The Federal Democratic Republic of Ethiopia
Ministry of Health

<table>
<thead>
<tr>
<th>COUNTRY/NOTE: ETHIOPIA</th>
<th>Project Name: Metekel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval year: 2003</td>
<td>Launching year: 2004</td>
</tr>
<tr>
<td>Reporting Period: From: January 2011 To: December 2011</td>
<td></td>
</tr>
<tr>
<td>(Month/Year) (Month/Year)</td>
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<tr>
<td>Project year of this report: (circle one)</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
</tr>
<tr>
<td>Date submitted: January 2012</td>
<td>NGDO partner: The Carter Center</td>
</tr>
</tbody>
</table>

AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL

WORLD HEALTH ORGANIZATION

WHO/APOC, January 2012
ANNUAL PROJECT TECHNICAL REPORT
TO
TECHNICAL CONSULTATIVE COMMITTEE (TCC)

ENDORSEMENT

Please confirm you have read this report by signing in the appropriate space.

OFFICERS to sign the report:

Country: Ethiopia

National Coordinator: Mihret Hiluf
Signature: ...
Date: 28/01/2012

Zonal Oncho Coordinator: Ato Beyene Jara
Signature: ..............
Date: January 2012

NGDO Representative: Dr. Zerihun Tadesse
Signature: .........
Date: 25/12/2012

This report has been prepared by Name: Ato Beyene Jara

Designation: Zone onchocerciasis Coordinator
Signature: ...................
Date: January 2012

WHO/APOC, January 2012
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This report has been prepared by Name: Ato Beyene Jara
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Signature: ......................
Date: January 2012
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WHO/APOC, January 2012
Acronyms

APOC  African Programme for Onchocerciasis Control
ATO   Annual Treatment Objective
ATrO  Annual Training Objective
CBO   Community-Based Organization
CDD   Community-Directed Distributor
CDTI  Community-Directed Treatment with Ivermectin
CSM   Community Self-Monitoring
HEW   Health Extension Workers
LGA   Local Government Area
MOH   Ministry of Health
NGDO  Non-Governmental Development Organization
NGO   Non-Governmental Organization
NOTF  National Onchocerciasis Task Force
PHC   Primary health care
REMO  Rapid Epidemiological Mapping of Onchocerciasis
SAE   Severe adverse event
SHM   Stakeholders meeting
TCC   Technical Consultative Committee (APOC scientific advisory group)
TOT   Trainer of trainers
UNICEF United Nations Children’s Fund
UTG   Ultimate Treatment Goal
WHO   World Health Organization
ZHD   Zone Health Department
Definitions

(i) **Total population**: the total population living in meso/hyper-endemic communities within the project area (based on REMO and census taking).

(ii) **Eligible population**: calculated as 84% of the total population in meso/hyper-endemic communities in the project area.

(iii) **Annual Treatment Objective** (ATO): the estimated number of persons living in meso/hyper-endemic areas that a CDTI project intends to treat with ivermectin in a given year.

(iv) **Ultimate Treatment Goal** (UTG): calculated as the maximum number of people to be treated annually in meso/hyper-endemic areas within the project area, **ultimately** to be reached when the project has reached full geographic coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).

(v) **Therapeutic coverage**: number of people treated in a given year over the total population (this should be expressed as a percentage).

(vi) **Geographical coverage**: number of communities treated in a given year over the total number of meso/hyper-endemic communities as identified by REMO in the project area (this should be expressed as a percentage).

(vii) **Integration**: delivering additional health interventions (i.e. vitamin A supplements, albendazole for LF, screening for cataract, etc.) through CDTI (using the same systems, training, supervision and personnel) in order to maximize cost-effectiveness and empower communities to solve more of their health problems. This does not include activities or interventions carried out by community distributors outside of CDTI.

(viii) **Sustainability**: CDTI activities in an area are sustainable when they continue to function effectively for the foreseeable future, with high treatment coverage, integrated into the available healthcare service, with strong community ownership, using resources mobilized by the community and the government.

(ix) **Community self-monitoring (CSM)**: The process by which the community is empowered to oversee and monitor the performance of CDTI (or any community-based health intervention programme), with a view to ensuring that the programme is being executed in the way intended. It encourages the community to take full responsibility of ivermectin distribution and make appropriate modifications when necessary.

WHO/APOC, January 2012
FOLLOW UP ON TCC RECOMMENDATIONS

Executive Summary

The project named “Metekel Zone Community Directed Treatment with Ivermectin” (CDTI) is funded by the African Program for Onchocerciasis Control (APOC) and its partner The Carter Center. CDTI was initiated in 2004 and has 8 years project life.

There are 366 communities in four meso/hyper endemic woredas. The 2011 updated census figure indicates there were a total of 156,942 people in the communities.

