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*Vector Biology
and Control Project*

**Project Design and Implementation
of the Ivermectin Delivery Program**

By J. Madison Seymour, Ph.D.

VBC Report No. 81239

Author

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Executive Summary

The U.S. Agency for International Development's (A.I.D.'s) Ivermectin Delivery Program (IDP) is a pilot ivermectin distribution program in targeted countries in Africa and Latin America.

The purpose of the three-year IDP is to assess the feasibility of using U.S.-based private voluntary organizations (PVOs) to strengthen indigenous health systems' ability to provide cost-effective, sustainable delivery of ivermectin.

This document is intended to guide the PVOs in developing effective ivermectin delivery activities in specific African and Latin America countries, and to provide a framework for evaluating those activities. It gives the IDP a project format, and describes the program using a logframe and a narrative of the program's goal, purpose, outputs and activities. The document also provides an implementation schedule, a monitoring and evaluation plan, and a scope of work for the Vector Biology and Control (VBC) Project, which will provide technical support and program monitoring assistance to the PVOs selected to implement the program.

A.I.D.'s Bureau of Research and Development, Office of Health (R&D/Health), is responsible for the IDP. VBC is an R&D/Health project that provides technical assistance, training and information to vector-borne disease control programs in A.I.D.-assisted countries.

Onchocerciasis, or "river blindness," is caused by the parasite *Onchocerca volvulus*, which is transmitted by biting black flies (*Simulium damnosum*). An estimated 18 million people are infected with onchocerciasis. Years of exposure to intense black fly biting have rendered some 340,000 people blind due to massive accumulations of parasites in their bodies. Another 300,000 are estimated to have suffered significant visual loss. Onchocerciasis is endemic in Yemen and some 33 countries in Africa and Latin America.

Since the 1970s, A.I.D. has supported the Onchocerciasis Control Program (OCP), a large, multidonor aerial and ground-spraying program to control black fly larvae in West Africa. These control efforts were successful, interrupting onchocerciasis transmission in 90 percent of the program areas and resulting in significant decreases in onchocerciasis-related blindness and disability. However,

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pockets of infected populations remain, and there is always a threat of a resurgence of the black fly population. This is particularly true for villages along waterways in savannah areas.

In the mid-1980s, the drug ivermectin was found to be highly effective in killing microfilariae, or immature parasites. Since ivermectin was licensed for human use in 1987, it has become the drug of choice for treating onchocerciasis. Merck, Sharp and Dohme, the pharmaceutical company that developed ivermectin (trade name Mectizan), donates the drug to organizations that have the capacity to deliver ivermectin to infected populations.

In fiscal year (FY) 1991, the U.S. Congress earmarked \$5 million for onchocerciasis control, prevention and eradication. Half of the funds are to support the OCP in West Africa. The other \$2.5 million is earmarked to support A.I.D.'s IDP in targeted countries of Africa and Central America.

The IDP follows a recommendation of A.I.D.'s impact evaluation on onchocerciasis: to develop a cost-effective ivermectin delivery system with adequate epidemiological surveillance. The program presents technical and institutional challenges. Technically, the challenge is to implement an effective IDP. The institutional challenge is strengthening indigenous institutions by training health workers to establish and operate ivermectin delivery programs.

The IDP has five components:

1. distribution of ivermectin to infected people by village health workers (VHWs) through primary health care systems;
2. training for VHWs and other indigenous health workers;
3. education for rural communities about the disease and treatment with ivermectin;
4. epidemiological and sociological studies to identify infected communities and appropriate ways to treat them; and
5. a monitoring system to determine whether the objectives of each component are being met.

The long-term coordinator will be a key participant in the IDP. His or her primary responsibilities will be to: backstop IDP activities; provide technical assistance to the PVOs in the field; monitor the program by reviewing reports and making field visits; and coordinate the midterm and final evaluations. A health information system specialist will assist PVOs in establishing adequate field monitoring systems to provide information about program progress. The final evaluation will determine how successful the PVOs' pilot effort was, and whether it is worth emulating.

1. Introduction

The Ivermectin Delivery Program (IDP) is the U.S. Agency for International Development's (A.I.D.'s) response to the congressional challenge to develop a pilot ivermectin distribution program in targeted countries in Africa and Latin America where onchocerciasis is a public health problem. In FY 1991, the U.S. Congress earmarked \$2.5 million to support ivermectin distribution. This document was prepared to outline how the IDP will be managed, monitored and evaluated, and to provide guidance for the PVO personnel who implement the pilot program.

In February 1991, A.I.D.'s Bureau of Research and Development, Office of Health (R&D/Health) asked interested U.S.-based private voluntary organizations (PVOs) to submit proposals describing how they would design and implement ivermectin distribution activities. At that time, R&D/Health determined that the Vector Biology Control (VBC) Project should provide technical support and program monitoring skills to the IDP. VBC is A.I.D.'s resource for technical assistance, information services and institutional development in vector-borne disease control.

R&D/Health received the proposals in March 1991 and held a formal review to select the best proposals in early April. I was hired as a VBC consultant in mid-March to coordinate the review and summarize the proceedings (Annex 1). After the review, I began to address the three tasks in my scope of work:

- "1. Produce a **Scope of Work (SOW)** for the Long Term Technical Assistant who will manage the PVO ivermectin Distribution System project for three years. Production of the SOW will necessitate participation in planning the three year project. Initially this includes development of the project Log-frame. It may include other deliverables related to this planning effort, such as manpower and cost requirements for VBC to maintain oversight of approved projects during the three year period.

2. Produce a **Monitoring and Evaluation Plan** which VBC would assist the PVOs in implementing to ensure uniformity in reporting, monitoring and evaluation. Substantively this includes the reporting of: project designs; methods of collecting and analyzing data; project benchmarks and deliverables. This will also include a **mechanism** for summarizing individual project reports for timely presentation for R&D/H review. Finally, it will include a **schedule** for interim and final evaluations of respective projects, possibly to include pre-established criteria for such evaluations.

3. Produce a **plan for two workshops** for the managers of the approved projects to discuss issues common to all projects, to reach agreement on issues of coordination and reporting, and to share concepts and methods that may enhance each of the projects and to improve the original proposals. One workshop will be for U.S. based PVOs to be held in Washington immediately after the projects are awarded in September, 1991. The second will be in Africa and Latin America on a country by country basis in 1991 - 1992. The plan will include objectives, topics, tentative schedules, human and material resources and logistical arrangements."

It became apparent that background work was needed to complete these tasks. It was decided that a formal project description of the IDP should be written. This began with a logframe and was completed with a narrative description of the goal, purpose, outputs and component activities (chapter 2). An implementation schedule was added (chapter 3). A decision was also made to substitute the term "delivery" for "distribution" in the ivermectin program's title. The former term was considered more appropriate because it implied a system of components that supported the distribution of ivermectin rather than a simple pill distribution. The title "long-term technical assistant" was changed to "coordinator."

In late April I attended the First InterAmerican Conference on Onchocerciasis, sponsored by PAHO, in Guatemala City and Tapachula, Mexico. This meeting gave me an opportunity to discuss A.I.D.'s effort with conference participants, who were very knowl-

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edgeable about the disease and ivermectin treatment. Participants included international experts on onchocerciasis and PVO managers.

After returning from the meeting, I wrote the monitoring and evaluation plan (chapter 4) and the scope of work for VBC (chapter 5). After a planning session with PVO representatives in June 1991, an agenda was developed for IDP Implementation Workshops.

2. Project Description of the IDP

Ivermectin Delivery Program (IDP)

This chapter describes a prototype Ivermectin Delivery Program (IDP). It is based on the criteria for ivermectin distribution issued by R&D/Health and also on a recently published manual, *Mass Distribution of Ivermectin* by Dr. Robert Pond. The prototype is more an activity than a project, although it follows the A.I.D. project structure, with a logframe and a description of the component activities. It states the purpose of the IDP and identifies the activities that A.I.D. endorses to achieve project objectives. Where appropriate, it is intended to guide PVOs in developing ivermectin delivery activities in specific African and Latin American countries, and to provide a framework for evaluating those activities.

Problem and rationale

Onchocerciasis, or "river blindness," is caused by the parasite *Onchocerca volvulus*, which is transmitted by biting black flies (*Simulium damnosum*). An estimated 18 million people are infected with onchocerciasis. Years of exposure to intense black fly biting have rendered some 340,000 people blind due to massive accumulations of parasites in their bodies. Another 300,000 are estimated to have suffered significant visual loss. Onchocerciasis is endemic in Yemen and some 33 countries in Africa and Latin America.

The Onchocerciasis Control Program (OCP), which is funded by 31 donors, including A.I.D., has used aerial and ground spraying of larvicides to interrupt onchocerciasis transmission in 90 percent of the program area in West Africa. In addition, the incidence of blindness and disability caused by onchocerciasis has been reduced substantially (*Impact Review of the Onchocerciasis Control Program*, A.I.D., Wash, D.C. 1986). Despite the success of the OCP, pockets of infected populations remain, and there is always a threat of a resurgence in the black fly population. This is particularly true for villages along waterways in savannah areas. Thus, the extent of

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the onchocerciasis problem has been reduced but never completely overcome.

In the mid 1980s, the drug ivermectin was found to be highly effective in killing microfilariae, or immature parasites. Licensed for human use in 1987, ivermectin has become the drug of choice for treating onchocerciasis. Merck, Sharp and Dohme, the pharmaceutical company that developed ivermectin (trade name Mectizan), donates the drug to organizations that have the capacity to deliver ivermectin to people infected with onchocerciasis.

In FY 1991, the U.S. Congress earmarked \$5 million for control, prevention and eradication of river blindness. Half the funds were earmarked to support the OCP, and the other \$2.5 million was to support A.I.D.'s Ivermectin Distribution Program (IDP) in African and Central American countries. The IDP is a three-year pilot effort. It follows a recommendation made in A.I.D.'s impact evaluation on onchocerciasis to develop a cost-effective ivermectin delivery system with adequate epidemiological surveillance.

Program Goal, purpose, and outputs (See logframe)

The program's goal is to reduce the impact of onchocerciasis to a level that no longer represents either a public health problem or an obstacle to socioeconomic development. This is also the goal of the OCP, which was established in Ougadougou in 1974. While considerable progress has been made since then in treating and controlling the disease, this goal is still valid and attainable.

The purpose of the IDP is to assess the feasibility of using U.S. PVOs to strengthen indigenous health institutions' ability to design, implement and manage cost-effective, sustainable ivermectin delivery programs. The program presents technical and institutional challenges. Technically, the challenge is to implement an effective IDP. Institutionally, the challenge is to strengthen indigenous health institutions by training health workers to establish and operate ivermectin delivery programs.

Five end-of-project status (EOPS) conditions will measure whether the IDP's purpose has been achieved:

- o that an indigenous and decentralized IDP is **totally responsible** for managing the distribution of ivermectin, and is supported by appropriate training, health education, surveys and monitoring;
- o that a targeted number of qualified indigenous health workers and village health workers are operating the IDP according to specified occupational criteria;
- o that a targeted number of ivermectin tablets have been distributed to individuals in hyperendemic communities;
- o that the costs of delivery operations are recovered at an acceptable rate; and
- o that treatment costs are at an acceptably low level.

While the specifics of these conditions will vary from country to country, the conditions will essentially be the same for each program activity.

