Niger

FY2018

Control of Neglected Tropical Diseases

Annual Work Plan
October 1, 2017 – August 31, 2018

Date: July 15, 2017

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ALB	Albendazole
APOC	African Program for Onchocerciasis Control
BCC	Behavior Change Communication
CBM	Christoffel Blinden Mission
CDD	Community- Drug Distributor
CSI	Center for Integrated Health (Centre de Santé Intégré in French)
DEP	Directorate of Studies and Programming (Direction des Etudes et de la Programmation in French)
DPHL	Pharmacy and Laboratory Directorate (Direction des Pharmacies et Laboratoires in French)
DQA	Data Quality Assessment
DFID	Department for International Development (UK)
DRSP	Regional Directorate of Public Health (Direction Régionale de Santé Publique in French)
DSA	Disease Specific Assessment
EU	Evaluation Unit
FHI 360	Family Health International 360
FOG	Fixed Obligation Grant
FTAS	Filariasis Transmission Assessment Survey
FTS	Filariasis Test Strip
HD	Health District
HDP	Health Development Plan
HKI	Helen Keller International
HRA	High-risk adult
ICT	Immunochromatographic test
IEC	Information, Education and Communication
INDB	Integrated NTD Database
IVM	Ivermectin
ITI	International Trachoma Initiative
JNM	National Micronutrient Days (Journées Nationales des Micronutriments in French)
JNV	National Vaccination Days (Journées Nationales de Vaccination in French)
JSI	John Snow Inc.
LANSPEX	National Public Health and Reference Laboratory (Laboratoire National de Santé Publique et d'Expertise in French)
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MoPH	Ministry of Public Health (Ministère de la Santé Publique in French)
NGO	Non-Governmental Organization
NTD	Neglected Tropical Diseases
NTDP	Neglected Tropical Diseases Program

OCP	Onchocerciasis Control Program
ONPPC	National Office of Pharmaceutical and Chemical Products (Office National des Produits Pharmaceutiques et Chimiques in French)
OV	Onchocerciasis
PCT	Preventive Chemotherapy NTDs
PDS	Health Development Plan (Plan de Développement Sanitaire in French)
PNDO/EFL	National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis (Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filariose Lymphatique in French)
PNLBG	National Schistosomiasis and Soil-Transmitted Helminthiasis Control Program (Programme National de Lutte contre la Bilharziose et les Géohelminthes in French)
PNSO	National Eye Health Program (Programme Nationale de Santé Oculaire in French)
Pre-TAS	Pre-Transmission Assessment Survey
PZQ	Praziquantel
RISEAL	International Network for Planning and Control of Schistosomiasis (Réseau International Schistosomiases Aménagement et Lutte in French)
RPRG	Regional Program Review Group
SAE	Serious Adverse Events
SAFE	Surgery, Antibiotics, Facial Cleanliness and Hygiene, and Environmental Improvements
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative
STH	Soil-Transmitted Helminthes
TA	Technical Assistance
TAS	Transmission Assessment Survey
TEC	Trachoma Expert Committee
TEO	Tetracycline Eye Ointment
TF	Trachomatous Inflammation – Follicular
TIPAC	Tool for Integrated Planning and Costing
TSS	Trachoma Surveillance Survey
TT	Trachomatous Trichiasis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

COUNTRY OVERVIEW

1. *General country background*

The Republic of Niger is a landlocked republic covering an area of 1,266,491 km^2 that shares a border with Mali, Nigeria, Algeria, Libya, Burkina Faso, Benin, and Chad. It is divided into eight administrative regions and 44 health districts (HDs) until 2014. As of 2014, these 44 HDs have increased to 72, all of which are now considered functional and have been taken into account in the planning and budgeting for Niger's FY18 mass drug administration (MDA) campaigns. However, for purposes of continuity and given that the redistricting process takes time to reflect in the workbooks, the historical background and work plan narrative continue to refer to the original 44 HDs for this year. As of 2017, the country's population is 20,002,190, with a projected population of 20,782,276 in 2018. Niger is one of the world's poorest countries but has significant natural resources, such as uranium and oil.

Niger's health system is based on the health pyramid recommended by the World Health Organization (WHO). It consists of 3 levels:

- **Central level** (responsible for strategic support), which includes the central administration (3 general departments and 15 central departments), 8 national specialized reference centers, 16 national programs, 3 national hospitals, and 1 national reference maternity hospital. The neglected tropical disease (NTD) programs (National Schistosomiasis and Soil-Transmitted Helminthiasis Control Program (Programme National de Lutte contre la Bilharziose et les Géohelminthes in French or PNLBG, National Eye Health Program (Programme Nationale de Santé Oculaire in French or PNSO and National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis (Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filariose Lymphatique in French or PNDO / EFL) and coordination (provided by a focal point) are attached to the Directorate of Studies and Programming (Direction des Etudes et de la Programmation in French or DEP), Ministry of Public Health (MoPH).

- **Intermediate level** (responsible for technical support) includes 8 Regional Directorates of Public Health (Direction Régionale de Santé Publique in French or DRSP), 6 regional hospital centers, and 2 regional reference maternity hospitals. For NTDs, there is a focal point in each DRSP that coordinates all NTD-related activities.

- **Peripheral level** (responsible for operational support) which includes 72 HDs (formerly 44 HDs), 33 district hospitals with 26 functioning operating blocks, 913 health centers (Centre de Santé Intégré in French or CSI) and 2,516 health posts. In each HD, there is a focal point to coordinate all NTD activities in the HD. This focal point works with CSI chiefs who constitute the operational level responsible for carrying out distribution activities using community drug distributors (CDDs). CDDs are volunteers chosen by the village chief in agreement with the CSI chief from a list of criteria pre-established by the national Neglected Tropical Disease Program (NTDP). Community involvement is established at the different levels through health committees, management committees, community-based organizations and mutual health insurance groups (groups in which members contribute a fixed amount of money each month, and receive financial support when they fall ill to cover the cost of treatment).

The MoPH of Niger receives the following support for NTDs, in addition to the funding provided by the United States Agency for International Development (USAID):

- **The State**: The state has created a budget line for NTDs and has planned to allocate 100 million FCFA per year since 2012. However, these funds are not always received by the NTDP. There is another line for all programs of the MoPH, which occasionally supports NTD programs for certain activities. Other aspects of the State's support include the salaries of health and education agents, space for storage and meetings, water, electricity, and vehicle use. The State has recently contracted a loan from the World Bank for the support of activities to combat seasonal malaria and NTDs and, therefore, Niger anticipates an increased investment into NTD activities.

