether sufficient Mectizan is being ordered and received yearly, and in good time.

This indicator assesses whether the programme is functioning effectively.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The order forms for the district/LGA exist, and should be based on FLHF and community requests.</td>
<td>- Examination of all Mectizan ordering and stock control documentation at this level.</td>
</tr>
<tr>
<td>b. The Mectizan should be available at this level in time for distribution at the time requested by the communities.</td>
<td>- Interviews with staff at this level (managers and pharmacist).</td>
</tr>
<tr>
<td>c. There should be no reports of shortages and/or late supply. If there have been shortages, there should be specific plans to remedy them.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the situation with Mectizan supply at the last distribution:

Treatment summary forms from the community were used by the DMO to request for mectizan. The DMO estimates the tablets needed for next treatment cycle by adding 10% to tablets used for the current treatment cycle. No order forms are found at this level. Time of distribution seemed not to be in line with community decision. There were no reports of shortages in most of the districts visited.

Describe the situation the previous year:

In year 2002, shortages were reported in some districts

Describe the situation the year before that:

There was no shortage of Mectizan

If there are problems with obtaining the Mectizan that is required:
- Why is this?

Mectizan orders were based on tablets used in the previous year plus 10%. The quantity was not enough in year 2003 as a result of increased turn out due to intensive mobilization. Instalimental supply of drugs to the district also created a problem.

- Which steps are being taken to improve the situation?

No steps are taken

Analysis

- When writing the report you have to summarise:
  + The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in Mectizan supply at this level?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4.2 Check whether Mectizan is being collected, stored and effectively delivered within the government system at this level.

This indicator assesses whether the programme is functioning **efficiently**, its processes are **simple**, and it is becoming more **integrated** into the government system.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The Mectizan should be controlled within a government system. This does <strong>not</strong> have to be the system routinely used for the supply of other drugs.</td>
<td>Examination of:</td>
</tr>
<tr>
<td>b. The system should be effective, uncomplicated and efficient.</td>
<td>• All Mectizan ordering and stock control documentation at this level.</td>
</tr>
<tr>
<td>c. The district/ LGA should ideally fetch its Mectizan from the project level itself (although use of the routine MoH drug supply system to districts is acceptable). In either case transport should be supplied and paid for by government at this level.</td>
<td>• Vehicle log books and/ or trip authority forms.</td>
</tr>
<tr>
<td></td>
<td>• Interviews with staff at this level (managers, pharmacist, drivers).</td>
</tr>
</tbody>
</table>

**Findings**

**Describe the present situation:**

*Mectizan is controlled within the government system. The DMO goes to collect mectizan from provincial level or they bring it to the DMO, especially the additional allocation. Transport is paid by the government. Mectizan is stored separately by the CBH. Mectizan stock forms are completed when the drugs are collected (a sample of mectizan disbursement form was seen).*

If the Mectizan supply is not being administered within a government system:

* Why is this?

Not Applicable

* Which steps are being taken to improve the situation?

Not Applicable

**Analysis**

* When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

* Your overall judgement: is this indicator for sustainability being achieved?

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<thead>
<tr>
<th>Fully</th>
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<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
5. Indicators of activities and processes: training and HSAM

5.1 Check whether staff members at this level are being used appropriately as trainers.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. Staff should routinely only train staff at the FLHF level, and not at the community level. | - Examination of training materials, plans/programmes, reports:  
  * At this level.  
  * At the FLHF level. |
| b. Staff should have empowered staff at the FLHF level to see to their own training needs as much as possible, and to conduct training activities at the community level independently. | - Interviews with:  
  * Staff at this level (the trainers).  
  * Staff at FLHF level (the trainees). |
| c. Wherever possible staff at this level should conduct their own training for CDTI, if they have need for such training. |  
  * CDDs. |

Findings

Describe the present situation:

Health personnel are trained yearly. In year 2003, the district trained both COPs, CDDs and Social Mobilizers in a session at the district headquarters. Only one person at the FLHF was trained.

Describe the situation the year before:

In year 2002 the district trained the COPs who in turn trained the CDDs.

If staff members are not being used appropriately:

- Why is this?

The district personnel thought that the COPs were not providing adequate training for the CDDs. In addition they thought that since many of the COPs were newly transferred to the project areas, they may not be in a position to carry out adequate training for the CDDs.

- Which steps are being taken to improve the situation?

The CDDs were trained together with the COPs hoping that the COPs will continue with training of CDDs subsequently.

Analysis

- When writing the report you have to summarise:

  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in the way in which staff are being used as trainers:

- Your overall judgement: is this indicator for sustainability being achieved?

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<thead>
<tr>
<th>Fully</th>
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<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
5.2 Check whether **training is being planned and carried out in an efficient and integrated manner.**

*This indicator assesses whether the programme is functioning efficiently.*

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. There should be an objective need for each episode of training. This means there should be evidence that staff to be trained lack knowledge and skills to perform the job, and the training should then focus on this deficiency only. Repeat training of already skilled staff should not happen. | * Examination of training materials, plans/programmes, reports:  
* At this level.  
* At the FLHF level.  
* Interviews with:  
* Staff at this level (the trainers).  
* Staff at FLHF level (the trainees).  
* CDDs. |
| b. If circumstances permit training for CDTI should be integrated with other training, e.g. in in-service training programmes. | |
| c. Resources for training (human, transport etc.) should be efficiently used:  
* Using as few staff members as possible.  
* Using as little time as possible (without sacrificing quality)  
* Choosing the most cost-effective site etc. | |

**Findings**

Describe the present situation:

*In year 2003, both COPs and CDDs were trained by the district team in one session. Training was not targeted due to transfer of health centre staff (COPs). Training was also not integrated. Few trainers were used during the training. One day training for CDDs and two days for COPs. APOC paid for the training.*

Describe the situation the year before:

*Training was not integrated even in year 2002. The training of COPs was done by the district team, while that of CDDs was by COPs.*

If training is not efficient and integrated:

- Why is this?

*Training of personnel on Mectizan distribution came as a campaign and included health centre staff (COPs)*

- Which steps are being taken to improve the situation?

*Next year the CDDs would not be trained at the district level and therefore training of health centre staff (COPs) on CDTI would be integrated with other PHC programmes.*

**Analysis**

- When writing the report you have to summarise:  
  * The evidence about how well this indicator is being achieved.  
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in training activities – is it becoming more efficient and integrated?

- Your overall judgement: is this indicator for sustainability being achieved?

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<tr>
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</table>

Sustainability evaluation instrument no. 1 – national level – March 2003 version
5.3 Check whether staff at this level is planning and carrying out HSAM activities in an efficient manner.

This indicator assesses whether the programme is functioning efficiently and effectively, and whether managers are taking ownership of the programme.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Staff members identify situations where decision makers lack information about/commitment to CDTI, and undertake activities to inform and persuade these persons.</td>
<td>Examination of:</td>
</tr>
<tr>
<td>b. HSAM activities are properly planned. They are only carried out where there is an objective need for them, and not as a matter of routine.</td>
<td>* HSAM plans/programmes and reports.</td>
</tr>
<tr>
<td>c. Such activities should only be carried out at this district/LGA level, and at times at the FLHF level (but only when staff at that level asks for help).</td>
<td>* Year plans and annual reports.</td>
</tr>
<tr>
<td>d. There is evidence that these HSAM activities have been effective and have led to action.</td>
<td>* Minutes of planning meetings.</td>
</tr>
<tr>
<td></td>
<td>* Interviews with:</td>
</tr>
<tr>
<td></td>
<td>* Staff (programme and management) at this level.</td>
</tr>
<tr>
<td></td>
<td>* Civil authorities at this level.</td>
</tr>
<tr>
<td></td>
<td>* Staff and civil authorities at the FLHF level.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

HSAM was carried out at the District to the DOs. HSAM has led to more awareness at the community level. There is also increase in coverage. HSAM was carried out when treatment coverage was discovered to be low in the previous years. Social mobilization agents were used. HSAM was therefore carried out based on need.

Describe the situation the year before:

Town criers were used and it was not clear to the communities the issues involved in oncho control. Social mobilization agents were not used in this year.

If HSAM activities are not being carried out efficiently and effectively:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in HSAM activities - is it becoming more efficient?

- Your overall judgement: is this indicator for sustainability being achieved?

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<tr>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6. Indicators of resources: financial

6.1 Check whether appropriate amounts are budgeted for planned CDTI activities at this level.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The costs for each CDTI activity in the year plan at this level should be clearly spelt out in a budget.</td>
<td>- Examination of the budget documents.</td>
</tr>
<tr>
<td>b. There is evidence of a cost reduction/containment strategy (e.g., targeted training, HMAS and monitoring/supervision; training conducted at FLHF level etc).</td>
<td>- Interviews with health service and local government managers at this level:</td>
</tr>
<tr>
<td>c. Managers at this level should have a clear estimate of the funds that will be available to them for CDTI in the coming year, and should be able to justify this belief.</td>
<td>* Technical managers.</td>
</tr>
<tr>
<td>d. The total amount budgeted for in the year plan should fall within this estimated income.</td>
<td>* Treasurer/administrator.</td>
</tr>
</tbody>
</table>

Findings

The budget and estimated income:
- At the previous distribution:
  - No budget for CDTI in year 2003 by government

- For the previous year:
  - No budget for year 2002 by government

- For the year before that:
  - No budget for year 2001 by government

If budgeting has been inappropriate:
- Why is this?

