



Côte d'Ivoire

FY 2018

Control of Neglected Tropical Diseases

Annual Work Plan
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Submitted to: Bolivar Pou
Project Director
END in Africa Project
FHI360
bpou@FHI360.org

Submitted by: Family Health International 360 (FHI360)

For more details, please contact: Joseph B. Koroma
Associate Director Technical
END in Africa Project – Regional Hub
FHI360 Ghana Office
JKoroma@fhi360.org



Table of Contents

COUNTRY OVERVIEW.....	5
1. General country background.....	5
2. National NTD Program Overview.....	7
3. Snapshot of NTD Status in Côte d'Ivoire.....	12
PLANNED ACTIVITIES.....	12
1. Capacity Strengthening Strategy	12
2. Project Assistance.....	14
a. Strategic Planning	15
b. NTD Secretariat.....	17
c. Building advocacy for a Sustainable National NTD Program	18
d. Mapping.....	18
e. MDA coverage	19
f. Social Mobilization to Enable NTD Program Activities	20
g. Training	22
h. Drug and Commodity Supply Management and Procurement.....	24
i. Supervision for MDA.....	25
j. Monitoring and evaluation	26
k. Supervision for M&E and DSAs	28
l. Dossier Development	28
m. Short-term Technical Assistance	28
3. Planned FOGs to local organizations and/or governments.....	30
4. Cross-Portfolio Requests for Support.....	31
5. Maps	32
APPENDICES	35

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

ACRONYMS AND ABBREVIATIONS

AE	Adverse Event
ALB	Albendazole
APOC	African Program for Onchocerciasis Control
BCC	Behavior Change Communication
CD	Community Distributor
CDTI	Community Directed Treatment with Ivermectin
CNTD	Center for Neglected Tropical Disease
CSRS	Swiss Center for Scientific Research [Centre Suisse de Recherche Scientifique]
DGSHP	Office of the Director General of Health and Public Hygiene [Direction Générale de la Santé et de l'Hygiène Publique]
DOLF	Death to Onchocerciasis and Lymphatic Filariasis
DPML	Department of Pharmaceuticals, Medication and Laboratories [Direction de la Pharmacie, Médicaments et Laboratoires]
DQA	Data Quality Assessment
ESM	Epidemiological Surveillance Managers
FHI360	Family Health International 360
FOG	Fixed Obligation Grant
FPSU	Filarial Programmes Support Unit
FTS	Filariasis test strip
FY	Fiscal Year
GoCI	Government of Côte d'Ivoire
GSK	Glaxo Smith Kline
GTMP	Global Trachoma Mapping Project
HD	Health District
HKI	Helen Keller International
HR	Health Regions
ICRC	International Committee of the Red Cross
ICT	Immuno-Chromatographic Test
IEC	Information, Education and Communication
INDB	Integrated NTD Database
IVM	Ivermectin
LF	Lymphatic filariasis
M&E	Monitoring & Evaluation
MDA	Mass Drug Administration
MDP	Mectizan Donation Program
MF	Microfilaridermia
MPA	Minimum Package of Activities
MRU	Mano River Union
MSHP	Ministry of Health and Public Hygiene [Ministère de la Santé et de l'Hygiène Publique]
NTD	Neglected Tropical Diseases
Oncho	Onchocerciasis
PCT NTD	Neglected Tropical Diseases targeted through Preventive Chemotherapy and Transmission Control
PZQ	Praziquantel
OCP	Onchocerciasis Control Program

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

PNLSGF	National Program for the Control of Schistosomiasis, Soil-transmitted Helminthiasis and Lymphatic Filariasis [Programme National de Lutte contre la Schistosomiase, les Géohelminthiases et la Filariose Lymphatique]
PNSO-LO	National Program for Eye Health and the Fight Against Onchocerciasis [Programme National de Santé Oculaire et de la Lutte contre l'Onchocercose]
REMO	Rapid Epidemiological Mapping for Onchocerciasis
RGPH	General Population and Habitat Census [Recensement General de la Population et de l'Habitat]
RPRG	Regional Program Review Group
SAC	School age children
SAE	Severe Adverse Event
SAFE	Surgery for trichiasis cases, Antibiotics to treat the community pool of infection, and Facial cleanliness/Environmental improvement to reduce transmission
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative
SOP	Standard operational procedures
STH	Soil-Transmitted Helminthiasis
TEC	Trachoma expert committee
TEO	Tetracycline eye ointment
TF	Trachomatous Inflammation Follicular
TIPAC	Tool for Integrated Planning and Costing
TIS	Trachoma impact survey
TT	Trachomatous trichiasis
WAHO	West African Health Organization
WHO	World Health Organization

COUNTRY OVERVIEW

1. General country background

Côte d'Ivoire is located on the south-central coast of West Africa, below the Equator between latitude 10° North and longitude 4° West, and is bordered by the Atlantic Ocean in the south, Ghana in the East, Liberia and Guinea in the West, and Burkina Faso and Mali in the North. Côte d'Ivoire is a member of the Mano River Union (MRU) that includes neighboring countries such as Liberia, Guinea and Sierra Leone that are all also endemic for neglected tropical diseases targeted through preventive chemotherapy (PCT NTDs).

It has a surface area of 322,463 sq. km, of which 318,003 sq. km is land, and measures 600 km from North to South and 600 km from East to West. Côte d'Ivoire has a mild tropical climate with annual average temperatures between 26° C and 27° C and a high humidity of more than 70%. Equatorial and southern savanna types of climate prevail. North of approximately 8° N latitude, the southern savanna type of climate occurs, characterized by the parching wind known as the harmattan, which blows from the northeast beginning in December and ending in February. The dry season lasts from November to March and is followed by a single rainy season from April to October that produces annual precipitation with totals ranging from around 45 inches (1,100 mm) in the northeast and center to approximately 60 inches (1,500 mm) in the north-west.

For administrative purposes, Côte d'Ivoire is divided into 31 regions, 12 districts, 108 departments, 520 sub-prefectures, 197 communes and more than 8,500 villages. It has two (2) autonomous districts (Abidjan, which is the economic capital, and Yamoussoukro, which is the political capital). Yamoussoukro is located in the center of the country, 248 km from Abidjan. According to the projections made by the General Population and Habitat Census (in French, Recensement General de la Population et de l'Habitat or RGPH) in 2014, the population of Côte d'Ivoire in 2018 is estimated at 25,077,810 inhabitants¹. The health care system of Côte d'Ivoire is divided into 20 Health Regions (HR) and 83² Health Districts (HD). The HD is the operational unit of the health care system and is also the unit that plans and organizes the activities necessary for the optimal management of the populations' health problems, with the full participation of those populations.

Recent political and social crises (2002-2012) have taken a heavy toll on the country's health system. Nationwide many hospitals and health centers were vandalized and remain in bad shape. After the last post-electoral crisis of 2012, international partners have been supporting the country to restore basic health services, improve food security and foster social cohesion that benefits millions of Ivorians in the regions most affected by the crisis. Despite the country's steady recovery, gaps remain in restoring basic services such as healthcare.

In Côte d'Ivoire, there are many programs established for the control of Neglected Tropical Diseases (NTDs) including programs targeting PCT NTDs and programs targeting case management NTDs such as Buruli ulcer, yaws, and leprosy. A decision was recently taken by the Ministry of Health and Public Hygiene (Ministère de la Santé et de l'Hygiène Publique or MSHP) in Côte d'Ivoire to have a National Program for the Control of NTDs targeted through Preventive Chemotherapy headed by a National Coordinator instead of the previous 2 programs (the National Program for the Control of Schistosomiasis, Soil Transmitted Helminthiasis and Lymphatic Filariasis (Programme National de Lutte contre la Schistosomiase, les Géohelminthiases et la Filariose Lymphatique or PNLSTGF) and the National Program for Eye Health and Onchocerciasis Control (Programme National de Santé Oculaire et de la Lutte contre l'Onchocercose or PNSO-LO)). The new National Program for the Control of PCT NTDs (referred to in this document as PCT NTD program) will continue to receive financial and technical support from several NTD partners besides the United States Agency for International Development (USAID) as detailed in table 1 below, key among which are the following: END

¹Projection of the National Institute of Statistics (INS) 2018.

² Divo Health District has been divided into two (02) districts: Guitry and Divo.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Fund, Sightsavers, Schistosomiasis Control Initiative (SCI); and the World Health Organization (WHO). It is, however, worth noting that even with the support of the partners mentioned in Table 1 below, the geographic coverage for the 5 PCT NTDs has increased to almost 100% due to support from USAID that started in fiscal year (FY) 2016. USAID funding has provided the opportunity for Côte d'Ivoire to almost complete all mapping (mapping for trachoma is still ongoing); improve the quality of mass drug administration (MDA) to reach 100% geographical coverage and ≥80% programmatic coverage; properly implement the required activities for monitoring and evaluation (M&E) including disease specific assessments (DSAs); and to build local capacity for implementation of M&E activities, all in accordance with WHO guidelines.

Table 1a: Non-END in Africa NTD partners working in country, donor support and summarized activities

Partner	Location (Regions/States)	Activities	Is USAID providing direct financial support to this partner? (Do not include FOG recipients)	List other donors supporting these partners/activities
MSHP	Central level, 20 endemic HRs and 83 endemic HDs	Provides human resources, budget and equipment for operations	No	None
		Ensures exemption from custom tariffs for the donated tablets used for lymphatic filariasis (LF), onchocerciasis (oncho), soil-transmitted helminthiasis (STH), and schistosomiasis (SCH) MDA	No	WHO, Mectizan Donation Program (MDP), Merck & Co. Inc., GlaxoSmithKline (GSK), Merck Serono
	Central level, 3 endemic HRs and 5 endemic HDs	Ensures exemption from custom tariffs for the donated Zithromax tablets and suspension used for trachoma MDA	No	International Trachoma Initiative (ITI) Pfizer
END Fund /Sightsav ers	17 HDs	Financial support for integrated LF, oncho and STH MDA	No	None
	3 HDs	Financial support for oncho MDA	No	None
	2 HDs	Financial support for trachoma mapping	No	None
MDP	Central level/ 77 endemic HDs	Donation of IVM in sufficient quantities for LF and oncho MDA and covering of transportation costs for the donated medicines up to the country's airport	No	None
GSK	Central level/ 74 endemic HDs	Donation of ALB in sufficient quantities for LF MDA and covering of transportation costs for donated medicines up to the country's airport	No	None
ITI/Pfizer	3 HRs/5 HDs	Donation of Zithromax tablets and suspension in sufficient quantities for trachoma MDA and covering of transportation	No	None

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

		costs for donated medicines up to the country's airport		
WHO Côte d'Ivoire	Central level/ 83 HDs	-Technical support for the request and donation of NTD medicines (IVM and ALB) and the implementation of NTD activities -Facilitates all customs formalities for donated IVM, ALB and Zithromax up until delivery to the PCT NTD program	No	None
Washington University of Saint-Louis	PCT NTD program at Central level, Abidjan	Supply of computing and logistics materials,	No	None
University of Philadelphia (Death to oncho and LF (DOLF) Project)	Akoupé, Abengourou and Agboville HDs	Support for operational research	No	None
		Financial and technical support for LF, oncho and STH MDA	No	None
SCI	PCT NTD program at Central level	Logistics support	No	None
	PCT NTD program at Central level, 16 endemic HRs and 39 endemic HDs	Technical and financial support for the implementation of information, education and communication (IEC)/behaviour change communication (BCC) activities for SCH	No	None
	PCT NTD program at Central level, 16 endemic HRs and 39 endemic HDs	Financial and technical support for SCH MDA and SCH impact assessment	No	None

2. National NTD Program Overview

The MSHP had created six programs to combat all NTDs endemic in the country with two of them responsible for PCT NTDs (PNLSGF and PNSO-LO). However, a new National Program for the Control of PCT NTDs headed by a National Coordinator was recently created by the MSHP to replace the former 2 PCT NTD programs. The PCT NTD program is directly linked to the Office of the Director General of Health and Public Hygiene (Direction Générale de la Santé et de l'Hygiène Publique or DGSH) and specifically target LF, oncho, SCH, STH (round worm (*Ascaris lumbricoides*), whipworm (*Trichuris trichuria*) and hookworm (*Ancylostoma duodenale* and *Necator americanus*) and trachoma. FY18 will be the third year of USAID support to the PCT NTD program in Côte d'Ivoire provided through the END in Africa project. All activities planned for FY18 will be implemented strictly per the most recent WHO guidelines, protocols and standard operational procedures (SOPs). All 5 PCT NTDs mentioned above are endemic in Côte d'Ivoire and are targeted as follows: LF, trachoma and oncho are targeted for elimination; while SCH and STH are targeted for control because of the high reinfection rate noted and the predisposition of many communities to the two diseases due to poor environmental sanitation.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Control/elimination activities for the 5 PCT NTDs will be integrated as much as possible to improve efficiency and maximize the use of the limited available resources. Treatment of LF is with ALB and IVM tablets. ALB is also effective against STH and is one of the drugs used for STH control, while IVM is also used for treating oncho. Therefore, MDA for LF and oncho are integrated with added benefit for STH where these diseases are co-endemic. SCH treatment with PZQ is also integrated with STH treatment with ALB in HDs where both diseases are co-endemic because the targeted population for these 2 diseases is usually school-age children (SAC). Besides MDA campaigns, the current Côte d'Ivoire NTD strategic plan (2006-2020) includes mapping the different diseases, IEC/BCC, advocacy, M&E including epidemiological and entomological monitoring, capacity building, operational research, care for the NTD sequelae (hydrocele, lymphedema and elephantiasis), community self-monitoring, and vector control.