- **World Bank** provides funding (in the form of a loan) to the MoPH through the NTD / Malaria Regional Sahel Project. This multi-year funding supports NTD control in 17 HDs bordering Burkina Faso and Mali. Support is provided for the acquisition of drugs for case management, for logistics (acquisition of vehicles and motorcycles), support for the organization of the MDA (i.e., support for additional CDDs), monitoring and evaluation, and management of complications.

- **Conrad N. Hilton Foundation**: Provides funding through The Carter Center and Helen Keller International (HKI) to support the PNSO to implement the SAFE strategy (Surgery, Antibiotics, Facial cleanliness and Environmental improvements) in Niger, with special focus on trachomatous trichiasis (TT) surgery, face washing, behavior change communication (BCC) through radios and school health, latrine construction, and monitoring and evaluation. The Carter Center also supports trachoma MDA through the procurement of 1% tetracycline eye ointment (TEO) for children under six months.

- **Schistosomiasis Control Initiative (SCI):** In 2017, the MoPH and SCI have set up a new direct partnership whereby SCI supports the PNLBG. For the next MDA campaign (FY18) SCI will support acquisition of praziquantel (PZQ) for adults, MDA for schistosomiasis (SCH), coverage surveys for SCH and soil-transmitted helminths (STH), and support some office costs of the PNLBG program.

- **Sightsavers:** Has historically provided support to the PNDO/EFL for surveillance activities in 5 HDs that were previously endemic for onchocerciasis (OV). The project ended in 2016.

Table 1: 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
Government of Niger	Central level and all 8 regions	• Administrative organization and institutional support to the NTD Program • Human resources • Clearing medications from customs • Salaries for NTD Program staff • Meeting space and space to store drug • Logistical support • Capacity building • School health	No	None
WHO	Central level	• Technical and institutional support	No	Several

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
		• Capacity building • Assistance with drug donation (Mectizan® or Ivermectin (IVM) and albendazole (ALB) for the PNDO/EFL and PZQ for the PNLBG)		
Helen Keller International (HKI)	National level and all regions	• Support the entire process for organizing MDA campaigns to control NTDs from cascade training to social mobilization, distribution, monitoring and assessment, including a national report. • Support for all monitoring/assessment and surveillance activities • Support for the planning process for all activities to prevent, control and eliminate NTDs • Institutional support for the NTDP	Yes	No
	Central level and the regions of Diffa, Dosso, Maradi, Tahoua, Zinder	• Support the PNSO for trichiasis surgery • Information, education and communication (IEC) activities for trachoma (sensitization via community radio stations) • Support to the School Health Office to teach about trachoma in schools	No	Conrad N. Hilton Foundation
The Carter Center	Central level, and the regions of Diffa, Tahoua, Maradi, Tillabéri and Zinder	• Support to the PNSO in trachoma MDA with the purchase of 1% tetracycline eye ointment • IEC activities for trachoma (sensitization via community radio stations) • Sanitation (latrine construction, support for Community-Led Total Sanitation • Support to the School Health Office to teach about trachoma in schools	No	Conrad N. Hilton Foundation, Lions Clubs International Foundation
SCI	Central level and regions of Dosso, Tahoua, Niamey, Tillabéri, Zinder, Maradi and Diffa	• Support to the PNLBG for coverage surveys and the management of high-transmission areas (hot spots) and operations support • Support to the PNDO/EFL for the organization of hydrocele surgery camps • Support for MDA in all SCH endemic HDs (END in Africa and SCI will co-support integrated MDA for LF/SCH/STH in 6 HDs in FY18)	No	Department for International Development of the British government (DFID)
United Nation's Children Fund (UNICEF)	Central and regional levels	• Support to the PNLBG for the organization of deworming campaigns for children under five jointly with National Vaccination Days (JNV) and National Micro-Nutrient Days (Journées Nationales des Micronutriments in French or JNM) with an ALB donation.	No	Several

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
Sightsavers	Central level	• Support to the PNDO/EFL in epidemiological and entomological surveillance for OV from 2012-2016.	No	Several
Lions Clubs of Niger	Central level	• Support to the PNSO for complete eye health (including capacity building for health agents)	No	Several
CBM	Central level and the regions of Dosso, Niamey and Tillabéri	• Support to the PNSO for complete eye health (including capacity building for health agents)	No	Several
World Bank	Central level and 17 HDs	• Support to all NTD/preventive chemotherapy (PCT) programs in the three following areas: • Institutional capacity building • Community campaigns (with emphasis on cross-border actions) • Monitoring/assessment • Morbidity management support for LF and trachoma	No	None

2. *National NTD Program Overview*

USAID support for the NTDP in Niger began in 2007. The program combined three disease-specific programs: The PNLBG, the PNSO and the PNDO/EFL. From 2007 to 2011 USAID provided support via the intermediary of the NTD Control Program managed by Research Triangle Institute (RTI) International with the SCI/International Network for Planning and Control of Schistosomiasis (Réseau International Schistosomiases Aménagement et Lutte in French or RISEAL) as the in-country partner. The Carter Center provided support for the trachoma MDA during this period. The first integrated MDA was carried out in 2007 in the Tahoua, Dosso and Tillabéri regions. In 2008, the MDA was extended to the Maradi region and Niamey was added in 2009. In 2010 the geographical coverage was extended to 100% of the mapped HDs requiring MDA.

Since 2011, USAID has provided support in Niger via the END in Africa project managed by Family Health International (FHI) 360 with HKI as the in-country partner. USAID financing is provided to the three NTD programs (PNLBG, PNSO and PNDO/EFL) for the implementation of integrated NTD activities throughout the country. The activities include mapping, MDA, capacity building, social mobilization, training, advocacy, supply chain management and monitoring and evaluation (M&E). In FY2016, support was extended to the Pharmacy and Laboratory Directorate (Direction des Pharmacies et Laboratoires or DPHL), via a focal point dedicated to NTDs to ensure the quality of all drugs used in the country. In addition, support is also provided to the National NTD Coordinators for office supplies and fuel. In Niger's master plan, lymphatic filariasis (LF), trachoma and OV are diseases targeted for elimination as a public health problem. SCH and STH are targeted for control.

Lymphatic filariasis

Baseline mapping for LF began in 2003. Mapping of the last HDs suspected of being endemic was conducted in 2013/2014 by immunochromatographic test (ICT) in Arlit and Bilma HDs in the region of Agadez. In addition, due to the high number of cases of hydrocele and lymphedema reported in Filingué, the HD was mapped again in 2014 using ICT per the request of the National Coordinator. The mapping showed that Arlit warrants MDA (prevalence by ICT >1%), and MDA began in FY2015. The results of the mapping showed that neither Bilma nor Filingué required MDA.