Five outputs must be achieved during the three-year period to fulfill the purpose of the program: 1) required surveys conducted; 2) indigenous health trainers and workers trained; 3) ivermectin pills distributed; 4) communities educated about onchocerciasis and the use of ivermectin; and 5) a monitoring system in place and working.

| Narrative Summary (NS) | Measurable Indicators (OVI) | Means of Verification (MOV) | Important Assumptions |
|--|--|---|--|
| <p>Goal:</p> <p>1 To reduce the impact of onchocerciasis to a sufficiently low level so that it no longer represents either a public health problem or an obstacle to socioeconomic development.</p> | <p>1.1 Incidence in the target areas of each IDP country reduced by by _____ % during the life of the project</p> | <p>1.1 National and local health records.</p> | <p>(goal to supergoal) 1.1</p> |
| <p>Purpose:</p> <p>1 To assist PVOs participating in the IDP to strengthen indigenous health institutions to design, implement and manage an ivermectin delivery program that is sustainable.</p> <p>2 To assess the institutional and epidemiological impact of the IDP.</p> | <p>1.1 Supported by an increased capability in training, health education, surveillance, and monitoring counterpart health institutions assume greater responsibility for the various components of the IDP.</p> <p>1.2 Targeted number of qualified indigenous health workers are operating the IDP according to specified criteria.</p> <p>1.3 Targeted number of ivermectin tablets distributed to individuals in prioritized communities.</p> <p>1.4 Costs of delivery are at an acceptably low level.</p> <p>2.1 Monitoring system, capable of determining if component objectives are achieved, is in place.</p> | <p>1.1 Health records and site inspection.</p> <p>1.2 Health personnel and training records.</p> <p>1.3 Mectizan inventory records.</p> <p>1.4 Health financial records.</p> <p>2.1 Health information system records</p> | <p>(purpose to goal) 1.1 Ivermectin remains a safe and effective treatment for onchocerciasis.</p> <p>2.1</p> |
| <p>Outputs:</p> <p>1 surveys conducted for disease prevalence and community knowledge, attitudes and perceptions of onchocerciasis.</p> <p>2 Indigenous health trainer and health workers trained and being supervised in IDP procedures.</p> | <p>1.1 Targeted number of individuals screened for infection.</p> <p>1.2 Targeted number of communities selected for distribution of ivermectin.</p> <p>1.3 Targeted number of communities surveyed in terms of their knowledge, attitudes and perceptions of onchocerciasis.</p> <p>2.1 Training needs assessment conducted.</p> <p>2.2 Targeted number of indigenous health trainer and health</p> | <p>1.1 Health oncho survey records and results</p> <p>2.1 MON and IDP training records.</p> | <p>(output to purpose) 1.1 There are information gaps and needs regarding prevalence and KAP surveys.</p> <p>2.1</p> |

| | | | |
|---|---|--|--|
| <p>3 Ivermectin pills distributed according to prescribed procedures.</p> | <p>workers trained and supervised in IDP procedures.</p> <p>3.1 Targeted number of individuals selected and treated according to prescribed protocol.</p> | <p>3.1 Mectizan inventory control records.</p> | <p>3.1</p> |
| <p>4 Communities educated regarding nature of onchocerciasis and the procedures for using ivermectin.</p> | <p>4.1 Targeted number of communities educated about onchocerciasis and the use of ivermectin.</p> | <p>4.1 Field records and site inspection.</p> | <p>4.1 Community can and wants to have onchocerciasis education.</p> |
| <p>5 Monitoring system in place and used to manage project implementation.</p> | <p>5.1 Key decision-makers involved with IDP use monitoring system.</p> | <p>5.1 Field records and site inspection.</p> | <p>5.1 Decision makers able to use the information from the MIS.</p> |
| <p>Activities:</p> <p>TECHNICAL ASSISTANCE:</p> <p>A.I.D./VBC provide timely and appropriate assistance to PVOs and their local counterparts to:</p> <p>conduct prevalence and incidence surveys.</p> <p>assist trainers at appropriate levels within the existing health delivery system.</p> <p>assist indigenous health agency to distribute ivermectin according to prescribed procedures.</p> <p>assist appropriate indigenous health educators to educate communities regarding nature of onchocerciasis and procedures for using ivermectin.</p> <p>assist appropriate health information personnel to establish and operate a monitoring system.</p> <p>ASSESSMENTS:</p> <p>Monthly reports analyzed and shared with PVOs</p> <p>Mid-term (formative) conducted and lessons shared with PVOs</p> <p>Final evaluation</p> | <p>Inputs/Resources:</p> <p>Facilitation:</p> <p>ie. in-country workshops</p> <p>Technical Assistance:</p> <p>ie. MIS</p> <p>Evaluations:</p> <p>ie. Mid-term</p> | | <p>(activity to output)</p> |

Program components and activities (See logframe)

Each of the outputs listed above will be the focus of one of the program's components. Each component and its objectives and activities will be discussed separately below.

Surveys

The initial objective of the surveys is to identify endemic communities. Preliminary screening will be done by reviewing the results of previous skin snipping, blindness or epidemiological surveys. Either rapid assessment or skin snipping methods (or combination of both) will be used to identify more precisely endemic communities. Proper sampling methods must be employed to ensure that communities in greatest need of ivermectin treatment are selected. The criterion for selecting communities for mass distribution of ivermectin should be that at least 40 percent of all men age 20-60 are infected. This would be roughly equivalent to requiring a prevalence of 20 percent in the overall population. When the prevalence of infection drops below 20 percent, onchocerciasis is no longer endemic and blindness from the disease is rare.

A second objective of the surveys is to better understand the target communities' knowledge, attitudes and perceptions (KAP) of onchocerciasis, ivermectin treatment and alternative treatments (e.g. nodulectomies). PVOs and indigenous health workers can use information from KAP surveys to formulate appropriate health education and delivery strategies. If the KAP surveys are conducted as mid-term or final evaluations, they could help determine whether the objectives of some program components were met. The KAP surveys need not be exhaustive and can sample a few communities to identify community members' general understandings of the nature of the disease, its causes and cures.

A third objective of the surveys may be following up the initial surveys after the ivermectin distribution to determine the impact of pill distribution on endemic communities. The same individuals who were initially surveyed should be tested again.

Because follow-up surveys are expensive, conducting them will be optional. Assuming that initial surveys accurately determined the prevalence of infection in a sample of communities, it may be appropriate to calculate the impact of ivermectin distribution based upon data on the coverage achieved.

PVOs are encouraged to work with host-country survey researchers, epidemiologists and field personnel to gather, organize and interpret survey data. This will help ensure that the host-country personnel learn the skills necessary to continue research on their own. PVOs should also strive to develop sustained linkages between the appropriate research staff in the Ministry of Health (MOH) epidemiological units and the IDP field staff responsible for selecting target communities for ivermectin distribution.

Training

The objective of training is to provide those implementing the IDP — mainly health workers, village health workers (VHWs) and health trainers — with the knowledge and skills necessary to complete their tasks. PVOs should consider four factors in providing assistance for the training component: needs assessment, structure, skills and methods.

Needs assessment

PVOs can initiate a training needs assessment to determine the skills required and the number and qualifications of the people needed to implement each component of the program. The structure of each assessment will vary depending upon the availability of appropriately trained individuals and information about them, and the scope of a country's program. An assessment should begin with a rapid estimate of training needs for each component. This will be refined and detailed as information about training needs is collected. Assessments need not be exhaustive nor overly detailed, and should be conducted at the outset of the program.

Structure

The number of individuals to be trained and their qualifications will vary with each program. Most likely they will consist of the health trainers, health workers and VHWs. This suggests that a tiered training structure would be appropriate. PVO personnel would work with the health trainers to train health workers at health centers or clinics. Then the health workers - perhaps accompanied by the trainers - would train VHWs at field sites or in the communities. In smaller programs, the same people may distribute ivermectin, educate the community and maintain records; hence, they should be trained in all these areas. In larger programs, which may have health specialists for some of these tasks, different people would be trained in specific areas. Whatever the size of a program, PVO personnel can ensure that the training cascades from the health centers to field sites or communities.

Skills

PVOs can help health trainers develop skills to train workers in the five component areas:

- o **Ivermectin Distribution.** The most appropriate people, most likely the VHWs, will learn how to: select the onchocerciasis patients who can be treated with ivermectin according to a simple protocol; weigh patients; record essential patient and pill data; observe patients swallowing the pill; give final instructions; and identify and refer people with serious reactions to the treatment. If mobile teams are used, special training in vehicular use and maintenance will be necessary.

- o **Onchocerciasis health education (OHE).** Special health educators, health workers or possibly VHWs will learn the four basic categories of the OHE curriculum and appropriate ways to convey that information to communities (both described in the OHE component). They will learn how to understand community health practices related to onchocerciasis, how to convey scientific concepts and causal linkages about the disease to the community, how to describe ivermectin treatment, and how to motivate community members to seek out and use the drug. They will also be trained in conducting individual and group visits, and in using visual aids and radio-assisted instruction.

- o **Surveys.** Much of the survey work will most likely be done by specialists already trained in survey research, statistical analysis and epidemiology. If additional or different specialists are needed, they will be recruited and trained in the appropriate survey and analytical methods.

- o **Training.** PVO personnel can orient the health trainers in training health workers (and possibly VHWs) in the appropriate knowledge and skills needed for survey work, health education, pill distribution, and gathering information for monitoring. A trained cadre of health trainers will continuously train health workers for participation in and expansion of the IDP, thus contributing to the program's institutional sustainability.

- o **Monitoring.** Workers responsible for gathering, transmitting and using IDP information will be trained in data gathering or recording techniques, developing and using information forms, organizing data for computer processing, and generating reports. Most likely, people will be trained in different skills according to their responsibilities in this monitoring system. For example, VHWs will record patient, pill and cost data on simple forms; health workers will collect this data and organize it for computer use; and health specialists will input, process and retrieve the data for monitoring activities.

Methods

Practical training methods such as role playing, learning by doing and team exercises will be emphasized. Training methods used will reflect the backgrounds of the trainees and the complexity of the skills being taught. In some cases, such as the training of information specialists, the training methods may combine discussion, reading and practice.

Ivermectin distribution

The objective of this component is to distribute the required number of pills to communities selected for treatment according to the required procedures.

The actual distribution of ivermectin will be decentralized rather than "vertical." Since the target group of the IDP is the community, it is best that the people responsible for distributing ivermectin be from the communities themselves. In most cases they will probably be VHWs, who form the foundation of many successful primary health care programs throughout the world. VHWs have proved themselves capable and, when properly trained and supervised, they can safely and effectively deliver a variety of health services. If provided transportation, such as motorcycles, bicycles or bus fare, VHWs can visit many homes in and around their communities. PVOs are encouraged to integrate the IDP with an ongoing primary health care system if

this is feasible so that ivermectin distribution becomes one of the many services performed by VHWs.

The simple procedures that must be followed for community-wide distribution of ivermectin fall into five categories:

- o **Screening** eligible ivermectin recipients. VHWs select people eligible to receive ivermectin treatment according to their weight (adults and children who weigh 15kg or more can receive ivermectin), health (no obvious symptoms of a debilitating illness), and pregnancy status (women who are not pregnant or have not delivered a baby recently).
- o **Weighing** recipients on a simple bathroom scale.
- o **Recording** essential patient and pill data. This may vary by program, but the essential data for the monitoring system are: the record of people treated (e.g. name, age, sex and weight); the number of pills dispensed and the number leftover after an administration period; and the number and type of adverse reactions. Data should also include cash amounts collected as user fees. Only data that will be used for surveillance and project management should be collected. In general, the number of variables monitored should be kept to a minimum.
- o **Distributing** pills to each individual and observing that the recipient swallows the pill.
- o **Instructing** recipients to take another pill six months or year later, depending on the treatment protocol, and urging them to contact a health worker in the event of any adverse reactions to the treatment.
- o **Managing** adverse reactions. If a VHW is trained in managing simple adverse reactions, he or she should treat them if they occur. It is more important, however, for VHWs to know how to refer a patient to health workers, nurses or physicians.

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VHWs should be supervised regularly to ensure that ivermectin distribution follows the procedures outlined above. Supervisory health workers or nurses must monitor the tasks of the VHWs. Ideally, health workers who trained the VHWs should also supervise and support them through regular visits. Where such a supervisory arrangement already exists as part of an established primary health care system, supervision of ivermectin distribution can be readily integrated. Where this arrangement does not exist, a similar one should be established. Senior health workers, nurses or even physicians should regularly monitor the VHWs activities through the field health supervisor. Thus, a three-tiered system will supply, guide and reinforce the VHWs. PVOs are encouraged to monitor the supervisory activities to ensure that adequate supervision takes place at each tier.

If using VHWs to distribute ivermectin is not feasible, several alternatives are available:

- o clinic-based health workers can conduct home visits in nearby communities to distribute ivermectin and deliver OHE messages;
- o ivermectin can be dispensed to people who visit local health centers for health care;
- o mobile teams based at provincial health centers can deliver ivermectin and OHE messages to communities throughout their province; or
- o a combination of these "center-to-community" alternatives can be adapted to local needs and resources.

These approaches tend to be "vertical" but may be necessary to establish an IDP. Once training and supervision networks of VHWs have been established, however, a decentralized approach that focuses on VHWs as the primary ivermectin distributors should be adopted.

Onchocerciasis health education (OHE)

The objective of OHE is to provide target communities with the knowledge necessary to understand the nature and cause of onchocerciasis and participate in the ivermectin treatment program. OHE should motivate people to follow the treatment procedures.

OHE works from the premise that a target community already has a set of concepts, terms, causal linkages and beliefs about the onchocerciasis and its treatment. The community's perspective may or may not reflect current medical understanding of the disease. The OHE approach, then, is to adapt scientific knowledge and treatment of onchocerciasis to the prevailing community perspective on the disease. In some cases, OHE may build upon this "folk system" while in others it may have to confront it or obviate it altogether.

A KAP survey should provide a basis for developing an appropriate OHE approach. This approach is essential to achieving the OHE objective of changing community perspectives and gaining a commitment from the community to use ivermectin treatment.

OHE curriculum

"Curriculum" is defined here as a set of knowledge, skills and attitudes to be conveyed and accepted by a target population. Tentatively, four broad curriculum categories are proposed for OHE:

- o **The Disease.** Through the use of local terms and concepts, a simple but accurate modern concept of the disease will be learned. This includes its symptoms, causes, development, and deleterious effects upon an individual, community and society. People must learn the interrelationships of the three agents -- the human host, the parasite and the black fly vector. This understanding can be achieved through simple presentations using previously learned concepts and understandings about these interrelationships.