They did not know that they had to budget. They thought there was already funds available from APOC and SS1. There was also cost recovery system

- Which steps are being taken to improve the situation?

Letters have just been written to COPs to come with plans and budgets during planning/feedback meeting in Buea

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in the budgeted amount and the expected income:

- Your overall judgement: is this indicator for sustainability being achieved?
<table>
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<tr>
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Sustainability evaluation instrument no.1 – national level – March 2003 version
Check whether the government at this level is budgeting and disbursing increasing amounts for CDTI yearly, and in good time.

This indicator assesses whether the programme is becoming integrated, and whether government is beginning to accept ownership of the programme and can mobilise the resources it needs.

### Characteristics of the indicator

<table>
<thead>
<tr>
<th>A.</th>
<th>B.</th>
<th>C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relative budgetary contributions of the local government and other partners to CDTI should be clearly spelt out.</td>
<td>The amount that the government has budgeted in one or more specific CDTI budget lines should be increasing yearly. By the end of Year 5 of APOC funding the bulk of CDTI expenses at this level should be met from local government funds; by the end of Year 3 at least half of it.</td>
<td>The amounts actually disbursed from such budget lines should be increasing yearly, as a proportion of total expenses. (Note that actual disbursement is more important than budgeting, and is a real sign of political commitment).</td>
</tr>
</tbody>
</table>

### Sources of information

- Examination of:
  - Budget documents (government and NGDO)
  - Records of disbursement and expenditure (ledgers, orders, approvals for expenditure etc.)
- Interviews with health service, local government and NGDO managers at this level:
  - Technical managers.
  - Treasurer/administrator.

### Findings

The budget and disbursements:

- For this year:

  *No corresponding funds were budgeted for oncho control by government in year 2003, however funds were released for fuelling and maintenance of vehicles at this level.*

- For the previous year:

  Same as above

If the government proportion of expenditure is not increasing proportionately:

- Why is this?

  Not Applicable

- Which steps are being taken to improve the situation?

  Not Applicable

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Examine the trend in government budgeting and disbursements:

### Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6.3 Check whether in case of a deficit between estimated costs and the amount provided by the government, dependable provision is being made to meet it.

This indicator assesses whether management is able to mobilise the resources it needs, as well as its commitment to ownership.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. If there is a shortfall the management should have specific and realistic plans to bridge it.</td>
<td>Inspection of:</td>
</tr>
<tr>
<td>b. If it is planned that non-government sources of funding are to be used after APOC funding ends, written commitment for this should have been obtained at the highest level in these donor organisations.</td>
<td>* The budget documents (government and NGDO)</td>
</tr>
<tr>
<td></td>
<td>* Records of expenditure (ledgers, orders, approvals for expenditure etc.).</td>
</tr>
<tr>
<td></td>
<td>* Letters of agreement.</td>
</tr>
<tr>
<td></td>
<td>* Interviews with health service and local government managers at this level:</td>
</tr>
<tr>
<td></td>
<td>* Technical managers.</td>
</tr>
<tr>
<td></td>
<td>* Treasurer/administrator.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

Government did not budget for CDTI activities in year 2003. They are expecting allowances for CDDs from central government at this level. All planned CDTI activities were supported from the provincial level using APOC funds.

Describe the situation the previous year:

Government did not budget for year 2002. All planned CDTI activities were supported from the provincial level using APOC funds.

If the shortfall cannot be met:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Examine the trend in shortfall and how it is to be supplemented:

- Your overall judgement: is this indicator for sustainability being achieved?

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<thead>
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</tbody>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6.4 Check whether funds disbursed for CDTI from the budget at this level are efficiently managed.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The budget holder should be using a control system with the following elements: * Approval of each item of expenditure. * Allocation of expenditure against specific budget headings. * Regular calculation of residual amounts under budget headings.</td>
<td>Inspection of: * The budget documents (government and NGDO). * Financial control records (ledgers, orders, approvals for expenditure etc.).</td>
</tr>
<tr>
<td>b. All the funds released yearly should be spent as budgeted.</td>
<td>interviews with health service and local government managers at this level: * Technical managers. * Treasurer/administrator.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

• Approval of expenditure:

All activities are funded using APOC funds. Funds from APOC and SSI are sent to the district (DMO) by the delegation. The DMO approves the funds but most approvals are done at provincial level. Available funds from APOC were spent as budgeted.

• Allocation of expenditure:

The allocation of APOC and SSI funds is done at the provincial level

• Regular insight into budget line balances:

Not Applicable

If the funds are not being well managed:

• Why is this?

Most financial management is done at the provincial level

• Which steps are being taken to improve the situation?

Not Applicable

Analysis

• When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

• Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
7. Indicators of resources: transport and other material resources

7.1 Check whether adequate and appropriate transport and materials are available for necessary CDTI activities at this level.

This indicator assesses whether the programme is functioning effectively, and whether it is able to mobilise the resources it needs.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There are adequate numbers of appropriate, functional vehicles available for necessary CDTI activities.</td>
<td>• Inspection of:  * Each vehicle in the pool; its source; its functional status.  * Stocks of materials for training and HSAM.  * Interviews with managers at this level: transport officers, programme managers.</td>
</tr>
<tr>
<td>b. The running costs for these vehicles are met by the government.</td>
<td></td>
</tr>
<tr>
<td>c. There are sufficient materials available for training and HSAM.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

<table>
<thead>
<tr>
<th>Type of vehicle</th>
<th>No.</th>
<th>Source</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle</td>
<td>1</td>
<td>Govt.</td>
<td>Not suitable for CDTI (Toyota Tercel)</td>
</tr>
<tr>
<td>Motorcycle</td>
<td>12</td>
<td>APOC</td>
<td>Functional</td>
</tr>
<tr>
<td>Motorcycle</td>
<td>1</td>
<td>SOWEDA</td>
<td>Functional</td>
</tr>
<tr>
<td>Motorcycle</td>
<td>1</td>
<td>SSI</td>
<td>Not functional and not suitable</td>
</tr>
<tr>
<td>Motorcycle</td>
<td>6</td>
<td>Govt.</td>
<td>Functional</td>
</tr>
<tr>
<td>Training/ HSAM</td>
<td>No.</td>
<td>Source</td>
<td>Adequacy for CDTI tasks**</td>
</tr>
<tr>
<td>material</td>
<td>45</td>
<td>APOC</td>
<td>Not adequate</td>
</tr>
<tr>
<td>T-shirts</td>
<td>NA</td>
<td>APOC</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Flipcharts</td>
<td>NA</td>
<td>APOC</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

* APOC, MoH, NGDO, other (specify)  ** Is it working? Is there enough of it for the job? Is it suitable for the job?

Describe the availability/ suitability/ functionality of the present vehicles and materials, considering the work still to be done in the coming 5-10 years:

The Motor vehicle is not suitable for CDTI work. Most motorcycles are functional and are suitable for supervision. HSAM materials are available but inadequate

If transport and materials are inadequate and funded from non-government sources:

- Why is this?

Government has not made provision for the production of HSAM materials at this level

- Which steps are being taken to improve the situation?

No steps are being taken

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
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<tr>
<th>Fully</th>
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Sustainability evaluation instrument no.1 – national level – March 2003 version
7.2 Check whether transport at this level is adequately and appropriately maintained.

*This indicator assesses whether the programme is functioning effectively and efficiently.*

### Characteristics of the indicator

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>There is a routine maintenance schedule for each vehicle, which is adhered to and recorded. This includes weekly driver maintenance, scheduled garage servicing, and replacement of worn tyres.</td>
</tr>
<tr>
<td>b.</td>
<td>The costs for vehicle and equipment maintenance and repair are met by the government. Repairs are rapidly and efficiently done.</td>
</tr>
<tr>
<td>c.</td>
<td>Staff have ways of coping when vehicles break down or are not available, so that CDTI activities are not disrupted.</td>
</tr>
</tbody>
</table>

### Sources of information

- Inspection of:
  - Vehicle and equipment maintenance schedules.
  - Vehicle and equipment maintenance records.
- Interviews with managers at this level: transport officers, programme managers.

### Findings

Describe the present situation:

**Government funds are used for vehicle maintenance. Vehicles are maintained regularly but this is not documented. This maintenance is done by local mechanics using government funds.**

Make particular enquiries about the ability of the government to pay for maintenance, repairs and tyre replacement:

**Government has a budget line for vehicle maintenance and has the ability for continued maintenance**

If the vehicles are not being well maintained, and/ or the government is not paying:

- Why is this?

  Not Applicable

- Which steps are being taken to improve the situation?