Thirty-three HDs in Niger are endemic for LF and began treatment in 2007 (except for Arlit HD which began treatment in FY2015). Between 2013-2016, a total of 17 HDs have passed the transmission assessment survey (TAS 1) and met the criteria to stop MDA (Say, Kollo, Tillabéri and Téra in the Tillabéri region; Guidan Roumdji, Dakoro, in the Maradi region; Madaoua in the Tahoua region; Boboye in the Dosso region; Niamey 2, 3, 4, and 5 in the Niamey region and Gouré, Magaria, Matameye, Mirriah, Zinder Commune in the Zinder region). Three HDs in the Diffa region (Diffa, Maine Soroa and N'Guigmi) will conduct TAS 1 in July 2017 to assess whether they may also stop MDA.

In FY16, the PNDO/EFL conducted a pre-transmission assessment survey (pre-TAS) in 11 HDs: in Tahoua region (Konni, Illéla, Keita, Tahoua, Bouza, Tchintabaraden), Dosso region (Gaya), and Maradi region (Madarounfa, Mayahi, Aguié, Tessaoua). All six HDs in Tahoua region passed the pre-TAS and will conduct TAS 1 in FY18 (planned for January 2018). All four HDs in Maradi and the HD of Gaya failed the pre-TAS and have since completed one additional round of treatment in FY17. The four HDs in Maradi will implement MDA in November 2017 and, pending good MDA coverage results, will plan to conduct re-pre-TAS at least six months after the campaign (May 2018). Gaya HD will treat in March 2018 and conduct a re-pre-TAS in July 2018 along with Arlit HD if funding is available (not supported by END in Africa). Although Tanout HD passed pre-TAS in FY15, the HD had not received Regional Program Review Group (RPRG) approval for TAS 1 due to an insufficient number of successive MDA rounds with >65% coverage. Following the FY17 MDA, Tanout is now eligible for TAS1 in FY18 (planned for February 2018).

Finally, 8 HDs (Tera, Say, Kollo, Boboye, Madaoua, Tillabéri, Dakoro, Guidan Roumdji) were approved by RPRG for the TAS2, which will be conducted in October-November 2017. Niamey 2, 3, 4 and 5 HDs and Gouré HD will also conduct TAS 2 in 2018 after receiving approval from RPRG. However, these surveys are planned in August 2018 after the end of the END in Africa project, and the NTDP will seek out other funding for this activity.

The Niger MoPH intends to eliminate LF as a public health issue by 2020 using the following strategies:

- MDA of IVM and ALB reaching at least 65% of the population at risk and 80% of the eligible population in endemic HDs.
- Surgery for hydrocele cases and care for lymphedema cases. This means that active search is required to find the people with these conditions.
- Improved MDA monitoring.
- Implementation of BCC using information, education and communication (IEC) materials focused on preventing the disease and improved participation during the MDA campaigns.
- Vector control with the cooperation of the National Malaria Control Program.
- Operational research.
- Capacity building for program staff.

Onchocerciasis

Onchocerciasis (OV) mapping via skin snip was conducted between 1974 and 1976. Five HDs were declared OV endemic: Kollo, Say, Tera, Boboye and Gaya. Vector control measures were conducted between 1976 and 1987 with the support of the Onchocerciasis Control Program (OCP). The WHO declared the disease was under control in 2002 and it was no longer a public health problem. Niger has never conducted Community-Directed Treatment with Ivermectin (CDTI) in the five endemic HDs since prevalence in these HDs is under the threshold requiring treatment. However, all the OV endemic HDs were treated for LF with IVM and ALB. These treatments began in 2007 for Kollo, Say, Tera and Boboye, and from 2011 for Gaya.

In January 2015, entomological surveys (with the support of Sightsavers and the African Program for Onchocerciasis Control (APOC)) and epidemiological surveys (with USAID support) were carried out in the three HDs which successfully passed their LF TAS in 2013 (Kollo, Say and Téra). The prevalence in each HD was 0% Mf for the epidemiological survey and 0% for the entomological survey.

In FY16, the NTDP conducted entomological surveys, which resulted in the capture of 127,333 black flies that were all OV-negative following DNA testing conducted at the Multi-Disease Surveillance Center (MDSC)/WHO laboratory in Ouagadougou. An epidemiological evaluation was conducted up to 20 km around the spawning grounds of the black flies in Boboye HD. For this purpose, more than 3,000 children under 10 years of age were tested using the OV16 rapid diagnostic tests (RDT) and 3 positives were detected. As a prelude to OV16 enzyme-linked immunosorbent assay (ELISA), blood spots were made on blotting papers; these blood spots will be tested once the ELISA test is approved.

In FY18, the PNDO/EFL plans to conduct OV epidemiological surveys in accordance with WHO guidelines for stopping MDA using OV16 ELISA in Tera, Gaya and Kollo HDs with support from END in Africa, and in Say HD with support from Sightsavers. Fieldwork for the OV surveys (i.e., collection of blood spots) in Tera and Kollo HDs is planned for December 2017, immediately following the LF TAS2 surveys in these same HDs. The OV survey in Gaya HD will be conducted in February 2018, prior to LF MDA which is scheduled for March 2018. Analysis of results using ELISA will be performed in the PNDO/EFL laboratory in Niamey.

To help the program to prepare its elimination dossier for OV, an Onchocerciasis Elimination Committee (OEC) was formerly created in Niger in January 2017. This committee is comprised of National and International experts (see “Capacity Building” section). The OEC will meet once in FY18 with support from END in Africa.

Schistosomiasis

The PNLBG was officially launched in 2004. Forty-three HDs out of the 44 in the country (except for Bilma) are endemic for SCH. The assessment methods used are urinary filtration and Kato-Katz for stools. MDA with PZQ started in 2004-2005 and took place every other year, targeting school-aged children (SAC) and high-risk adults (HRA). The MDAs were financed by SCI/RISEAL and then by the USAID NTD program through RTI / SCI / RISEAL from 2007 to 2010 and, finally, by USAID’s END in Africa program, implemented by FHI360 / HKI, from 2011 to date. From November 2004 to May 2007, three successive surveys were carried out by the Center for Medical and Health Research in eight sentinel sites located in the regions of Tillabéri, Dosso and Tahoua. The total average prevalence rate was 75.4%. A year later, following the MDA, the average prevalence had decreased considerably to approximately 37.4%. After another year, the average prevalence was 35.7%.