In FY17, USAID financing covered 15 HRs and 62 HDs in Côte d'Ivoire. Fifty-seven HDs were targeted for activities to control LF, oncho and STH; 12 for trachoma elimination, and three for SCH MDA among adults. The activities supported by USAID in FY17 included MDA, capacity building, training, DSA, data management, and social mobilization through IEC and BCC. The PCT NTD program also received logistics support that included procurement of 26 laptop computers (21 computers delivered to 21 HDs and 5 being used at the national level) that is expected to facilitate and simplify the use of the Integrated NTD Database (INDB).

❖ LYMPHATIC FILARIASIS

Mapping for LF using immunochromatographic test (ICT) cards started in 2000 but was only completed in 2014 due to different socio-political crises during these years. According to currently available mapping results, 74 of the 83 HDs are LF endemic (among which 65 are co-endemic for LF and oncho), and 9 HDs are non-endemic. The number of LF endemic HDs has increased from 61 in FY16 to 74 after remapping of 14 HDs for LF, which was based on recommendations of the WHO NTD Regional Program Review Group (RPRG) for Africa, showed that another 12 HDs are LF endemic, and Divo HD was divided into 2 HDs (Guitry and Divo).

LF MDA started in 2012 after a decade of conflict in the country with the treatment of 4 HDs. No treatment was conducted in 2013 due to lack of funding. In 2014, the same 4 HDs were treated together with 25 other HDs. In 2015 only 26 HDs were treated. However, in FY16 geographic coverage moved up to 100% for the then 61 LF endemic HDs with USAID funding covering 41 of the 61 HDs for LF treatment. Since the number of LF endemic districts have increased to 74 in FY17, USAID funds in FY2018 will be used to support MDA in 57 LF endemic HDs with a target population of 13,524,811 people to still maintain geographic coverage for LF at 100%, capacity building through trainings of actors as well as sensitization and social mobilization of at risk populations, and supervision of MDA activities. The other 17 HDs will be covered with financial support from Sightsavers and END Fund.

❖ ONCHOCERCIASIS

Oncho control in Côte d'Ivoire began in 1974 with the former WHO West African Onchocerciasis Control Program (OCP). Under the OCP, the country was divided into 3 strategic areas: (i) initial area (northern zone); (ii) southern extension zone; and (iii) forest area. From 1974 to 1998, the treatment strategy was based on vector control through aerial larviciding along river basins (Sassandra, Marahoué, Bandama, Comoé, and Black Volta) and their affluents. From 1990 to 1996, OCP used mobile teams of health workers to distribute IVM in the southern extension area. There was then very little community participation and production costs to the health system were high. Since 1996 Community Directive Treatment with Ivermectin (CDTI) is being implemented in the country's southern extension area. The CDTI strategy complemented the vector control activities of OCP and contributed to the success of the OCP whose mandate ended in 2002.

Thus, at the closure of OCP in 2002, after more than 20 years of control activities, epidemiological evaluation for oncho was conducted through detection of microfilaridermia (MF) using skin snip methodology in the initial area and nodule detection using rapid epidemiological mapping for onchocerciasis (REMO) methodology in the

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

southern extension and the forest area. The epidemiology of oncho in Côte d'Ivoire was described as follows: (i) Initial area: oncho MF prevalence reduced from 60% with a blindness rate of 10% to a MF prevalence of 5% with zero blindness rate; (ii) southern extension zone: oncho nodule prevalence was between 5% and 15%; (iii) forest area: the oncho nodule prevalence was around 60% in endemic villages. The political and military crisis that started in 2002 had a negative impact on achievements made in oncho control such as (i) loss of the database and other resource materials; (ii) loss of logistics; (iii) deterioration of the epidemiological profile; (iv) withdrawal of control partners; (v) loss of skilled human resources; (vi) termination of epidemiological and entomological surveillance; (vii) interruption of mass treatment with IVM for 3 consecutive years between 2002 and 2004.

In 2005, oncho control activities were resumed in a difficult environment with the support of the African Programme for Onchocerciasis Control (APOC), Helen Keller International (HKI), CARITAS of Man, and the International Committee of Red Cross (ICRC). Since then there have been irregular treatments for oncho due to lack of funding. Thus, between 2005 and 2013 the geographical coverage was between 22.32% and 46.5%, and therapeutic coverage was between 10.41% and 35.1%. Also, the different entomological and epidemiological surveillance activities conducted since then have indicated a resurgence of oncho transmission across the country. Thus, the northern zone of the country (the Black Volta and Comoé at the border between Côte d'Ivoire, Burkina Faso and Ghana) considered to be 'cleaned' at the closure of OCP in 2002 is noted to now have a prevalence of about 37% (Black Volta in the village of Posséo) and 19.4% (Comoé in the village of Kafolo). Furthermore, 2013 epidemiological assessments show the situation is also deteriorating in the Marahoué and BIA regions with a prevalence of 15.83% and 35.4% respectively. In 2014, an epidemiological assessment in HDs that have never been covered also detected 8 HDs with prevalence ranging from 1.1% to 8%, thus increasing to 67 the number of oncho-endemic HDs.

The FY18 WorkPlan is taking into consideration the paradigm shift from oncho control to oncho elimination, and all HDs with prevalence $\geq 1\%$ will continue to be treated. There are also ongoing plans to establish an Oncho Expert Committee. Currently, there are 68 oncho endemic HDs and 74 LF endemic HDs with the division of Divo HD, among which 65 are coendemic for oncho and LF. This means there are 65 oncho/LF coendemic HDs, 3 oncho-only HDs (68 less 65), and 9 LF-only HDs (74 less 65). A total of 77 out of 83 HDs will be treated for oncho and LF, and USAID will support activities in 57 HDs while the remaining 17 HDs will be covered by Sightsavers and END Fund. In line with new WHO guidelines on oncho elimination, all districts receiving regular annual MDA should undergo epidemiological evaluation every 3-5 years to determine the current oncho prevalence level and assess the impact of MDAs on the oncho prevalence with time. Eight out of the 22 HDs that have completed 7 years of regular treatment with $\geq 80\%$ program coverage will be evaluated for the year 2018. In FY18, 68 oncho endemic HDs, most of them co-endemic with LF, will be treated, and the generous contribution of the American people via USAID is requested for the implementation of MDA for oncho in 49 HDs co-endemic with LF.

❖ TRACHOMA

There were very few data available on the prevalence of trachoma and the distribution of endemic areas in Côte d'Ivoire. Furthermore, very few of the HDs have staff trained on eye care, especially in frontline health facilities. District health professionals are also not trained on trachoma screening. Consequently, not much attention was given to this disease within HDs. A study on trachoma was initiated by the West African Health Organization (WAHO) that was conducted in 2008 by the Swiss Centre for Scientific Research (Centre Suisse de Recherche Scientifique or CSRS) and the PNSO-LO (formerly known as Program National de Lutte contre la Cecite or National Program for Blindness Prevention-PNLC). This study was conducted as part of the drive to complete trachoma mapping in the West African Region and involved six departments (prefectures) of northern Côte d'Ivoire namely Odienné, Tengrela, Boundiali, Korhogo, Bouna and Ferkessédougou. These departments were chosen because they are close to Mali, Guinea Conakry and Burkina Faso, all countries affected by trachoma. The results of the survey conducted in 2008 showed the prevalence of active trachoma

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

(trachoma inflammation follicular or TF) among children 1-9 years was less than 10% in the HDs of Tengrela, Boundiali, Korhogo, Bouna and Ferkessédougou, except in two villages of the Departments of Odiénne Bogoba (10.7%) and Tiolasso (24.5%). Unfortunately, no action was taken to address the situation due to the political crisis and the military division of the country into two zones that had damaged the country's health profile, depriving northern areas of all the relevant health services, and exacerbating the trachoma situation witnessed.

Table 1b: TF and TT rates for HDs already mapped in Côte d'Ivoire in 2015 and 2017*

Health Region	Health District	Age-adjusted TF Prev (%)	Age- and Sex-Adjusted TT prev (%)	Year of study
Boukani Gontougou	Bouna	8.6	0.8	2015
Hambol	Dabakala	6.4	0.0	2015
Kabadougou Bafing	Odienné	15.0	0.1	2015
Kabadougou Bafing	Minignan	15.0	0.1	2015
Kabadougou Bafing	Touba	20.1	0.2	2015
Poro Tchologo	Boundiali	22.5	0.2	2015
Poro Tchologo	Ferké	3.9	0.0	2015
Poro Tchologo	Ouangolo	5.2	0.0	2015
Poro Tchologo	Tengrela	6.5	0.6	2015
Tonkpi	Zouan Hounien	14.2	0.0	2015
Worodougou	Séguéla	5.4	0.0	2015
Cavally-Guemon	Toulepleu	9.3	0.0	2017
Cavally-Guemon	Bolequin	9.3	0.0	2017
Indenie Duablin	Agnibilekrou	2.3	0.1	2017
Cavally-Guemon	Kouibly	3.5	0.0	2017
N'Zi-Ifou	Prikro	2.0	0.0	2017
N'Zi-Ifou	M'Bahiakro	2.0	0.0	2017
N'Zi-Ifou	Bocanda	6.7	0.1	2017
Tonkpi	Man	6.2	0.0	2017
Indenie Duablin	Abengourou	2.6	0.0	2017

Considering the decision of the international NTD community that all NTD endemic countries should complete NTDs mapping by the end of 2015, NTD partners (Sightsavers and the Global Trachoma Mapping Program or GTMP) decided to support trachoma mapping in the country. Thus, 11 HDs in the north that were considered at risk were initially selected for trachoma mapping. Results of TF prevalence among children 1-9 years showed that 9 of the 11 HDs mapped are endemic for trachoma. The PCT NTD program believes strongly that the remaining 72 HDs should be mapped for trachoma and was able to conduct a pre-mapping rapid assessment survey or prospection in FY16 funded by USAID in 33 of the 72 HDs located in the northern and central parts of the country. The results of the rapid assessment survey, which is based on the identification of TF in children 1-9 years and trichomatous Trichiasis (TT) in those ≥15 years of age, indicate that 23 HDs are trachoma suspect HDs that should be mapped. The PCT NTD program conducted mapping of 9 out of the 23 HDs in FY17 with financial support from USAID and Sightsavers and technical support from the Tropical Data group. Four HDs including 3 located in the Western Region were declared endemic for trachoma, thus validating the evidence from the prospection and the need for further prospection and mapping.