  Not Applicable

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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</tbody>
</table>
7.3 Check whether the transport available at this level is appropriately managed and used, in an integrated way.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Transport is used at this level, and to undertake support activities at the FLHF level. It should not be used for CDTI implementation activities at the community level.</td>
<td></td>
</tr>
<tr>
<td>b. Trips made for CDTI purposes should be properly authorised in writing by the relevant official. Each trip undertaken should be recorded in a log book.</td>
<td></td>
</tr>
<tr>
<td>c. Transport provided for CDTI, and that provided for other programmes, should be combined as a pool to be used for legitimate activities of all programmes at this level.</td>
<td></td>
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<tr>
<td>- Inspection of vehicle control documents:</td>
<td></td>
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<tr>
<td>* Copies of trip authorities (also noting destination and purpose)</td>
<td></td>
</tr>
<tr>
<td>* Log books.</td>
<td></td>
</tr>
<tr>
<td>* The supervision plan/matrix.</td>
<td></td>
</tr>
<tr>
<td>- Interviews with managers at this level: transport officers, programme managers.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

No log book for motor vehicle. Motorcycle log books are available but not used. The DMO authorizes the use of vehicles. The transport is combined as a pool to be used for all programs

If the transport is not being well managed:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
Check whether there are appropriate and realistic plans for the replacement of transport and materials when APOC support comes to an end.

This indicator assesses whether the programme managers are taking ownership of the programme, and are able to find resources for it.

### Characteristics of the indicator

<table>
<thead>
<tr>
<th></th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Management should know that replacements will be needed before the end of the programme, and have specific, realistic plans to meet the need at that time.</td>
<td>Inspection of letters of agreement.</td>
</tr>
<tr>
<td>b. It should be planned that the government will:</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>* Provide replacements for vehicles.</td>
<td>* Programme managers at this level:</td>
</tr>
<tr>
<td>* Maintain existing vehicles.</td>
<td>administrators, technical managers.</td>
</tr>
<tr>
<td>* Provide stationery and materials for training and HSAM.</td>
<td>* NGDO project managers.</td>
</tr>
<tr>
<td>c. If it is planned that replacement will be from non-government sources, written commitment for this should have been obtained at the highest level in these donor organisations (end of Year 5), or negotiations should have started (end of Year 3).</td>
<td>* High-ranking local government officials.</td>
</tr>
</tbody>
</table>

### Findings

**Describe the present situation:**

There is no plan to replace these vehicles.

If the plans for replacing vehicles and materials are unsatisfactory:

- **Why is this?**

  * **Government has lukewarm attitude towards provision of vehicles to the district**

- **Which steps are being taken to improve the situation?**

  No steps are taken.

### Analysis

- **When writing the report you have to summarise:**
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Your overall judgement: is this indicator for sustainability being achieved?**

<table>
<thead>
<tr>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no. 1 – national level – March 2003 version
8. Indicators of resources: human resources

8.1 Check whether staff at this level is skilled and knowledgeable, regarding the implementation of CDTI in its area of operation.

This indicator assesses whether the programme has been able to develop sufficient resources for itself.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. Staff should have enough knowledge and skill to undertake all the key CDTI activities themselves: planning, training, HSAM, ensuring Mectizan supply, monitoring/ supervision.  
 b. Staff at this level should remain in one post for at least five years.  
 c. There should be immediate training (in CDTI) of new, unskilled project staff members who have CDTI responsibilities. | * Inspection of:  
 * Staff files.  
 * Monitoring reports.  
 * Activity reports.  
 * Interviews with  
 * Managers and other staff at this level.  
 * Staff at the project level  
 * Staff at the FLHF level. |

## Findings

Describe the present situation:

- **Particulars of current staff**

<table>
<thead>
<tr>
<th>Area of skill</th>
<th>No. of persons qualified in this area</th>
<th>No. of persons competent enough to perform the job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Training and HSAM</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Monitoring/ supervision</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Mectizan ordering/ distribution</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

- Information about staff stability

Staff have enough knowledge and skill and are stable in post. They spend between 4-5 years in post

- Information about in-service training:

  * **Seminars and workshops are being attended by DMO, CBH and CBAF**

If the staff at this level lack skills, and are often transferred:

- Why is this?

**Not Applicable**

- Which steps are being taken to improve the situation?

**Not Applicable**

## Analysis

- When writing the report you have to summarise:
  
  * The evidence about how well this indicator is being achieved.
  
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
8.2 Check whether staff members at this level are committed to their CDTI work.

This indicator assesses whether the programme has been able to develop sufficient resources for itself.

Characteristics of the indicator

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Staff members express satisfaction with their present responsibilities</td>
</tr>
<tr>
<td>b.</td>
<td>There is evidence of specific motivational practices and rewards within the programme: awards, financial incentives, compensation in cash or kind.</td>
</tr>
<tr>
<td>c.</td>
<td>Salaries/ wages and allowances are paid regularly.</td>
</tr>
<tr>
<td>d.</td>
<td>Staff members mention non-financial rewards inherent in CDTI work.</td>
</tr>
<tr>
<td>e.</td>
<td>There is evidence from partners and workers at the FLHF level that staff members are committed to their CDTI work.</td>
</tr>
</tbody>
</table>

Sources of information

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection of:</td>
</tr>
<tr>
<td>* Staff files (for performance records and awards).</td>
</tr>
<tr>
<td>* Documentation about incentive schemes.</td>
</tr>
<tr>
<td>Interviews with</td>
</tr>
<tr>
<td>* Managers and other staff at this level.</td>
</tr>
<tr>
<td>* Local government officials.</td>
</tr>
<tr>
<td>* NGDO project staff.</td>
</tr>
<tr>
<td>* Staff at FLHF level.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

All staff at this level show some commitment and expressed satisfaction with their job. They need however be more committed to CDTI which is more tasking than most of the other health programs. Salaries are paid regularly.

If staff members appear to have little commitment to CDTI work:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
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<tr>
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<th>Not at all</th>
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</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
9. Indices of output: coverage

9.1 Check whether the district/ LGA has a satisfactory geographical coverage rate.

This indicator assesses whether the programme is effective – if the rate is poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. All sub-districts and</td>
<td>* Inspection of:</td>
</tr>
<tr>
<td>communities identified by the</td>
<td>* Distribution reports and statistics at community level, for</td>
</tr>
<tr>
<td>latest REMO should be under</td>
<td>this district/ LGA, for the past 3 years.</td>
</tr>
<tr>
<td>treatment (i.e. the geographical</td>
<td>* REMO list of endemic communities for this district/ LGA.</td>
</tr>
<tr>
<td>coverage rate is 100%).</td>
<td>* Interviews with:</td>
</tr>
<tr>
<td>b. This rate should be stable or</td>
<td>* Staff at district/ LGA level.</td>
</tr>
<tr>
<td>increasing.</td>
<td>* Staff at FLHF level.</td>
</tr>
</tbody>
</table>

Findings

The geographical coverage situation in the district/ LGA:

- At the last distribution:

  All communities identified by REMO were treated (100%). Many hypo endemic communities were also under treatment. However, the treatment strategy in these communities is the clinic based treatment

- The year before:

  Same as above

- The year before that:

  Same as above

If the geographical coverage rate is poor:

- Why is this?

  Not Applicable

- Which steps are being taken to improve the situation?

  Not Applicable

Analysis

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it, and how this is likely to affect sustainability.

- What is the trend in geographical coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully (100% of communities are doing CDTI)</th>
<th>Highly (95-99% of communities – stable or increasing)</th>
<th>Moderately (90-94% of communities – stable or increasing)</th>
<th>Slightly (85-89% of communities – stable or increasing)</th>
<th>Negligibly (&lt;85% of communities)</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
+9.2 Check whether the district/ LGA has a satisfactory therapeutic coverage rate.  
This indicator assesses whether the programme is effective – if the rate is poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. All communities in the district/ LGA should have a therapeutic coverage rate of 65% or higher. | • Inspection of:  
• Distribution reports and statistics at community level, for this district/ LGA, for the past 3 years.  
• REMO list of endemic communities for this district/ LGA.  
• Interviews with:  
* Staff at district/ LGA level.  
* Staff at FLHF level. |
| b. These rates should be stable or increasing. | |

**Findings**

The therapeutic coverage situation in the communities in the district/ LGA:

- At the last distribution:

  67% of communities visited had treatment coverage of more than 65%. It was noticed that the number of persons treated in hypo endemic communities was very high. For example in Muyuka District, 27.5% of persons treated were from hypo endemic communities

Census update is not properly carried out

- The year before:

  38% of the communities had coverage more than 65%. Number of persons treated from hypo endemic communities was also high

  Census update was not properly carried out

- The year before that:

  22% of the communities had coverage more than 65%. Number of persons treated from hypo endemic communities was also high

  Census update is not properly carried out

If the therapeutic coverage rate is poor:

- Why is this?

  Community members were not properly sensitised on the importance of treatment in the previous years

  Cost recovery, the fear of severe adverse events also contributed to poor coverage

- Which steps are being taken to improve the situation?

  A campaign approach was used to mobilise the communities for treatment in year 2003. They hope to continue with this approach

**Analysis**

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in therapeutic coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully (100% of communities have a therapeutic coverage rate ≥65% - stable or increasing)</th>
<th>Highly (90-99% of communities)</th>
<th>Moderately (80-89% of communities)</th>
<th>Slightly (70-79% of communities)</th>
<th>Negligibly (&lt;70% of communities)</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
APPENDIX VIB

COMPLETED CONSOLIDATED INSTRUMENTS FOR

HEALTH AREAS AND COMMUNITIES
Instrument 3: first line health facility (FLHF) level

NOTE:
- This instrument evaluates the level which finally interacts with the villages and communities, in ensuring that CDTI takes place in all the communities in its area of operations. This level has different names in different countries. In most countries there is a health centre – a clinic, or health centre, or dispensary, which we call a ‘first line health facility’. The health workers who work there are the ones who are responsible for training and supporting the CDDs in the villages.
- When we speak of a FLHF we therefore mean:
  * The health facility and its staff.
  * The accompanying political/ administrative mechanisms between the district/ LGA and community levels.
- By ‘FLHF team’ is meant the group of persons working in the first-line health facility and in its catchment area.
- The level below this one is of course the community, the villages. Here the CDDs – ‘community directed distributors’ – live and work. We refer to this level as the ‘community’ level.