Sentinel site surveys in 2010 revealed high re-infection rates. Thus, Niger decided to treat all river valley region areas annually (Tillabéri, Dosso and the Urban Commune of Niamey) and the other regions every

two years (Maradi, Diffa, Agadez, Tahoua and Zinder). Re-evaluation surveys were carried out from 2011 to 2014 in all the HDs. A meeting of SCH experts was held in November 2014 to examine the survey data and realign the treatment strategy to WHO guidelines. Per the new strategy, all endemic HDs will receive treatment annually, twice per year or once every two years (see the complete strategy in Appendix 9). In addition, "hot spots" (all villages where the SCH prevalence is greater than 45%) are covered by a specific treatment strategy (one or two treatments a year) and awareness-raising and case management will be intensified. As part of the implementation of the proposed new strategy of PNLBG, PZQ will be set up at health centers in high prevalence areas for the management of cases outside the campaigns using left over drugs from MDAs.

The PNLBG implements the following activities:

- Identification of high-transmission sources and mass treatment with PZQ (with ALB against STH where mass treatment against LF has been stopped) targeting school-age children and high-risk adults
- BCC
- Case management
- Drinking water supply and sanitation
- Capacity building for program staff
- Monitoring & evaluation
- Operations research

The PNLBG updated the list of endemic villages in FY16, as the population data currently used by the PNLBG is from 2004. Using such old data likely contributes to the issues experienced in ordering drug and this updated list will ensure that the correct amount of drug needed is sent to the different health levels for MDA. Uncertainty in the denominator has also made interpretation of coverage difficult. The activity revealed that the number of endemic villages increased from 3,179 to 5,980, an increase of 88%. This was the first endemic village update since 2004. The increase in endemic villages will have an impact on the MDA target population (the SAC population will remain the same since it is based on the entire district population, but the number of adults living in endemic villages that are targeted for treatment will change), the number of sentinel sites to be surveyed and the budget.

The PNLBG began implementing the new SCH strategy, developed in 2014, in which 4 HDs are treated twice a year (if funding is available), 14 HDs are treated once per year and the remaining 25 HDs are treated once every two years. The group of HDs conducting MDA every other year are divided into two alternating groups (see Table 1a): the first group of 21 HDs were treated in FY17 and do not need treatment in FY18; the second group of 4 HDs will be treated in FY18.

Table 1a: PZQ Treatment Cycle according to National Strategy.

Treatment scheme	# HD		PZQ treatment (x=one round)			Partners supporting PZQ MDA in FY18
			FY2016	FY2017	FY2018	
Twice per year	4		xx	Xx	xx	4: SCI
Annual	14		x	X	x	10: SCI 4: SCI/HKI
Every other year	25	21		X		
		4	x		x	2: SCI 2: SCI/HKI

Total number of HD needing treatment	43		22	39	22	
(Therapeutic break)			(21)	(4)	(21)	

For the FY18 SCH MDA, 15 HDs will be fully supported by SCI (Abalak, Filingué, Ouallam, Say, Tera, Kollo, Tillabéri, Boboye, Loga, Doutchi, Niamey 1, Niamey 2, Niamey 3, Niamey 4 and Niamey 5) and 6 HDs will be co-financed by SCI and HKI (Tchintabaraden, Gaya, Diffa, Mainé, N'Guigmi, and Tessaoua). Starting from June 2018, all the HDs eligible for the PZQ MDA (39/44) will be entirely supported by SCI, except for LF co-endemic HDs, which will continue to conduct integrated MDAs.

In addition to the PZQ MDA, the PNLBG conducts periodic sentinel site surveys in 17 HDs using the urinary filtration method and Kato Katz to determine the SCH and STH prevalence. In FY16, with support from the END in Africa project, PNLBG conducted an evaluation survey in these 17 sentinel sites with a cohort monitoring perspective. The results show persistence of the disease in most of the sites despite the treatments.

Soil-transmitted helminths

All of Niger's 44 HDs are considered endemic for STH. Based on the WHO definition, Niger has a low to moderate STH prevalence. Baseline data for STH in Niger is not available. The current national strategy is to treat all 44 HDs (even those with low or moderate prevalence) and is based on the fact most people do not have access to clean water or sanitation and have poor hygiene habits.

The MoPH's STH strategy consists of:

- MDA via LF treatment (IVM+ALB) or SCH treatment (PZQ+ALB). Note that not all HDs receive annual treatment for STH because certain HDs are not LF endemic (or have stopped treatment) and may not treat for SCH (e.g. Bilma HD) or do not treat annually for SCH.
- Deworming of children 12 to 59 months old during National Vaccination Days (JNVs) and twice annual deworming campaigns, funded by UNICEF. A campaign is scheduled for December 2017.
- Pregnant women are treated with ALB as part of the minimum treatment package during second trimester. This treatment is managed by MoPH's Directorate General of Maternal and Child Health.
- Implementation of BCC using materials focused on disease prevention and improving participation and compliance during the MDA campaigns.
- Improved access to clean water and sanitation.

The components of this strategy specifically supported by USAID include STH treatment via LF MDA in co-endemic HDs and the implementation of BCC strategies focused on improving participation and compliance during MDA campaigns.

In addition to the MDA, the PNLBG carries out periodic surveys at 17 SCH sentinel sites in 17 HDs and assesses STH at the same time. In FY16, PNLBG conducted an evaluation survey in these 17 sentinel sites with a cohort monitoring perspective (see Table 1b). The evaluation is a cohort study spanning five years and the PNLBG wishes to carry out an analysis after three years and a final evaluation at the end of five years. The data from FY16 show district-level STH prevalence below 20% except in one sentinel site.

Table 1b. Most recent STH prevalence data by district (FY16)

Regions	Districts	Villages	Number surveyed	Prevalence (%)	Types of parasites	Intensity of infection[1]	
						Min	Max
Agadez	Tchirozerine	El mecki	60	15	Ancylostoma Ascaris Trichuris trichiura	010	121
Diffa	Mainé Soroa	Boudoum	60	0			
Dosso	BOBOYE	Bangou koukou	60	10	Ascaris, Trichuris trichiura	0 0	1 1
	GAYA	Kawara N' Débé	60	6,66	Ascaris, Trichuris trichiura Enter vermicularis	0 0 0	2 1 2
Maradi	Dakoro	Mougoudou	60	1,66	Ascaris	0	1
	Madarounfa	Doutchi Begoua	60	3,33	Ascaris	151	203
	Tessaoua	Takassaba Maradi	60	3,33	Ascaris	2	5
Niamey	Niamey 5	Saga Gourma	60	0			
Tahoua	Madaoua	Téké	60	5	Ascaris, Ankylostoma Trichuris trichiura Enter vermicularis	0 0 0 1	2 1 1 2
	Tchintabaraden	Gambane	60	6,66	Enter vermicularis Ascaris, Trichuris trichiura	1 0 0	2 1 1
Tillabéri	Filingué	Bomberi	60	3,33	Ascaris	0	2
	Kollo	Firwa	60	15	Ascaris Ankylostoma	1 1	3 2
	Ouallam	Gabdey Bangou	60	10	Ascaris	1	6
	Say	Rouga	60	6,67	Ascaris	1	2
	Téra	Yalwani	60	8,33	Ascaris Ankylostoma	1 0	4 1
Zinder	Mirriah	Doungouram	60	0			
	Zinder Commune	Midick	60	20	Ascaris Enter vermicularis	24 0	264 1