At present, the general situation for trachoma in Côte d'Ivoire is as follows: (1) through mapping 14 HDs are known to be endemic for trachoma (10 in 2015 and 4 in 2017) while 6 HDs (1 HD in 2015 and 5 HDs in 2017) are known to be endemic (see table 1b above for TF and TT rates); (2) among the 14 endemic HDs 4 were treated in FY16 and 5 in FY17; (3) trachoma impact survey (TIS) was conducted in Bouna (1 of the 14 endemic HDs) in FY17 because it has baseline TF prevalence between 5% and 9.9%, needed only 1 MDA round and was among the 4 HDs treated in FY16; (4) pre-mapping rapid assessment survey was conducted in 33 HDs among which 10 HDs were determined to be non-endemic while 23 were determined to be highly suspect for

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

trachoma and need mapping; (5) mapping was conducted in FY17 in 9 of the 23 HDs that need mapping and 14 HDs are yet to be mapped; (6) there are 39 HDs remaining in the central and southern parts of the country that should undergo pre-mapping rapid assessment survey; and (7) there are currently 14 HDs in which the SAFE (Surgery for TT, Antibiotic therapy, Facial cleanliness and Environmental improvement) strategy should be implemented. Currently, WHO recommends at least one annual treatment for all endemic HDs with TF prevalence between 5 and 10% followed by an impact assessment. Séguéla HD with baseline TF prevalence of 5.4% among children 1-9 years and was treated in 2017 now qualifies for a TIS in FY18. Therefore, among the 14 trachoma endemic HDs only 12 HDs will be treated in FY18 because Bouna has passed TIS in FY17 and Séguéla will conduct TIS in FY18 with a pass expected. Zithromax tablets and suspension needed for trachoma MDA are donated by Pfizer through ITI, but infants 0-6 months should be treated with 1% tetracycline eye ointment (TEO) that is currently not donated and must be purchased.

In FY18, the generous support of the American people through USAID will be needed to (i) implement MDA for trachoma in 12 endemic HDs with a target population of 2,251,832 people, (ii) conduct TIS in Séguéla HD, (iii) purchase 94,720 tubes of 1% TEO for 47,360 children 0-6 months of age, (iv) conduct mapping of trachoma in 14 trachoma suspect HDs, and (v) pre-mapping survey or prospection for trachoma in 39 HDs.

❖ SCHISTOSOMIASIS

Among the then 82 HDs of Côte d'Ivoire (currently 83 HDs), 22 were mapped for SCH in 2012, 16 in 2013 and 44 in 2014. Mapping results have shown only 2 HDs (Nassian and Tanda) are not endemic for SCH. Per the strategy recommended by WHO for treatment of SCH and adopted by Côte d'Ivoire, 3 HDs with SCH baseline prevalence $\geq 50\%$ should be treated each year, 43 HDs with prevalence between 10% and 49% should be treated once every two years, and 35 HDs with a prevalence less than 10% should be treated once every three years.

In FY17, MDA for SCH was conducted in 39 HDs targeting a total of 3,076,144 persons including 3 HDs with SCH prevalence $\geq 50\%$ where the estimated population of 450,590 people ≥ 15 years was treated, 24 HDs that have a prevalence between $\geq 10-49.9\%$, while 12 HDs have a prevalence $< 10\%$. MDA was conducted among SAC only in 36 HDs and was fully funded by SCI while for the 3 HDs with prevalence $\geq 50\%$, MDA among SAC was funded by SCI while MDA among adults was funded by USAID targeting a population of 450,590 people. Thus, treatment costs in these 3 HDs were co-shared by SCI and USAID.

In FY18, MDA among SAC with a targeted estimated population of 2,911,864 people will be conducted in 35 HDs, including the 3 HDs with SCH prevalence $\geq 50\%$. School-based MDA in the 35 HDs will be financed by SCI, while MDA costs for the 3 HDs with prevalence $\geq 50\%$ will be co-shared by SCI and USAID with USAID covering the costs of treating an estimated 462,099 people ≥ 15 years of age.

❖ SOIL-TRANSMITTED HELMINTHIASIS

Mapping of STH was integrated with SCH mapping as described above and it has been demonstrated that all 82 HDs (now 83) are endemic for STH with prevalence $\geq 1\%$. Per WHO guidelines on treatment for STH, only 29 HDs have STH prevalence $\geq 20\%$ and require MDA. No HD had STH prevalence $\geq 50\%$. The PCT NTD program plans to integrate all treatment for STH with either treatment for LF or SCH in HDs where the diseases are co-endemic. Among the 29 HDs with STH prevalence $\geq 20\%$, 22 are also LF endemic while 7 are also SCH endemic. In FY17, the 22 LF-STH co-endemic HDs were treated during LF-Oncho-STH MDA, and 2 HDs were treated during the SCH MDA. However, 5 HDs in this category could not be treated because SCH treatment was not conducted in these HDs in FY17. In FY18, the 22 HDs co-endemic for STH and LF with an estimated target population of 3,573,592 people will also be covered by LF-Oncho integrated MDA while another 5 HDs will be treated through SCH MDA covered by SCI. It should be noted that 2 HDs in this category will not be covered in FY18 because SCH MDA will not be conducted in these 2 HDs in FY18.

3. Snapshot of NTD Status in Côte d'Ivoire

Table 2: Snapshot of the expected status of the NTD program in Côte d'Ivoire as of September 30, 2017

		Columns C+D+E=B for each disease*			Columns F+G+H=C for each disease*				
		MAPPING GAP DETERMINATION			MDA GAP DETERMINATION		MDA ACHIEVEMENT	DSA NEEDS	
A	B	C	D	E	F		G	H	I
Disease	Total No. of Districts in COUNTRY	No. of districts classified as endemic**	No. of districts classified as non-endemic**	No. of districts in need of initial mapping	No. of districts receiving MDA as of 09/30/17		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/17	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/17	No. of districts requiring DSA as of 09/30/17
					USAID-funded	Others			
LF	83	74	9	0	57	17	0	0	Pre-TAS: 0 TAS: 0 Baseline survey: 0
SCH		81	2	0	3	81 ¹	0	0	Impact assessment: 24 HDs
STH		83	0	0	22	7 ²	0	0	
Oncho		68	15	0	49	19 ³	0	0	
Trachoma		14	16 ⁴	53 ⁵	5	0	8	1	TIS: 1 HD

¹Only 39 HDs were treated for SCH in FY17 per WHO treatment guidelines; 43 HDs were in an off-treatment year in FY17. SCI covers treatment of SAC in all 81 HDs. USAID supports treatment of adults only in 3 of the 81 HDs that have SCH prevalence of ≥50%.

²These 7 HDs are covered through SCH MDA supported by SCI

³MDA in these 19 HDs was supported by Sightsavers and END Fund

⁴These include 6 HDs from mapping in 2015 and 2017, and 10 HDs from prospection in FY16.

⁵These include 14 trachoma suspect that should be mapping in FY18 and the 39 HDs that will undergo prospection for trachoma in FY18.

PLANNED ACTIVITIES

1. Capacity Strengthening Strategy

USAID funding through the END in Africa project has enabled the attainment of 100% geographic coverage for the PCT NTDs by enabling the country to attain complete coverage of all currently known endemic HDs. The PCT NTD program has almost completed mapping for all the 5 PCT NTDs (only trachoma mapping is still ongoing), and the programs already have the required skills to conduct mapping for all 5 PCT NTDs with minimal technical support from partners. For oncho, the PCT NTD program can conduct epidemiological surveys such as skin snip and OV16 RDT but do not have the capacity to test dry blood spots samples for OV16 ELISA, which may not be required at this early stage of program implementation. For LF the PCT NTD program has the required skills for mapping using filariasis test strip (FTS) and baseline survey using thick blood film method and FTS. The methodologies used for the baseline survey will be used for impact assessment only after 5 rounds of MDA in another 3-5 years. Trachoma mapping methodology was acquired through training conducted by the GTMP and is thus used for all additional mapping being conducted. DSAs for SCH and STH (mapping and impact assessment) were/are supported by SCI and have so far progressed well. Since implementation for all 5

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

diseases is still in the early stages, the focus over the next 2-4 years will be on ensuring high-quality MDAs with good epidemiological, programmatic and geographic coverage, and ensuring sustainability of the PCT NTD program in the country through extra efforts to raise supplementary funds either locally or internationally for the sustainability of the PCT NTD program. High-quality MDAs for the diseases will be ensured through training and refresher trainings of all NTD actors at different levels (national, regional, district, health facility and community) before the MDAs, supportive supervision of the MDAs at all levels and monitoring of PCT NTD program implementation.

Cognizant of the effort made by development partners to bring Côte d'Ivoire to this stage in the fight against PCT NTDs, the PCT NTD program will develop strategies to mobilize resources locally and internationally not only to maintain the gains of the fight but also to effectively carry out surveillance of these diseases post treatment in order to prevent their recurrence. Thus, the staff of the 2 programs that were trained in May 2017 on strategies to mobilize resources will start using their newly acquired skills in FY18 in diverse ways. A presentation at the Council of Ministers is planned to improve the knowledge of Ministers, hopefully, change their perception of NTDs and advocate for the creation of a budget line for PCT NTDs in the MSHP overall budget. They will pass on the skills they have acquired to the regional and district health teams through facilitation of training at the different levels, and continue advocacy efforts among regional governors (Prefects) who are the administrative heads of the regions and play an important role in the approval of activities within regions and districts. Furthermore, special advocacy efforts will be made to obtain financial support from the local private sector (cellular telephone companies, coffee-cacao and cotton-cashew companies, forestry companies, rubber producers, palm oil producers, banana producers and gold, manganese and diamond mining companies) that can help sustain efforts to control PCT NTDs.

Table 3: Project assistance for capacity strengthening

Project assistance area	Capacity strengthening interventions/activities	How these activities will help to correct needs identified in situation above
a. Strategic Planning	<ul style="list-style-type: none"> - Develop an SCH and STH transition plan - Finalize and validate the document being prepared with Deloitte support on financing strategy 	<ul style="list-style-type: none"> - Deloitte is currently supporting the NTDP to develop a document on financing strategies that will guide the NTDP on raising funds from the local private sector. The process is expected to help the NTDP raise funds locally, improve financial sustainability of the NTDP in general and ensure sustainability of SCH and STH activities post LF.
b. NTDP Secretariat	<ul style="list-style-type: none"> - Provide office supplies, internet access and data storage hardware 	<ul style="list-style-type: none"> - Build and maintain the NTDP's operational capacities
c. Establish advocacy strategy to ensure sustainability of NTDP activities	<ul style="list-style-type: none"> - Continue to work with Deloitte to establish a local resource mobilization mechanism during the project's transition phase 	<ul style="list-style-type: none"> - Sustain the financial resources needed for NTD control and elimination - Sustain the achievements being made on NTD control and elimination
d. Mapping	<ul style="list-style-type: none"> - Continue to work with the Tropical Data coalition to complete mapping for trachoma - Build capacity of the NTDP M&E officers on the ArcGIS software 	<ul style="list-style-type: none"> - Complete mapping for trachoma - Enhance production of high-quality disease maps that can be used for reporting, better advocacy and resource mobilization
e. MDA coverage	<ul style="list-style-type: none"> - Support for MDAs in HDs: <ul style="list-style-type: none"> o 57 HDs for LF; o 35 HDs for SCH; o 29 HDs for STH; o 49 HDs for oncho o 12 HDs for trachoma - Develop a strategy to reach above 80% of individuals targeted and eligible for treatment 	<ul style="list-style-type: none"> - Contribute to achieving elimination/control objective of the NTDP - Improve and maintain effective treatment coverage

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

f. Social Mobilization to Enable PCT NTD program Activities	- Hold advocacy meetings with administrative authorities (Deputy Prefects) to improve their knowledge on the basic concepts of PCT NTDs and enhance their support to NTD control and elimination	- It is expected that involving administrative leaders will improve population participation in the MDAs for better compliance to NTD treatments and reduce bureaucratic barriers for PCT NTD program implementation.
g. Training	- New/refresher training of only field supervisors (district health workers) and CDDs on the basic concepts of PCT NTDs and MDA campaigns - Continue training of regional and district M&E officers on the INDB - Training of representatives of the media	- Help ensure training of the many new supervisors and CDDs, and continue to sustain high quality of MDAs and effective treatment coverage - Enhance and strengthen proper implementation of the INDB at district level and ensure better management of PCT NTD data - Improve reporting on PCT NTDs in the local media and enhance sensitization and visibility of the NTDP
m. Short-term Technical Assistance	- Training of the NTDP personnel at central level on basic M&E for PCT NTDs (the interventions for monitoring impact of treatment and evaluation for each PCT NTD, and the indicators that should be monitored) - Supervision/monitoring of all M&E related interventions (trainings on and implementation of impact assessments and evaluations) at district and community level	- As the NTDP has now achieved 100% geographic coverage for 4 of the 5 PCT NTDs and continues to maintain high MDA quality, attention is shifting towards general M&E for all 5 PCT NTDs. The NTDP has requested support through training of central level NTDP staff. - Ensure that central level NTDP staff support M&E related interventions through facilitation, supervision and monitoring of trainings, impact assessment and evaluations at district and community levels.