### The focus of this level’s activities in CDTI

The main function of this level is to work with the village communities, so that CDTI is established in them:
- Mobilising them to become involved in CDTI, by selecting CDDs.
- Training the CDDs and supporting them in their work.
- Arranging a dependable supply of Mectizan for them, at the right time each year.
- Helping them to collect and forward the coverage data for their community.

Geographical name of this FLHF: KUMBA MBENG. KOMBONE. MEANJA CAMP, EBOJ. NDIBENJOCK. MUYUKA.

Project: SOUTHWEST I

Researcher: OGUNGBEMI. EBAH. KORVE. KIRUMBI

Date: JUNE 16th - 19, 2003

RESPONDENT: CHIEFS OF POST,

Abbreviations/ acronyms
- CDD: community directed distributor
- CDTI: community directed treatment with ivermectin
- FLHF: first line health facility
- HSAM: health education, sensitisation, advocacy, mobilisation – i.e. activities which are aimed at getting all the key players to participate wholeheartedly in the programme
- NGDO: non-governmental development organisation
1. Indicators of activities and processes: planning

1.1 Check if there is a written year plan for CDTI in the FLHF area.

This indicator assesses whether the programme is being planned in an effective and integrated manner, and whether management is beginning to accept ownership of the programme.

**Characteristics of the indicator**

<table>
<thead>
<tr>
<th>a.</th>
<th>There should be a written plan or timetable in existence, for the most recent round of CDTI (this is recommended).</th>
</tr>
</thead>
<tbody>
<tr>
<td>b.</td>
<td>Ideally the plan should be integrated into the overall year plan for the FLHF area.</td>
</tr>
<tr>
<td>c.</td>
<td>Ideally CDTI should form part of the ‘minimum’ or ‘recommended’ package for this level</td>
</tr>
</tbody>
</table>

**Sources of information**

- Inspection of:
  - The written year plans.
  - Minutes of planning meetings.
  - Interviews with staff at this level.

**Findings**

Describe the present situation:

- **A written plan exists and was prepared during Health appraisal meeting held at the FLHF. The plans contain all CDTI activities, duration and cost. The CDDs and village chiefs participated in developing the plans.** The implementation of the plan for 2003, tagged Campaign approach did not comply with the CDTI strategy and may not be sustainable. **There was no overall integrated year plan and no sustainability plan for the post APOC period had been developed.**

If there is no written plan for CDTI:

- **Why is this?**

**A written plan exists.**

- **Are any steps being taken to improve the situation?**

**Not Applicable**

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Your overall judgement: is this indicator for sustainability being achieved?**

<table>
<thead>
<tr>
<th>Fully</th>
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<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
2. Indicators of activities and processes: leadership

2.1 Check whether the FLHF management team is taking full responsibility for CDTI at this level, in an integrated manner.

This indicator assesses whether the CDTI project is integrated into the health system, and whether management is beginning to accept ownership of the programme.

Characteristics of the indicator

| a. The FLHF management team and all health staff at this level consider the program as theirs and are initiating the key CDTI activities: planning, monitoring/supervision, training, HSAM, Mectizan ordering/distribution. |
| Sources of information |
| Inspection of year plans. |
| Interviews with: |
| * Management team at this level. |
| * Senior political figures at this level. |
| * Staff at the district/LGA level. |

b. The political head/senior politician at this level should know about CDTI and have participated in some CDTI activities.

Findings

Describe the present situation:

The Chiefs of Post consider CDTI to be their programme and usually initiates and implement all CDTI activities at this level based on directives from DMOs. Chiefs, quarter heads, and health committee chairpersons, participated in mobilizing the communities. The chiefs and quarter heads selected some CDDs while others were selected by the communities. Mectizan ordering is done at the district level. In some cases, COPs appoint and terminate the appointment of CDDs. However, implementation of CDTI was not integrated with other health activities at this level.

If DMT is not taking full responsibility for CDTI:

- Why is this?

FLHF takes full responsibility for CDTI activities at this level

- Are any steps being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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<th>Moderately</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
3. Indicators of activities and processes: monitoring/supervision

3.1 Check whether routine and necessary data concerning CDTI activities at this level are being transmitted entirely within the government system.

This indicator assesses whether the programme is becoming more integrated into the national health system.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. The reporting process should be within the government system, not using other resources. Data being transmitted includes: coverage reports; distribution reports; Mectizan statistics; training reports. | * Examination of reports and report forms. * Interviews with:  
  * Managers and staff at this level.  
  * Staff at the district/ LGA level. |

Findings

Describe the present situation:

*Reports of CDTI activities such as treatment summaries and supervision reports were produced in three copies, one is submitted to the district by the Chief of posts during their weekly reports, two kept at the health post. They are transmitted on time.*

If CDTI data at this level are not being processed within government system:

* Why is this?  

_Data at this level are being processed within government system._

* Are any steps being taken to improve the situation?  

_Not Applicable_

Analysis

* When writing the report you have to summarise:  
  * The evidence about how well this indicator is being achieved.  
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.  

* Your overall judgement: is this indicator for sustainability being achieved?  

_Fully_  
_Moderately_  
_Slightly_  
_Not at all_  
_Not applicable_
3.2 Check whether health service staff at this level is routinely and efficiently supervising CDTI activity at the communities on site in an integrated manner.

- This indicator assesses whether the CDTI programme is being implemented efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Although one routine supervision visit per community per year is necessary, supervision visits should focus more on communities where there are proven problems – each supervision visit must be justified.</td>
<td>Examination of:</td>
</tr>
<tr>
<td></td>
<td>* Supervisory checklists, plans, itineraries and reports.</td>
</tr>
<tr>
<td></td>
<td>* Log books.</td>
</tr>
<tr>
<td>b. During visits to communities FLHF staff should turn their attention to as many health related programmes and problems as possible.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td></td>
<td>* Staff at this level.</td>
</tr>
<tr>
<td></td>
<td>* Village heads and CDDs.</td>
</tr>
</tbody>
</table>

**Findings**

Describe the present situation:

- Chiefs of post supervise the supervised several times during the distribution of Mectizan. Supervision was integrated in only a few FLHF and was not targeted at solving specific CDTI problems. In some health facilities the COP is assisted by other nurses and the health committee chairperson while in some communities, the district supervisors also supervise communities. Supervision is fully funded by APOC.

If health service staff members are not routinely and efficiently supervising CDTI:

- Why is this?

Supervision of CDTI for 2003 was carried out as part of the project Campaign Approach aimed at remediing the project defects. Hence, supervision was intensive, routine and not targeted.

- Are any steps being taken to improve the situation?

No steps are being taken.

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>
3.3 Check whether there is a routine process of management of problems and successes, which are indicated by the monitoring system (coverage data, visits and reports)

This indicator assesses whether the programme is being implemented efficiently and effectively, and whether management is beginning to accept ownership of the programme.

### Characteristics of the indicator

| a. | As soon as problems are identified through supervisory visits, coverage data etc. (e.g. communities with low coverage) health staff at this level should deal with them. |
| b. | Where relevant such problems should be passed on to the relevant community to deal with, with the necessary support – thus empowering communities to make decisions on CDTI and cope with problems. |
| c. | Successes should be noted and reported, and appropriate feedback given to communities. |
| d. | There should be evidence of action taken based on recommendations in previous monitoring exercises. |

### Sources of information

- Examination of the following documents:
  * Year plans and annual reports.
  * Minutes of staff/planning meetings.
  * Reports of previous monitoring exercises.
  * Letters of commendation.
- Interviews with:
  * Staff at this level: in-charge and others.
  * Community leaders and CDDs.

### Findings

Describe the present situation:

Some problems such as non-use of measuring sticks and refusals were managed on the spot, while others such as mass refusals were referred to the district team for intervention. Community members were sensitised on the need to take the drug. Other problems observed include lack of support for CDDs and communities perception of CDTI as government's project. There is no reward system in place to encourage health workers and CDDs that show outstanding commitment to CDTI.

If there is no routine process of managing problems and successes:

- Why is this?

**Problems and successes are routinely managed.**

- Are any steps being taken to improve the situation?

**Not Applicable**

### Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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<tr>
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<th>Moderately</th>
<th>Slightly</th>
<th>Not at all</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4. Indicators of activities and processes: Mectizan® procurement and distribution

4.1 Check whether sufficient Mectizan is being ordered annually, and in good time.

This indicator assesses whether the programme is functioning effectively.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The order forms for the FLHF area exist, and orders should be based on the requests from the community.</td>
<td>Examination of all Mectizan ordering and stock control documentation at this level.</td>
</tr>
<tr>
<td>b. The Mectizan should be available at this level in time for distribution at the time requested by the communities.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>c. There should be no reports of shortages and/or late supply. If there have been shortages, there should be specific plans to remedy them.</td>
<td>* Staff at this level (managers and pharmacist).</td>
</tr>
<tr>
<td></td>
<td>* Village leaders and CDDs.</td>
</tr>
</tbody>
</table>

Findings

What happened at:

- The last round of treatment?
  - There are no order forms, but there is a mectizan inventory at the Health district for distribution to FLHF. The quantity of drugs ordered was not adequate but remedial measures were taken to make up for the difference. The drugs needed were determined by adding 10% of the drugs used in the previous year. Mectizan arrived on time even though not at the time selected by the communities. The ordering was done at the district level where the COPs collect their drugs.