- o **Treatment:** Based upon this understanding of the diseases, the use of ivermectin to treat onchocerciasis will be learned. People should understand how the drug arrests the disease, which individuals are eligible for the treatment, possible adverse effects and necessary follow-up measures.
- o **Treatment Priority.** A commitment should be established within the target group about the importance of the treatment program. OHE messages should emphasize how a few simple practices can reduce or eliminate discomfort, pain and possibly blindness; why it is necessary for the people to take this treatment seriously; and how the treatment will benefit the community socially and economically.
- o **Treatment-seeking behaviors.** The target community must fully understand treatment procedures. These procedures include understanding and complying with the treatment protocol, encouraging others to seek and comply with treatment, and informing those who are removed from or resistant to OHE messages about ivermectin treatment. Since marginal or migrant groups are often most at risk of infection, it is important that measures be taken to inform them about available treatments for onchocerciasis.

Community acceptance of OHE

Before working in any community, health educators must understand the general tenets underlying a community's understandings, beliefs and attitudes about onchocerciasis and its treatment. Community agents can then make "rapid assessments" of how these beliefs are practiced in target communities. The assessment should identify priorities for specific items in the curriculum. Rapid assessment could be combined with a program to begin educating communities about current medical understandings of onchocerciasis and ivermectin treatment. Once village health educators have introduced this information and assessed the communities'

knowledge of the disease, they can motivate (if necessary) the community members to accept treatment procedures.

These three processes — community assessment, initial education and motivation to accept the treatment — may take place at the same time or as a series of steps. The sequence and combination of activities will depend on a community's KAP results.

OHE Implementation alternatives

Implementation of OHE can be simple or multifaceted, depending upon community needs and the resources available. The following alternatives can be used alone or in combination:

- o mass communication of the curriculum through radio, television and newspapers;
- o community visits by health workers either as part of the ivermectin distribution program or within other health care activities;
- o initial visits with community leaders and then with the community as a whole to establish a network of local people to amplify and reinforce OHE messages;
- o radio broadcasts with OHE messages and cassette programs to be used by OHE workers during their community visits;
- o household visits by OHE workers to meet with small groups or family heads;
- o visits with marginal community members or migrant groups, which could be combined with ivermectin distribution; and
- o combining OHE with ivermectin distribution, which can strengthen the impact of the message.

A rigorous evaluation is not necessary to assess whether the OHE objective was achieved. Informal conversations with community members can reveal their understanding about the nature of onchocerciasis and their acceptance and use of the treatment. If a KAP survey is conducted as part of a midterm or three-year evaluation, it could include items to assess whether the objective had been met.

Monitoring system

The objective of the monitoring system is to determine whether the component objectives were achieved. It will also provide data for financial tracking, training needs, periodic reports and evaluation. This system, along with technical assistance required to implement it, is explained in detail in the Monitoring and Evaluation Plan (Section 4).

A health information system (HIS) specialist can assist PVOs in developing monitoring systems during the first six months of the IDP. The specialist will first complete a general HIS design for all IDP country programs. Then he or she will work with each PVO on the following tasks:

- o The PVOs will help the management unit in the indigenous health system develop an IDP monitoring system. The management unit will be the starting point for developing the system, as well as the central point for collecting, processing, analyzing and using the information. It will develop surveys, forms and procedures for collecting and organizing the information. In addition, the management unit will assist field personnel in gathering, organizing and processing data.
- o Using the data from the monitoring system, the management unit will issue monthly reports on the progress of each component and any problems encountered. PVO personnel will also use this data to issue semiannual status reports for each component and on the IDP activity as a whole.

Although the PVOs will help indigenous health systems in many countries establish and manage an IDP, all country programs should have common characteristics that will maximize their effectiveness.

Simplicity

Each component should be as simple as possible. Initial surveys to identify endemic communities might be rapid assessments rather than full-scale epidemiological studies. Distribution of ivermectin should follow the basic protocol outlined above. Training need only convey the essential skills in a practical and applicable way. Simple OHE messages should emphasize disease comprehension and treatment-seeking behaviors. Most important, the monitoring system should include only the items, activities and costs essential to determining whether the IDP is meeting its objectives.

Decentralized

Two decades of experience with primary health care systems has indicated that community-based health workers can provide basic health care services to rural populations effectively if they are supported and supervised properly. The IDP is based on this premise. "Vertical" approaches are costly, rely too heavily upon vehicles, and do not encourage local communities to participate in delivery efforts. It might be appropriate for an IDP to begin with a vertical approach, allowing planners, supervisors and trainers to gain first-hand experience with ivermectin distribution. Their experiences can set examples for VHWs and community members about how the delivery system should work. Once the IDP gathers momentum, however, health supervisors and workers should hand over responsibility for distribution (and possibly OHE) to trained and supervised VHWs.

Cost-effective

No discrete criterion will be supplied for determining whether a program is cost-effective. Here, cost-effectiveness refers to the ability of an IDP to keep operational costs as low as possible — \$.50 per pill is clearly more desirable than \$1.00 per pill. At least two basic factors can contribute to cost-effectiveness. First,

there should be a simple, operational, and attainable cost-recovery plan. Most likely, this will be based upon user-fees — a patient will pay a fee for the service of being provided ivermectin (not for the pill itself). Part of this fee could be used to remunerate VHWs to provide a palpable incentives for them to serve the community. The remainder could contribute to defraying the overall operations of the IDP. Second, IDP management should keep logistical, equipment, travel, training, and other administrative costs as low as possible, and keep track of these costs through the monitoring system. When cost aberrations are detected, IDP management should make appropriate adjustments immediately.

Transferable

The first end-of-project condition emphasizes that indigenous health personnel will manage the IDP. This means that PVOs collaborate with indigenous health workers to manage the IDP at the beginning of the project and gradually shift full management responsibility to host-country personnel. This process will be outlined in each PVO's detailed implementation plan (DIP) with benchmarks indicating when health personnel are completing specific tasks. The transition of management responsibility will be done informally through continuous and intensive interaction between PVO and health personnel. PVO personnel will help their host-country counterparts develop IDP management skills through conversations, response to questions, timely information provided in the field or at meetings, setting models through example, direct tutoring and coaching, formal meetings and training, feedback and support.

Integrated

If possible, the IDP should become part of an existing or evolving primary health care system developed by the MOH. Previously trained VHWs who are providing preventive and curative health services to their communities would also be trained in ivermectin distribution and OHE. In addition, health personnel and networks that support VHWs can also be trained to support the VHWs in their IDP responsibilities. If there is no established primary health care system, the IDP should be

modeled closely after health programs managed by PVOs and other non-governmental organizations (NGOs). On the other hand, if no primary health care system is operating, the IDP may serve as a catalyst for other health care services the MOH or NGOs can provide. In any event, PVOs should take a "lateral" look to link the IDP with ongoing or potential primary health care services.

Systemic

The structure and operations of the components should interact and reinforce one another, forming a health care system, not simply a program to distribute pills. After surveys have identified endemic communities, training should prepare health personnel to treat community members with ivermectin and to educate them about onchocerciasis and treatment-seeking behavior. Regular monitoring is necessary to ensure that the system is efficient and meets its objectives. If an efficient ivermectin delivery system serves a responsive community, the community will probably continue to seek out those services, thus contributing to the system's sustainability.

Sustainable

If an IDP has the characteristics described above, it is likely to be financially and institutionally sustainable. Financially, the IDP should strive to pay for itself through cost recovery and efficient management of costs and operations. Institutionally, the IDP should strive to become part of an indigenous health care system that meets the needs of endemic communities.

3. IDP Implementation Schedule

| | Year 1 | Year 2 | Year 3 |
|---|--|--|---|
| 1. Detailed Implementation Plan Development and Review | xx | | |
| 2. Surveys Review of existing information Additional surveys Rapid assessments Epidemiological studies KAP surveys Selection of areas for ivermectin distribution Follow-up surveys | x xxxxxxxxxxx x x | x x | x x x |
| 3. Monitoring System General design Country IDP designs Data management Reporting and information use | x xxxx xxxxxx xxxx | xxxxxxxxxxx xxxxxxxxxxx | xxxxxxxxxxx xxxxxxxxxxx |
| 4. Training Needs assessment Establish training structure Training activities | xx xx xxxxxxx | xx | xx |
| 5. OHE KAP surveys/needs assessment Community visits | x x xxx xxxx | x x xxx xxxx | x x xxx xxxx |
| 6. Ivermectin Distribution Vertical start-up VHW distribution | xxxx xxxx | xxxxxxxxxxx | xxxxxxxxxxx |
| 7. VBC Support Workshops Technical assistance Monitoring system Other assistance Reporting Semi-annual reports Facilitating information Special donors Coordinating evaluations Field trips Reporting to R&D/Health | xx xx x x xxxxxxx xx xxxxxxx | x x xxxxxxxxxxx xx xxxxxxxxxxx | x xxxxxxxxxxx xx xx xxxxxxxxxxx |

4. Monitoring and Evaluation Plan

Monitoring System

This section outlines how monitoring and evaluation will take place. The monitoring system will be developed in four stages, which are described below. First, a prototype monitoring system for all five IDP country activities will be developed. Second, the prototype will be adapted to each IDP activity in five countries. In the third stage, a health information system (HIS) specialist will be needed to develop the general design of the monitoring system and adapt it to each country IDP. The specialist's scope of work (SOW) is described below. Fourth, mid-term and final evaluations will be conducted.

Monitoring system functions

The monitoring system has six functions:

- o to document the implementation of the IDP components;
- o to determine whether this implementation is meeting component objectives;
- o to provide financial data to determine whether the IDP is cost-effective;
- o to help identify training needs;
- o to facilitate reporting; and
- o to provide an information base for midterm and final evaluations.

Monitoring system design

Framework

An essential first step in the design of the monitoring system is to develop indicators for each system component. The framework presented below, an "IDP Monitoring SYSTEM," provides the basis for the design. In the left column of the framework are six factors: locus of responsibility, personnel, commodities, activities, performance, and costs. In the top row are four components of the IDP: surveys, training, ivermectin distribution and onchocerciasis health education. Each of the cells contains items, activities, or questions about the operations of each component as they relate to the six factors. Most of the items, activities or questions in each box are indicators for which data can be collected. A key task of the HIS specialist will be to operationalize these items into **indicators and performance indicators**.

The **indicators** are relatively easy to develop because each item can be quantified. For example, the number of pills distributed and the number leftover during a certain period, or the cost of fuel or maintenance for vehicles, are indicators. However, the **performance indicators** are more difficult to develop because they are behavioral standards against which the performance of each activity will be measured. For example, a trained VHW has specific activities to perform when distributing ivermectin (noted in abbreviated form in the framework). The key activities for the other components (training, surveys, OHE) should be specified in behavioral terms as performance indicators.

Once the performance indicators have been identified, the appropriate methods for measuring component activities against these performance indicators will have to be established. For example, measuring whether a VHW performs his or her activities according to the standards requires observation of the VHW performing these activities and a scale to rate his or her performance. An alternative method is to interview both VHWs and villagers to determine whether they agree that a VHW performed the activities according to the standards.

Groups of related indicators will constitute operational components in the monitoring system. The four components in the top row of the framework — surveys, training, distribution and OHE — could be added to the two factors in the left column of the framework — locus of responsibility and costs. Together these six components could be the core of the monitoring system. Data collected for indicators in each component would be sufficient for monitoring IDP implementation. More components could be added, if needed.

Structure

The monitoring system design should also consider the system as a structure or network. Data from different points are collected, organized and passed on to other points for aggregation and analysis. It would be appropriate to collect data and exchange information at three levels: local communities, clinics or health centers, and hospital or administrative centers (including the PVO center). The kind of data collected, who collects them, methods of collection, and storage of data will most likely follow this three-tiered structure. That is, community data will be collected by VHWs or health workers visiting the community. This data will be organized and processed at the clinic level, then passed on to the administrative center either in hard or computerized form. If an MOH or NGO management unit is located at that administrative center, the unit will most likely be the institutional base of the monitoring system.

Computer usage

The monitoring system will be designed to use an existing software program or one developed for the IDP. The simple health information program used for the IEF/Malawi Vitamin A project is a useful model and could be readily adapted to the IDP. A new program could be developed from an existing one and adapted to the IDP. Either way, the program should be simple, user-friendly and adaptable. It is impossible at this point to determine how many computers will be needed for each country program. This will be done by the HIS specialist when he or she visits each IDP activity.

Forms and manuals

The design will include drafting prototype forms for gathering data for each operational unit (e.g. training, distribution). The forms will be adapted to the data needs of each country. The system design will also include production of training and user manuals for the computer program. Each manual should contain the steps necessary for using the program in each operational unit.