2. Project Assistance

The following are activities planned for FY18 that are proposed for USAID financing subject to agreements with the MSHP that will be implemented through fixed obligation grants (FOGs):

- Integrated LF/oncho/STH MDA in 57 HDs with a target population of 13,524,811 people, including 49 LF/Oncho co-endemic HDs and 22 LF/STH co-endemic HDs;
- MDA for SCH among people ≥15 years of age in the 3 SCH hyper-endemic HDs with a target population of 462,099 people;
- MDA (mass antibiotic therapy) for trachoma in 12 HDs with a target population of 2,251,832 people;
- Epidemiological evaluation of oncho in 8 HDs that have already completed at least 7 rounds of annual MDA;
- Mapping of trachoma in 14 HDs;
- TIS in Séguéla HD;
- Prospection for trachoma in 39 HDs;
- Procurement of 1% TEO for Trachoma MDA (94,720 tubes) and mapping (48,134 tubes);
- Coordination meetings with (deputy) prefects to advocate for support to the PCT NTD program and improve sensitization and community mobilization;
- Training on the INDB for M&E officers in 35 HDs of 5 regions;
- Implementation of the INDB tool in the 57 HDs financed by USAID;
- Meeting to coordinate and create an integrated 2018 action plan for the PCT NTD program;
- Annual summary meeting for PCT NTD activities supported by USAID in 2018;
- A 1-day launch of national MDA for PCT NTDs in an HD with representation from the Cabinet, USAID Côte d'Ivoire, the DGSHP, NTD partners, administrative authorities, religious authorities, customs authorities and the community;
- Meeting to validate post-MDA LF-ONCHO, SCH and trachoma data;

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

- Workshop for media agents to improve their knowledge on PCT NTDs and facilitate better reporting of PCT NTD information;
- Broadcasting of institutional films on PCT NTD;
- Workshop on the restitution of the TIS;
- Participation in international meetings organized by PCT NTD partners;
- Workshop to update TIPAC;
- Inventory control of trachoma drugs through inventory taking and documentation of post-MDA stock in the 12 HDs that will be treated in FY18.

🚧 Activities financed by other partners

❖ SCI

- MDA for SCH among SAC in 35 HDs, financed by SCI;
- SCH Impact assessment in sentinel sites before the MDA;
- Post-MDA coverage survey for SCH.

❖ Sightsavers/END FUND

- Integrated LF-Oncho MDA in 17 HDs;
- MDA for oncho only in 3 HDs;
- Post-MDA coverage survey after the integrated LF-oncho MDA.

❖ Center for NTDs (CNTD) formerly as Filarial Programmes Support Unit (FPSU)

- Participation in the next MRU cross-border collaboration meeting on PCT NTDs (4 participants).

❖ WHO/Geneva

- Participation in the meeting of the Global Elimination of Trachoma (GET) 2020 partnership.

❖ Tropical DATA

- Participation in Tropical Data training, Dakar

a. Strategic Planning (Budget Location: Activities 1, 4, 6, 20, 31 & ODC line 115)

Total cost for activities in this section: **\$147,555**

Family Health International (FHI 360) manages the End Neglected Tropical Diseases in Africa (END in Africa) project in collaboration with Deloitte Consulting LLP (responsible for financial management and capacity building). The END in Africa project was extended in FY16 to cover control/elimination of PCT NTDs in Côte d'Ivoire and was being implemented by the MSHP via two PCT NTD programs (PNLSGF and PNSO-LO). Currently, the MSHP has replaced the previous 2 PCT NTD programs with one PCT NTD program headed by a National Coordinator. FY18 is the third year of USAID support for PCT NTD control in the country. The support to the PCT NTD program in Côte d'Ivoire is being provided in 3 ways: **(1)** through FHI 360/END in Africa project staff working from the FHI 360 Office in Abidjan that support the PCT NTD program directly on a day to day basis; **(2)** through the END in Africa project regional hub in Accra that has technical, M&E, finance and grants experts that will also support the PCT NTD program in Côte d'Ivoire; **(3)** the END in Africa project will liaise and collaborate with other NTD partners when necessary to support the PCT NTD program in Côte d'Ivoire especially when the technical assistance (TA) needed is not available within the project regional hub in Accra. To this effect, the project will collaborate with other NTD partners within the USAID portfolio to provide any needed TA and will recruit further expertise outside of the USAID portfolio when needed through the technical assistance facility (TAF). The PCT NTD program implementing activities for control/elimination of the 5 PCT NTDs in Côte d'Ivoire are being supported currently to continue an integrated approach to implementation. Meanwhile, the PCT NTD program has received and continue to receive TA from the END in Africa project for the development of country level annual work plan including the FY18 work plan and FOG packages that will be submitted to USAID for approval.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

The main objective of the END in Africa project for Côte d'Ivoire in FY18 is to maintain 100% geographic coverage and ≥80% programmatic coverage for PCT NTD MDAs in HDs in need of treatment and to continue mapping for trachoma in another 14 HDs. The project will implement all activities of the FY18 NTD work plan in accordance with WHO guideline, protocols and SOPs. The project will collaborate with all NTD partners that are involved in the efforts to control/eliminate PCT NTDs in Côte d'Ivoire through joint planning, coordination and review meetings. The project will also maintain continuous contact with all NTD partners operating in Côte d'Ivoire to ensure that there is no duplication of funding and to maximize the use of available funding for better implementation of the PCT NTD program.

❖ Coordination for forecasting to establish drug quantities and Review of drug distribution performance for PCT NTDs in FY18.

For an effective management of drugs and supplies relating to PCT NTDs, a national committee was set up within the MSHP to coordinate supply chain management (SCM) of essential NTD medicines and other NTD medical logistics that brings together the PCT NTD program, the Directorate of Pharmacy and Medicines Laboratories (Direction de la Pharmacie, du Medicament et Laboratoires or DPML), the National Program for the Development of the Pharmaceutical Industry, and the National Warehouse (Nouvelle Pharmacie de la Sante Publique or NPSP). This committee organizes two annual meetings to (i) develop and implement the annual SCM plan for PCT NTD medicines and logistics; (ii) monitor the plan on a quarterly basis; (iii) implement an information feedback system at all levels of the supply chain; and (iv) conduct critical analysis (strengths and weaknesses) of the supply chain system. USAID Funds will serve to support these technical meetings of the drug committee. These meetings will also serve as an excellent forum to discuss and make projections and submit applications for all drugs needed in FY19. The WHO Joint Application Package (JAP) will be used to request for ALB, IVM and PZQ, while the ITI application form will be utilized for requesting Zithromax tablets and suspension. It is proposed that USAID funds be used to procure TEO for the treatment of children <6 months old in 12 trachoma-endemic HDs.

❖ Planning of cross-border activities in the fight against NTD

Treatment of border populations in West Africa is challenging because there is always movement of people between countries from one side of the border to another with little control of movements. This means that there could be a duplication of treatment when some people receive treatment several times because they are in different countries when MDA is performed. In the same context, some populations are missed entirely when some people are in another country while treatment is carried out in their country of origin. The response to this has been a strong effort by countries to organize cross-border meetings of PCT NTD programs to try and establish synchronized MDA for PCT NTDs within neighboring countries. Such meetings also provide an opportunity for countries to share experiences on NTD control/elimination strategies. The PCT NTD program in Côte d'Ivoire has in the past received support from Sightsavers to conduct or participate in cross-border meetings with the PCT NTD program of Burkina Faso for synchronized MDA and coverage survey. Furthermore, Côte d'Ivoire has been taking part in MRU cross-border meetings with support from Sightsavers and CNTD Liverpool Since 2011. The MRU meetings provide opportunities for synchronization of NTD MDAs in Côte d'Ivoire with NTD MDAs conducted in Liberia and Guinea Conakry. To date, no cross-border activities have been carried out with the NTD program in Ghana and MDAs of both countries are not yet synchronized. In the FY18 Work Plan, Côte d'Ivoire will send 4 participants to the next MRU meeting with support from CNTD Liverpool.

❖ Planning of activities to mobilize resources

In the Côte d'Ivoire NTD Master Plan (2016-2020), the PCT NTD program hopes to strengthen resource mobilization strategies and sustainability of funds to continue the fight against NTDs. The PCT NTD program wishes to start advocacy within the MOH, Ministry of Finance and the private sector to improve government/MOH contribution and raise funds locally to maintain implementation of PCT NTD interventions

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

in Ivory Coast. This will be done through meetings with different divisions of the MOH, during which representatives of the divisions will be introduced to the basic concept of PCT NTDs and the need for MOH contribution for sustaining PCT NTD interventions will be explained. Advocacy meetings will be conducted with MOH leadership within the:

- Administrative and Financial Affairs division,
- Planning and Information division,
- Pharmacology division, and
- Ministry of Economy and Finance.

Hopefully, these meetings will facilitate the creation of a line-budget for the PCT NTD program field activities and increase the general budget allocation for the PCT NTD program.

Also, a meeting will be held with local private businesses, local elected officials (Mayors, districts and regional council representatives) to develop a public-private partnership for financing and sustaining PCT NTDs interventions. A resource mobilization plan (strategic social partnership and advocacy plan) is currently being finalized by the PCT NTD program with support from Deloitte to guide this process.

❖ Deputy Prefects' coordination meeting

As part of the ongoing advocacy and social mobilization efforts that will hopefully create favourable environment for implementation of the PCT NTD program within regions and districts, meetings were organized in FY17 to improve the knowledge of regional and departmental prefects on PCT NTDs and to elaborate the role they can play as regional and departmental administrative heads to facilitate better community compliance with treatment and implementation of PCT NTD program. This process will be continued in FY18 through similar meetings with deputy prefects who will benefit from a training on the basics of PCT NTDs.

❖ END in Africa Closeout meeting

Between July and September 2018 FHI 360 will conduct close out activities in Ivory Coast that will include organization of a 1-day meeting to mark the closeout of the END in Africa Project in Ivory Coast. The event will bring together USAID, FHI 360, MOH, NTDP and other NTD partners in Ivory Coast including SCI, END Fund, MAP International and Sightsavers to share the achievements, lessons learnt and possible future perspectives of the project. Key media groups will be invited to cover the event, during which key project documents highlighting achievements will be distributed. The exact date of this meeting will be decided in consultation with the USAID Mission in Ivory Coast.

b. NTD Secretariat (Budget Location: Activity ODC line 34)

Total cost for activities in this section: **\$16,215**

Although there were 2 PCT NTD programs working together in the national efforts to control/eliminate PCT NTDs in Côte d'Ivoire (PNISO-LO and PNLSGF), the END in Africa project has advocated with the DGSHP for a focal point for PCT NTDs to be officially appointed in Côte d'Ivoire and Dr. Aboulaye Meite, former Director-Coordinator of the PNLSGF has been appointed National Coordinator of the newly created PCT NTD program in Côte d'Ivoire.