  - The round of the year before?
    - Same as above except that there was no campaign in 2002. There were also insufficient Mectizan.

  - The round the year before that?
    - Same as above

If sufficient Mectizan is not being obtained annually:

- Why is this?
  - There was no rational approach for determining the quantity of mectizan ordered.

- Are any steps being taken to improve the situation?
  - Nothing

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in Mectizan ordering and supply?

- Your overall judgement: is this indicator for sustainability being achieved?
<table>
<thead>
<tr>
<th>Fully</th>
<th>Highly</th>
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<th>Not at all</th>
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</table>
4.2 Check whether Mectizan is being collected, stored and effectively delivered within the government system at this level.

This indicator assesses whether the programme is functioning efficiently, its processes are simple, and it is becoming more integrated into the government system.

### Characteristics of the indicator

| a. The Mectizan should be controlled within a government system. This does not have to be the system routinely used for the supply of other drugs. |
| b. The system should be effective, uncomplicated and efficient |
| c. The FLHF level should fetch its Mectizan from the district/ LGA level itself, by means of transport supplied and paid for by government at this level. |
| d. Communities should fetch their Mectizan from the FLHF themselves. However in situations where villages are very far from health centres, or where it is easy/practicable for FLHF staff to deliver the Mectizan, they may help with the delivery. |

### Sources of information

- Examination of:
  - All Mectizan ordering and stock control documentation at this level.
  - Vehicle log books and/or trip authority forms.
  - Interviews with staff at this level (managers, pharmacist, drivers).

### Findings

Describe the present situation:

Mectizan was received and stored within the government system. The Chiefs of post collected their Mectizan from the district with APOC/SSI Motorbikes fuelled by Government. The drugs were stored in a safe place at the health centre. In most cases CDDs collected their drugs from the health centres and used their money for transportation. The quantity of drugs ordered was not adequate but remedial measures were taken to make up for the difference.

If Mectizan is not being received and stored within a government system:

- Why is this?

* Not Applicable

- Are any steps being taken to improve the situation?

* Not Applicable

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
5. Indicators of activities and processes: training and HSAM

5.1 Check whether training is being planned and carried out in an efficient manner.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. There should be an objective need for each episode of training. This means there should be evidence that CDDs to be trained lack knowledge and skills to perform the job, and the training should then focus on this deficiency only.</td>
<td>- Examination of training materials, plans/programmes, reports at this level.</td>
</tr>
<tr>
<td>b. Resources for training (human, transport etc.) should be efficiently used:</td>
<td>- Interviews with:</td>
</tr>
<tr>
<td>- Using as few staff members as possible.</td>
<td>- Staff at this level (the trainers).</td>
</tr>
<tr>
<td>- Using as little time as possible (without sacrificing quality)</td>
<td>- CDDs (the trainees).</td>
</tr>
<tr>
<td>- Choosing the most cost-effective site etc.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

*Training of COPs was done jointly with CDDs at the district level and this was carried out every year and restricted to the COPs as other health staff in the health center were not trained. The district team carried out training of CDDs at the district head quarters.*

Describe the situation the year before:

*Training of COPs was carried out at district level.*

*In this year training of COPs and CDDs was done separately. Training was restricted to the COPs and CDDs, as other health staffs were not involved. The COP conducted the training of CDDs in the presence of CBH.*

If training is not efficiently done in an integrated manner:

- Why is this?

*Training was not targeted and efficiently carried out because of the campaign approach that was primarily aimed at improving coverage.*

*Lack of information on the need to involve other health personnel at the centers in CDTI.*

- Are any steps being taken to improve the situation?

No steps.

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in the way training is done – the method and content?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
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<tr>
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<th>Not applicable</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
5.2 Check whether staff at this level is planning and carrying out HSAM activities in an efficient manner.

This indicator assesses whether the programme is functioning efficiently and effectively, and whether managers are taking ownership of the programme.

### Characteristics of the indicator

**a.** Staff members identify situations where decision makers lack information about commitment to CDTI, and undertake activities to inform and persuade these persons.

**b.** HSAM activities are properly planned. They are only carried out where there is an objective need for them, and not as a matter of routine.

**c.** There is evidence that these HSAM activities have been effective and have led to action.

### Sources of information

- Examination of:
  - HSAM plans/programmes and reports.
  - Year plans and annual reports.
- Interviews with:
  - Staff at this level.
  - Civil authorities at this level.
  - Community leaders and CDDs.

### Findings

**Describe the present situation:**

Social mobilizers carried out HSAM. Churches, town criers, and group meetings were used to sensitize the community. HSAM activities were carried out as routines but not targeted at solving problems identified during monitoring. Although more persons were treated this year, problems such as lack of support for CDDs and sense of ownership of CDTI by the communities still persist. Health education materials such as posters and flip charts were provided by APOC but not adequate.

**Describe the situation the year before:**

**HSAM was not properly planned and targeted at solving specific CDTI problems.**

If staff is not effectively engaged in HSAM:

- Why is this?
  - Lack of ownership and commitment in spite of adequate resources

- Are any steps being taken to improve the situation?

  **No steps taken.**

### Analysis

- **When writing the report you have to summarise:**
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- **Examine the trend in HSAM activities – is it becoming more efficient?**

- **Your overall judgement: is this indicator for sustainability being achieved?**

<table>
<thead>
<tr>
<th>Fully</th>
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</tr>
</thead>
</table>

Sustainability evaluation instrument no. 1 – national level – March 2003 version
6. Indicators of resources: financial

6.1 Check whether the costs involved in planned CDTI activities at this level are clearly defined and budgeted for.

This indicator assesses whether the programme is functioning efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The costs for each CDTI related activity in the year plan should be clearly spelt out in a budget. These activities include monitoring/supervision, training, HSAM, and arranging Mectizan supply.</td>
<td>• Examination of the budget documents (government and NGDO).</td>
</tr>
<tr>
<td>b. The staff should be able to justify the amount they plan to use. There should be evidence of cost containment (e.g. by targeting training, HSAM and supervision).</td>
<td>• Interviews with:</td>
</tr>
<tr>
<td></td>
<td>* FLHF team managers (leader, treasurer).</td>
</tr>
<tr>
<td></td>
<td>* Local government managers at this level (chairperson, administrator, treasurer).</td>
</tr>
</tbody>
</table>

Findings

What happened at:

- The last round of treatment?

Funds for CDTI were provided by APOC. There were no funds budgeted and released from government.

- The round of the year before?

Same as above.

If costs involved in CDTI related activities are not clearly defined

- Why is this?

There was no clearly defined budgetary line.

- Are any steps being taken to improve the situation?

None

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in the way costing for CDTI related activities is done?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
6.2 Check whether sufficient funds to cover these costs are being disbursed from FLHF and/or district/ LGA resources.

This indicator assesses whether the programme is becoming integrated, and whether management is beginning to accept ownership of the programme and can mobilise the resources it needs.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Funding disbursed is enough to enable targeted, essential CDTI activities at this level to be carried out.</td>
<td>Examination of:</td>
</tr>
<tr>
<td>b. The relative contributions of all sources of funding should be clearly spelt out.</td>
<td>* Budget documents (government and NGDO)</td>
</tr>
<tr>
<td>c. The proportion provided by the government (FLHF and/ or district/ LGA levels) should be the major one by now (end of Year 5) or covering at least half of expenditure (end of Year 3).</td>
<td>* Records of disbursement and expenditure (ledgers, orders, approvals for expenditure etc.)</td>
</tr>
<tr>
<td>* Interviews with:</td>
<td></td>
</tr>
<tr>
<td>* District/ LGA level managers (technical and administrative).</td>
<td></td>
</tr>
<tr>
<td>* NGDO managers at this level.</td>
<td></td>
</tr>
<tr>
<td>* FLHF team managers (leader, treasurer).</td>
<td></td>
</tr>
<tr>
<td>+ Local government managers at this level (chairperson, administrator, treasurer).</td>
<td></td>
</tr>
</tbody>
</table>

Findings

How much was provided by the government:

- Last round of treatment?

*FLHF depended mostly on APOC fund. Relative contributions were not clearly spelt out and in some health areas, CDDs were paid from health centre funds pending re-imbursement from central government.*

- The round of the year before?

*There was a cost recovery system where CDDs were paid. Government did not provide any fund for other core CDTI activities.*

- The round the year before that?

Same

If the proportion supplied by the government is not the major one by now:

- Why is this?

*The project is not fully accepted as government project.*

- Are any steps being taken to improve the situation?

None

Analysis

- When writing the report you have to summarise:

  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in the relative proportion of resources contributed by the official health service?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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</table>

Sustainability evaluation instrument no.1 - national level – March 2003 version
7. Indicators of resources: transport and other material resources

7.1 Check whether adequate and appropriate transport and materials are available for necessary CDTI activities at this level.