AID/W network

Finally, the system design could link the field monitoring systems with R&D/Health by simply forwarding diskettes with country data along with the semiannual reports. This would enable the R&D Health officer and the VBC IDP coordinator to review the data.

Country monitoring system design**Institutional base**

The PVOs should establish an institutional base for the monitoring system soon after the IDP activities begin. As noted above, this base most likely will be in a central management unit of the MOH or an NGO. If a health information system is in place, efforts should be made to integrate the IDP monitoring system into this existing structure.

Needs assessment

The HIS specialist will review information needs for each country IDP. He or she will review and evaluate data needs for reporting and project management, as well as data sources at the community, clinic/health center, and hospital/administrative levels. Based upon this review, the specialist will develop a specific design for information flow, and select appropriate data inputs and outputs. He or she will then submit the proposed IDP monitoring system design to the PVOs and their local health counterparts for review and revision.

Computer Installation

Following the specifications of the design, the computer hardware and software package will be installed. Both will be adapted to meet specific IDP country needs.

Training

At the central management unit, the HIS specialist and PVO personnel will train the key host country staff members who will manage the IDP and operate the monitoring system. Health trainers will also be included in this training. It might be useful to preface the monitoring system training with a short review course on basic computer operations to ensure that all participants are computer-literate. Under the supervision of PVO personnel, the health trainers may train health workers from clinics or health centers in using computers and aggregating community data. The health trainers should also train VHWs in the administration, tabulation and processing of forms for collecting community data on ivermectin distribution and OHE sessions (if applicable).

Field testing

The initial operations of the monitoring system will test its overall structure and components to determine whether the linkages from the central management unit to the field are correctly arranged. The testing will also review the effectiveness of forms, manuals and procedures for data collection, aggregation and analysis. Problem identification and resolution will be undertaken at both the central and field levels. Feedback mechanisms to the clinic and community levels will also be field tested, and adjustments made as required.

Priority should be given to adapting the monitoring system to the country IDPs. Ideally, the tasks identified in this section should be completed within six months after the activity start-up date.

Data management

Continuous monitoring

Field testing should have confirmed which indicators and data elements enabled the system to monitor IDP implementation. The appropriate people will collect data from sources at the three different levels of the IDP and regularly input those data into the monitoring system. Data from initial inputs and previous surveys will provide baseline measures. Continuous input of data will enable the monitoring system to fulfill the functions listed on p. 29. New data elements will be created and added to the data set if needed.

Data quality checks

The health personnel operating the monitoring system will be trained to screen data received from reports, data forms and other sources to check for outlying values, nonsense data or internal inconsistencies. Data quality problems will be reviewed and addressed.

Reporting

It is recommended that reporting be kept to a minimum of monthly and semiannual reports. Tentative formats for these reports will be developed with the participating PVOs at the upcoming IDP workshop in Washington, D.C. The HIS specialist will probably need to revise the report formats as he or she develops the general and in-country designs for the IDP monitoring system. The IDP project management unit will be responsible for preparing and issuing the monthly report with PVO assistance.

Monthly report

This report should contain data tables for each component of the IDP activity. Qualitative narratives describing the progress and problems of each component during the month, as well as any recommended actions for the next month, should also be

included. This report will be circulated to all operating units in the IDP, relevant MOH or NGO offices, and to R&D/Health.

Semiannual report

This report should also contain data tables for each component and accompanying descriptive narratives. A suggested format is:

- o activity progress by component;
- o general and specific issues or problems;
- o needs and budgetary deviations;
- o planned activities and/or modifications from the DIP;
and
- o requests for future assistance.

The semiannual report will be circulated to the same audience as the monthly report. The VBC coordinator will synthesize the semiannual reports from each PVO into one semiannual report reflecting the activities of the entire IDP.

SOW of the Health Information Specialist (HIS)

Since development of an IDP monitoring system is vital to assessing the feasibility of delivering ivermectin through PVOs, it is recommended that a Health Information Specialist (HIS) provide technical assistance during the first six months of the activity. This is to ensure that: 1) all PVO monitoring systems have the same components and a common structure to facilitate standardized reporting and 2) the monitoring system is adapted to the specific IDP in each country.

The tasks outlined below are suggested for inclusion in the HIS specialist's technical services.

General design

The HIS specialist will design a prototype monitoring system to serve as a model for the systems established by PVOs in each IDP country. To design the system, he or she should:

1. Develop indicators and performance indicators for each component of the program, such as pill distribution, training, OHE, surveys, finances, and locus of responsibility (see pp. 30-31);
2. Outline the structure of the monitoring system;
3. Identify the appropriate computers and software package to be used;
4. Develop prototype forms for data collection for each program component, and manuals for training and reference; and
5. recommend how to link the country monitoring systems with A.I.D./Washington.

Country IDP Design

The HIS specialist will visit each of the five IDP countries to help the PVOs establish their monitoring system. His or her tasks will include the following:

1. Advise PVO personnel on selecting an institutional base for the monitoring system or, if the base has already been selected, review its appropriateness;
2. Supervise a rapid assessment of data needs for reporting and project management and of data sources at the different program levels;
3. Develop a specific design for information flow based on the needs assessment and select appropriate data inputs and outputs;

4. Prepare the approved design for implementation;
5. Adapt the training manuals and system documentation;
6. Train the appropriate health trainers, who in turn will train health workers to use the monitoring system; and
7. Supervise field tests of the monitoring system. Problem identification and resolution will occur during this period at both central and field levels.

Data management and reporting

The specialist may return to the countries to observe the data management and reporting of the system once it is operating. This may be necessary if systems are not operating correctly or are slow in producing the required information.

Level of effort

The HIS specialist will be needed for at least six months, including one month at VBC to design the system at the outset of the IDP activity, and one month in each of the participating countries. He or she may also be needed for follow-up work throughout the IDP.

Evaluation

One objective of the pilot IDP is to assess whether PVOs can effectively transfer the full management of an ivermectin delivery program to host-country counterparts. As such, it is imperative that the evaluation process be planned adequately and financed sufficiently.

Scope

It is proposed that each of the IDP activities in five countries be evaluated at midterm (18 months after project start-up) and 36 months after start-up. The emphasis of the midterm evaluation

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would be to identify project strengths, weaknesses and ways to improve the project. The emphasis of the final evaluation would be to determine whether the project met the purpose and output objectives, and whether it accomplished anything worth emulating. It is also proposed that one PVO representative participate in the evaluations. Each evaluation should take approximately three weeks to complete.

Questions

Both midterm and final evaluations will address the questions listed below.

| Component | Questions |
|--------------------------------|---|
| 1. Surveys (prevalence) | 1.1 Were appropriate rapid assessments used? |
| | 1.2 Were the targeted number of individuals screened on a preliminary basis? |
| | 1.3 Were the targeted number of individuals included in skin snipping surveys? |
| | 1.4 Were the targeted number of communities selected for ivermectin distribution? |
| (follow-up) | 1.5 Did the same individuals and communities receive follow-up surveys? |
| 2. Training (needs assessment) | 2.1 Was the assessment produced on time? Was it comprehensive? Did it accurately identify IDP training needs? |
| Training activities | 2.2 Were the targeted number of health trainers, health workers and VHWs trained on time? |
| | 2.3 Did their training follow the objectives and procedures outlined in the DIP? |
| | 2.4 Are the individuals using their training on the job? |
| | 2.5 Are they being supervised on the job? |

3. Ivermectin distribution

3.1 Were the targeted number of individuals selected according to the final selection criteria (e.g. weight, good health, pregnancy status)?

3.2 Did people receive ivermectin according to the MEC procedures?

3.3 Were adverse reactions treated appropriately?

3.4 Was the pill distribution recorded accurately? Were the records collected?

4. Oncho health education

4.1 Were the targeted number of communities educated about onchocerciasis and the use of ivermectin?

4.2 Was this education effective in providing them with knowledge about the disease, and in motivating them to seek ivermectin treatment?

5. Monitoring system

5.1 Did the responsible health personnel correctly perform appropriate procedures for operating the monitoring system (e.g., data collection, processing, analysis, reporting)?

5.2 Did key decision-makers involved with IDP use the monitoring system?

6. Financial management

6.1 Were the relevant costs and revenues recorded and processed in the monitoring system?

6.2 Were the treatment costs kept to an acceptably low level?

6.3 Were the costs of delivery operations recovered at an acceptable rate?

7. Locus of responsibility

7.1 Do the PVOs demonstrate a progressive shift in responsibility from themselves to host country counterparts for executing IDP component activities?

7.2 Do these counterparts demonstrate that they will be able to continue executing the IDP after the PVOs leave?

Qualifications of evaluators

Expertise in four areas is required: epidemiological surveys, health information systems, health education and training, and rural health delivery systems. Language proficiency at the FSI 3 level is needed in French for evaluating programs in Cameroon, Burkina Faso and Niger, and in Spanish for the Guatemala program. Previous A.I.D. evaluation experience is desirable.

Issues

It is preferable that evaluators participate in more than one IDP evaluation to help ensure standardization of the evaluation methodology. However, it may be difficult to obtain evaluators who can serve on more than one evaluation team. Team members will need to travel extensively in-country, most likely by air and land. This will require additional planning and expenses. The evaluation teams will depend upon the quality and quantity of the data from the health information systems in each country.

IDP MONITORING SYSTEM

Purpose: To monitor IDP component activities to determine if component objectives are being met.

| | (1) Surveys | (2) Training | (3) Ivermectin Distribution | (4) Oncho health Education (OHE) |
|--------------------------|--|--|--|--|
| Locus of Responsibility: | PVO → HCN | PVO → HCN | PVO → HCN | PVO → HCN |
| Personnel: | # surveyed # surveyors | # trained # trainers | # patients treated # health workers operating # health staff operating # VHWs operating | # educated # educators |
| Commodities: | vehicles, motorcycles, bicycles; units of fuel & maintenance equipment materials | vehicles, motorcycles, bicycles; units of fuel & maintenance equipment materials facilities. | vehicles, motorcycles, bicycles; units of fuel & maintenance # pills ordered # pills distributed # pills leftover # procedures manuals | vehicles, motorcycles, bicycles; units of fuel & maintenance equipment materials facilities |
| Activities: | Prevalence survey: # preliminary screening # skin snips # selected for Ivermectin distribution Above data for Incidence survey | training needs assessment conducted training sessions for HWs and VHWs conducted in IDS procedures | Distribution procedures: ♦ screening ♦ weighing ♦ registering ♦ observing pill swallowing ♦ final instructions ♦ adverse reactions treated | Health workers educate: ♦ communities ♦ groups ♦ individuals ♦ through radio broadcasts |
| Performance: | Was existing survey data available and useful? Was preliminary screening adequate and sufficient in #? Was skin snipping adequate and sufficient in #? Were sufficient #s selected for Ivermectin distribution? | Was quality of training needs assessment adequate? Were training sessions adequate? Were training sessions timely? Were a sufficient # of trainees trained? | Were the six procedures followed adequately? | Did visits or broadcasts take place periodically to targeted communities, groups or individuals? Was there evidence that learning took place? |
| Costs: | equipment, material, field trip costs | facilities, materials, equipment and training session costs | user fees collected VHW remunerations paid out staff salaries by level commodity costs by level | facilities, materials, equipment costs |

5. VBC Scope of Work

The following scope of work is for the coordination of PVO implementation of the Ivermectin Delivery Program. This assignment has four objectives:

- o to provide guidance on PVO proposal revisions, detailed implementation plans (DIPs), monitoring systems, reporting formats and procedures, and related documents;
- o to backstop and support PVO implementation efforts through reporting, technical assistance and site visits;
- o to monitor PVO activities from the perspectives of the DIPs and the IDP project description; and
- o to coordinate the midterm and final evaluations.

This coordinating role is likely to be a part-time job. However, after a six month review of the IDP, R&D/Health will be able to decide whether the program requires a full-time coordinator.

Workshops

The coordinator will organize several workshops for the IDP. The first will be held in Washington, D.C., during the summer or early fall of 1991; the others will be held in each of the five IDP countries. Coordination of these workshops includes the following tasks:

- o adapt the appropriate objectives and agenda of activities for the workshops;
- o establish a date and location for the workshop;
- o work with PVO personnel to identify and invite participants;

- o provide logistical support for each workshop, including translation facilities (if necessary), audiovisual equipment, notebooks and refreshments;
- o serve as (or provide) a moderator for each conference; and
- o prepare a report that summarizes the conference proceedings.

The IDP coordinator should be able to complete these tasks without assistance for the Washington, D.C., workshop but will need assistance for the in-country workshops. During preparation of the latter, the coordinator will rely upon the PVOs or possibly the USAID technical officer for assistance. The coordinator should arrive in-country before the workshop to finalize the preparations.

Technical assistance

VBC will provide limited technical assistance in the field to the PVOs. The PVOs will most likely need assistance in developing their monitoring systems. Other needs will be specified as they arise.