Besides technical support, the END in Africa project will support the PCT NTD program secretariat with office equipment, office sundry expenses (Courier, photocopying, and Printing), equipment maintenance and repairs (A/C repairs, printers), communications expenses (telephone, internet, other electronic services), generator running expenses (fuel + maintenance), office stationery and IT maintenance services by outsourced service providers.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

c. Building advocacy for a Sustainable National NTD Program (Budget Location: Activities 1 & 16)

Total cost for activities in this section: \$

USAID support to the PCT NTD program will be in its third year of implementation in FY18 and success of planned activities will depend on a good advocacy for greater attention to NTD activities from the national health authorities (the cabinet of the Minister of Health, the DGSHP and other lined units within the MSHP that collaborate with the PCT NTD program). The PCT NTD program in collaboration with the END in Africa team will conduct special meetings to brief members of the MSHP hierarchy on PCT NTD activities and request for support and participation of the MSHP hierarchy in some major NTD activities. An appeal will be made for the creation of a national PCT NTD day, the inclusion of PCT NTDs within the Minimum Package of Activities (MPA) of frontline health facilities, and for the strengthening collaboration with the National Malaria Program for integration of activities of the 2 public health programs.

The PCT NTD program will conduct a national launch of the PCT NTD MDAs before the MDAs start to get media attention and give visibility to the PCT NTD program in Côte d'Ivoire. This launch will also be used to announce the MDA cycle officially. Launching of PCT NTD MDA will be a solemn ceremony performed by the Minister of Health and Public Hygiene or her representative.

The WHO recommends the setting up of a national steering committee for the PCT-NTDs and a committee of experts that will guide the country policy towards elimination and control of the PCT-NTDs. Thus, a plea will be made to the highest authorities of the MSHP for their establishment.

The lack of funding from the Government of Côte d'Ivoire (GoCI) for PCT NTD field activities is a huge constraint for the PCT NTD program and a challenge to the sustainability of the fight against these PCT NTDs in Côte d'Ivoire. Since donor funding may be limited with time, the GoCI should be able to allocate some funds for implementation of PCTNTD activities when and if current donor support ends. Advocacy will, therefore, be conducted within the MSHP and the Ministry of Economy and Finance hierarchy for a budget allocation to be made by the GoCI that will allow the PCT NTD program to perform major field activities for PCTNTD control/elimination if external funding reduces or is stops. The PCTNTD program has been working in consultation with Deloitte Consulting LLP to develop an advocacy and resource mobilization document that will be used in FY18 to advocate for financial support from the private sector in Côte d'Ivoire (coffee-cacao and cotton-cashews companies, food-producers). Advocacy efforts will be made to establish public-private partnerships that will involve local private enterprises and elected officials (City Hall, districts, regional councils).

The advocacy efforts mentioned above will have attained their objectives if:

- A ministerial decree establishing a national PCT NTD day is signed;
- A ministerial decree establishing the creation of the steering committee and the international committee of experts for PCT NTD is signed;
- An emergency fund for PCT NTD is created;
- PCT NTD interventions are included within MPA of frontline health facilities.
- Some activities of the PCT NTD and Malaria programs are integrated (e.g. distribution of PCT NTD medications and bed nets for the Malaria program, and integration of home management of malaria and distribution of PCT NTD medication. These can be done by CDDs already working within the PCT NTD program).

d. Mapping (Budget Location: Activity 33)

Total cost for activities in this section: **\$368,192**

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Mapping (and baseline studies) for LF, oncho, SCH and STH is now completed after the confirmation mapping for LF in 14 HDs in FY16 and baseline studies conducted for LF in FY17. A total of 74 HDs are endemic for LF, 68 HDs for oncho, 81 HDs for SCH and all 83 HDs for STH. Mapping is yet to be completed for Trachoma. In 2015, 11 HDs were mapped for trachoma and 9 were determined to be trachoma endemic. Among the remaining 72 HDs, a rapid assessment was conducted in 33 HDs in FY16 to identify HDs that are suspect for trachoma and should be mapped. Twenty-three of the 33 HDs were determined to be highly suspect for trachoma. However, due to limited resources, only 9 out of the 23 HDs were mapped in FY17. Currently, 20 of the 83 HDs are mapped for Trachoma among which 13 are trachoma endemic, and 7 are non-endemic. In 2018, 14 HDs will be mapped using the Tropical Data protocol while prospection will be conducted for trachoma in the other 39 remaining HDs to identify HDs that are trachoma suspect and therefore should be mapped. The support of USAID is requested to conduct mapping of the 14 HDs, prospection of the 39 remaining HDs, procurement of **48,134 tubes** of 1% TEO for use during mapping, capacity building on ArcGIS, and the purchase of the “ArcGIS” software that will be used to produce quality maps.

e. MDA coverage (Budget Location: Activities 9, 17a, 17b & 28)

Total cost for activities in this section: **\$806,598**

Table 4: USAID supported coverage results for FY16

PCT NTD	# Rounds of annual distribution (add additional rows for different treatment frequencies)	Treatment target (FY16) #DISTRICTS	# Districts not meeting epi coverage target in FY16* (explain reasons below)	# Districts not meeting program coverage target in FY16* (explain reasons below)	Treatment targets (FY16) # PERSONS	# persons treated (FY16)	Percentage of treatment target met (FY16) PERSONS
LF-ONCHO	1	41	0	0	10,296,946	9,351,761	90.82%
SCH	1	3	0	0	450,590	357,869	81.37%
STH	1	15*	0	0	2,563,689	2,298,526	89.66%
TRA	1	4	0	0	732,008	667,319	91.16%

*HDs treated as part of LF MDA.

Table 5: USAID-supported districts and estimated target populations for MDA in FY18

PCT NTD	Age groups targeted (per disease workbook instructions)	Number of rounds of distribution annually (add additional rows for different treatment frequencies)	Distribution platform(s)	Number of districts to be treated in FY17	Total # of eligible people to be targeted in FY17	Number of districts that will be treated during FY18	Total number of people likely to be targeted in 2018
Lymphatic filariasis	Entire population ≥5 years	1	Community-based MDA	57	13,189,199	57	13,524,811
Onchocerciasis	Entire population ≥5 years	1	Community-based MDA	49*	10,720,180	49*	10,992,730
Schistosomiasis	Adult population	1	Community-based MDA	3	450,590	3	462,099

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

	≥15 years of age						
Soil-transmitted helminthiasis	Entire population ≥5 years	1	Community-based MDA	22	3,484,593	22	3,573,592
Trachoma	The entire population	1	Community-based MDA	5	997,907	12	2,252 832

**These 49 HDs are among the 57 HDs to be treated for LF.*

f. Social Mobilization to Enable NTD Program Activities (Budget Location: Activities 1, 5, 10, 13, 14, 15, 24 & 26)

Total cost for activities in this section: **\$324,851**

In the past 2 years, the PCT NTD program has been focused more on establishing high quality MDA campaigns and scaling up MDA to 100% geographic coverage. This should continue for trachoma since mapping is still ongoing. Although reported coverage for PCT NTDs is good in the past 2 years, supervision and monitoring of MDA campaigns show poor treatment coverage in some villages. The PCT NTD program wishes to use IEC materials to ensure high quality MDA with good treatment coverage in all targeted villages and avoid having PCT NTD hotspot areas after years of treatment. Therefore, the PCT NTD program has identified continued good social mobilization and distribution of IEC materials as key requirements for maintaining high quality MDA campaigns with good coverage. Sensitization and social mobilization activities will, therefore, be conducted to make MDA during year three (FY18) of the project a success. These activities will touch on all levels of the health pyramid and all social strata.

In FY17, the PCT NTD programs organized meetings with regional governors/prefects to improve their knowledge on PCT NTDs so they can support sensitization and social mobilization efforts for PCT NTDs within regions and districts. The regional prefects have themselves strengthened the capacities of departmental prefects in their respective regions under the supervision of the PCT NTD programs. The involvement of these prefects in sensitization and social mobilization has been greatly appreciated and has enabled increased mobilization of communities during MDA campaigns. One important recommendation from prefects was that their deputies (deputy prefects) need also to be trained and encouraged to participate in sensitization and social mobilization efforts in FY18 for the PCT NTDs because they administer lower, semi-rural areas.

Posters and pamphlets were designed before the 2017 MDA, pre-tested and judged to be appropriate for sensitization prior to being reproduced in sufficient quantities for the 2017 MDA campaigns. Since these tools were handy for the 2017 MDA, they will be reproduced once again in sufficient quantities for the FY18 MDA. As part of sensitization and social mobilization, previously developed posters will be reproduced in sufficient quantities to be used as IEC materials and will be distributed to health centers, administrative buildings, places of worship (mosques and churches), primary, secondary and high schools, market places, and other areas in villages where people meet in endemic HDs. Previously developed pamphlets will also be produced in sufficient quantities and will also be distributed in schools, public services buildings, places of worship and places with a large degree of influence such as markets and transportation hubs. They will also be used by CDDs and public criers to sensitize the population on PCT NTDs.

Institutional films on PCT NTDs have been created and will be regularly broadcasted on national television. These films will cover how diseases are transmitted, complications, prevention and above all aspects of the MDA. Commercials will be broadcasted in French on national television during time slots with large audiences shortly before, during and after the MDA campaigns. These advertisements will specify the HDs targeted by the MDA, the time and duration of the MDA. In each endemic HD, local radio stations will be incorporated to broadcast information in the most commonly spoken local languages. Sensitization and social mobilization via

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

local radio stations in local languages are judged to be very important, as a significant portion of the population is illiterate (unable to read or write French).

In collaboration with departmental health directors, meetings for sensitization and community mobilization will be organized by regional and department prefects. Given these regional and departmental prefects are respected in their regions and HDs, they can have a significant effect on getting populations to comply with treatment during PCT NTD MDAs.

T-shirts are regarded as very important for CDDs and other MDA actors during MDA campaigns because they are an important means of identifying the CDDs and other MDA actors during MDA campaigns and thus facilitate their access to households. T-shirts will be produced in sufficient quantities.

For MDA campaigns within urban settings, mobilizers with megaphones will be hired to move around in the target groups of communities and conduct sensitization and social mobilization on PCT NTDs prior to the beginning of MDA campaigns to ensure complete adherence. This will be in addition to use of the national radio for the same purpose. Although the national radio covers the entire country, most villages located in within rural settings do not receive radio signals. The PCT NTD program will therefore use town criers in villages to conduct sensitization and social mobilization for the PCT NTDs in local languages before MDA campaigns given that radio signals do not reach most villages.

The PCT NTD program wishes to note that no official evaluation of the materials, messages and approaches discussed here has been conducted in the first 2 years of the PCT NTD program in Côte d'Ivoire. However, all IEC and other materials used for advocacy, sensitization and social mobilization are pretested in the field after they are developed and then validated during a workshop that has participants from the PCT NTD program and local communication specialists. The materials to be reproduced in FY18 have either been pre-tested and validated or will undergo such before they are reproduced. The PCT NTD program however recognizes the need for evaluation of the sensitization strategies and will request TA on this in the near future.

To strengthen awareness-raising and social mobilization activities in villages during epidemiological evaluations, the support of USAID is requested for the purchase of eight (8) tripod projector screens, eight (8) projection pointers and two (2) sets of mobile sound materials (speakers and microphones). Furthermore, as media agents are good relays of the visibility of activities in the fight against PCT NTD on the national level, improving their knowledge on PCT NTDs will enable better reporting of PCT NTD interventions.