This indicator assesses whether the programme is functioning effectively, and whether it is able to mobilise the resources it needs.

### Characteristics of the indicator

<table>
<thead>
<tr>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOC</td>
<td>Functional</td>
</tr>
<tr>
<td>Govt.</td>
<td>Functional</td>
</tr>
<tr>
<td>APOC</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOC</td>
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</tbody>
</table>

**Inspection of:
* Each vehicle being used: its source; its functional status.
* Stocks of materials for training and HSAM.
* Interviews with the FLHF management team.

### Findings

**Type of transport**

<table>
<thead>
<tr>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOC</td>
<td>Functional</td>
</tr>
<tr>
<td>Govt.</td>
<td>Functional</td>
</tr>
</tbody>
</table>

**Training/HSAM material**

<table>
<thead>
<tr>
<th>Source*</th>
<th>Adequacy for CDTI tasks**</th>
</tr>
</thead>
<tbody>
<tr>
<td>APOC</td>
<td></td>
</tr>
</tbody>
</table>

**APOC, MoH, NGDO, other (specify)**

**Is it working? Is there enough of it for the job? Is it suitable for the job?**

Describe the availability/suitability/functionality of the present vehicles and materials, considering the work still to be done in the coming 5-10 years:

Training/HSAM materials produced with APOC have been distributed to the communities but are inadequate. In most health centres, motorcycles were not available for supervision.

If transport and materials are inadequate and funded from non-government sources:

- Why is this?
  * Government has not made provision for the production of HSAM materials in their budget at the National level.
- Which steps are being taken to improve the situation?
  * No steps are taken

### Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

### Your overall judgement: is this indicator for sustainability being achieved?

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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
7.2 Check whether transport at this level is adequately and appropriately maintained.

This indicator assesses whether the programme is functioning effectively and efficiently.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. There is a routine maintenance schedule for vehicles (where relevant), which is adhered to and recorded. | Inspection of:
* Vehicle and equipment maintenance schedules.
* Vehicle and equipment maintenance records. |
| b. The costs for vehicle and equipment maintenance and repair are met by dependable sources (e.g. the government). | |
| c. Repairs are rapidly and efficiently done. | |
| d. Staff have ways of coping when transport breaks down or is not available, so that CDTI activities are not disrupted. | Interviews with the FLHF management team. |

Findings

Describe the present situation:

The Chief of post uses health centre funds for fuelling and maintenance of motorcycles while tyres and tubes were supplied by APOC. There are logbooks but not in use.

Make particular enquiries about the ability of the government to pay for maintenance, repairs and tyre replacement:

*FLHF can pay for maintenance of motorcycles and repaired if the project is perceived as their own.*

If the vehicles are not being well maintained, and/or the government is not paying:

- Why is this?
  
  *Not Applicable*

- Which steps are being taken to improve the situation?
  
  *Not Applicable*

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>

7.3 Check whether the transport available at this level is appropriately managed and used, in an integrated way.

This indicator assesses whether the programme is functioning efficiently.

### Characteristics of the indicator

| a. Trips made for CDTI purposes should be properly authorised in writing by the relevant official. Each trip undertaken should be recorded in a log book. |
| b. Transport provided for CDTI, and that provided for other programmes, should be combined as a pool to be used for legitimate activities of all programmes at this level. |

### Sources of information

- Inspection of vehicle control documents:
  - Copies of trip authorities (also noting destination and purpose)
  - Log books.
  - The supervision plan/matrix.
- Interviews with the FLHF management team.

### Findings

Describe the present situation:

Transport provided for APOC activities is used for both CDTI and other health programmes. Logbooks are available but not used. The Chief of post uses health centre funds for fuelling and maintenance of motorcycles.

If the transport is not being well managed:

- Why is this?

**Not Applicable**

- Which steps are being taken to improve the situation?

**Not Applicable**

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
<th><strong>Highly</strong></th>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
Check whether there are appropriate and realistic plans for the replacement of transport and materials when APOC support comes to an end.

This indicator assesses whether the programme managers are taking ownership of the programme, and are able to find resources for it.

Characteristics of the indicator

| a. Management should know that replacements will be needed before the end of the programme, and have specific, realistic plans to meet the need at that time. | Sources of information |
| b. It should be planned that the government will: | |
| * Provide replacements for vehicles. | • Inspection of letters of agreement. |
| * Maintain existing vehicles. | • Interviews with: |
| * Provide stationery and materials for training and HSAM. | * The FLHF management team. |
| c. If it is planned that replacement will be from non-government sources, written commitment for this should have been obtained at the highest level in these donor organisations (end of Year 5), or negotiations should have started (end of Year 3). | * NGDO project managers. |
| | + High-ranking local government officials. |

Findings

Describe the present situation:

There are no plans for replacement of vehicles and materials

If the plans for replacing vehicles and materials are unsatisfactory:

• Why is this?

The oncho program is considered as APOC/SSI program

• Which steps are being taken to improve the situation?

None

Analysis

• When writing the report you have to summarise:

  • The evidence about how well this indicator is being achieved.
  • Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

• Your overall judgement: is this indicator for sustainability being achieved?

<table>
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<tr>
<th>Fully</th>
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</tr>
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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
8. Indicators of resources: human resources

8.1 Check whether the team at this level is skilled and knowledgeable, regarding the implementation of CDTI in its area of operation.

This indicator assesses whether the programme has been able to develop sufficient resources for itself.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Staff should have enough knowledge and skill to undertake all the key CDTI activities themselves: planning, training, HSAM, ensuring Mectizan supply, monitoring/ supervision.</td>
<td>Inspection of:</td>
</tr>
<tr>
<td>b. Staff at this level should remain in one post for at least five years.</td>
<td>* Staff files.</td>
</tr>
<tr>
<td>c. There should be immediate training (in CDTI) of new, unskilled project staff members who have CDTI responsibilities.</td>
<td>* Monitoring reports.</td>
</tr>
<tr>
<td></td>
<td>* Activity reports.</td>
</tr>
<tr>
<td></td>
<td>* Interviews with</td>
</tr>
<tr>
<td></td>
<td>* Managers and other staff at this level.</td>
</tr>
<tr>
<td></td>
<td>* Staff at the district/ LGA level.</td>
</tr>
<tr>
<td></td>
<td>* Village leaders and CDDs.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

- Particulars of current staff

<table>
<thead>
<tr>
<th>Area of skill</th>
<th>No. of skilled persons</th>
<th>Level of skill: is it adequate to perform the job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>8</td>
<td>Adequate</td>
</tr>
<tr>
<td>Training and HSAM</td>
<td>10</td>
<td>Adequate</td>
</tr>
<tr>
<td>Monitoring/ supervision</td>
<td>10</td>
<td>Adequate</td>
</tr>
<tr>
<td>Mectizan ordering/ distribution</td>
<td>5</td>
<td>Adequate</td>
</tr>
</tbody>
</table>

- Information about stability and in-service training:

They are stable in the job for at least five years
The COPs are skilled, knowledgeable and committed to CDTI implementation

If the staff at this level lack skills, and are often transferred:

- Why is this?

Not Applicable

- Which steps are being taken to improve the situation?

None

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully</th>
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</tr>
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</table>
9. Indicators of output: coverage

9.1 Check whether the geographical coverage in the FLHF area is satisfactory.

This indicator assesses whether the project is effective – if the rate is poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. All villages identified by the latest REMO should be under treatment (i.e. geographical coverage should be maintained at 100%). | • Inspection of:  
  * Distribution reports and statistics at community level, for this FLHF area, for the past 3 years.  
  * REMO list of endemic communities for this FLHF area.  
  * Interviews with staff at FLHF level. |
| b. The rate should be stable or increasing. | |

Findings

The geographic coverage situation:

- At the last distribution:

  *All the villages identified by REMO were treated (100% coverage). All the hyper/meso and hypo endemic communities are being treated using APOC fund.*

- The year before:

  *All the villages identified by REMO were treated (100% coverage)*

- The year before that:

  *All the villages identified by REMO were treated (100% coverage)*

If geographical coverage is poor:

- Why is this?

  *Not Applicable*

- Are any steps being taken to improve the situation?

  *Not Applicable*

Analysis

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in geographical coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

| Fully (100% of communities are doing CDTI) | Highly (95-99% of communities – stable or increasing) | Moderately (90-94% of communities – stable or increasing) | Slightly (85-89% of communities – stable or increasing) | Negligibly (<85% of communities) |

Sustainability evaluation instrument no.1 - national level - March 2003 version
Instrument 4: community level

NOTE:
- This instrument evaluates the CDTI programme at the level of villages and communities, where the actual distribution of Mectizan takes place. We use the term ‘community’ to refer to both villages (in societies where there are well-defined villages) and communities where family groups are fairly isolated from each other, and do not live in a ‘village’ in the accepted geographical sense of the word.
- In these communities we find the following persons are involved in the CDTI programme:
  * The community or village leadership – both traditional and elected.
  * The community directed distributors (CDDs) – the persons who have been selected by the community to do the distribution of Mectizan.
  * The other, ‘ordinary’ community members, who take the Mectizan yearly. In this document these persons will be referred to as ‘community members’.

When collecting information from ‘ordinary’ community members discussion groups should be conducted.