Training of trainees (ToT), training of health workers, recruiting and orientation of CDDs and community supervisors were some of the activities accomplished prior to drug distribution. ToT was given to 11 zone and woreda management staff. Cascade trainings

<table>
<thead>
<tr>
<th>Number of Recommendation in the Report</th>
<th>TCC RECOMMENDATIONS</th>
<th>ACTIONS TAKEN BY THE PROJECT</th>
<th>FOR TCC/APOC MGT USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Involve kebeles leaders in all CDTI activities at kebeles levels</td>
<td>Kebele leaders were involved in the CDTI activities, including the selection of CDDs and follow up of Mectizan distribution</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Conduct advocacy at kebele level</td>
<td>Advocacy before MDA and during MDA has been conducted using existing opportunities like: Social meetings, Religious gatherings, Market places and community based development areas.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Use checklist for supervision at all levels</td>
<td>Standard checklist for supervision of CDTI activities was the tool used at all levels</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Implement recommendations from monitoring and evaluation</td>
<td>Recommendations from monitoring and evaluation is the instrument used to improve the CDTI program</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Conduct CSM and HSM</td>
<td>Community self monitoring is not done in 2011 as per APOC guideline. However, representatives of communities appraised the activities accomplished through review meetings conducted at Kebele level.</td>
<td></td>
</tr>
</tbody>
</table>
were also organized to 213 health workers and 13 district staff. A total of 1413 CDDs and 133 community supervisors participated after they had received orientation.

Out of the 366 communities, 6 villages are not treated. Treatment is given to 112,227 persons making the therapeutic coverage 72%.

Table 1 Treatment summary over the years, Metekel zone 2011

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Total population endemic areas</th>
<th>Annual Treatment Objective</th>
<th>Number of persons treated</th>
<th>Therapeutic coverage</th>
<th>ATO coverage</th>
<th>UTG Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>120,234</td>
<td>100,997</td>
<td>65,914</td>
<td>55</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>2005</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2006</td>
<td>118,421</td>
<td>99,474</td>
<td>79,113</td>
<td>67</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>2007</td>
<td>140,182</td>
<td>117,753</td>
<td>99,660</td>
<td>71</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>2008</td>
<td>142,056</td>
<td>119,327</td>
<td>100,149</td>
<td>71</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>2009</td>
<td>147,524</td>
<td>123,920</td>
<td>104,363</td>
<td>71</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>2010</td>
<td>151,284</td>
<td>127,078</td>
<td>121,072</td>
<td>80</td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td>2011</td>
<td>156,942</td>
<td>131,831</td>
<td>112,227</td>
<td>72</td>
<td>85</td>
<td>85</td>
</tr>
</tbody>
</table>

The project didn’t attain good result in terms of therapeutic and geographic coverage. Absentees and refusals together were also significant (12%). High number of absentees and refusals together with missed villages were the basic reasons of low therapeutic coverage of this year. Late arrival of ivermectin influences the achievement by affecting the commencement of the distribution time.

A 22% CDD attrition is documented this year making the CDD population ratio to be 1:111. The reason for high attrition is not well understood, but inconvenient of the time for them is believed to be the possible cause.

1. Overview of the population

Based on the 2007 National Census, the entire zonal population is projected at 309, 851 in 2011. Nearly half of population lives in four Meso/hyper endemic woredas. Agriculture, hunt and trade are common practices of living. A number of day laborers (tens of thousands) migrate from the other areas of the country to these areas. These people have the potential to contract the disease when the treatment coverage doesn’t meet the minimum requirement.
2. Training data

Similar to the previous years, two days TOT was organized for persons recruited for zone health department and woreda management health office. Overall, 11 health staff (2 per woreda three from ZHD) have attended the training. The training was given collaboration with by The Carter Center staff.

Similar trainings were also organized in each woreda. A total of 213 health workers 56 (26%) of them have received for the first time while the remaining 157 received the previous trainings. The number of health workers who received the training is higher than the previous year. This is related to expansion of health facilities and deployment of new health workers. The training is given by persons who have taken the TOT. Zone health department and The Carter Center staff have given assistance and played the facilitation role.

Reportedly, one day orientation (half day for malaria and half day for Oncho) was given to 1413 (143, new and 1270 refresher). Similarly, 133 community supervisors, (majority of them new) have the orientation. Both the number of CDDs and community supervisors involved this year is less by 394 and 64 persons from last year respectively.

3. Challenges and how they were overcome.

Mectizan shortage was reported form all woredas. Unwillingness of some CDDs and community supervisors to continue working was additional challenge to access the service. The underdeveloped infrastructure (road access) made conducting supportive supervisions difficult. Drug shortage was partly addressed by mobilizing it from other CDTI projects (Oromia and Southern regions). In those areas where there are no functional community supervisors, health extension workers have played the role of community supervisors besides to their task.

Opportunities:
The ever expansion of basic health service and the deployment of health extension workers who can work at lower health facility level is an opportunity for the program. These people are directly supporting the program in many ways.
SECTION 1: Background information

1.1. General information

Description of the Project

Metekel zone is located in the North-west part of Ethiopia. Metekel is one of the three zones in Benshangul Gumuz People's Regional State. Gilgel-Beless is the capital of the zone where the zonal onchocerciasis control coordination office is based. The zone is divided administratively into seven woredas and 127 kebeles known as the lowest administrative units of the government structure. The zone has a surface area of 22,028 square km. The climate of the zone is classified as tropical. There are two distinct seasons i.e. rainy and cool weather from June – October and hot and dry weather from November to May. The temperature ranges from 25°C – 42°C. The topography of the land is classified as 82% low land, 10% semi highland and 8% highland.