Table 6: Social Mobilization/Communication Activities and Materials Checklist for NTD work planning

Category	Key messages	Target population	IEC Activity (e.g., materials, medium, training groups)	Where/when will they be distributed?	Frequency	Has this material/message or approach been evaluated? If no, please detail in narrative how that will be addressed
Prevention of PCT NTD	Information on PCT NTDs to encourage populations to take drugs regularly and to respect preventive measures (sleeping under mosquito nets, washing hands and face, using latrines, avoiding swimming)	The entire community	Posters	Display in health centers, public services buildings, markets, places of worship, transportation hubs. One week prior to the beginning of MDA and during the entire duration of MDA	Only once	No

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

			Pamphlets	Distributed to MDA actors (CDDs/ supervisors) to sensitize schools – primary, secondary and high, in public service buildings and within the community. During the MDA campaign	Only once	No
MDA participation	Indicate the place of launch, HDs targeted for the PCT NTDs and treatment periods	The entire community	Banners	In HDs where the launch will take place	Once during the entire campaign	No
	Slogan: Together we can fight NTD [Ensemble luttons contre les MTN]	The entire community	T-shirts	In all HD during the MDA	Only once	No
	Information on campaign dates, the HDs concerned and target populations	The entire community and media bodies.	National television	Before, during and after the MDA campaign in each target HD	Twice a day for 5 days prior to beginning of MDA, during MDA and 2 days after MDA	No
	Information on campaign dates, the HDs concerned and target populations	The entire community and media bodies.	National radio and local radio	Before, during and after the MDA campaigns on the national level and in each HD targeted in French and local languages	Twice a day for 5 days before beginning of MDA, during MDA and 2 days after MDA	No

g. Training (Budget Location: Activities 2, 3, 7, 8, 22 & 23)

Total cost for activities in this section: **\$450,188**

Both programs in charge of PCT NTDs in Côte d'Ivoire have identified the need for further training/refresher training of all the actors involved in the MDA each year to achieve better performance regarding program coverage. The PCT NTD program believes training and refresher training of all categories of staff that are involved in MDAs each year will maintain high quality of the service they provide and motivate them to continue providing this service. Training for MDAs will be held at all levels in a cascaded manner to ensure that all the people involved in the MDA have received some training relevant to the MDA for the year.

Overall, regional and district health teams (including Sanitary Action Service Managers (SASM), district Focal Points, Epidemiological Surveillance Managers (ESM) and Pharmacists/Pharmaceutical Preparers and Managers [Pharmaciens/Préparateurset Gestionnaires en Pharmacie or PPM) are trained by central level PCT NTD program staff. District teams train local supervisors under the supervision of the regional team for PCT NTD programs. Local supervisors, in turn, train CDDs under the supervision of district and regional teams as well as central level representatives of the PCT NTD program. All training sessions to be conducted in FY2018 will include topics on adverse events (AEs) and how to manage AEs especially severe adverse events (SAEs). Cases of SAEs will be referred depending on their severity to the district or regional hospitals for the appropriate treatment. All SAEs must be reported, from communities to district health authorities, who then forward the reports to the PCT NTD program. The NTD Program directors subsequently inform partners of any SAE including FHI 360, USAID, the drug manufacturing companies and WHO.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

A large part of the training conducted in the past 2 fiscal years will not be repeated in FY18 as regional and district health teams will not be trained. However, the ESMs in some regions and HDs will be trained on the INDB, and those who are already trained will be required to use the tool in FY18. All local MDA supervisors and CDDs will be trained once again in FY18 to maintain good coverage. Since the beginning of PCT NTD activities, media representatives have always relayed information on PCT NTDs without any training on these pathologies. The result is that the communities receive messages that do not always meet the expectations of the PCT NTD programs. Therefore, the PCT NTD programs are planning to improve the knowledge of media agents through a workshop in FY18.

Table 7: Training Targets

Training Groups	Training Topics	Number to be Trained			Number Training Days	Location Training	Name other funding partner (if applicable, e.g., MOH, SCI) and what component(s) they are supporting
		New	Refresher	Total trainees			
Deputy prefects	Basic concepts of PCT NTD	456	0	456	1	Each department	None
HR and district ESM not yet trained on the INDB	Basic concepts on the NTD database	45	0	45	5	5 regional administrative centers	None
Media agents	To be familiar with PCT NTD and to adapt their communication messages to achieve the objectives of the PCT NTD program	60	0	60	1	Abidjan	None
Supervisors (staff of frontline health facilities such as health centers and health posts)	-Basic concepts of PCT NTD	61 LF Oncho	2331 LF/ Oncho	2392 LF/Oncho	1	HDs	None
	-Implementation of MDA	60 SCH	41 SCH	101 SCH	1	HDs	None
	- Management of side effects	136 Trachoma	147 Trachoma	283 Trachoma	2	HDs	None
	-Supervision and monitoring of MDA	35,400 LF Oncho 13,315 SCH	0	35,400 LF Oncho 13315 SCH 1825 Trachoma	1	Health centers	SS/END FUND SCI
	-Management and supply of MDA drugs						
	-Social mobilization for MDA						
	Reporting results of MDA campaigns including cases of SAE						

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

		1,825 Trachoma					
CDDs	Administration of drugs per the WHO protocol and the reporting of treatment data using reporting tools	743	29,012	29,755	1	Health areas/ villages	None
		22	902	924	1	Health areas/ villages	None
		5,031	5,475	10,506	1	Health areas/ villages	None

h. Drug and Commodity Supply Management and Procurement (Budget Location: Activities 10, 11, 12, 25, 31, ODC line 49)

Total cost for activities in this section: **\$295,637**

Drug forecasting and quantification are usually made based on the target population determined in advance by the PCT NTD program. Request for NTD drugs is usually submitted at least 6 months and sometimes up to one year in advance so that they can be available in the country at least 2 months before the start of MDA. The 2-month timeframe allows for distribution of the drugs from the national level to the regions, districts and communities before the start of MDA campaigns. NTD drugs requested are either donated by pharmaceutical companies or bought when the medicines involved are not donated. For FY18, requests for IVM, ALB and PZQ were submitted through WHO and MDP against the April 15, 2017 deadline and are expected on time for the MDAs to be implemented in FY18. WHO usually acts as consignee on these shipments. Zithromax tablets and suspension are also being requested through ITI and the trachoma expert committee (TEC). Since TEO for treatment of trachoma in children <6 months is not donated, USAID is requested to procure these medicines for the PCT NTD program in Côte d'Ivoire. The WHO Country Office in Côte d'Ivoire will also be requested to act as consignee for drugs donated through ITI and for those that will be purchased by the partners.

Upon arrival at the airport, all PCT NTD drugs and supplies are cleared by WHO (usually using local private clearing agencies that must be paid for service provided) and delivered to the PCT NTD program designated warehouse. So far, this has not been a major challenge because the number of HDs treated was small, and so was the amount of drugs managed. In 2018, the PCT NTD program has scaled up and continue to scale up geographic coverage for these NTDs to 100% with USAID fund. Therefore, the capacity of the PCT NTD program office to provide storage is now inadequate. With support from USAID, a Memorandum was signed between the PCT NTD program and the NPSP to perform management and distribution to the regions and districts of some NTD drugs. The NPSP, therefore, performs storage, handling and delivery of PCT NTD medicines and supplies from the capital to the district medical stores. The PCT NTD program will work with the NPSP to track drug inventories and ensure proper management of medicines at all levels from the airport to the districts. The NPSP has the necessary software needed for inventory management for medications that are located in their stores. They will provide stock levels on a regular basis (quarterly) for each of the items in their possession. Currently, IVM, ALB and PZQ tablets are stored in the PCT NTD program warehouse (that also organizes their distribution to districts) while Zithromax tablets and suspensions that are bulkier are stored at the NPSP.

Distribution of drugs and medical supplies from the district level to the health facilities and communities is achieved through training sessions conducted within HDs. Frontline health facility staff collect supplies for their catchment areas when they attend the district level MDA training. Using the same approach, the CDDs also collect supplies for their communities when they come to the Frontline health facility for training on MDA strategy, drug handling and data collection.

To coordinate a system of having two warehouses to store PCT NTD program drugs, one semi-autonomous (high capacity) and one free (low capacity), a committee is brought together with members from the different

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

drug management entities of the MHSP and FHI 360. The reverse flow of NTD drugs up to the HD is used for drugs not used during the MDA in communities as follows: the health facility staff collects unused drugs from the CDDs and returns them to the district health authorities. This information is used for forecasting future needs for NTD drugs. Post MDA meetings are organized at the district level in addition to MDA supervision to perform data validation and ensure the return of drugs distributed in the different districts and regions. A higher-level post MDA review is performed by the PCT NTD program to evaluate the MDAs.

The Districts Pharmacists will provide information on the remaining drugs to the District Manager who will share this information with the PCT NTD program at national level. With this information, the PCT NTDP deducts the total number of drugs remaining from what is needed for the next forecasting exercise. After each MDA, a team from the central level will perform a randomized evaluation on some districts to ensure the effective return of medicines in HDs for storage. This practice will be enhanced when it comes to Zithromax as all districts conducting MDA for trachoma shall be visited to ensure the proper management of returned drugs.

Regarding the equipment used during MDAs, the measuring poles are very important because they determine the number of tablets for each person. Each year this equipment needs to be developed for CDDs and an inventory performed on such equipment. For trachoma, this tool has never been developed for the implementation of the MDA in the country. USAID support is therefore needed to procure these tools for trachoma MDA.

During MDAs people presenting with AEs are taken care of first in the Frontline health facility. If the side-effects persist, the person is sent to the referral hospital. Side effects are reported using case finding sheets developed by the PCT NTD program. Frontline health facility staff are responsible for reporting cases of side effects. The reporting forms drafted for Frontline health facility level reporting has some basic information that includes the nature of the AE, the number of cases and the treatment provided to the patient. The PCT NTD program works with all actors at the different levels to ensure that all cases of AE due to PCT NTD drugs are reported and followed through by the districts. In the end, the information is reported to the central level (PCT NTD program) where cases are also tracked and filed.