The IDP coordinator will: draft the scopes of work for each type of assistance; recruit the appropriate technical assistant; monitor, support and evaluate technical assistance; and ensure that technical assistants submit a report for each assignment.

The coordinator will ensure that each report from a technical assistant contains at least the following information: 1) type of activity, geographic location of activity, dates of assignment, team composition and member names; 2) objective of the assignment and scope of work; 3) activities performed during the assignment; 4) findings and a summary of any technical reports resulting from assignment; and 5) recommendations for future directions or opportunities for assistance.

Monitoring system component

The coordinator will detail the general SOW for an HIS specialist outlined in chapter 4. Six months are needed to complete this specialist's tasks, which include: 1) designing a monitoring system that operationalizes the framework specified in the IDP project description and 2) adapting that system to the realities of the IDP in each country. This specialist should be recruited as soon as possible after the IDP begins.

Other activities

The coordinator will develop SOWs for tasks needed in other components or activities by the PVOs. For example, one or more PVOs may need a health trainer to assist in developing an OHE component or to conduct a KAP survey.

Additional assistance

The coordinator will backstop the PVOs by supplying them with requested materials, information or related assistance as needed.

Reporting

Semiannual status reports

The coordinator will produce semiannual status reports for A.I.D. He or she will receive a semiannual report from each PVO that follows a standard format. The coordinator will synthesize these reports into one status report for that reporting period.

PVO reports will document the progress of IDP activities and indicate what must be done to ensure continued progress. The reports will describe program accomplishments during the reporting period, activities planned for the next six months, and any project and budgetary deviations or modifications from the DIP. The format for these reports will be developed with the

PVOs at the Washington, D.C., workshop at the outset of the project. A suggested format is:

- o activity progress by component;
- o general and specific issues or problems;
- o needs and budgetary deviations;
- o planned activities and/or modifications from the DIP;
and
- o requests for future assistance.

The PVOs will write their reports using information from the monitoring system. The length of the reports should not exceed 10 pages.

Facilitating information flow

The coordinator will serve as the focal point for reporting to and from the PVOs in the field. The flow of information will include:

1. information to PVOs from international journals, conferences and donors about onchocerciasis, ivermectin treatment, delivery systems or related matters that may assist the PVOs in implementing the IDPs;
2. information between PVOs about special field experiences (e.g., problems, activities, experiments) they have encountered, which would be useful for all PVOs to know; and
3. information to interested outside parties such as universities, consulting firms and donors about the PVOs' progress, activities or noteworthy accomplishments.

Special donors

The coordinator will initiate and sustain regular reporting to donor agencies, such as WHO, PAHO and the OCP, interested in the control of onchocerciasis using ivermectin. The content of this reporting will be similar to that noted in 3.2.

Coordinating evaluations

The coordinator will backstop the midterm and final evaluations. The details on the scope, questions, qualifications of evaluators, and issues are covered in the Plan on Monitoring and Evaluation in chapter 4. The coordinator will:

- o recruit evaluators and write their SOWs;
- o participate in the midterm and final evaluations as a team member to the extent possible;
- o review the reports from each evaluation team and synthesize them into one midterm evaluation document and one final evaluation document;
- o distribute these documents to the appropriate participants and reviewers for comment (e.g., health and project officers in the A.I.D. Missions, regional bureaus and the Bureau of Research and Development, the appropriate PVOs, host-country health officers, the Mectizan Expert Committee and the evaluation team members; and
- o finalize the documents following the reviewers' comments.

In the case of the midterm evaluation, there may be recommendations for one or more PVO activity to vary from the direction specified in the DIP(s). Hence, additional technical assistance, budgetary alterations or other changes may be required. The coordinator will respond accordingly to implement any changes authorized by R&D/H.

Field trips

The coordinator will make two field trips to the PVO IDP activities in Africa and Central America — one midway between the IDP start-up date and the midterm evaluation, and one midway between the midterm and final evaluations. The purpose of these trips is to backstop and monitor field activities first hand. The coordinator will meet and discuss IDP activities with PVO personnel and their host-country health counterparts. He or she will also visit communities to observe IDP component activities and, if possible, to discuss them with community leaders. The coordinator will write trip reports following the format suggested in chapter 2.

Reporting to R&D/Health

The coordinator will report on IDP activities to the IDP technical officer in R&D/Health through weekly meetings and monthly reports. The format of these reports will be the same as outlined above for PVOs in Section 3.1.

Qualifications for the IDP coordinator

The coordinator should have the following qualifications:

- o at least five years of project management experience in A.I.D. or other donor or consulting agencies;
- o a graduate degree, preferably an MPH, a social sciences degree or an MBA;
- o French language proficiency at a minimum of FSI 3;
- o management skills, including team leadership, conceptualizing implementation approaches, and writing documents;
- o community development experience, such as Peace Corps experience in rural development or participation in rural development projects, or training in sociology or anthropology.

6. Proposed Budget**IDP Distribution Program
Combined Budget Years 1-3**

| Line Item | Total Cost |
|-----------------------|-------------------|
| Labor cost | 38,229 |
| Overhead | 24,849 |
| Consultant/Evaluation | 247,488 |
| Travel | 15,763 |
| Per Diem | 10,719 |
| ODC | 15,763 |
| IDC | 103,915 |
| Total | 456,726 |

7. Plan for IDP Implementation Workshops

There will be two kinds of workshops. The first, a general workshop for all PVOs receiving IDP grants, will be held at the VBC office in Washington, D.C. July 29 - 30, 1991 (see Annex 2). The purpose of this workshop will be to review, discuss and resolve issues that are common to all IDP activities. The second will be a series of two-day workshops in each of the countries where a PVO is implementing an IDP activity. The purpose of the in-country workshops will be to review and approve each PVO's Detailed Implementation Plan (DIP).

Washington workshop

Representatives from the PVOs, VBC, A.I.D.'s Office of Health and Bureaus for Africa (AFR) and Latin America and the Caribbean (LAC), the Mectizan Expert Committee, other relevant donors, and different R&D/Health projects will be invited to the Washington workshop. The workshop agenda was developed at a June 1991 meeting with R&D/Health, VBC and the PVOs. Issues related to the IDP design, implementation and monitoring/evaluation plan to be discussed at the workshop are described below.

Design

Two logframes

Discussion at the June 1991 meeting revealed the need for two logframes: a technical one to serve as a prototype for the individual logframes each PVO will design as part of its DIP, and a programmatic logframe to identify the kinds of reporting, monitoring and evaluation A.I.D. expects from the PVOs. The logframe in chapter 2 of this document approximates what the PVOs expect as a technical prototype. R&D/Health will construct a programmatic logframe before the workshop, which will be discussed and reviewed by workshop participants.

IDP goal, purpose, outputs and components

Participants will assess the technical feasibility of the IDP as described in the project description (chapter 3).

Grant agreement format

Workshop discussion should focus on how PVOs can respond to format items and their appropriateness to IDP activities.

Implementation

DIP guidelines

While each PVO will develop its DIP according to specific country needs and constraints, all the DIPs have common elements. The implementation schedule (chapter 3) is a first attempt at specifying these elements. Workshop participants will attempt to identify these elements more precisely.

Quality assurance

The project officer from R&D/Health's quality assurance project will suggest how aspects of that project can apply to IDP activities. Discussion of the performance indicators in the monitoring system (chapter 4) has already touched on the need to develop behavioral standards as a basis for monitoring implementation. These standards must be built into IDP activities as quality criteria.

Financial management

The project officer from R&D/Health's financial strengthening project will lead the discussion on ways to ensure the financial soundness of IDP activities.

Financial sustainability

Workshop participants will explore ways for IDPs to contribute to financial sustainability. These might include cost-sharing among state and local governments, beneficiary user fees, labor contribution, taxes or cross-sectoral subsidies.

SOW of IDP coordinator

The items in chapter 5 should be reviewed.

Technical assistance

Workshop participants should discuss the forms of technical assistance available to the PVOs during IDP implementation, and how they can access that assistance through VBC's IDP coordinator.

PVO needs and capabilities

The PVOs will review and discuss their past experiences as they relate to the IDP activities and what they will need to implement them successfully.

Monitoring and evaluation

Monitoring system

Participants will discuss the monitoring system presented in chapter 4. Is the system too complex? If so, can it be simplified? Should the system be used only for monitoring, or should it include a health information system? Will PVOs be able to use the system efficiently in the field? Does it serve their needs? If not, how should it be changed?

Reporting

Are the reporting requirements outlined in chapter 4 adequate? If not, how should they be changed?

Evaluation

Chapter 4 calls for a midterm and a final evaluation. Is this structure and the requirements for evaluations acceptable to the PVOs? If not, how should they be changed?

In-country workshops

Based upon discussion and approval of the DIP guidelines, the PVOs will develop their DIPs. These will be completed by fall 1991 to be discussed and reviewed at the in-country workshops. The IDP coordinator and representatives of the implementing PVO, the country's A.I.D. Mission, R&D Health, and appropriate host-country health officers should attend each in-country workshop. The purpose of these workshops is to arrive at consensus on the proposed DIP as the basis for implementing the IDP activity. Other issues will be discussed as needed. The workshop will take place at the PVO in-country headquarters and should take no longer than two days.

Annex 1. Trip Report Summary

First InterAmerican Conference on Onchocerciasis (IACO) held in Guatemala City and Tapachula, Mexico, April 28 - May 1, 1991

Overview

The first Interamerican Conference on Onchocerciasis (IACO) was sponsored by the Pan American World Health Organization (PAHO) to review the PAHO XVI Resolution regarding the eradication of diseases in the Americas — in this case onchocerciasis. The purposes of the meeting were to:

- o review available information on onchocerciasis control activities in the endemic countries (Guatemala, Mexico, Venezuela, Brazil, Ecuador and Colombia);
- o review data from recent experiences on mass distribution of Mectizan^R (ivermectin) at the community level; and
- o develop a multinational strategic plan towards eliminating onchocerciasis in the Americas.

The first three days of the conference were spent pursuing the first two purposes through formal presentations, open discussions, and working groups. Although an outline for a PAHO strategic plan for onchocerciasis had been developed for the conference, a formal plan was not produced, and only a brief summary of the proceedings emerged from the conference. It is anticipated that a PAHO onchocerciasis control plan will be produced in the future based on the conference proceedings.

Emphasis during the first three days was on epidemiological surveys and assessments of onchocerciasis, surveillance, indicators and interventions, including ivermectin distribution. Day one began with formal introduction ceremonies and speeches, and continued with general comments on the use of ivermectin and other control activities in the Americas. Then, for the remainder of the opening

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day and part of the second day, participants presented the findings of field research on:

- o onchocerciasis diagnosis,
- o epidemiological protocols for assessing onchocerciasis,
- o epidemiological studies of onchocerciasis, including computer mapping and modeling,
- o methods and indices for measuring the prevalence and densities of microfilaria,
- o nodulectomies, and
- o the distribution, use and impact of ivermectin.

The morning session on the second day concluded with an open discussion about the feasibility of "eliminating and eradicating" onchocerciasis. This included discussion of the sustained and mass distribution of ivermectin, the need for patient compliance, the role of health education in building compliance, how operational research could complement field research, and how to integrate ivermectin distribution into other health services delivery programs.

Discussion participants concluded that total eradication of onchocerciasis was impossible. Although there was a consensus that onchocerciasis transmission could not be completely eliminated, participants agreed that with ivermectin, the disease could be controlled to levels that would not represent a public health problem in the Americas.

Further discussion focused on health education and KAP studies or knowledge, attitudes and perceptions of onchocerciasis. (This is included on the summary of health education below.) The second half of the second day was spent traveling from Guatemala City to Tapachula.

The third day was spent in working groups. There were three working groups:

- o rapid epidemiological assessment,
- o epidemiological surveillance (in which I participated), and
- o assessment of the impact of interventions.

Each group worked separately and reported to the conference as a whole at the end of the day.

The fourth day was devoted primarily to writing summaries of the previous three days' activities. The summaries were to include information relevant to the PAHO strategic plan. At the same time, three working groups covered other issues, such as donor agencies and onchocerciasis control, PAHO member nation relationships and onchocerciasis control, and health education. I participated in the health education group.

A plenary meeting was scheduled for 4 pm to discuss the draft conference report. Unfortunately, the conference began to break up in the afternoon as individuals or small groups were still writing, and a few participants departed altogether. In fact, there had been organizational problems throughout the conference regarding participants' roles and assignments. Smaller groups did not always follow through on their charge to produce a document and report to the conference as a whole.