The total population of the zone was estimated at 309,851 in 2011. Agriculture is the main source of income for the vast majority of the zone population. Unofficial reports indicate that a number of day laborers (tens of thousands) visit for agricultural activities. This group people have likely to contract onchocerciasis as there is no system in place to access the service.

Health Service

The zone has one district hospital that serves the entire zone population. The majority (93%) of the population has access to primary health services by seven health centers and ninety-one health posts. The health posts and health centers are the ones providing primary health service to the community. Health posts are the lower health service units and staffed by health extension workers. These workers are meant for providing basic health service including providing education to the communities. The HEWs are contributing a paramount role in the CDTI activities: involve actively in recruiting, CDDs and community supervisors, giving orientation, supervise the drug administration, collect, compile and submit reports. Therefore the health extension program is taken as the opportunity to enhance implementing the CDTI activities to the grass root level.
1.1.1 CDTI woredas

As it is shown in the above map, the CDTI woredas are situated in Metekel zone. The 2003 REMO has labeled Dangur, Pawi, Guba and Mandura as endemic for onchocerciasis. The CDTI was launched in 2004 following the approval. Thus far, seven rounds of drug distribution have taken place. The zone had failed to perform second treatment round therefore the number of treatment rounds is less by one year.

Eighty six kebeles and 366 villages are available in the CDTI woredas. The number of villages has increased by 59 from the previous year. The additional villages are reported from Dangur woreda.

Though remarkable progress is being made in infrastructure development, majority of the kebeles have still no road access. This makes provision of support to health facilities and CDDs difficult. The census update done in 2011 revealed that a total of 156,942 people live in the CDTI woredas. The census result of this year is lower than the previous year. This is due to unavailability of reports from 6 villages located in Pawi and Mandura woredas. The Annual Treatment Objective was set as 131,831 of whom 112,227 persons have been received ivermectin making a therapeutic coverage of 72%. The project hasn’t treated the entire villages; therefore the geographical coverage is reduced from 100% in the previous years to 97%.

Table 1: Number of health staff involved in CDTI

<table>
<thead>
<tr>
<th>District</th>
<th>Total Number of health staff in the entire project area</th>
<th>Number of health staff involved in CDTI activities.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B1</td>
<td>B2</td>
<td>B3=B2/ B1 *100</td>
</tr>
<tr>
<td>Dangur</td>
<td>104</td>
<td>69</td>
<td>66</td>
</tr>
<tr>
<td>Pawi</td>
<td>79</td>
<td>51</td>
<td>65</td>
</tr>
<tr>
<td>Guba</td>
<td>43</td>
<td>43</td>
<td>100</td>
</tr>
<tr>
<td>Mandura</td>
<td>65</td>
<td>50</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>213</td>
<td>73</td>
</tr>
</tbody>
</table>

Not all health staff involved in the CDTI activities. Health workers working at health centers mostly don’t involve in the activities whereas health extension workers and nurses who work at health posts usually involve. Woredas having relatively small number of health workers involve all of them.
1.1.2. Partnership

The CDTI activities are being implemented with the financial, logistics and technical support from WHO/APOC, The Carter Center, CDDs and entire communities. The health staff and other sector offices (schools, training institutions) have shown their partnership by providing training halls, transporting mecitizan.
### 1.2. Population

Table 2: Communities and population at risk in the **entire project area** whether they are treated or not during the reporting period

<table>
<thead>
<tr>
<th>CDTI Districts in the entire project area</th>
<th>Total population in the entire project area</th>
<th>Number of communities/villages in</th>
<th>Population of</th>
<th>Ultimate treatment Goal (UTG)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Meso-endemic zone in the project area</td>
<td>Hyper-endemic zone in the project area</td>
<td>Meso-endemic zone in the project area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$A_2$</td>
<td>$A_2$</td>
<td>$A_4$</td>
</tr>
<tr>
<td>Dangur</td>
<td>51609</td>
<td>155</td>
<td>0</td>
<td>155</td>
</tr>
<tr>
<td>Pawi</td>
<td>52807</td>
<td>0</td>
<td>49</td>
<td>49</td>
</tr>
<tr>
<td>Guba</td>
<td>14974</td>
<td>45</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>Mandura</td>
<td>37552</td>
<td>117</td>
<td>0</td>
<td>117</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>156942</strong></td>
<td><strong>317</strong></td>
<td><strong>49</strong></td>
<td><strong>366</strong></td>
</tr>
</tbody>
</table>

**UTG** = calculated as the maximum number of people to be treated annually in meso/hyper endemic areas within the project area, **ultimately** to be reached when the project has reached full geographic coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).

- *The number of communities labeled as Meso/hyper is based on the baseline study.
- ** There is a 7266 difference in population from the report submitted previously. This difference is due to the 12 villages that were not covered by MDA.

Was a census for the project done during the reporting period? Yes [ ] No [ ]

If No, what is the source of the data in the table above?

---

WHO/APOC, January 2010
If you are using the term community or village, define what constitutes the community or village. This will help understand the profile of the project area.