For the FY18, the technical and financial support of USAID will be requested for (i) the purchase of 1% TEO, (ii) fees for the management of Zithromax and 1% TEO by the NPSP, (iii) logistics management and inventory control including reverse logistics, (iv) the transportation of drugs from the HD level to targeted communities and return of unused drugs from communities to the HD level, and (v) the incineration of empty vials and other wastes resulting from PCT NTD interventions in each HD. Regarding the destruction of expired drugs, the DPML is referred to for procedural formalities following counting.

i. Supervision for MDA (Budget Location: Activities 18, 19, 29 & 30)

Total cost for activities in this section: **\$335,303**

Supervision of MDAs is planned at different levels of the health system and so will be conducted at the national, regional, HD and community levels. FHI 360 has 3 permanent staff working from the FHI 360 office in Abidjan who will work with the national NTD office and be part of the national level supervisory team. Supervision of MDA will be expanded to include members of the top management team of the MSHP including the DGSHP and his deputy. This way regional and district health authorities will understand the importance of the project and will be motivated to give project activities the necessary attention when they are to be implemented in their regions and districts. The central level NTD teams will also conduct supervision at the different levels to ensure proper implementation of MDAs and the quality of supervision conducted by this level. During these supervision, debriefing is organized, and relevant issues are identified, discussed and recommendations made so that problems can be addressed while the MDA is still ongoing.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Supervision during FY18 will include:

- *Training:* Region and district health management staff trained in the previous year will not receive refresher training in FY2018. Also, all the other actors (district health advisors, data managers, pharmacists, nurses, midwives and school doctors) will not be trained in FY18. However, training of supervisors and CDDs will continue and will be supervised by regional and district health staff supported by the central level
- *MDA:* to ensure appropriate MDA organization and implementation, supervision is organized from all levels of the health pyramid. Supervision forms are designed and made available to supervisors. Coordination meetings in the HDs and regions are carried out before, during and after the MDA to provide recommendations for addressing problems detected through supervision. The feedback provided will allow better coordination of the ongoing activity. The communication focal point in the districts will be responsible for supervising mass sensitization and social mobilization campaign around MDAs for NTDs, which are held in the district (local radio passage, social mobilization meetings).
- *Drugs Management:* Regarding drugs and other medical supplies, the staff of the NPSP and regional/district pharmacists will be involved in the supervision process to ensure the availability, delivery, proper storage and distribution of drugs to the targeted communities. Central level NTD personnel will supervise all the steps involved from receipt of drugs from the NPSP to the distribution in the villages. Regional Pharmacists will supervise drug storage and distribution in the HDs. HD Pharmacists will perform the supervision of drug management within Frontline health facility and during MDAs in communities.
- *Data Management:* To ensure accuracy and quality of data reported at the Frontline health facility level and timeliness in gathering MDA information, data collection will be supervised by the regional and district data managers. CDDs use tally sheets to count the number of people who receive the drugs. They report daily using a reporting form the number of individuals receiving treatment. The compilation of the different tally sheets is done at Frontline health facility level while compilation of all Frontline health facility data is performed at the district level.

j. Monitoring and evaluation (Budget Location: Activities 32, 33 & 34)

Total cost for activities in this section: **\$140,871**

Monitoring and evaluation of MDA

Since PCT NTD program implementation is in the early stages, the focus will be on monitoring and supervising MDAs. MDA data in FY18 will be reported through the Disease and Program Workbooks every 6 months. The main objective of M&E in this project is to develop a system that will provide prompt information needed to measure program performance in terms of results, effects and impact on the target population. This will include building capacity of the technical team through training to enable them better understand the indicators, better manage the collection, analysis and interpretation of data for making programmatic decisions. To carry out M&E activities at various sites of the program, based on budget availability, M&E officers within the HDs will be equipped with 45 computers with data compilation software. The END in Africa project will ensure that the required data collection tools (reporting forms) are available and adequate for the implementation of MDAs and DSAs.

Data collection procedures, analysis and feedback: Data will be collected by the CDDs who will compile the data by village/community. These compiled data will then be forwarded to the Frontline health facility manager who will compile data from different CDDs they supervise and transfer the data to the district M&E officer after verification. Following that, a report is developed and transmitted to the district and then regional data manager in a defined timeline. The last step of MDA data management will be the compilation of all data collected by district and region data managers in the appropriate reporting forms that will be transmitted to the PCT NTD program at central level. Finally, the PCT NTD program at central level will share the MDA data with FHI 360. For evaluation activities, a data quality assessment (DQA) will be conducted using a designed

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

questionnaire and a validated standard methodology to identify weaknesses in the M&E system based on which improvements can be made in the future.

Procedures and data dissemination: The dissemination of data collected will be made through the PCT NTD program and a report shared with USAID. Also, an annual review meeting will be organized to present the results of all PCT NTD program activities. Moreover, PCT NTD program unit in charge of M&E activities will organize and provide feedback to HRs and HDs.

Monitoring of other PCT NTD activities: monitoring of other PCT NTD activities will enable the PCT NTD program to make adjustments when needed for better outcome during program implementation. Monitoring will be conducted using specially designed check lists that will be used by all field actors and supervisors. Furthermore, regular meetings will be held by the PCT NTD program and NTD partners to discuss the progress of NTD activities and challenges. Similarly, the PCT NTD program will hold monthly meetings with the FHI360 Country project team to discuss project implementation and ensure that solutions can be found for challenges identified as early as possible.

Use of the INDB tool as part of a national web application: After the training of the central level on the INDB, training of district and regional ESM was conducted in FY16 and FY17 (15 in 2016 and 26 in 2017). The INDB is now accepted by the PCT NTD program as very essential for data management and the control of PCT NTD. However, inadequacies have been noted during its use, including, among others:

- The difficulty in transmitting data from the peripheral level to the central level;
- The difficulty of archiving and securing data within HDs;
- The difficulty of interacting with other users (e.g. from other districts).

To address these inadequacies, the PCT NTD programs are planning to improve its use via a locally available online application that will allow the following:

- Better archiving of the NTD database;
- Centralization of the NTD database;
- Use of a secure connection for sign-in (username and password);
- Access to the INDB from any location;
- Ensure the traceability of the actors making entries in the database;
- Importation of available databases in Office Access format into the platform;
- Preservation of existing application while also making it more flexible;
- Search for data in the centralized NTD database will be easier.

For FY18, the implementation of this online application will require the financial support of USAID.

Monitoring and evaluation of the impact of MDA on PCT NTDs

Epidemiological monitoring as a part of the PCT NTD program allows the assessment of MDA impact on disease status within affected communities and helps reduce areas that can remain as pockets of infection. Data collected must be compiled and analyzed to facilitate decision-making. Given the large amount of data produced, a district-level INDB will be created and data entry clerks will be hired to electronically enter reported data for each district and upload the data into the NHIS2. Some representatives of key PCT NTD partners (including partners within END in Africa project), as well as other stakeholders, will be given access to participate in the review and analysis of PCT NTDs data within NHIS2 and can use the data for decision-making.

Trachoma impact study

The Séguéla HD, with a prevalence of between 5 and 10%, benefited from one round of treatment (antibiotic therapy) for trachoma. Per the current WHO SOPs for trachoma, this HD will undergo a TIS and MDA will not be continued if TF rate among children 1-9 years is less than 5%.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Table 9: Reporting of DSA supported with USAID funds that did not meet critical cutoff thresholds as of September 30, 2017

NTD	Number of remaining endemic districts (same as Table 2)	Type of DSA carried out (add extra rows as needed for each type)	Number of DSAs conducted with USAID support	Number of EU that did not meet critical cutoff thresholds	Why did the EU not "pass" the DSA?	Post-DSA failure activities (be specific about timeframes)
Lymphatic filariasis	74	0	0	0	0	0
Onchocerciasis	68	Epi Eval	6 HDs	0	0	0
Schistosomiasis	81	0	0	0	0	0
Soil-transmitted helminthiasis	83	0	0	0	0	0
Trachoma	14	TIS	1 HD	0	0	0

Table 10: Planned Disease-specific Assessments for FY18 by Disease

Include additional rows for each type of DSA to be undertaken for each disease

Disease	No. of endemic districts	No. of Evaluation Units	No. of Evaluation Units planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, FTS, etc.)
Lymphatic filariasis	74	-	0	-	-
Onchocerciasis	68	-	0		
Trachoma	14	-	1	TIS	TF, TT

k. Supervision for M&E and DSAs (Budget Location: Activities 32 & 34)

Total cost for activities in this section: **\$66,471**

A research protocol is written per WHO guidelines for all DSAs and presented for approval to the ethics and scientific research committee, which ensures good research practices in the country. The different structures, which consist of research institutes (Felix Houphouët Boigny University, Nangui Abrogoua University, the CSRS, the Medical and University Entomology Center and Tropical Data) can be requested to carry out these DSA.

During different DSAs, joint supervision of technical teams in the field is carried out by PCT NTD program staff and FHI 360 representatives. Also, the country is in the process of establishing a technical advisory committee for control of PCT NTDs that will ensure the scientific oversight of assessments and ensure that efforts to control PCT NTDs adhere to WHO guidelines and recommendations.

l. Dossier Development

No interventions are planned in FY18 in relation to dossier development as the PCT NTD program in the country is in the early implementation phase.

m. Short-term Technical Assistance (Budget Location: Activities 6, 20 & 21)

Total cost for activities in this section: **\$28,825**

Côte d'Ivoire will require the following short term technical assistance in FY18:

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

- **Updating the tool for integrated planning and costing (TIPAC):** In 2018, END in Africa will provide technical support through a Deloitte Technical Advisor on financial sustainability and capacity building to the PCT NTD program in a workshop to update the TIPAC with current programme data and funding. The updated tool will help generate reports on disease situation and funding gaps that could be used in advocacy and resource mobilization.
- **Advocacy for resource mobilization:** As the strategic social partnership and advocacy plan is being finalized in FY17, the following activities are planned as part of the resource mobilization strategy in FY18: developing a financial strategy that supports the PCT NTD Master Plan (2016-2020), improve performance management and enhance sustainability, implementation of the advocacy strategy to enable effective resource mobilization and partnership development, and maximizing the use of available resources to achieve the objectives indicated in the Master Plan.
- **Finalization of the Trachoma Action Plan (TAP):** WHO guidelines require each country to have a TAP as part of the implementation of the SAFE strategy. In 2016, the END in Africa project hired a consultant and supported a workshop to develop a TAP. However, given the complexity of the implementation of the SAFE strategy and the actors needed for implementation of the SAFE strategy, the country is having trouble finalizing this strategic document and will need the support of USAID to hire another consultant that will help finalize this document.
- **Capacity building regarding M&E:** M&E is an essential part of attaining the objectives of the PCT NTD program. PCT NTD programs are therefore requesting training for capacity building on M&E for PCT NTD program to ensure that the aims and objectives of the END in AFRICA project are attained.

Table 11: Technical Assistance request from END in AFRICA PROJECT

Task-TA needed (Relevant Activity category)	Why needed	Technical skill required; (source of TA (CDC, RTI/HQ, etc))	Number of Days required and anticipated quarter	Funding source (e.g., country budget, overall budget, CDC funding)
Internal support (e.g., RTI/HQ, USAID, CDC)				
Updating the TIPAC	To update the TIPAC with current program data and funding. The updated tool will help generate reports on disease situation and funding gaps that could be used in advocacy and resource mobilization	TIPAC expertise (Deloitte)		USAID budget
Advocacy for resource mobilization	Support the PCT NTD program to develop a financial strategy that supports the PCT NTD Master Plan (2016-2020), improve performance management and enhance sustainability, implement the advocacy strategy to enable effective resource mobilization and partnership development, and maximize the use of available resources to achieve the objectives indicated in the Master Plan.	Technical on financing strategy (Deloitte)	One week, 1 st quarter (October, November, December)	USAID budget

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

Training on Monitoring-evaluation of program	The PCT NTDP focus was on maintaining good MDA coverage. Attention is now shifting towards general M&E for all 5 PCT NTDs. The NTDP has requested support through training of central level NTDP staff on the interventions for monitoring impact of treatment and evaluation for each PCT NTD, and the indicators that should be monitored. The central-level staff can then support such trainings and supervise/monitor M&E activities at district and community levels.	Technical expertise on monitoring-evaluation of PCT NTD programs	One week, 1 st quarter (October, November, December)	USAID budget
Support to finalize the TAP	WHO guidelines require each country to have a TAP as part of the implementation of the SAFE strategy	Technical expertise on trachoma (USAID, FHI 360 and WHO)	One week, 1 st quarter (October, November, December)	USAID budget

3. Planned FOGs to local organizations and/or governments

Table 12: Planned FOG recipients - include for all subpartners as well

FOG recipient (split by type of recipient)	No. of FOGs	Activities	Target Date of FOG application to USAID
MSHP	07	<ul style="list-style-type: none"> • Coordination and operational workplan meeting/DABOU (4 days) • Coordination meeting with governors (local administrative authorities) • LF-Oncho MDA in 28 HDs • Annual meeting on LF-Oncho-STH-Trachoma activities/YAMOOUSSOUKRO (2 days) • Purchase of materials for LF/Oncho MDA in 57 HDs • Transportation of drugs and materials for LF/Oncho MDA in 57 HDs • Sensitization and social mobilization for LF/Oncho MDA in 57 HDs • Training of Data Managers of region and districts (35 HDs) on INDB (5 pools) • SCH MDA in 3 HDs • Capacity building of supervisors for LF/Oncho MDA in 57 HDs • Capacity building of CDDs for LF/Oncho MDA in 57 HDs • Dissemination of NTD sensitization movie • Training of media staff/ABIDJAN (1 day) • Supervision of Capacity building of sessions for LF/Oncho MDA in 57 HDs • Supervision of LF/Oncho MDA in 57 HDs • Workshop on validation of post-MDA for LF/Oncho + report redaction/BOUAKE (3 days) • Duplication of forms, sheets for LF/Oncho MDA in 57 HDs • Develop media plan and broadcasting for LF/Oncho MDA in 57 HDs • MDA launch ceremony/ABOISSO • LF-Oncho MDA in 29 HDs • Implementation of INDB in 57 HDs (7 pools) • Capacity building of supervisors for trachoma MDA in 12 HDs • Capacity building of CDDs for trachoma MDA in 12 HDs • Supervision of Capacity building sessions for trachoma MDA in 12 HDs 	October 1, 2017