1. Intensity measured per 2mg fecal sample: ≥ 499 eggs = moderate to high intensity; ≤ 499 eggs = low intensity

Trachoma

Trachoma control began in Niger in 2002 following baseline mapping with the WHO simplified grading system. At the time, 33 out of 42 HDs were considered endemic and warranted MDA (trachomatous inflammation-follicular (TF) ≥5% in children one to nine years old). Of the other nine HDs, four were totally urban and considered non-endemic and have never been mapped (Niamey I, Niamey 2, Niamey 3 and Maradi); one HD was at less than 5% at the time of reference mapping (Loga) and the four HDs of the Agadez region (Arlit, Bilma, Tchirozerine and Agadez) were not suspected to be endemic. However, based

on the recommendations of the Trachoma Expert Committee, the PNSO mapped the Agadez region in 2014 with USAID support. Of the four HDs, two had a low endemicity level: Bilma (9.9%) and Tchirozérine (6.9%). The other two (Agadez and Arlit) had a TF prevalence of <5%. Therefore, 35 HDs are considered to be endemic upon initial mapping.

MDAs began gradually with two HDs in 2002 and scaled up to 33 HDs between 2004 and 2009. Following the results of the mapping in the Agadez region, MDA was conducted in the two endemic HDs in FY16, marking 100% geographical coverage of the 35 endemic districts.

The PNSO plans to eliminate trachoma as a public health problem by 2020 through the WHO-recommended SAFE strategy, operational research, capacity building for PNSO staff, and monitoring and evaluation activities. The SAFE strategy includes the following four components:

- S (Surgery): Management of trichiasis cases (trichiasis surgery)
- A (Antibiotics): Zithromax and tetracycline 1% TEO mass treatment to interrupt transmission, targeting 100% of the population
- F (Facial Cleanliness): promoting facial cleanliness and hygiene
- E (Environmental change): improved access to clean water and sanitation

This strategy involves impact assessments after one, three, five or seven years of MDA based on prevalence, although no HD in Niger currently warrants more than three years of treatment. To date, 23 HDs have passed the trachoma impact assessment (TIS), demonstrating TF<5% among children ages 1-9 following the recommended number of rounds of MDA. The current epidemiological situation as of August 1, 2017 is the following:

- 26 HDs have a prevalence of TF <5%
  - Initial mapping (3): Loga, Arlit, Agadez
  - TIS (23): Tera, Say, Kollo, Filingué, Aguié, Tillabéri, Dosso, Doutchi, Gaya, Boboye, Abalak, Konni, Bouza, Keita, Madaoua, Illéla, Tchintabaraden, Tahoua, Dakoro, Zinder Commune, Tanout, Matameye, Madarounfa.
- 06 HDs have a prevalence of TF between 5% and 9.9%: Bilma, Tchirozerine, Guidan Roumdji, Mayahi, Magaria, Ouallam (4 will treat in FY18 and 2 will undergo TIS in Q1 of FY18 to determine if MDA is warranted)
- 06 HDs have a TF prevalence between 10% and 29.9%: Tessaoua, Mirriah, Gouré, Diffa, Mainé Soroa, N'Guigmi
- 06 HDs are not suspected to be endemic and have never been mapped: Maradi Commune, Niamey 1, Niamey 2 and Niamey 3, Niamey 4, Niamey 5. The PNSO would like to conduct mapping in these urban and peri-urban areas in 2018 with funding from the Conrad N. Hilton Foundation.

Seven HDs will be eligible for trachoma impact survey (TIS) in FY18. These include Diffa, Mayahi, Guidan Roumdji, Magaria, Tchirozerine, Ouallam, and Bilma. In FY17, three TIS were carried out. The results of these surveys indicate that Aguié will stop MDA while Bilma and Tchiro must continue with one more round of treatment followed by a TIS six months later in FY18. In addition, 13 post-MDA trachoma surveillance surveys (TSS) at district-level are planned for October 2017 (Table 1b). Of the three TSS carried out in FY17, results of two HDs (Say and Filingué) showed a TF prevalence of less than 5%, but one HD (Ouallam) needs to conduct one more round of MDA.

Table 1b. List of HDs in need of surveillance survey

Region	District	Year of last survey	%
			TF 1-9 years
DOSSO	Loga	2009	3.90
DOSSO	Gaya	2011	0.00
TAHOUA	Tchintabaraden	2012	0.20
TAHOUA	Abalak	2012	1.50
ZINDER	Tanout	2012	3.40
AGADEZ	Arlit	2014	3.60
AGADEZ	Agadez	2014	3.90
DOSSO	Doutchi	2014	1.91
TAHOUA	Tahoua	2014	0.58
TAHOUA	Bouza	2014	1.15
TAHOUA	B Konni	2014	1.91
TAHOUA	Madaoua	2014	2.55
TAHOUA	Keita	2014	3.48

Surveys are needed to prepare the elimination validation dossier that each country must submit to the WHO to validate elimination. The PNSO will conduct these TSS in chronological order starting with the first HD with a TF <5% for children aged 1 to 9 years in the baseline survey (Loga, Arlit, Agadez). The protocols used for TIS and TSS conducted previously and for those planned for FY18 will be in accordance with WHO guidelines and Tropical Data.

3. *Snapshot of NTD status in country (table)*

Table 2: Snapshot of the expected status of the NTD program in NIGER 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			
Lymphatic filariasis	44[1]	33	11	0	13	0	0	20[2]	Re-pre-TAS : 5 Pre-TAS : 1 TAS 1 : 7 TAS 2 : 13 (8 planned for FY18 under END)
Onchocerciasis		5[3]	39	0	0	0	0		5
Schistosomiasis		43	1	0	30[4]	13	0	0	17 sentinel site surveys
Soil-transmitted helminths		44	0	0	36	5	3[5]	0	17 sentinel site surveys
Trachoma		35	9	0	12[6]	0	0	23	TIS: 7[7] TSS: 13