The term communities or village is a structure comprising 25 – 40 households.
Is there any other information of interest about the population in the project area? If so, include it here.

Some communities are settlers/seasonal workers coming from highland areas of the country. These groups of people usually leave the area when they finalize harvesting their crops usually after February. Commencing mass administration before February will maximize annual therapeutic overage.
SECTION 2: Implementation of CDTI

2.1. Timeline of activities

Table 3: Timeline of activities for the areas treated in the current year

<table>
<thead>
<tr>
<th>District/LGA</th>
<th>Mobilization of communities</th>
<th>Training of health staff and CDUs</th>
<th>Census/Update</th>
<th>Drug distribution</th>
<th>Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Starting month</td>
<td>Completion month</td>
<td>Starting month</td>
<td>Completion month</td>
<td>Starting month</td>
</tr>
<tr>
<td>Dangur</td>
<td>March</td>
<td>March</td>
<td>February</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>Pawi</td>
<td>March</td>
<td>March</td>
<td>February</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>Guba</td>
<td>March</td>
<td>March</td>
<td>February</td>
<td>February</td>
<td>March</td>
</tr>
<tr>
<td>Mandura</td>
<td>March</td>
<td>March</td>
<td>February</td>
<td>February</td>
<td>March</td>
</tr>
</tbody>
</table>

- All the necessary preparations for the MDA such as training of health staff, distributions of IEC materials were began beginning from March. However, drug distribution was started late April and extended in some woredas up to October. Late arrival of the drug from the center affects the distribution time which in turn resulted in the distribution period to be extended beyond one month. Prolonged distribution period in most of the time makes health staff reluctant to closely follow resulting poor outcome. The six villages in Mandura woreda was the result of this.
2.2. Advocacy

Though not intensive as the previous year, officials at zone and woreda levels have been communicated and sensitized on the program. It is believed that year round advocacy would help getting the full support of leaders, sector offices for smooth implementation of the CDTI. The other importance of conducting advocacy is to harmonize the activities with the government developmental activities. The government has in most of the case schedule with the community and sector offices. Making advocacy helps harmonizing activities and avoids conflicts. Advocacy should be done on yearly basis to address newly assigned officials or decision makers. Accordingly, 7 officials/delegates from ZHD, woreda health offices, woreda administration have been mobilized. Officials who were mobilized had supported by giving directions to sector offices, kebele leaders. Some officials provided vehicles for transportation drugs, supervision activities. Few leaders visited CDDs during other community visits.

In most of the time, zone and woreda officials have busy schedule. As a result repeat visit or phone contact is mandatory. Non functional or absence of onchocerciasis taskforces or at zone and woreda levels continued to be a problem to access these people easily. Re-establishing the taskforce at zone and woreda levels would facilitate communication.

2.3. Mobilization, sensitization and health education of at risk communities

Mobilization and sensitization of communities were carried out mainly by CDDs and health workers (HEWs). Informal reports show that communities' perception towards the drug reaches the highest level. Communities have understood that the drug has additional side benefit of deworming and effects on other ectoparasites. Despite this fact, maintaining community mobilization is very important. Reportedly, level of active community participation varied depending on how intensively mobilized and sensitized.
2.4. Community involvement

Table 4: Communities participation in the CDTI (Please add more rows if necessary)

<table>
<thead>
<tr>
<th>District/LGA</th>
<th>Total no. of Communities in the entire project area</th>
<th>Number of community members as supervisors</th>
<th>Number with community members as supervisors</th>
<th>Percentage</th>
<th>Number of CDDs and the communities involved</th>
<th>Number of communities /villages with female CDDs</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B₄</td>
<td>B₅</td>
<td>B₆= B₅/ B₄ *100</td>
<td>B₇</td>
<td>B₈</td>
<td>B₉= B₇+B₈</td>
<td>B₁₀</td>
</tr>
<tr>
<td>Dangur</td>
<td>155</td>
<td>65</td>
<td>42</td>
<td>150</td>
<td>27</td>
<td>177</td>
<td>NA</td>
</tr>
<tr>
<td>Pawi</td>
<td>49</td>
<td>23</td>
<td>47</td>
<td>582</td>
<td>70</td>
<td>652</td>
<td>NA</td>
</tr>
<tr>
<td>Guba</td>
<td>45</td>
<td>7</td>
<td>16</td>
<td>170</td>
<td>10</td>
<td>180</td>
<td>NA</td>
</tr>
<tr>
<td>Mandura</td>
<td>117</td>
<td>32</td>
<td>27</td>
<td>361</td>
<td>43</td>
<td>404</td>
<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>366</td>
<td>127</td>
<td>35</td>
<td>1263</td>
<td>150</td>
<td>1413</td>
<td>NA</td>
</tr>
</tbody>
</table>

A 21% CDD attrition is reported this year compared mainly from three woredas (except Mandura). There is no clear reason for dropout that needs further investigations.

Attendance of female members of the community at health education meetings

In most cases the involvements female to attend for health education and related activities is low. The tribal culture compounded by prevailing illiteracy influences the participation of female in health education meetings and serving as CDDs.
In general, how do you rate the participation of female members of the community meetings when CDTI issues are being discussed (attendance, participation in the discussion etc)?