### The focus of this level's activities in CDTI

The main function of this level is to **distribute the Mectizan yearly to the community members**:
- Communities select CDDs, who are supported by the leadership and the other community members.
- The CDDs update the community census every year; distribute the Mectizan appropriately; and send a report on the distribution to the FLHF level.

Geographical name of this community/village: ETAM I, EBU/EHOM, YORGE, NDISE, OWE II, MAKANGA II, BAROMBI KANG LONG STREET, BAROMBI KANG NATIVE, BOLE DEPENDA, BOA BAKUNDU, MILE 29 AND MEANJA CAMP

Project: SOUTHWEST I, CAMEROON

Researcher: KORVE, OUNGGBEMI, KIRUMBI AND EBAH

Date: JUNE 16-19, 2003

RESPONDENT: COMMUNITY

### Abbreviations/ acronyms

CDD community directed distributor
CDTI community directed treatment with ivermectin
FLHF first line health facility
HSAM health education, sensitisation, advocacy, mobilisation – i.e. activities which are aimed at getting all the key players to participate wholeheartedly in the programme
NGDO non-governmental development organisation
1. **Indicators of activities and processes: planning and management**

1.1 Check whether CDDs are planning and managing their CDTI work efficiently.

*This indicator assesses whether the programme is efficient and simple. The more streamlined and time-efficient the job, the higher its sustainability.*

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. CDDs choose visiting times and routes which will make the work less burdensome.</td>
<td>- Inspection of community treatment registers.</td>
</tr>
</tbody>
</table>
| b. CDDs arrange with the community leadership for help with specific problems, such as families who are not willing to participate in the programme. | - Interviews with:  
  * CDDs.  
  * Community members.  
  * Community leaders.  
  * FLHF staff. |
| c. CDDs carry out census and distribution during the same visit (using this census data for the following year’s order). | |

### Findings

Describe the present situation:

In approximately 50% of the communities health personnel chose the time of the day when Mectizan will be distributed to the communities. In the remaining 50% the CDDs decided the time of distribution of Mectizan. The CDDs go house to house to get people before they go to the farm. In some communities the village leadership is involved in solving specific problems while in others the CDD does not involve them in solving specific problems such as high rate of refusals.

In most communities census and distribution are carried out at different times.

Quantity of Mectizan® is determined by the District using quantity of Mectizan® distributed the previous year plus 10%.

If CDDs are not working efficiently:

- Why is this?
  
  Because the communities are not well sensitized about their ownership of the program.

- Are any steps being taken to improve the situation?
  
  No steps are taken

### Analysis

- When writing the report you have to summarise:
  
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?
  
<table>
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<tr>
<th>Fully</th>
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</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
2. Indicators of activities and processes: leadership and ownership

2.1 Check whether community leadership is managing problems with the distribution.

This indicator assesses whether the programme is effective, and whether the community is taking ownership of it.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. The community leadership should be taking responsibility for the distribution of Mectizan within the community.</td>
<td>Inspection of minutes of community/council meetings (where available).</td>
</tr>
<tr>
<td>b. If coverage (geographical and therapeutic) is not adequate or not being maintained, the leadership should understand the reasons for this.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>c. Together with the community at large, the leadership should identify and solve problems related to the distribution.</td>
<td>* CDDs.</td>
</tr>
<tr>
<td></td>
<td>* Community members.</td>
</tr>
<tr>
<td></td>
<td>* Community leaders.</td>
</tr>
<tr>
<td></td>
<td>* FLHF staff.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

The community leadership and members do not perceive that CDTI program belongs to them. Community leadership is not directly involved in managing problems. The leadership just know that there is Mectizan distribution, but problems arising from distribution process are reported by the CDD directly to the FLHF staff.

If the community leadership is not involved in the distribution:

- Why is this?

They perceive that it belongs to government

- Are any steps being taken to improve the situation?

No steps

Analysis

- When writing the report you have to summarise:
  + The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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<tr>
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</tr>
</thead>
</table>
2.2 Check whether the community at large has been involved in taking decisions on the distribution process.

This indicator assesses whether the community is taking ownership of the programme.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The community should have taken responsibility for decisions such as:</td>
<td>• Inspection of minutes of community/ council meetings (where available).</td>
</tr>
<tr>
<td>* The selection/ changing of CDDs.</td>
<td>• Interviews with:</td>
</tr>
<tr>
<td>* The timing and mode of distribution.</td>
<td>* CDDs.</td>
</tr>
<tr>
<td></td>
<td>* Community members.</td>
</tr>
<tr>
<td></td>
<td>* Community leaders.</td>
</tr>
<tr>
<td></td>
<td>* The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

In some communities the CDDs are selected by the community members while in others they are appointed by the village head. Timing of distribution was decided by the health personnel, while the mode was decided by community.

If the community is not sufficiently involved in taking decisions:

- Why is this?

They have not been properly sensitised.

- Are any steps being taken to improve the situation?

No steps taken so far.

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
2.3 Check whether the community members value and accept long-term annual treatment. 

This indicator assesses whether the community is taking ownership of the programme.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Community members should be able to mention one or more advantages of taking Mectizan.</td>
<td>Interviews with: CDDs. Community members. Community leaders. The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
<tr>
<td>b. Community members should express the need for annual treatment with Mectizan.</td>
<td></td>
</tr>
<tr>
<td>c. People should show understanding of the need for, and express interest in long term treatment with Mectizan.</td>
<td></td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

In all communities visited, community members were able to mention some of the advantages of taking Mectizan® which include improved vision, expulsion of worms, eradication of skin rashes etc. They also expressed interest in long term treatment on an annual basis.

If community members do not value and accept the treatment:

- Why is this?

Not Applicable

- Are any steps being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</tr>
</thead>
</table>
3. Indicators of activities and processes: monitoring

3.1 Check whether CDDs are reporting appropriately to the FLHF level.

This indicator assesses whether the programme is effective. If such reporting is not taking place, Meizizen supply will be compromised, which is bad for sustainability.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Reports to the FLHF level should get there on time. Reports may be summary reports, or the original community distribution record, depending on the level of skill of the CDD.</td>
<td>• Inspection of community distribution reports.</td>
</tr>
</tbody>
</table>
| b. Adequate transport should have been arranged for distribution records/reports to be handed to the appropriate person. | • Interviews with:  
  * CDDs.  
  * The persons supervising CDDs: FLHF staff, lay supervisors etc. |

Findings

Describe the present situation:

In previous years the CDDs delivered the reports to the FLHF level. In 2003 in most cases the health staff from the FLHF came to collect the reports from the CDDs. They delivered the reports on time.

In some communities the CDD was found to have summary reports, but in many cases they had original community distribution records.

No adequate transport arranged for the distribution of the reports.

If the reporting by CDDs is poor:

- Why is this?

Not Applicable

- Are any steps being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
4. Indicators of activities and processes: obtaining and managing Mectizan

4.1 Check whether the right amount of Mectizan is received.

This indicator assesses whether the programme is effective. If the right amounts are received it will foster community ownership, which is good for sustainability.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. All community members who were eligible for treatment got it, and some Mectizan was left over for absentees and those who were temporarily non-eligible.</td>
<td>• Inspection of treatment register for the community (held by CDDs; or at higher levels)</td>
</tr>
</tbody>
</table>
| b. There should be a rational explanation about how the amount ordered for the community is calculated (on the basis of population). | • Interview with:  
  * CDDs.  
  * Community members.  
  * Community leaders.  
  * The persons supervising CDDs: FLHF staff, lay supervisors etc. |

Findings

What happened at:

- The last round of treatment?

Not all the eligibles were treated and drugs were not left over for the treatment of absentees and the temporary non-eligibles. There was no rational explanation on how the amount of Mectizan® tablets needed is ordered. They use tablets distributed in the previous year plus 10%.

All remaining Mectizan® was taken back immediately to the provincial headquarters.

- The rounds before that?

Same as above

If the wrong amount of Mectizan was received:

- Why is this?

The calculation made for ordering Mectizan® tablets was not based on population figures but was based on number of people took Mectizan® tablets in the previous year plus 10%.

- Are any steps being taken to improve the situation?
- No steps

Analysis

- When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
- What is the trend in Mectizan supply?

- Your overall judgement: is this indicator for sustainability being achieved?

<table>
<thead>
<tr>
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</table>

Sustainability evaluation instrument no.1 - national level - March 2003 version
4.2 Check whether the CDDs or community members themselves fetch the yearly supply of Mectizan.

*This indicator assesses whether the project fosters community ownership.*

**Characteristics of the indicator**

| a. | The CDDs or community members fetch the Mectizan they need every year, from a designated and mutually acceptable place. |
| b. | Adequate transport should have been arranged for Mectizan to be collected from such a place. |
| c. | In the case of remote communities, the district LGA, in collaboration with FLHFs, should ensure that supplies reach such groups. |

**Sources of information**

- Interviews with:
  - CDDs.
  - Community members.
  - Community leaders.
  - The persons supervising CDDs: FLHF staff, lay supervisors etc.
  - District LGA staff.

**Findings**

What happened at:

- The last round of treatment?

*In most cases the staff of the FLHF took Mectizan® to the CDDs in the communities.*

- The rounds before that?

*Most CDDs collected drugs from the FLHF. In some cases CDDs paid for their transportation while in others the village council paid for the transport.*

If community members or CDDs have not been collecting the Mectizan:

- Why is this?