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

		<ul style="list-style-type: none"> • Develop media plan and broadcasting for trachoma MDA in 12 HDs • Trachoma MDA in 12 HDs • Supervision of trachoma MDA in 12 HDs • Post-trachoma MDA drugs inventory in 12 HDs • Trachoma mapping in 14 HDs • Conduct trachoma TIS in Séguéla HD • Workshop to debrief on Séguéla HD TIS/ABIDJAN (1 day) • Purchase trachoma MDA materials for 12 HDs • Duplication of forms, sheets for trachoma MDA in 12 HDs • Transportation of materials for trachoma MDA in 12 HDs • Trachoma prospection in 39 HDs 	
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4. Cross-Portfolio Requests for Support

MDA: Bocanda and Mankono HDs are part of the 29 HDs that have STH prevalence $\geq 20\%$ and should be treated in FY18. It should be noted 22 of the 29 HDs are already covered by LF MDAs while the 7 other HDs (including these 2 HDs) are covered through integration with SCH MDA. However, although the 2 HDs are coendemic for SCH and oncho, they do not qualify for SCH MDA in FY18 in line with SCH treatment cycle and treatment for oncho does not cover all villages of the 2 HDs as only oncho endemic villages in HDs are generally treated. It is desirable that these 2 HDs be treated somehow for STH in FY18.

Morbidity management and disability prevention (MMDP): The reporting system established for MDA campaigns includes a report of cases of morbidity, and an increasing number of cases of morbidity related to LF and oncho is being reported. The PCT NTD program considers MMDP an important aspect of program implementation in Côte d'Ivoire and wishes to start some MMDP activities in FY18, but no funding is available currently for MMDP.

Current WHO guidelines on trachoma recommend implementation of the SAFE strategy for the elimination of the disease. However, only antibiotic therapy is currently done in the country. The multi-sectoral nature of the other SAFE interventions and the need for extra coordination should, however, be noted. The following are proposed to cover other aspects of the SAFE strategy: identification and care of TT cases, training of surgeons on TT surgical procedures, procurement of surgery boxes for TT, operational costs for TT surgeries, creation of a data management system for TT surgery, social mobilization to increase the surgery rate and management of relapses after TT surgery. The support of WASH partners in country is needed to cover the F and E aspect of the SAFE strategy, namely, hand and face washing, the construction of latrines, the supply of potable water.

Table 13: Cross-Portfolio Requests for Support

Identified Issue/Activity for which support is requested.	Which USAID partner would likely be best positioned to provide this support?	Estimated time needed to address activity
MDA in the 2 HDs that should be treated for STH in FY18 but not covered by LF or SCH MDA	HKI SCI	The whole year
Morbidity management and disability prevention: <ul style="list-style-type: none"> - Lymphedema (washing, antibiotic, antifungal and analgic/antipyretic therapy) - hydroceles (surgery) 	HKI CNTD BMG Foundation	The whole year
Training in: <ul style="list-style-type: none"> - planning and strategic health information - Logistics and drug management- - M&E - Epidemiology 		The whole year
		The whole year
		The whole year
		The whole year
		The whole year

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

- International health policy - TT surgery	None	The whole year
Care for trachoma morbidity (TT surgery)	HKI Sightsavers	The whole year
Face washing, improvement of the environment	WASH partners	The whole year
Vector control (mosquitoes, black flies, molluscs)	SCI	The whole year
Prospection to update black fly breeding site	Sightsavers END FUND HKI	The whole year

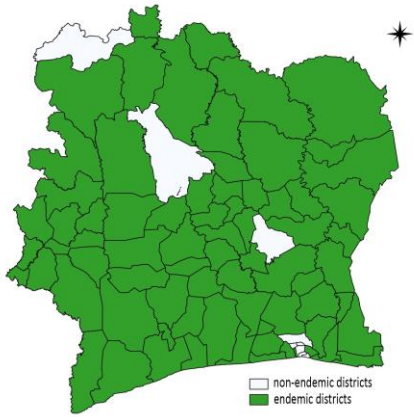
5. Maps

Each of the 20 HRs and all 83 HDs of Côte d'Ivoire are endemic for at least one PCT NTD. In FY18, USAID funding will either directly or indirectly support PCT NTD activities in all HRs, and all HDs as USAID funding is being requested not only for disease specific activities in a large proportion of the 83 HDs but also for general PCT NTD program management including supply chain management that will cover all HRs and HDs.

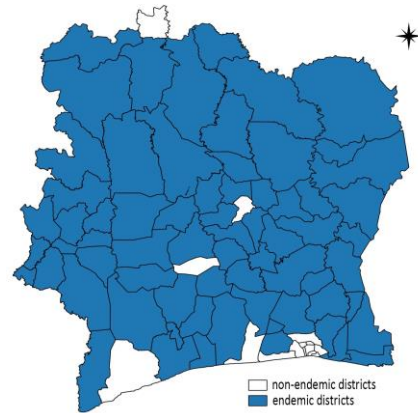
The maps below show the current endemicity of the 83 HDs for the 5 PCT NTDs (LF, oncho, SCH, STH and trachoma) and will be updated further when mapping for trachoma is completed.

FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

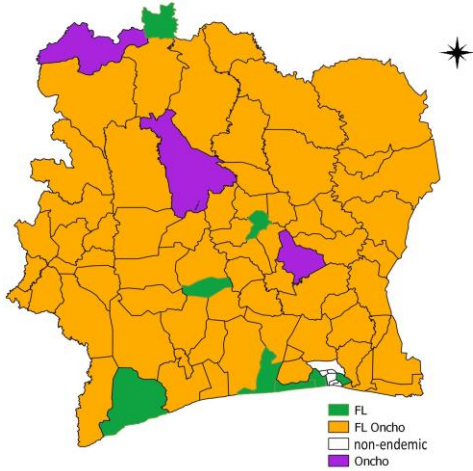
LF endemicity Map (Final, FY2017)



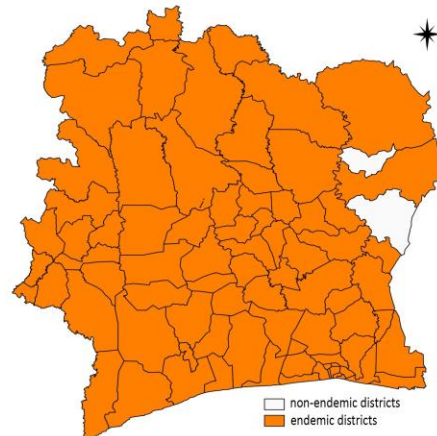
Oncho endemicity Map



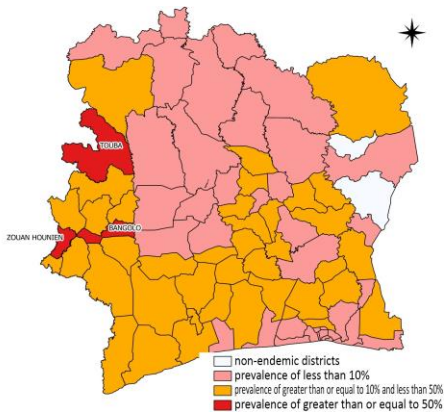
LF-Oncho Co-endemicity map (Final, FY17)



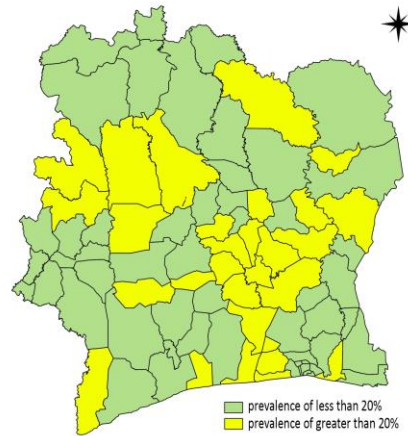
SCH endemicity map



SCH Map by prevalence category

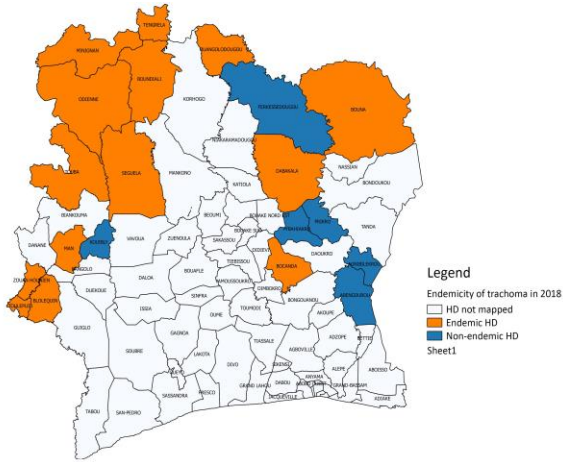


Map of STH endemicity

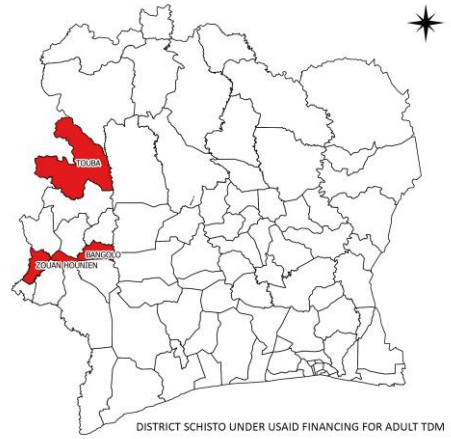


FY18 END IN AFRICA CÔTE D'IVOIRE WORK PLAN

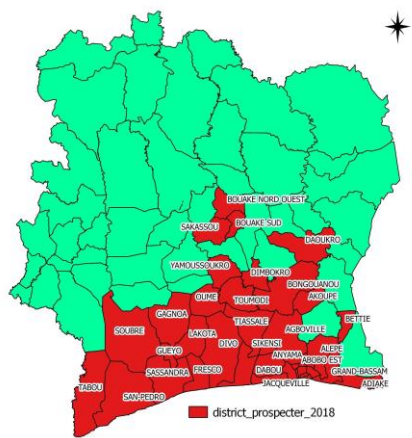
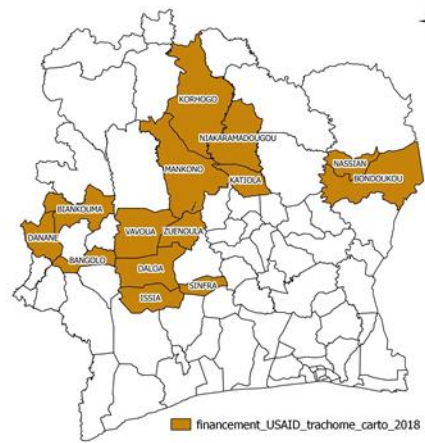
Map of current trachoma endemicity



SCH MDA planned under USAID support in FY18



LF-Oncho MDA areas in FY18



APPENDICES

1. Country staffing/partner org chart (replicated from overall work plan)
2. Work plan timeline
3. Workplan deliverables
4. Table of USAID-supported provinces/states and districts affected by the disease/activity
5. FY17 Q1-2 Country SAR
6. Program Workbook
7. Diseases Workbook
8. Country budget