1. The various recent redistricting in Niger has increased the number of HDs to 72. However, in FY17 only 44 HDs were considered and 42 in FY16. The workbooks still represent the 42 HD. In FY18, the 72 HD will be considered in planning, budget and workbooks. To facilitate understanding of the past, Table 2 is filled per the old sub-division (44 HD) while Niger awaits redistribution of the FY18 workbooks to 72 HDs.
2. To date, 17 out of 33 LF endemic HDs have reached the criteria to stop-MDA. This figure assumes that as of Sept 30 2017, the 3 HDs undergoing TAS 1 in Diffa region in July 2017 will have passed. However, Niger has tentatively planned for LF MDA in 16 HDs in FY18, including the 3 HDs undergoing TAS 1 in Diffa, in the instance that these HDs need MDA (Diffa is an insecure area bordering Nigeria that experiences a considerable amount of population movement).
3. The 5 HDs (Tera, Say, Kollo, Boboye and Gaya) are currently being evaluated to demonstrate elimination of OV. Epidemiological and entomological assessments were conducted in 4 HDs in FY16. The last HD, Gaya, failed the LF pre-TAS in FY16 and will undergo OV assessment as early as FY19 along with the TAS 1.
4. These are all the HDs receiving support for MDA through USAID in FY17, including those treated once every two years. The FY17 SCH campaign involved 26 HDs treated with USAID support. Starting in FY18, SCI will support MDA in all SCH-endemic HDs and END in Africa and SCI will share the cost for integrated MDA in LF/SCH/STH co-endemic HDs.
5. 3 HDs (Bilma, Loga, Doutchu) did not treat for LF or SCH in FY17 and therefore did not receive STH MDA. In FY18, 16 HDs will receive IVM+ALB for LF/STH (of which 6 will receive IVM+ALB+PZQ co-financed by HKI and SCI), 16 will receive PZQ+ALB, and the remaining 12 HDs will receive ALB only with support from SCI.
6. 12 HDs currently have TF >5%. In FY18 9 HDs will conduct MDA and the other 3 will undergo impact assessment in November 2017 to determine if MDA is warranted.
7. Two TIS in Guidan Roumdji and Mayahi HDs will be re-programmed to FY18 (November 2017) due to a delay implementing the FY17 MDA and the need to conduct the TIS 6 months later.

PLANNED ACTIVITIES

1. Capacity Strengthening Strategy

Country's current ability to secure resources, implement, manage, and evaluate an integrated NTD program (need assessment)

Integrated control of NTDs began in Niger in 2007 with the creation of a National Coordination composed of a National Focal Point, based within the MoPH, supported by the three (3) Coordinators of National programs; The PNSO, the PNDOEFL, and the PNLBG. Apart from the USAID funds, mobilized through the END in Africa project, there are other partners such as the Carter Center, the World Bank, SCI, UNICEF, Sightsavers and WHO that support the MoPH for implementation of NTD interventions. Also, the MoPH and some development partners signed the Compact, which is a Memorandum of Understanding in the context of health sector funding. The aim of this Compact is to establish a joint platform, led by national authorities, that brings together the efforts of all stakeholders in the sector, from situation analysis and identification of sectoral priorities to implementation, and monitoring and evaluation of the Health Development Plan (Plan de Développement Sanitaire in French or PDS). It is supported by the PDS Common Implementation Fund. In view of the depletion of resources, especially for NTDs, following the withdrawal of certain partners and the attainment of the objectives of the elimination of certain NTDs, the MoPH is proposing to all its partners to join this common pool.

To better support integrated NTD control, the program has developed an NTD Master Plan 2017-2021 that integrates national strategies and WHO guidelines and aims to eliminate several NTDs in the near future (2020). For the implementation of this plan, the State mobilizes human resources for health and national education at central, regional, departmental and community level.

The main channels for resource mobilization used by the program are:

- Annual meetings for the preparation and evaluation of the Annual Action Plans of the various structures of the MoPH
- The annual meeting to develop the Work Plan of the MoPH
- Meetings of the Technical and Financial Partners of the MoPH
- National Forums
- National launches of mass campaigns
- Mass campaign evaluation meetings
- NTD coordination meetings
- Meetings of NTD stakeholders
- Advocacy meetings at district level

USAID supports all of the above activities, with the exception of the national forum and the meetings of technical and finance partners of the MoPH, which are supported by the World Bank. In FY18, the annual meeting to develop the work plan will be supported by other partners.

The program has several achievements to its credit, including the complete mapping of PCT NTDs, the organization of MDAs in all endemic HDs and implementation of several disease specific assessments (DSA). Gradually LF and trachoma endemic HDs continue to meet the criteria for stopping MDA. However, shortcomings persist. Some HDs struggle to achieve targeted coverage rates, and others despite the good reported coverage rates fail in TIS and must continue treatment. These insufficient results have different contextual causes but are also due to persistent shortcomings in the implementation of campaigns

(planning, order and management of drugs, MDA organization, MDA coverage data management, training).

These gaps persist because there is a lack of human resources at the national coordination, inadequate advocacy at all levels, and shortcomings in communication flow between national and partner actors.

Improvements are made each year in drug management, data collection, retrieval, and analysis. However, technical support to enhance the quality of MDA implementation is still needed as well as advocacy to strengthen the positioning and visibility of NTDs and improve coordination of NTD activities at the central and decentralized level.

Project strategy for capacity building for different technical, managerial, financial and operational functions:

For the proper implementation of the NTD program, technical, managerial, financial and operational capacity-building activities are planned each year. These various capacity building activities are carried out through the joint implementation of the activities (planning, document preparation of the program, ordering of drugs, drug dispatching plan, supervision, evaluation), various training courses (cascade training for MDA, training of surveyors, training on the management of fixed obligation grants (FOGs) and preparation of supporting documents), monitoring and evaluation of the quality of activities (independent monitoring, data quality assessment) that help to strengthen the systems. Thus, capacity building on the Integrated NTD Database (INDB) and the Data Quality Assessment (DQA) has been done to date and will continue in FY18. A key challenge is the constant movement of personnel, which means that trained personnel can find themselves in an area where their skills may not be useful and vice versa; this results in shortcomings in staff capacity and the need to re-train new staff from year-to-year.

Monitoring of capacity building and assessment of progress:

In support to implementation of NTD Master Plan activities, several capacity building activities have been carried out for NTDP staff. Mechanisms have been put in place to monitor and evaluate the progress made and the impact of different technical, managerial, financial and operational capacity building. These mechanisms are: supervision at all levels (central, regional, departmental and village levels) and annual review meetings at national, regional and sub-regional level. Improvements have been noted in the planning and execution of activities according to schedule, the timeliness and quality of reports, and in the quality of reported coverage data. Less localised stock out or drug expirations was observed in FY17.
On the other hand, some points not sufficiently supported will be reinforced, such as the staffing of the coordination of the NTDs in the MoPH for a better appropriation of the activities of the Program and the improvement of communication systems between the different partners.