-No comment on this point due to the above mentioned fact.
Incentives provided by communities for the CDDs.

No any form of incentive given to CDDs by the communities.

Attrition of CDDs: Is attrition a problem for the project? If yes, how is it addressed?

As it is mentioned above, this up to 21% attrition is reported from three woredas. Compared to the previous years, this year attrition is significant. There are no clear reasons the attrition, however; inconvenience of the distribution time may be attributed to high number of CDD attrition.

2.5. Capacity building

- Describe the adequacy of available knowledgeable manpower at all levels:

The government is aggressively working to access basic health services to the communities with particular emphasis to deprived communities like B/Gumiz region. The number of health staff available in project woredas is increasing from time to time. All new health workers receive training every year to ensure the availability of knowledgeable staff at all levels. Therefore, it is believed that there are adequate staffs who can support the CDTI activities.

- Where frequent transfers of trained staff occur, state what the project is doing, or intends to do, to remedy the situation. (The most important issue to describe is what measures were taken to ensure adequate CDTI implementation where not enough knowledgeable manpower was available or if staffs are frequently transferred during the course of the campaign).

Compared to the previous years, the staffs in the project woredas are becoming stable and the number of health workers leaving the area becomes low. Whatever the case, health workers and management staff receive training yearly. Accordingly, of the total health staff, 73% of them had been trained in 2011 or retained on integrated activities of Malaria and CDTI activities.
Table 5: Training at the different levels of CDTI implementation *(Please add more rows if necessary)*

<table>
<thead>
<tr>
<th>District/LGA</th>
<th>Number of Districts' staff trained</th>
<th>Number of Health center/post staff trained</th>
<th>Number of other trainers of trainees (TOTs)</th>
<th>Number of CDDs trained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ATrO</td>
<td>New</td>
<td>Refr</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>C1</td>
<td>C2</td>
<td>C3</td>
<td>C4= C2+C3</td>
</tr>
<tr>
<td>Dangur</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pawi</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Guba</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Mandura</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>ZHD staff</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12</td>
<td>0</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>% Achievement</td>
<td>108%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 'New', 'Refr': If detail not available, provide the corresponding total only. Make sure that there is no double counting.
Table 6: Type of training undertaken

(Tick the boxes where specific training was carried out during the reporting period)

<table>
<thead>
<tr>
<th>Type of training</th>
<th>CDDs</th>
<th>Other Community members</th>
<th>Community supervisors</th>
<th>Health Workers (FLHF)</th>
<th>MOH staff or Other</th>
<th>Political Leaders</th>
<th>Others (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How to conduct Health education</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of SAEs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSM</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHM</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Any other comments
  No additional comment.

2.6. Treatments

2.6.1. Treatment figures

If the project is not achieving 100% geographical coverage and a minimum of 65% therapeutic coverage or the coverage rate is fluctuating, state the reasons and the plans being made to remedy this.

Twelve villages (six from Pawi and another six from Mandura) are omitted from drug distribution. Pawi woreda failed to provide the service due to shortage of drugs where as reluctance of the woreda health office management body was reason for failure.
Table 7: Treatment and SAEs by district/LGA in all areas at risk *(Please add more rows if necessary)*

<table>
<thead>
<tr>
<th>District/LGA</th>
<th>Communities/Villages</th>
<th>Population</th>
<th>Number of persons who refused the treatment</th>
<th>Number of serious adverse events (SAEs)</th>
<th>Number of absentees</th>
<th>Number of SAEs referred to the health post/hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total # of communities/villages in the meso/hyper-endemic areas</td>
<td>Total population of the meso/hyper-endemic areas</td>
<td>Geographical coverage (%)</td>
<td>Annual Treatment Objective</td>
<td>Number of persons treated</td>
<td>Therapeutic coverage (%)</td>
</tr>
<tr>
<td>Dangur</td>
<td>155</td>
<td>51609</td>
<td>100</td>
<td>Ds</td>
<td>43352</td>
<td>74</td>
</tr>
<tr>
<td>Pawi</td>
<td>49</td>
<td>52807</td>
<td>88</td>
<td>Ds</td>
<td>44358</td>
<td>59</td>
</tr>
<tr>
<td>Guba</td>
<td>45</td>
<td>14974</td>
<td>100</td>
<td>Ds</td>
<td>12578</td>
<td>82</td>
</tr>
<tr>
<td>Mandura</td>
<td>117</td>
<td>37552</td>
<td>85</td>
<td>Ds</td>
<td>30449</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>366</td>
<td>156942</td>
<td>97</td>
<td>Ds</td>
<td>131831</td>
<td>72</td>
</tr>
</tbody>
</table>

**ATO = The estimated number of people living in meso/hyper-endemic areas that a CDTI project intends to treat with ivermectin in a given year.**

**UTG = The maximum number of people to be treated in meso/hyper-endemic areas within the project area, ultimately to be reached when the project has reached full geographical coverage (normally the project should be expected to reach the UTG at the end of the 3rd year of the project).**
2.6.2 What are the causes of absenteeism?
The coincidence of the distribution period with farming period was the cause absenteeism. It was identified that some villages started lately even after they had received the drug.