VBC Ivermectin Delivery Program (IDP)

Throughout the conference I talked to individual participants about the viability and appropriateness of the proposed Ivermectin Delivery Program, showing them the logframe and monitoring plan. Overall, their reaction was favorable, and most commented on the detail and practical approach of this program. The following are a few of their suggestions:

- o **Consider integrating the IDP into an existing primary health service.** The physicians working in Ecuador and Equatorial Guinea (Africa) emphasized that while onchocerciasis needs to be addressed, there are more urgent needs to address diseases such as infant diarrhea, malaria, tuberculosis, intestinal worms and polio among the target populations. Also, as evidenced by the KAP study findings discussed on day two of the conference, target groups may not perceive onchocerciasis as a serious problem. The treatment of onchocerciasis should be seen as part of a package of primary health care services.
- o **Keep it simple.** Only a few people are needed to operate IDP pill distribution, recordkeeping and preliminary surveys. In addition, keep the number of items that need to be recorded small and the protocol for administration simple to make recordkeeping simple.
- o **Adaptability.** Field testing will help adapt a program. One cannot expect a prototype to be replicated uniformly, and adjustments will be needed. For example, should a PVO use mobile teams, village health workers supervised by mobile nurses, or a combination of the two for its delivery system?
- o **Monitoring and supervision are extremely important.** Hands-on personnel are needed to can monitor VHWs' perform.

- o **The use of simple education methods and illustrations are essential to conveying the basic disease and treatment concepts to nonliterate groups.** These simple techniques facilitate understanding by helping people focus their thoughts and questions.
- o **Be aware of respondent (patient) acquiescence.** Do the patients tell you what they really think or need to know about the disease, or do they tell you what they think you want to hear? This can really be a problem among marginal and nonliterate subsistence groups.

Annex 2. IDP Washington Workshop Report

Ivermectin Delivery Program

Workshop Report

July 29 and 30, 1991

***Vector Biology Control
Rosslyn, VA***

Facilitator: Heather Sutherland

Ivermectin Delivery Program

Executive Summary

A two day workshop was held July 29 and 30, 1991 in the offices of the Vector Biology Control Project (VBC) for a new program entitled the Ivermectin Delivery Program (IDP). This three year pilot program is to deliver ivermectin in Niger, Nigeria, Burkina Faso, Cameroon and Guatemala.

Three Private Voluntary Organizations (PVO), Africare Inc., The International Eye Foundation (IEF) and Helen Keller International (HKI) are involved in the delivery of Ivermectin to the five nations mentioned above. The purpose of the workshop was:

- o To clarify the roles and responsibilities of A.I.D., VBC and the PVOs and how they interrelate in regard to reporting, monitoring and evaluation.
- o To develop guidelines for the reporting system, MIS/HIS, Detailed Implementation Plan and accessing VBC's technical assistance.

Interviews were conducted with the three PVOs before the workshop by Jack W. Swartwood, Deputy Director for Administration of VBC and Heather Sutherland, Human Resource Development Specialist in cooperation with Dennis Carroll of Science & Technology/Health (S&T/H), Agency for International Development (A.I.D.). Heather Sutherland, Jack Swartwood and Dennis Carroll formed the facilitation team for the Workshop.

The Workshop Outcomes were:

1. Modification of the Project Design and Implementation of the Ivermectin Delivery Program document.
2. A model format for the Detailed Implementation Plan.
3. The establishment of lines of communication between A.I.D., VBC and the PVOs.
4. Availability and access to technical assistance through VBC.
5. The steps necessary to complete a log frame matrix using software.
6. Clarification of the monitoring, evaluation and reporting systems.
7. Guidelines for the MIS/HIS.
8. Guidelines for the timing and agenda of the in-country workshops.

Overall, the workshop was considered a success in the eyes of the facilitation team and the participants.

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Appendix

- A Participants List**
- B Notes from the Interviews.**
- C Agenda Topics.**
- D Log Frame Software**
- E Reporting Forms from Africare.**
- F Report of Resolutions from PAHO.**
- G Activity Request Form.**

Ivermectin Delivery Program Workshop

Objectives

July 29 and 30, 1991

The overall session objectives considered were:

- I. TO CLARIFY :**
 - A.I.D./VBC Roles and Responsibilities
 - PVO Reporting Responsibilities
 - Purpose of the Monitoring System
 - Issues for Mid-Term and Final Evaluations

- II. TO DEVELOP:**
 - Guidelines for DIP
 - Guidelines for HIS
 - Format for Reporting
 - Guidelines for Accessing VBC TA

Specific Objectives of the Workshop were as follows:

1. To explain the availability and how to access technical assistance through VBC.
2. To develop the steps necessary to complete a Log frame matrix.
3. To establish the components of the Detailed Implementation Plan.
4. To clarify monitoring and evaluation issues and budgeting and reporting criteria.
5. To determine and list the program elements as they relate to specific goals.
6. To discuss Health Financing, Quality Assurance and Health Communication as they relate to the in-country programs.
7. To establish guidelines for the in-country workshops to include timing and agenda creation.

***Ivermectin
Delivery
Program***

July 29 and 30

Monday, July 29

**9:00 Welcome - Bob Wrin
and Bob Lennox**
**9:05 Objectives and Agenda- Heather
Sutherland**

**9:25 Introduction - Dennis Carroll
Topic 1 Roles and Responsibilities**

10:10 Topic 2 Design and Implementation

10:45 - 11:00 Break

11:00 Topic 3 Monitoring and Evaluation

11:45 Short discussion, summary.

During Lunch

**12:30 Protocol for Applying for Mectizan
Bruce Dull**

**1:00 pm Review and explanation
for afternoon working groups.**

**1:15 Three Working Groups.
Each group will have representatives
from each PVO group and will
choose a recorder.**

3:00 - 3:15 Break

3:15 Report from Working Groups

**4:00 Demonstration of log frame
software. Anneliese Schmid**

4:45 Summary and Plans for next day

Tuesday, July 30

9:00 Review and summary

9:15 PVO working groups.

**Each group completes log frames
relating plans to program elements
and detailed implementation plans.**

10:30 - 10:45 Break

10:45 Cross- Cutting Input

**Health Financing - Bob Emery
Quality Assurance - Jim Heiby
Health Communication - Holly Fluty
Consolidation before lunch.**

Working Lunch

**Small groups are invited to meet
around one of the three previously
introduced topics with speakers.**

1:30 Report from small groups.

Integration of new topics, discussion.

3:00 - 3:15 Break

**3:15 Guidelines formation
Incountry Workshops
- timing of workshops
- agenda for incountry workshops
Consensus - agreements understood.**

4:45: Wrap-up

5:00 : Closing

Workshop Outputs

Revised Model of the Detailed Implementation Plan

- A. Executive Summary**
- B. Background Statement: Program Sustainability and National Strategy (Key Players)**
- C. Organigram:**
 - Job descriptions for key staff
 - Project organigram
 - Discussion of roles and responsibilities among major partners, including supervisory responsibilities.
- D. Timetable: Plan of Action, what, who and when.**
- E. Major Program Elements:**
 - 1. Procurement and Logistics**
 - Apply for Mectizan, honoring three month lag.
 - Procure office equipment and supplies.
 - Procure technical supplies etc.
 - 2. Program Staffing, Planning, D.I.P. Development, Finance Management, Reporting System.**
 - Hire project staff
 - Develop Detailed Implementation Plan
 - Develop reporting system
 - 3. Survey**
 - Review relevant data
 - Conduct epidemiological survey
 - Map area epidemiologically
 - KAP survey, and others.
 - Operational Research

4. **MIS/HIS**
5. **Onchocerciasis Health Education Component**
Design OHE program
Create materials, plan distribution.
6. **Training, Technical Assistance, Workshops.**
Training strategy, materials, record forms
Hiring technical Assistance
Designing workshops
7. **Community Education and Motivational Campaign**
Planning strategy
Choosing media, distribution, i.e. door to door
8. **Mass Distribution of Ivermectin**
Keeping records, tied in with HIS/MIS and monitoring system
9. **Treat Reactions to Ivermectin**
Keep records, send information on each case to MERCK
10. **Monitoring and Evaluation**
Monthly reports collected in the field.
Monthly reports sent to PVO
Every three monthly reports sent to AID, (content to be decided)
Mid-term evaluation
Final evaluation, outside evaluator.
11. **Plan for Sustainability**
Small fee for service.

Development of MIS/HIS System

It was the opinion of the group that the MIS/HIS system should address the needs of:

- 1) USAID/AID/MEC
 - 2) PVO/Partner/MOH
 - 3) Project/Community
1. It is recommend that each PVO develop and describe the MIS/HIS when preparing the DIP to address Items 2 and 3. Submit copy to AID and adjust as needed to address AID's needs. The PVO MIS/HIS should be designed to capture needed quantitative information in regard to each Program Element.
 2. It is also recommend that AID/VBC develop and describe MIS/HIS to address item 1.

Steps for Developing Ivermectin MIS/HIS Guidelines.

1. Assess existing HIS - community, regional, and national.
2. Determine what type of data should be collected and find source of data.
3. Design forms and field test.
4. Processing and dissemination of data.
5. Next phase - Reporting.

Discussion on Reporting

Format and Frequency

The discussion on reporting frequency did not arrive at consensus because several of the represented PVOs thought that monthly reports to A.I.D. were too frequent. A semi-annual status report by PVOs and feeding into a comprehensive report by AID was thought to be too infrequent for AID's purpose. The content of the latter report would embrace the contents outlined in the hand out, by program elements. The program elements have been incorporated in the DIP outline on pages 5 and 6.

It was recommend to continue this discussion during the DIP development and the definition of MIS/HIS at project level, based on realistic appraisal of MIS/HIS capabilities and organizational needs.

Frequency of reports to AID were discussed in one of the working groups.

It was determined that the frequency of reports would remain undetermined until the HIS was designed and implemented. As there are a variety of actions being undertaken, it was agreed that the HIS would be the determinate of the reporting frequency.

Africare has used forms in the past that were shared with the group and are in Appendix D.

Guidelines for Accessing VBC and Technical Assistance

VBC will be accessible through the consultant who will be hired to design the MIS/HIS. Other activities VBC will sponsor are:

- In-country start-up workshops
- Regional mid-term workshops
- Mid-term evaluation
- Unanticipated needs

Opportunities will come up which the PVOs will want to explore. Spin offs will happen. VBC can assist in exploring possibilities through a PVO partnership. VBC can be approached in two ways by the PVOs:

- Direct contact with the soon to be hired IDP Coordinator with specifics or
- Complete activity request form (Appendix F).

In-Country Workshop Issues

In-country workshops will take place during the Fall of 1991. Start-up Workshops will take place in Cameroon, Niger, Burkina Faso, Guatemala, and Nigeria.

Goals of the workshops:

- 1. Team Building.**
- 2. Finalizing the Detailed Implementation Plan.**
- 3. Establishing roles and responsibilities.**
- 4. Development of HIS.**

Points of agreement for workshops:

Before the In-country Start-up Workshops, the PVOs meet in Washington with A.I.D. to develop a skeleton plan.

The In-Country Workshops should be convened by the MOH in partnership with PVO and A.I.D. to give the nation ownership of the program.

The workshop will take 3 days. The first two days will be devoted to developing the DIP as well as the HIS. The third day will be dedicated to team building, and will be broadened to include other groups.

| | | | |
|--------------------------|--------------|---|---|
| Workshop Pattern: | Day 1 | - | Detailed Implementation Plan Activity. |
| | Day 2 | - | Delineation of the HIS. |
| | Day 3 | - | Expanded participation by interested groups. |

Who will attend:

| | | |
|----------------------|---|---|
| VBC/ AID Team | - | VBC Ivermectin Coordinator |
| | - | HIS Coordinator |
| | - | In-Country Mission person |
| | - | Mectizan Expert |
| | - | PAHO, in Guatemala |
| | - | OCP and OCAEC in Africa |
| | - | World Bank and UNICEF in Nigeria |

When Workshops Will Take Place:

| | | |
|-----------------|---------------------|-----------------------------|
| IEF | Guatemala | Fall of 1991 |
| | Cameroon | Fall of 1991 |
| Africare | Nigeria | Early November, 1991 |
| HKI | Niger | Early November, 1991 |
| | Burkina Faso | Early November, 1991 |

Appendix A

Ivermectin Delivery Program Workshop

Participant List

July 29 and 30, 1991

Africare

Alan Alemain
Gabriel Daniel

Helen Keller International

David French
Robert Gern
Kirstan Larsen

River Blindness Foundation

Carlos Gonzalez-Peralta
Jeffery Watson
Keys MacManus

International Eye Foundation

Jack Blanks
Christine Witte

Tulane University

Barney Cline

Pan American Health Organization

Fernando Beltran

Mectizan Expert Committee

H. Bruce Dull

Vector Biology and Control

Jack W. Swartwood
Flemming Heegaard

Agency for International Development

Dennis Carroll
Adrienne Ertl

Facilitator: Heather Sutherland

Interview Notes
from
IEF, Africare, and HKI

Major Points

Monitoring and Evaluation:

- There is a need to cross-reference program activities to determine cost, i.e. vehicle use as ascribed to training overlapping with the the same vehicle as used for surveys, distribution and other activities on the grid.
- A monitoring criteria list of activities and things needs to be created, to clarify the monitoring process; possibly 10 -15 items.
- Monitoring and evaluation should be directly related to the goals.
- Frequency of monitoring needs to be established.
- Adapting the Child Survival guidelines for monitoring, evaluation and budgeting would be helpful.