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	• Technical assistance and support to workshop for the development of a transition plan for the treatment of STH in Niger • Support for coordination meetings • Validation of trachoma and LF surveillance plans	A clarified STH strategy will facilitate advocacy among new partners to take on STH treatment. Coordinating meetings facilitate coordination, problem solving and enhanced accountability, especially between the National Office of Pharmaceutical and Chemical Products (Office National des Produits Pharmaceutiques et Chimiques in French or ONPPC) and the Direction des Pharmacies et Laboratoires (DPHL). Clear guidance for HDs on surveillance after reaching LF and trachoma elimination criteria.
c. Building Advocacy for a Sustainable National NTD Program	• Support for the establishment of a committee to monitor the commitments made during the national NTD forum. Support to one annual meeting.	Monitoring of commitments will increase the chances of realization.
e. MDA Coverage	• Support to conduct coverage surveys • Support to independent monitoring of low performance HD (coverage or impact) • Support strengthening of the quality of supervision (see supervision section) • Strengthening the quality of MDA training (see training section)	Identification of problems attributed to low coverage in certain areas; implementation of solutions to improve coverage in preparation for DSAs
f. Social Mobilization to Enable NTD Program Activities	• Reinforced supervision and monitoring around effectiveness of social mobilization activities (see Supervision and M&E section)	Effective social mobilization strategies are implemented for MDA
h. Drug Supply and Commodity Management and Procurement	• Support to the national program to conduct physical drug inventory post-MDA • Support for drug transport	Enables timely drug delivery for MDAs and better reverse logistics management
j. M&E	• Support DQA • Support data collection and entry of historical data into the INDB.	Identify ways to improve the data collection system. Improve monitoring of the program and facilitate elimination dossier development.
k. Supervision for M&E and DSAs		
l. Dossier Development	• Training on compiling the elimination dossier to WHO • Meeting of the OEC	Improved understanding of dossier requirements and preparation of data for elimination dossiers.
m. Short-term Technical Assistance	See STTA section	

2. *Project assistance*

a. Strategic Planning

Location in Budget: Planning budget tab, subawards lines 108-110, ODC lines 143-147
Total cost for activities in this section: **$92,350**

1.	Strategic Planning		53,655,237	$ 92,350
7.1.a.	Annual Post-MDA Review Meetings at District Level	DRSP	9,242,500	$ 15,908
7.1.b.	Annual Post-MDA Review Meetings at Regional Level	National NTD Program, DRSP	14,621,764	$ 25,167
7.1.c.	Annual Post-MDA Review Meetings at National Level	National NTD Program	10,664,046	$ 18,355
8.1.a.	NTD Coordination Meetings	HKI	552,000	$ 950
8.1.b.	Onchocerciasis Elimination Committee	HKI	3,293,699	$ 5,669
8.1.c.	Annual Post-MDA Review Meetings at the Regional & National Levels (HKI attendance)	HKI	6,984,628	$ 12,022
8.1.d.	Workshop for development of a transition strategy for STH	HKI	5,558,300	$ 9,567
8.1.e.	LF and trachoma surveillance strategy validation workshop	HKI	2,738,300	$ 4,713

NTD coordination meetings (Three times a year) (ODC)
Quarterly meetings will be held with the National NTD Program (National NTD Focal Point, DPHL, DEP and Program Coordinators) and partners, including HKI, WHO, The Carter Center, the World Bank and SCI. The meetings will be held every three months to monitor and plan activities and find solutions to urgent problems arising during the implementation of activities. The meetings also provide the opportunity to fine-tune upcoming plans and address potential program changes. In FY18, special attention will be given to the MDA (planning, drug management/dispatching between HD and CSI, supervision) at each meeting. The meetings aim at a wide dissemination of information to all stakeholders, with the goal of determining concrete actions to solve the problems that arise. These meetings help improve the coordination between the different actors of the ministry, and between the different partners supporting the program for better synergy of action.

Onchocerciasis elimination committee (One meeting in FY18) (ODC)
OV control activities have been carried out since 1976 in Niger, and the disease is no longer a public health threat. The results of entomological and epidemiological assessments carried out over the past years indicate that OV is nearing elimination in Niger. The country is now committed to the process of demonstrating OV elimination and obtaining WHO verification. In line with WHO recommendations, an Elimination Committee was established to provide advisory support for the completion of the OV elimination dossier. The committee held its first meeting in January 2017. This meeting, which brought together national and international experts, made it possible to draw up a working agenda. According to this agenda, the committee meets twice a year or in case of necessity to decide on the activities that will be carried out for the control and monitoring of the disease, with the goal of demonstrating OV elimination. In FY2018, one OEC meeting will be supported by the END in Africa project during the second quarter.

Annual post-MDA review meetings (National, Regional, and District Levels) (Once in FY18) (FOG, ODC)
An evaluation and planning meeting is held at the end of the MDA campaign each year to capitalize on the lessons learned from the NTD program. The workshop brings together all key stakeholders (health, education and partners) to share the results of the campaign by HDs, to identify areas of strength, areas for improvement, lessons learned, and to make recommendations to improve future campaigns. To prepare for this national meeting, each region holds a regional assessment meeting that brings together the Governor, the administrative authorities, traditional leaders, DRSPs, Regional Department of National

Education, District Head Doctors, and the NTD focal points for education and health. A similar assessment meeting is also held at the district level with the health center heads, education sector heads and the administrative authorities and traditional leaders. The NTD programs also present their main activities for the coming year at these meetings to get feedback from the partners. The expected results of this review meeting are the sharing of the overall results of the NTD campaign as well as development of recommendations to improve future campaigns. Excel and PowerPoint reporting templates are provided to districts and regions to harmonize reporting. Support from the central level is provided prior to these meetings to ensure completion of the tools prior to the meeting (see Supervision). END in Africa support is required for one national review meeting in FY18; however, this cost will be split with SCI.

Workshop for development of a transition strategy for STH (Once in FY18) (ODC)
A five-day meeting will be organized to develop the transition strategy for the treatment of STH – three days in an expanded group and two in a select committee for the finalization of the document. The workshop will bring together NTD stakeholders; NTD programs, DEP, Health Promotion Directorate (DPS), School Health Office of the Ministry of National Education, National Health Information System (System National De l'Information Sanitaire in French or SNIS), Directorate for the Organization of Care, DPHL, UNICEF, World Bank, HKI and SCI. The objective of this workshop is to develop a sustainable and integrated strategy for the treatment of STH following the end of LF campaigns. Clarification of the strategy will facilitate advocacy for its funding and its multi-sectoral implementation. This workshop will be held in FY18 Q1 to ensure that the STH transition plan is finalized by the end of March 2018.