2.6.3 What are the causes for refusals?
No known.

2.6.4 Briefly describe all known and verified serious adverse events (SAEs) that occurred during the reporting period and provide (in table 8) the required information when available.

- In case the project did not have any cases of serious adverse events (SAE) during this reporting period, please tick in the box.

No SAE case to report  ✔
2.6.5. Trend of treatment achievement from CDTI project inception to the current year

Table 9: Treatments and coverage by calendar year for the entire project area

Please indicate the UTG for the project area 131831 (use this figure as the denominator in all UTG coverage calculations.)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Communities/Villages</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total # of communities/villages in the meso/hyper-endemic areas $E_1$</td>
<td>Annual Treatment Objective $E_2$</td>
</tr>
<tr>
<td>2004</td>
<td>145</td>
<td>145</td>
</tr>
<tr>
<td>2005</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2006</td>
<td>289</td>
<td>289</td>
</tr>
<tr>
<td>2007</td>
<td>289</td>
<td>289</td>
</tr>
<tr>
<td>2008</td>
<td>289</td>
<td>289</td>
</tr>
<tr>
<td>2009</td>
<td>290</td>
<td>290</td>
</tr>
<tr>
<td>2010</td>
<td>307</td>
<td>307</td>
</tr>
<tr>
<td>2011</td>
<td>366</td>
<td>366</td>
</tr>
</tbody>
</table>

WHO/APOC, January 2011
2.7. Ordering, storage and delivery of ivermectin

Mectizan® ordered/applied for by – (please tick the appropriate answer)

MOH ☑  WHO ☐  UNICEF ☐  NGDO ☐

Other (please specify): ________________________

Mectizan® delivered by – (please tick the appropriate answer)

MOH ☑  WHO ☐  UNICEF ☐  NGDO ☐

Other (please specify): ________________________

Please describe how Mectizan® is ordered and how it gets to the communities

Mectizan® ordering and distribution was done as per the existing government drugs and supplies management system. The Zonal health department submitted a request paper to FMoH the total amount based on the woredas requirement. Shipment of drugs and other supplies from FMoH to zone warehouse was facilitated by the ZHD. Similarly, woreda health offices transported to woreda and some times to health facility levels (depending on the accessibility and availability of vehicles. For most communities, the CDDs or community supervisors collected the drug from the FLHF. Only in a few cases did the FLHF staff deliver the drug to the communities during their visits for other health programme activities.

Table 10: Mectizan® Inventory (Please add more rows if necessary)

<table>
<thead>
<tr>
<th>District/LGA</th>
<th>Number of Mectizan® tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Requested</td>
</tr>
<tr>
<td>Metekel Zone</td>
<td>371500</td>
</tr>
</tbody>
</table>

Information was not available on the amount of Mectizan expired until this report time. The assumption there could be expired drugs.

- How are the remaining ivermectin tablets collected and where are they kept?

In principle the remaining drugs have be collected and stored at woreda health office in woreda pharmacy store and will be used in the next distribution schedule. However, it is known that some health facilities haven’t yet transported the remaining drugs to woreda.

List and briefly describe the activities under ivermectin delivery that are being carried out by health care personnel in the project area.

- FLHF responsible staff formally requests the woreda health office staff (pharmacy technician or person in charge of doing this section) transports to FLHF level when deemed necessary.
- Transportation and/or distribution of ivermectin to CDDs
- Collect the left over drugs from CDDs or community supervisors and transport to woreda warehouses.
- Audit and assess the condition of remaining drug
- Facilitate disposal of expiry or damaged drugs

Any other comments:
none

2.8. Community self-monitoring and Stakeholders Meeting

Has any training (of trainers) for community self-monitoring done in the project area?

The agenda is addressed during the two days zone level ToT which was organized in April 2011.

Table 11: Community self-monitoring and Stakeholders Meeting (Add rows if needed)

<table>
<thead>
<tr>
<th>District/ LGA</th>
<th>Total # of communities/villages in the entire project area</th>
<th>No of Communities that carried out self monitoring (CSM)</th>
<th>No of Communities that conducted stakeholders meeting (SHM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dangur</td>
<td>155</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pawi</td>
<td>49</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Guba</td>
<td>45</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mandura</td>
<td>117</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>366</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Describe how the results of the community self-monitoring and stakeholders meetings have affected project implementation or how they would be utilized during the next treatment cycle.

CSM is not yet implemented in the all program woredas, hence unable comment on this area. There was a single attempt in 2010 treatment year in which few communities had conducted reviewed the activities with health workers and leaders.

2.9. Supervision

2.9.1. Provide a flow chart of supervision hierarchy.

ZHD/NGDO → WHO → Health Facility → Community supervisors → CDDs
ZHD staffs, woreda health office staff together with The Carter Center have made joint supervision. The supervision covers all the entire process (trainings, distributions, health educations).

2.9.2. What were the main issues identified during supervision?

Woreda health office level
1. Woreda health offices were not able to provide assistance to health workers and down to community supervisors due competing activities.
2. Data discrepancy between woreda and Zone
3. Malaria was not properly integrated and no document on it.