Log Frames

- Each PVO could create their own logframe working toward their D.I.P.
- Comparing logframes could be a helpful exercise, looking for similarities and differences with each PVO and AID's logframe.
- Part of each PVO's logframe could be a capability statement.

Development of the D.I.P.'s moving toward Guidelines.

- Goal setting could be first step.
- PVO's capabilities could relate to the goal setting and implementation.
- Sustainability can be built in - what and how can cost recovery be made a reality, fee for service?
- Budget management must be flexible. A measure of trust could be built in.
- Institution building is an important factor, as is training and training materials.
- Reports can be written with these considerations; format, what frequency, distribution, audience, content.
- How will human migration patterns be monitored?

- How will HKI's village surveillance activity, or sentinel system be monitored?
How will they monitor the VHW whose purpose is to act as an early warning system.
- What is to be evaluated at the mid-term and final evaluations?

MIS-HIS

- How detailed should the data be?
- The in-field data should be clear, simplified and hand tabulated and gathered in-country to be put on a computer in-country. There is no practical need for computers in the field.
- Other considerations of the data: format, content, audience, retrieval purposes computer reports.
- Where could analysis take place?
- Training, where? and what kind?

University Liaison

- The main priority is to encourage in-country universities to get involved.
- Involving local universities is cost effective and allows the leverage of further resources. U.S. universities require too high a percentage of the budget.

VBC

- VBC should be viewed as same as AID. VBC should be viewed as a collaborator, i.e. Learn-Learn together and Learn-Apply from lessons learned.
- PVO's should know AID's expectations of VBC.
- Discussion should be held so the PVO's expectations of VBC can be discovered.
- VBC's roles and responsibilities need to be established in regard to:
 1. Technical assistance they can provide.
 2. PVO's access to VBC.
 3. What support VBC offers.
 4. What monitoring guidelines VBC will use.
 5. What management support will VBC provide.

Expectations and Relationship of:

- S&T/H, AID, USAID, and missions.

Program Elements

- What will be the Ivermectin delivery systems look like?
- What will HKI's sentinel system look like?
- What surveillance techniques will be used?
- How will health education and health communication be integrated?
- What staffing patterns will be used? Who will staff the programs?
- What training needs to occur, methods, materials?
- What services will each program provide? Will there be a fee for service?

**Ivermectin Delivery Program
Washington Workshop
July 29 - 30, 1991**

Appendix C

Agenda Topics

Monday, July 29

1. Roles and Responsibilities

A.I.D.'s Expectations: S&T Health will present a programmatic logframe for discussion and review.

Technical Assistance: Discussion will focus on available forms of A.I.D. technical assistance for the PVO's during implementation of the project, and how they might access that assistance through VBC.

PVOs needs and Capabilities: The PVOs will review and discuss their past experiences as they relate to the IDP activities and what they will need to implement them successfully.

2. Design and Implementation

Grant Agreement Format: Discussion will focus on how PVOs can respond to format items and their appropriateness to the IDP activity.

DIP Guidelines: While each PVO will develop their DIPs according to country needs and constraints, there were common elements to all the DIPs. Discussion will attempt to identify more precisely these elements.

3. Monitoring and Evaluation

Monitoring System: Discussion will focus on the purpose and the design of the monitoring system. Questions to be addressed are:

- Should the system be used only for monitoring, or should it include a health information system capability?
- Will the PVOs be able to use the system efficiently in the field?
- Does it serve PVOs needs? If not, how should it be changed?

Reporting: What should the PVO's reporting requirements be?

Evaluation: Review of the scope, timing and relative responsibilities of the mid-term and final evaluation.

4. The Mectizan Expert Committee

Applications: The Executive Secretary of the Mectizan Expert Committee will lead a discussion on how to apply for mectizan.

Tuesday, July 30, 1991

5. Cross Cutting Topics

Quality Assurance: The project officer from S&T Health's Quality Assurance Project will suggest how aspects of this activity can apply to the IDP activities. Discussion will focus on what constitutes appropriate performance indicators and how to build these into IDP activities.

Health Financing: The project officer from S&T/Health's financial strengthening project will lead discussions on how IDP activities can contribute to financial sustainability.

Health Communications: The project officer from S&T Health's HealthCom Project will lead discussions on the role of communication and social marketing in health activities.

6. In- Country Workshops:

Timing: Some discussion is needed to identify when these in-country workshops should be held. One possibility would be immediately following the completion of the DIP by the PVO, while the design team is still gathered in-country.

Agenda for the Workshop: Discussion should consider:
What issues need to be addressed in the workshop?
Who should participate?

Logical Framework for Summarizing a Project Design

Est. Project Completion: _____

Date of this summary: _____

Design Team: _____

| Narrative Summary (NS) | Objectively Verifiable Indicators (OVI) | Means of Verification (MOV) | Important Assumptions |
|---|---|-----------------------------|-----------------------|
| Goal: (the broader objective to which this project contributes) | | | (goal to supergoal) |
| Purpose: (aim or impact) | EOPS (End of Project Status) | | (purpose to goal) |
| Outputs: (deliverables or terms of reference) | 1.1 1.2 2.1 2.2 | | (output to purpose) |
| Activities: (key clusters or work breakdown structure) | Inputs/Resources: (budget) | | (activity to output) |

Supervisory Checklist

(for evaluation of the Community-Based Distributor)

After a CBW has finished distributing ivermectin, the supervisor should visit the community one final time to do the following tasks:

1. Collect the weighing scale or tape measure.

2. Collect the remaining ivermectin. Count the number of tablets of ivermectin remaining. Record this at the appropriate place (near to the bottom) on an Ivermectin Distribution Tally Record. Also, write on the tally record the name of the community, the name of the CBW, the dates of distribution, and the total number of tablets of ivermectin supplied to the CBW.

3. Collect the Household Ivermectin Treatment Records.

How many of these records are there? _____

4. Use the Ivermectin Distribution Tally Record to add up the treatments recorded on the Household Ivermectin Treatment Records: for each person whose name is on the household records, place a mark on the tally record to indicate the number of tablets given to them. Complete the Ivermectin Distribution Tally Record. Use an office pin or paper clip to attach the completed Tally Record to this Supervisory Checklist.

5. Collect the Reaction Forms.

How many reaction forms are there? _____

Ask "How many serious reactions occurred in this community?" _____

Note: For each serious reaction, ask the CBW to show you the specific Reaction Form. Use an office pin or staple to attach the Reaction Form to this Supervisory Checklist. Discuss each serious reaction with the CBW to make sure that it was handled appropriately. If the reaction was mishandled, comment in detail on the back of this Supervisory Checklist or on a separate sheet of paper.

6. Pick at random five Household Ivermectin Treatment Records. Ask the CBW to help you to find the house which corresponds to each of these five household records. Visit the five houses to interview the residents:

a) Read the names listed on the household record. Ask whether each of these people actually lives there and whether they received ivermectin. Ask someone to tell you the age of each person listed. Check that the age roughly agrees with what is written on the household form. Do you detect any major discrepancy between what is written on the household records and what the residents tell you?

i.- Yes/No ii.- Yes/No iii.- Yes/No iv.- Yes/No v.- Yes/No

If the answer is "Yes" for any house, explain on a separate piece of paper.

b) In each house, ask "Which disease will this new medicine treat? Why should people take this medicine?" For each house, indicate whether their answer is right or wrong

i.Right/Wrong ii.Right/Wrong iii.Right/Wrong iv.Right/Wrong v.Right/Wrong

If the answer is "Wrong" for any house, explain on a separate piece of paper.

c) In each house, ask "When should you take the drug again?" (correct answer "One year from now") For each house, indicate whether their answer is right or wrong.

i.Right/Wrong ii.Right/Wrong iii.Right/Wrong iv.Right/Wrong v.Right/Wrong

If the answer is "Wrong" for any house, explain on a separate piece of paper.

d) Is there anyone who is not satisfied with the work done by the HHD?

i. Yes/No ii. Yes/No iii. Yes/No iv. Yes/No v. Yes/No

If the answer is "Yes" for any house, explain on a separate piece of paper.

e) In each house, ask "Is there anyone here who will refuse to take the drug next time?"

i. Yes/No ii. Yes/No iii. Yes/No iv. Yes/No v. Yes/No

If the answer is "Yes" for any house, explain on a separate piece of paper.



7. How much allowance should the CBW be paid? _____

Tell the CBW how to collect his allowance.

Questions for Program Evaluation

The following questions should help the State Onchocerciasis Control Team and program planners to identify problems with the program. During evaluation exercises, team members should discuss ways to solve problems and improve the program.

I. For Interim Evaluations

A. Relations with Local Government and Formation of the LGA Oncho Control Team (LOCT)

1. Did the S.O.C.T. establish good relations with the LGA chairmen, secretary and head of the health department? Do these officials appear willing to support ivermectin distribution in the long-run? If not, why not?
2. Did the S.O.C.T. present a budget estimate to the chairman and discuss it with him? Did he object to any of the projected expenses? Did he promise to include adequate amounts in the budget for next year?
3. How much did the LGA contribute to this year's distribution? How many motorcycles? How much money?
4. Was a competent official appointed to be the LGA Oncho Coordinator? What about the Oncho Trainer? Did these staff actively and effectively participate in the distribution campaign this year? Will these staff be able to organize next year's distribution campaign almost on their own?
5. Did the SOCT (plus or minus the LGA Oncho Coordinator) interview each LOCW before he or she was selected to make sure that he or she was competent and motivated to do field work?
6. How can the training workshops for the LOCT be improved?

B. Mapping and Assessment

- 1. Did the SOCT and/or the LOCT prepare a map of each distribution area showing the location of communities and clinics and the distance (or travel time) between them on the existing roads ?**
- 2. Did they count houses and attempt to estimate the population of each community assessed ? How did their house counts and their estimate of population compare with the number of Household Ivermectin Treatment Records (HITR's) completed and the population estimate based on the HITR's ? If there are large differences between the two types of estimates can anyone explain why ?**
- 3. Prepare a table showing the names of communities assessed, their estimated populations, the number of people assessed, and the percentage of those assessed who had various signs of onchocerciasis. What is the estimated average prevalence of infection in each district ?**
- 4. Were there some communities which refused to cooperate with assessment ? Were there some communities where less than 30 adult males were assessed ? Can anyone explain why ?**
- 5. Did the S.O.C.T. conduct assessment in at least 2 communities in each district ? How do the results of the SOCT's assessment compare with the results of the LOCT's assessment ? If there are any major discrepancies, can anyone explain why ?**
- 6. Did all of the communities selected for mass distribution have an assessment suggesting that the prevalence of infection in adult males was greater than 40%. If there were some exceptions, can anyone explain why ?**

C. Selection of Referral Centers

1. Did the SOCT (plus or minus the LGA Oncho Coordinator) visit each of the referral centers before they were selected to make sure that they were adequately staffed.
2. Were some of the communities which received ivermectin more than two hours away from an adequately trained referral center? This was an oversight.

D. Health Education/Publicity

1. Does review of Monthly Field Summaries suggest that each endemic community was visited twice to inform it about ivermectin distribution?
2. Refer to the responses recorded for item 6b and 6c on the Supervisory Checklists. For each community, what is the percentage of informants who answer both questions correctly?

E. Training of Community-Based Workers (CBW's)

1. Did the LOCW's and the LGA Oncho Training do almost all of the teaching or did central program staff have to take charge?
2. How many CBW's attended each training workshop? More than 25 is too many.
3. Were there some villages that failed to send a CBW? Why did this happen?
4. Was a practical examination administered after each record form (the HITR and the Record Form for Reactions) was introduced? How did students perform on these exams?
5. Was individual instruction provided for students who performed poorly on the exams?

F. Ivermectin Distribution

1. Was a Supervisory Checklist and an Ivermectin Distribution Tally Record completed for each CBW? If not, why not?
2. Refer to the answers to item 6a of the Supervisory Checklist? Is there any evidence that certain CBW's falsified their records? According to the Tally Records, were there some CBW's that had more than 20 "extra" tablets of ivermectin? Were there some CBW's that had more than 20 missing tablets of ivermectin? Were CBW's questioned carefully if there was evidence of problems with their records? Was any action taken such as to reduce the incentive paid to them?
3. Refer to the answers to questions 6d and 6e on the Supervisory Checklists. Did anyone express dissatisfaction with the work performed by the CBW or the program in general? If so, why were they dissatisfied?
4. Did any of the CBW's complain about the work? If so, what did they complain about? Were they all paid eventually?
4. How many days did it take each CBD to finish 90% of the work. Divide the total amount paid to the CBD by this number of days to calculate the daily wage.
5. Review the Field Logs. Do they show that each CBD was visited at least twice?
6. In some cases, was final verification done more than seven days after the CBD started distribution? "Idle hands do the devils work".
7. Were all of the weighing scales returned in working condition?
8. How many tablets of ivermectin cannot be accounted for. Review the inventory records kept by the SOCT, by each LOCW and by any clinic to determine who had possession

of the tablets when they "went missing". From where in the distribution chain were the tablets diverted ?