Did not collect in year 2003 because of the mass campaign for Mectizan® distribution.

- Are any steps being taken to improve the situation?

*None*

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any): steps being taken to improve it; and how this is likely to affect sustainability.
  - What is the trend in CDDs or community members fetching the Mectizan they need?

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
5. Indicators of activities and processes: HSAM

5.1 Check whether CDDs and community authorities continue to be engaged in HSAM of other community members.

This indicator assesses whether the project is effective, and whether the community has taken ownership of it.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. CDDs/ community authorities identify situations where community members require information.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>b. CDDs/ community authorities take necessary steps to provide required information; encourage community members to provide resources; promote acceptance and ownership (meetings, sanctions, community by-laws).</td>
<td>• Community leaders.</td>
</tr>
<tr>
<td></td>
<td>• Community members.</td>
</tr>
<tr>
<td></td>
<td>• CDDs.</td>
</tr>
<tr>
<td></td>
<td>• The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

The CDDs provide information to community members when necessary. The contribution of the village chiefs was mainly to mobilise the communities using town criers. Promotion of acceptance and ownership by community authorities has not been addressed.

If CDDs and community leaders are not involved in HSAM:

- Why is this?

Not applicable

- Are any steps being taken to improve the situation?

Not Applicable

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.
  - Your overall judgement: is this indicator for sustainability being achieved?

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</table>
6. Indicators of resources: financing

6.1 Check whether the community has made arrangements to fund local costs of distribution.

This indicator assesses whether the project can mobilise the resources it needs, and fosters community ownership.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>a. The community should support individuals who are providing CDTI services for them.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>b. The community should make provision for the supply of record books, pencils, transport and other expenses incurred during CDTI.</td>
<td>• Community leaders.</td>
</tr>
<tr>
<td></td>
<td>• Community members.</td>
</tr>
<tr>
<td></td>
<td>• CDDs.</td>
</tr>
<tr>
<td></td>
<td>• The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
</tbody>
</table>

Findings

Describe the present situation:

In Year 2003 the CDDS were not compensated by the community but in the previous years they were compensated using cost recovery funds. Few of the CDDs were given funds for transportation by their communities during training/meetings. Supplies (stationary) were provided by APOC and the NGDO.

If the community is not supporting or helping to defray costs:

• Why is this?

The community is not adequately sensitised on the need to support their CDDs. They have been using funds from cost recovery to motivate CDDs in the previous years.

• Are any steps being taken to improve the situation?

No steps are taken

Analysis

• When writing the report you have to summarise:
  * The evidence about how well this indicator is being achieved.
  * Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

• Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no. 1 – national level – March 2003 version
7. **Indicators of resources: human resources**

7.1 Check whether there is a satisfactory ratio of CDDs to households.

This indicator assesses whether the project can mobilise the resources it needs, and whether the community has taken ownership of the programme.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. A ratio of at least one CDD to 20 households (or 2 CDDs per 250 population) is recommended.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td>b. The households for which CDDs are responsible should be close to their own homes.</td>
<td>- Community leaders.</td>
</tr>
<tr>
<td></td>
<td>- Community members.</td>
</tr>
<tr>
<td></td>
<td>- CDDs.</td>
</tr>
<tr>
<td></td>
<td>- The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
</tbody>
</table>

**Findings**

- The present ratio in the community:

  In most communities the ratio of CDDs to population was inadequate.

- The average distances that CDDs have to walk to get to homes:

  The households are close to the CDDs' s residence.

If the ratio of CDDs is too low:

- Why is this?

  The drop out rate of CDDs is high and their reluctance from members of the community to take on the responsibility because of poor incentives

- Are any steps being taken to improve the situation?

  No steps are taken

**Analysis**

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
7.2 Check whether all CDDs have received appropriate training.

This indicator assesses whether the project is effective.

### Characteristics of the indicator

| a. | CDDs should be skilled at their work: doing the census; giving the right dose; knowing who is not eligible; knowing what to do with side-effects |
| b. | There should be a plan in place for training CDDs to replace those who drop out, or when new ones are elected for other reasons. |

### Sources of information

- Interviews with:
  - Community leaders.
  - Community members.
  - CDDs.
  - The persons supervising CDDs: FLHF staff, lay supervisors etc.
- Observing CDDs at work.

### Findings

Describe the present situation:

CDDs know who is not eligible and knows that persons with severe adverse reactions have to be referred to the health centre. There is a plan for training all CDDs on an annual basis.

If CDDs appear unskilled, or if there is no proper plan for training replacements:

- Why is this?

  **Not Applicable**

- Are any steps being taken to improve the situation?

  **Not Applicable**

### Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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</table>
7.3 Check whether CDDs are willing to continue their work in CDTI.

This indicator assesses whether the programme has mobilised the resources it needs, and whether it fosters community ownership.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. CDDs should express willingness to continue with distribution in the long term, given the conditions which prevail in the community.</td>
<td>Interviews with:</td>
</tr>
<tr>
<td></td>
<td>- Community leaders.</td>
</tr>
<tr>
<td></td>
<td>- Community members.</td>
</tr>
<tr>
<td></td>
<td>- CDDs.</td>
</tr>
<tr>
<td></td>
<td>- The persons supervising CDDs: FLHF staff, lay supervisors etc.</td>
</tr>
</tbody>
</table>

b. Few CDDs in this community have dropped out from the distribution work.

Findings

Describe the present situation:

The CDDs are willing to continue with the distribution in most of the communities. In fact some CDDs feel that the health of their people is more important than the financial support they will get from their community. Many CDDs have dropped out, while others have threatened to stop distribution if they are not compensated.

If some CDDs are doubtful or unwilling to continue, or have dropped out:

- Why is this?

  Lack of motivation

  - Are any steps being taken to improve the situation?

  No steps are taken

Analysis

- When writing the report you have to summarise:
  - The evidence about how well this indicator is being achieved.
  - Reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- Your overall judgement: is this indicator for sustainability being achieved?

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Sustainability evaluation instrument no.1 – national level – March 2003 version
8. Indicators of output: coverage

8.1 Check whether the household coverage in the community is satisfactory.

This indicator assesses whether the project is effective – if the rate is poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
</table>
| a. All households and areas in the community are being treated. This includes the hamlets for which the community has agreed to be responsible. | • Inspection of:  
  * CDDs' treatment registers.  
  * Yearly distribution reports for that community.  
  * Interviews with:  
    * Community leaders.  
    * Community members.  
    * CDDs.  
    * FLHF level staff. |
| b. If this household coverage is not 100%, it should be improving. | |

Findings

The household coverage situation:

- At the last distribution:
  
  All households and areas in the community were treated. The geographic coverage was 100%.

- The year before:
  
  All households and areas in the community were treated. The geographic coverage was 100%.

- The year before that:
  
  Same as above

If household coverage is poor:

- Why is this?
  
  Not Applicable

- Are any steps being taken to improve the situation?
  
  Not Applicable

Analysis

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in household coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully (100% coverage of all households)</th>
<th>Highly (only nomads in the surrounding area were missed)</th>
<th>Moderately (the outlying hamlets were also missed)</th>
<th>Slightly (some wards of the community were also missed)</th>
<th>Negligibly (no-one got treated, or only a few families)</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version
8.2 Check whether the community has a satisfactory therapeutic coverage rate.

This indicator assesses whether the programme is effective – if the rate is poor the project is clearly struggling, and less sustainable.

<table>
<thead>
<tr>
<th>Characteristics of the indicator</th>
<th>Sources of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The community overall has a therapeutic coverage rate of 65% or higher.</td>
<td>Inspection of:</td>
</tr>
<tr>
<td>b. This rate should be stable or increasing.</td>
<td>* CDDs' treatment registers.</td>
</tr>
<tr>
<td></td>
<td>* Yearly distribution reports for that community.</td>
</tr>
<tr>
<td></td>
<td>* Interviews with:</td>
</tr>
<tr>
<td></td>
<td>* Community leaders.</td>
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<tr>
<td></td>
<td>* Community members.</td>
</tr>
<tr>
<td></td>
<td>* CDDs.</td>
</tr>
<tr>
<td></td>
<td>* FLHF level staff.</td>
</tr>
</tbody>
</table>

**Findings**

The therapeutic coverage situation in the community:

- At the last distribution:

  **67% of communities visited had a treatment coverage of more than 65%**

- The year before:

  **38% of the communities had coverage more than 65%**

- The year before that:

  **22% of the communities had coverage more than 65%**

If the therapeutic coverage rate is poor:

- Why is this?
  
  * There is big number of refusals
  * No mechanism was put in place to make sure absentees and refusals take the Mectizan drug.

- Which steps are being taken to improve the situation?

No steps are taken

**Analysis**

- When writing the report you have to summarise the reasons for poor performance (if any); steps being taken to improve it; and how this is likely to affect sustainability.

- What is the trend in therapeutic coverage?

- Your overall judgement: is this indicator of sustainability being achieved?

<table>
<thead>
<tr>
<th>Fully (the community has a therapeutic coverage rate ≥65% - stable or increasing)</th>
<th>Moderately (the therapeutic coverage rate is ≥65%, but it is unstable or decreasing)</th>
<th>Negligibly (the therapeutic coverage rate is &lt;65%)</th>
</tr>
</thead>
</table>

Sustainability evaluation instrument no.1 – national level – March 2003 version