Health facility level
1. Similar to woreda, frequency of visits/support to supervisors and CDDs were minimal
2. Missing CDD registers
3. Similar to woreda health offices, distribution of mectizan was not based on population data. Some health facilities added contingency to the farthest villages. This resulted in temporary shortage of mectizan with in the woreda.

2.9.3. Was a supervision checklist used? Yes,

2.9.3. What were the outcomes at each level of CDTI implementation supervision?
• Data discrepancy corrected
• The frequency of visits increased
• Missing registers replaced by new ones
• Shortage of mectizan solved by mobilizing from village to village
• Health workers motivated

2.9.5. Was feedback given to the person or groups supervised?
Immediate feedback is given to all supervised

2.9.6. How was the feedback used to improve the overall performance of the project?
The lesson learned from the repeat visit is that gaps identified during the previous supervision were corrected and adhered.
SECTION 3: Support to CDTI

3.1. Equipment

Table 12: Status of equipment *(Please add more rows if necessary)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toyota pickup</td>
<td></td>
<td>1</td>
<td>NF</td>
<td>1</td>
<td>F</td>
<td>4</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor cycles</td>
<td></td>
<td>6</td>
<td>NF</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk top computer</td>
<td></td>
<td>1</td>
<td>F</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LaserJet printer</td>
<td></td>
<td>1</td>
<td>NF</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photocopier</td>
<td></td>
<td>1</td>
<td>NF</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax machine</td>
<td></td>
<td>1</td>
<td>CNFR</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overhead projector</td>
<td></td>
<td>1</td>
<td>NF</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Megaphones</td>
<td></td>
<td>2</td>
<td>NF</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TV</td>
<td></td>
<td>1</td>
<td>F</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VCR</td>
<td></td>
<td>1</td>
<td>F</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generator</td>
<td></td>
<td>3</td>
<td>F</td>
<td></td>
<td>NA</td>
<td></td>
<td></td>
<td>2</td>
<td>F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Condition of the equipment (F=Functional, CNFR=Currently non-functional but repairable, WO=Written off, NA data not available)*

Replacement of the items is done in 2011. Replaced items are highlighted blue

How does the project intend to maintain and replace existing equipment and other materials?

Maintenance APOC donated vehicles is done according to government regulations. Unless there are financial constraints, vehicles especially the car receives regular service depending on the mileage. Regular service is not common for motorbikes. Replacement would seem difficult for zones and woredas, nonetheless vehicles and office equipment donated by other programs will be utilized whenever necessary since APOC donated vehicles and equipment are supporting other programs.
3.2. Financial contributions of the partners and communities

Table 13: Financial contributions by all partners for the last three years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>TOTAL Cash Budgeted (US$)</td>
<td>TOTAL Cash Released (US$)</td>
<td>TOTAL Cash Budgeted (US$)</td>
</tr>
<tr>
<td>MOH (Central + State)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MOH (District + zone)</td>
<td>5000</td>
<td>4408.7</td>
<td>5500</td>
</tr>
<tr>
<td>Local NGDO(s) (if any)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NGDO partner (The Carter Center)</td>
<td>7000</td>
<td>6009.5</td>
<td>12,000</td>
</tr>
<tr>
<td>Communities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>APOC Trust Fund</td>
<td>5651.11</td>
<td>3955.77</td>
<td>15242.85</td>
</tr>
<tr>
<td>TOTAL</td>
<td>17651.11</td>
<td>14373.97</td>
<td>32742.85</td>
</tr>
</tbody>
</table>

- If there are problems with release of counterpart funds, how were they addressed?
  In most cases, release of APOC fund is not flexible and doesn't arrive timely. Rather the fund from TCC is fast and flexible.
- Additional comments

CDTI activities have been implemented with integration of other health programs; however, lack of appropriate documentation usually possesses difficulty to clearly put explicitly and might underestimate government contribution.

3.3. Other forms of community support
- Describe (indicate forms of in-kind contributions of communities if any)
  Few communities assisted drug transportation from woreda health office to kebeles.

3.4. Expenditure per activity
- Indicate in table 14, the amount expended during the reporting period for each activity listed. Write the amount expended in US dollars using the current United Nations exchange rate to local currency. Indicate exchange rate used here

1USD = 16.32 Birr
Table 14: Indicate how much the project spent for each activity listed below during the reporting period