G. Management of Reactions

1. **Review the Reaction Forms. Evaluate each CBW according to the following criteria:**
 - a) **On what percentage of forms did they answer the three important questions--**
"Is it difficult for you to breath ?"
"Are you so dizzy that you fell down ?"
"Are you so dizzy that it is difficult to walk ?"
 - b) **When they dispensed chloroquine, what percentage of the time did they give an incomplete course ?**
 - c) **What percentage of the time did they dispense all three medicines to the patient ?**
2. **When the CBW made lots of mistakes on completing the forms, did the LOCW note this on the Supervisory Checklist ?**
3. **Review the Supervisory Checklists (item 5) and question the LOCW's to determine how many serious reactions occurred. For each serious reaction, was a form filled out by both a CBW and a health professional? If not, why not ? Was the serious reaction investigated carefully by the Oncho Coordinator and the SOCT ? If not, why not ? Each serious reaction must be carefully documented and the various reports should be included in the interim evaluation report.**

H. Program Management/Record Keeping

1. **Did each LOCW complete a Monthly Field Summary each month ? Do the LOCW's complete the forms correctly ?**
2. **Did the LOCW's complete the Field Log correctly ? Is there any reason to believe that the Field Log was completed fraudulently or that the motorcycle was used excessively for personal purposes.**
3. **Did the Oncho Coordinator play an active role in supervising the LOCW's and in reviewing the LOCW's**

records to determine how much field allowance they have earned ?

4. Is the D.F.O. or some other member of the S.O.C.T. in the habit of regularly completing a Monthly Field Summary of all of the work performed in the state ?
5. For each interim evaluation a table should be prepared such as that on page 7, summarizing much of the important information about work in the L.G.A. ?

I. Costs

For each interim evaluation, the expenditures should be totaled up and analyzed to determine the cost of treatment per village or per person treated. An example is shown on page 8.¹

¹This is taken from the Evaluation of Mass Distribution of Ivermectin in Ifelodun LGA, Kwara State.

II. End-of-First-Year and Final Evaluations

A. Community Knowledge, Attitudes and Practices²

Organize a focus group discussion with representatives of several participating communities. The local emir can probably help out. Ideally, the facilitator should not appear to have any connection with the program or any government agency. Rather than to pick communities at random, perhaps it would be better to select one or more communities in which some significant problem occurred (e.g. rumors, serious reactions, complaints about the CBW or the LOCW). The facilitator should be sure to select people who are truly representative of the community rather than just chiefs or school teachers. Questions to ask might include the following:

1. "What are the main problems in your communities?"
2. "What are the main health problems?"
3. List various health problems including blindness. Ask whether any of these are problems in their communities.
4. "When people in your communities are sick, with a fever for example, what do they do about such a problem?"
5. "Do you ever buy medicines from a local vendor? Do you trust that person?"
6. "Do you ever go to a clinic? What is your favorite clinic? Which do you prefer: a government clinic or some other clinic? Why?"
7. "Several months ago did someone from your community go from house to house to distribute small white tablets? What was this medicine for? What diseases did it treat? Did this medicine help people? How? Did people like the medicine? Did people object that the medicine was distributed by a non-professional? Did everyone trust the person that distributed the medicine? Did anyone have any complaints about this person? Were there some people who were not given the medicine? Why not? Did anyone get sick because of the medicine? Did anyone complain about the medicine? Do you want to take this

²The impact of the program on the community can best be judged through longitudinal "Knowledge, Attitudes and Practices" surveys and focus group discussions. Hopefully such surveys will be designed or even conducted by consultants specially hired for the purpose. Such consultants should design relevant evaluation questions, and methods.

medicine again? When is the next time that you should take the medicine? Would you be willing to pay for the medicine? If someone charged two naira to treat everyone in a house, do you think that some people would refuse?

8. "Why are some people blind? What causes blindness? Can worms cause blindness? etc..."

B. Involvement of the local government and NGO's

1. Talk with senior representatives of participating local governments and local NGO's. What are their leading priorities (i.e. felt needs) ?
2. Do they express ownership of the program or do they speak of "Africare's program" or "the Ministries program" ?
3. How much can they afford to spend each year on the program? Is N60,000 per year more than a local government can afford to spend on this program? Do they accept the fact that beginning next year they must pay all allowances and provide all the motorcycles?
4. Do they have any complaints or suggestions about the way that the program is organized?
5. If speaking to local government representatives, what do they think of the work being done by NGO's? Any problems with the NGO's?
6. If speaking to local NGO representatives, what do they think of the work being done by the local government? Any problems with the local government?
7. The evaluators will probably want to compare the work done by local government with the work done by NGO's. The evaluators must be careful, however, not to promote a rivalry or bad feelings.

C. Involvement of the State Ministry of Health

1. **Meet with the Commissioner of Health, the Director General, the Chief Medical Officer and the Director of the Epidemiology Unit. Remarks? Supportiveness? Expressions of ownership? Complaints? Suggestions? Requests?**
2. **Meet with the field workers who make up the S.O.C.T. to explore the same questions.**
3. **Meet with the local Africare staff to get their impressions on such critical questions as...**
 - ...are enough staff dedicated to the program?**
 - ...are enough vehicles dedicated to the program?**
 - ...does the D.F.O. dedicate adequate time to the program?**
 - If not, what can be done?**
 - ...is the D.F.O. qualified to plan and manage the program?**
 - If not, what can be done?**
 - ...does the SMOH care about this program?**
 - ...can the SMOH afford to operate this program?**

D. Africare's Performance

1. **Is the program sticking to its original timetable and budget and treating the expected numbers of people?**
2. **Are adequate records kept? Has an interim evaluation report been completed for each LGA where distribution has been completed?**
3. **Were all serious reactions adequately investigated and documented?**
4. **Is overall management of the program being gradually handed over to SMOH staff? If not, why not?**
5. **Next year, will the LOCT's be able to function with some degree of independence? If not, why not?**
6. **Has a qualified and dedicated Nigerian Project Adviser been recruited? Has he been properly oriented to the work? Will he be able to direct the program in the future?**

DEVELOPMENT SERVICES - DIOCESE OF YOLA

HOLY ROSARY SISTERS

P. O. BOX 4.
WUKARI.

Bali Postal Agency
Bali

Gongola State

March 6th 1991.

Dr. Bobina
Africare, P.O. Box 52839
Falomo, Ikoyi SW. Lagos.

Dear Dr. Bobina,

Creetings to you. I Hope you had a safe and pleasant journey back to Lagos. I was happy to meet you and your team last week as you passed through Bali. Our meeting was brief but it was good to hear of your work on river blindness and to exchange some ideas about the possibility of collaboration between us in the future

I would be pleased if you could do the following:-

- i Communicate with me at regular intervals and keep me informed about developments between your organization and the State and Local Governments here in Gongola
- ii Send me some background information on Africare

I feel you will understand my own position regarding this matter and indeed we discussed this briefly

It would be my hope and it would be important to our work here that we be permitted to treat those communities with whom we already have contact. This would be



EXECUTIVE COMMITTEE OF
THE DIRECTING COUNCIL

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HEALTH
ORGANIZATION

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THE REGIONAL COMMITTEE

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HEALTH
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Appendix F

PROPOSED RESOLUTION

PR/7 (Eng.)

STATUS OF THE ERADICATION/ELIMINATION OF CERTAIN DISEASES FROM THE REGION

THE 107th MEETING OF THE EXECUTIVE COMMITTEE,

Having seen Document CE107/10 reporting on the status of the eradication/elimination of certain diseases from the Region,

RESOLVES:

To recommend to the XXXV Meeting of the Directing Council the adoption of a resolution along the following lines:

THE XXXV MEETING OF THE DIRECTING COUNCIL,

Having seen Document CD35/___ on the status of the eradication/elimination of certain diseases from the Region;

Having regard to Resolution XVI of the XXIII Pan American Sanitary Conference; and

Recognizing that some countries have eradicated or eliminated poliomyelitis, neonatal tetanus, measles (in the Caribbean), urban rabies and foot-and-mouth disease, and that it is feasible to seek to eradicate or eliminate from the Region some communicable diseases (American trypanosomiasis transmitted through blood transfusion, leprosy, the nonvenereal treponematoses and onchocerciasis) and micronutrient deficiencies,

RESOLVES:

1. To adopt the following recommendations contained in Document CD35/___ for the elimination, eradication or control of certain diseases:

a) American trypanosomiasis:

- i) Where T. cruzi infection is endemic, Governments should frame plans of action for interrupting the vector transmission of T. cruzi;
- ii) Where T. cruzi infection is endemic but its distribution is not well defined, Governments should perform epidemiological studies to identify areas of high risk for transmission;
- iii) Where T. cruzi infection is transmitted by blood transfusion, Governments should devise plans of action to assure the safe use of human blood; these plans should address the strengthening of health services involved in such use.

b) Leprosy:

The Director should draw up a plan of action for the elimination of leprosy from the Region (defined as reduction to a prevalence of less than one case per 10,000 inhabitants), and present it to the 109th Meeting of the Executive Committee.

c) Nonvenereal treponematoses:

By 1994, the affected countries should complete epidemiological studies to determine the distribution of these diseases, the social circumstances of the affected population, and the major factors associated with transmission.

d) Onchocerciasis:

Adoption of the Multinational Strategic Plan of Action Toward Onchocerciasis Elimination in the Americas contained in Annex VI of Document CD35/___.

e) Iodine-deficiency disorders:

Adoption of the target of elimination of these disorders by the year 2000 and revision of the Plan of Action to that end, in keeping with the guidelines contained in Document CD35/___.

f) Vitamin A deficiency:

A plan of action should be drawn up in 1992 in accordance with the guidelines contained in Document CD35/___.

2. To urge the Member Governments:

- a) To continue giving priority to the effective prevention, control and surveillance of diseases preventable by immunization until they are eliminated;
- b) To foster the necessary collaboration and coordination between the different levels of the public sector, and between it and the private sector, for the completion and execution of updated plans of action to prevent, control, and maintain surveillance of:
 - i) the following infectious diseases: trypanosomal infections transmitted by blood transfusion, leprosy, the nonvenereal treponematoses (yaws and pinta), and onchocerciasis, and
 - ii) deficiencies of the following micronutrients: iodine and vitamin A;
- c) To introduce activities for the prevention and control of these diseases in their local health systems and encourage community participation and local programming so that the measures taken will be comprehensive and make use of all available resources.

3. To request the Director:

- a) To promote the mobilization of institutional, human and financial resources in the countries, the Region, and the rest of the world for the development and use of the infrastructures required to execute and maintain effective and consistent eradication/elimination programs;
- b) To foster the establishment, strengthening and proper functioning of epidemiological services that can analyze health situations, risk factors, and the characteristics of ecosystems, and evaluate social and health services;
- c) Promote technical cooperation for the development of epidemiological programs and surveillance in joint efforts for the preservation of transmission-free areas;
- d) Support the development of managerial and administrative capabilities at the lowest decision-making levels in order to promote local programming and the evaluation of prevention, control and surveillance methods in local situations.

at



EXECUTIVE COMMITTEE OF
THE DIRECTING COUNCIL

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THE REGIONAL COMMITTEE

WORLD
HEALTH
ORGANIZATION



RESOLUTION

VI

STATUS OF THE ERADICATION/ELIMINATION OF CERTAIN DISEASES FROM THE REGION

THE 107th MEETING OF THE EXECUTIVE COMMITTEE,

Having seen Document CE107/10 reporting on the status of the eradication/elimination of certain diseases from the Region,

RESOLVES:

To recommend to the XXXV Meeting of the Directing Council the adoption of a resolution along the following lines:

THE XXXV MEETING OF THE DIRECTING COUNCIL,

Having seen Document CD35/___ on the status of the eradication/elimination of certain diseases from the Region;

Having regard to Resolution XVI of the XXIII Pan American Sanitary Conference; and

Recognizing that some countries have eradicated or eliminated poliomyelitis, neonatal tetanus, urban rabies and foot-and-mouth disease, that the decision has been made to eliminate measles (in the Caribbean), and that it is feasible to seek to eradicate or eliminate from the Region of the Americas other communicable diseases such as American trypanosomiasis transmitted through blood transfusion, leprosy, the nonvenereal treponematoses and onchocerciasis, and micronutrient deficiencies,

RESOLVES:

1. To adopt the recommendations contained in Document CD35/___ for the elimination, eradication or control of certain diseases.