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expenditure ($ US)</th>
<th>Source(s) of funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug delivery from FMoH area to central collection point of community</td>
<td>834</td>
<td>GOV &amp; TCC</td>
</tr>
<tr>
<td>Mobilization and health education of communities (HSM)</td>
<td>2806.02</td>
<td>APOC &amp; TCC</td>
</tr>
<tr>
<td>Training of CDDs</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Training of health staff at all levels</td>
<td>11683.1</td>
<td>APOC+ TCC</td>
</tr>
<tr>
<td>Supervising CDDs and distribution</td>
<td>3283</td>
<td>APOC+TCC</td>
</tr>
<tr>
<td>CSM</td>
<td>6921</td>
<td>APOC</td>
</tr>
<tr>
<td>Internal monitoring of CDTI activities</td>
<td>564.3</td>
<td>TCC</td>
</tr>
<tr>
<td>Advocacy visits to health and political authorities</td>
<td>670</td>
<td>TCC</td>
</tr>
<tr>
<td>IEC materials</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Summary (reporting) forms for treatment</td>
<td>174</td>
<td>GOV</td>
</tr>
<tr>
<td>Vehicles/ Motorcycles/ bicycles maintenance</td>
<td>2132</td>
<td>GOV</td>
</tr>
<tr>
<td>Office Equipment (e.g. computers, printers etc)</td>
<td>174.5</td>
<td>TCC</td>
</tr>
<tr>
<td>Other miscellaneous expenses</td>
<td>1099</td>
<td>GOV</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30340.92</td>
<td></td>
</tr>
</tbody>
</table>

Total number of persons treated = 121072

Cost treatment = 0.30 USD

SECTION 4: Sustainability of CDTI

4.1. Internal; independent participatory monitoring; Evaluation

4.1.1 Was Monitoring/evaluation carried out during the reporting period? (Tick any of the following which are applicable)

- Year 1 Participatory Independent monitoring
- Mid term Sustainability Evaluation
- 5 year Sustainability Evaluation

WHO/APOC, January 2012
4.1.2. What were the recommendations?

- Training should be targeted
- Government budget should be explicitly spelt out at all levels
- Improve therapeutic coverage to highest level
- Improve documentation of CDTI activities especially at woreda level
- Mectizan should be available at the appropriate time
- The need to plan for vehicle and equipment replacement

4.1.3. How have they been implemented?

The ZHD and woreda health offices are trying to address the recommendations

4.2. Sustainability of projects: plan and set targets (mandatory at Yr 3)

Was the project evaluated during the reporting period? _ ____ no ____________________

Was a sustainability plan written? ________yes (during 5 yrs project evaluation)__________

When was the sustainability plan submitted? _ ____yes (during 5 yrs evaluation)__________

What arrangements have been made to sustain CDTI after APOC funding ceases in terms of?

4.2.1. Planning at all relevant levels

4.2.2. Funds

4.2.3 Transport (replacement and maintenance)

4.2.4. Other resources

4.2.5. To what extent has the plan been implemented
4.3. Integration

Outline the extent of integration of CDTI into the PHC structure and the plans for complete integration:

4.3.1. Ivermectin delivery mechanisms
Ivermectin and delivery mechanism is integrated into the existing government drug procurement and distribution system. Zone health department is responsible to transport Ivermectin from the Center until zone level. Each health office has transport its own share to woreda level and when necessary to FLHFs. The woreda plans to execute CDT activities by integrating with other health programs.

4.3.2. Training:
The CDTI activities including training of health workers are integrated are being implemented with other activities. The budgets from other sources are helping to train health workers and vice versa.

4.3.3. Joint supervision and monitoring with other programs
One of the directions of the government is to conduct joint supervisions and address related activities together. Health facility supervisions, drug collections and the likes were done along with malaria control activities (IRS spray, outbreak investigation and control. Health extension workers were assisting CDDs and community supervisors during door to door visit for routine health activities.

4.3.4. Release of funds for project activities
Release of funds for project activities is done based on the proposal prepared by appropriate person and presented to the zone or woreda head. Effecting payments or purchase of materials is done after it gets the approval of the head. The Carter Center manages its fund by its own. Training and other expenses are either effected immediately or reimburse based on the receipt or approved documents.

4.3.5. Is CDTI included in the PHC budget? Yes
As clearly mentioned earlier, CDTI is part of Malaria and Other Vector Borne Diseases. One can not find earmarked budget for Oncho specifically. The money allocated under this budget line includes CDTI activities.

4.3.6. Describe other health programs that are using the CDTI structure and how this was achieved. What have been the achievements?
Though difficult to measure the achievements, health programs such as Immunizations and malaria control activities use the structure. CDDs also support malaria during drug distribution.
4.3.7. Describe others issues considered in the integration of CDTI. No further comment

4.4. Operational research:- None

4.4.1. Summarize in not more than one half of a page the operational research undertaken in the project area within the reporting period.

4.4.2. How were the results applied in the project?

SECTION 5: Strengths, weaknesses, challenges, and opportunities

Strengths:
- Willingness and CDDs
- Integration of CDTI with other programs
- The positive attitude of communities towards the drug ivermectin
- Relatively stable staff

Weaknesses:
- Reluctance of some woreda health office such as Mandura to support the activities
- Data inconsistency at different levels
- Weak document and missing registers
- Absence of document on government financial contribution
- Presence of omitted villages

Challenges:
Problems related to transportation
- Poor infrastructure to reach CDT villages
- High fuel and maintenance cost
- Mobile nature of some communities
- Late arrival of drugs from the Center
- High rate of CDD attrition

SECTION 6: Unique features of the project/other matters

A mega project is underway in Guba woreda on Blue Nile riverbank. An estimated 15-20 thousands of laborers have been working. The project will stay for the next five years. As these groups of people living in endemic areas, there are possibilities of contracting the disease. Guba woreda health office has made an official request how to handle the issue.