LF and trachoma surveillance strategy validation workshop (Once in FY18) (ODC)
As part of the target for LF and trachoma elimination by 2020, two surveillance plans have been developed by the PNSO and PNDOEFL. The aim of this activity is to amend and validate these documents during a plenary meeting so that programs can have clear guidance for HDs when they reach elimination criteria for LF and/or trachoma. It will be a three-day workshop that will bring together participants from MoPH such as the NTD coordination unit, NTD programs, the Health Statistic Directorate, and others, including HKI.

b. NTD Secretariat

Location in Budget: Planning budget tab, ODC lines 149-150
Total cost for activities in this section: **$3,041**

2.	NTD Secretariat		1,803,150	$	3,104
8.2.a.	Support to the NTD Focal Point, PNLBG, and PNDOEFL	HKI	1,117,890	$	1,924
8.2.b.	Support to the MoPH's Direction of Pharmacies and Laboratories	HKI	685,260	$	1,179

Support for the NTD Focal Point, the PNLBG, and the PNDO/EFL (Every month or quarter)
The National NTD Focal Point requires support for its work. This support will consist mainly of office supplies and fuel. The World Bank will support office renovation and security guards for the MoPH. HKI will continue providing logistical support in FY18.

In FY18, the PNLBG will receive support from SCI for operations while the PNSO receives this support from HKI and the Carter Center through funding from the Conrad N. Hilton Foundation. The PNLO/EFL will continue to receive END in Africa support for telephone, internet and computer supplies.

Support for the MoPH's Pharmacy and Laboratory Directorate (Every month or quarter)

The DPHL is the organization that manages the drugs of the national health programs and non-governmental organizations (NGOs) in Niger. Thanks to its activities within the organization, the Ministry has begun to take an active part in managing NTD drugs. The DPHL focal point will continue to provide support to the various NTD programs in collaboration with the HKI logistics manager to coordinate all activities for NTD drug management before, during and after the campaigns. This includes storage, packaging, shipment, delivery, reporting and post-MDA inventory and other activities related to supply chain management. HKI support to the DPHL focal point will consist of internet, phone, office supplies and fuel support.

c. Building Advocacy for a Sustainable National NTD Program

Location in Budget: Planning budget tab, ODC lines 152-155, subawards lines 113-114

Total cost for activities in this section: **$32,896**

3.	Advocacy		19,112,845	$	32,896
7.3.a.	National Launch of the mass distribution campaign	National NTD Program	4,727,750	$	8,137
7.3.b.	Advocacy Meetings at the Health District Level	DRSP	2,735,000	$	4,707
8.3.a.	Commitments Committee	HKI	780,000	$	1,343
8.3.b.	Meetings with Regional Governors	HKI	4,220,595	$	7,264
8.3.c.	National Stakeholders Meeting	HKI	1,752,500	$	3,016
8.3.d.	National Launch of the mass distribution campaign	HKI	4,897,000	$	8,429

Government support through the MoPH is currently provided via an NTD-dedicated budget line, although it is difficult to mobilize those funds. Another budget line exists for MoPH projects and programs that support the NTD programs, but overall, local financing of NTDs is weak and inconsistent. It is difficult to mobilize resources for NTDs due to Niger's security problems and its multitude of health competing priorities, namely vaccination campaigns and the fight against malnutrition and malaria, which absorb a large share of the Ministry's funds and attention.

In FY17, as part of implementation of program activities and to strengthen advocacy and improve program visibility, several meetings were held with MoPH officials, the NTDP and HKI. These meetings were held during the courtesy calls HKI requested with the MoPH and the General Secretary, during working visits with these same officials, or during partner meetings called by the MoPH. HKI took advantage of these meetings to request increased support from the Government for NTDs, along with USAID's efforts, and to identify ways and means to sustain NTD activities. In FY18, the WHO, the leading advisor of the MoPH, will be asked to support efforts to strengthen advocacy activities with the goal of creating a sustainable NTD program in Niger.

In addition, Niger has recently obtained a loan from the World Bank through the Sahel Malaria/NTD project. This loan could be leveraged to improve visibility and motivate the MoPH to invest in the fight against NTDs. However, advocacy is still needed to improve the visibility of and interest in the program at the MoPH. Advocacy will focus on creating ongoing surveillance systems for diseases targeted for elimination – trachoma, OV and LF – and integrated treatment platforms for control diseases, including SCH and STH, as well as monitoring capacity using the NTD integrated database.

It is within the above context that the following activities have been planned for FY18:

Commitments Committee (once a year) (ODC)

A national forum will be held in September 2017 with financial support from the World Bank, during which contributions to the NTD program will be encouraged to continue NTD activities, establish post-MDA surveillance systems and implement sustainable NTD control strategies. Contributions from the MoPH,

parliamentarians, municipalities and other public and private sector players will be sought. A committee responsible for monitoring the commitments made during this forum will be set up and will meet during FY18 to follow up on the pledged commitments. Monitoring will take several forms. At the regional and district levels, health officials (i.e., regional health managers and district chief medical officers) will make mid-term visits to authorities who pledged commitments and will present the status of those commitments during the national assessment. The central level will also organize visits to authorities in Niamey and will delegate the regions to organize regular visits to local authorities. Monitoring of commitments will also be integrated into field supervision of activities, as appropriate. END in Africa will support one committee meeting in FY18.

Meetings with the regional governors (once a year) (ODC)

Meetings will continue with governors of the regions to obtain their buy-in for the NTD programs and their specific support for the MDA in their region. The governor has the authority to sign the regional FOGs and ensures that regional health directors execute planned activities. HKI handles the preparations for the meetings, working with the Ministry and local authorities to ensure that the governor attends. MoPH authorities (central and regional) and HKI managers take part in these meetings, at which an overview of the project is presented and the governor's involvement is sought. The governor is expected to inform the authorities of the regional departments of the presence of the supervision teams, facilitate inter-departmental support for logistical aspects, encourage religious and customary authorities to support the CDDs' work (in-kind and other), and help resolve problems (refusal management, reallocation of drugs from one region to another, etc.).

The first meeting is critical because the governor reports to the Ministry of the Interior although, per the contract, the MoPH is responsible for carrying out these activities. The meetings have been effective in raising governors' awareness about the importance of the NTD program and the goal of the FOG contracts. It concludes with the signing of the region's FOG(s).

National Stakeholders Meeting (once a year) (ODC)

This is an inter-sectoral steering committee (representatives from the Prime Minister's Office, the National Assembly, the Ministries of Health, Education, Finance, the Environment, Population, the Promotion of Women and the Protection of Children, the Interior and Communications) that will promote the integration of activities and be responsible for approving major strategic directions and the search for new funding if required. The committee will act as a pressure and defense group for the NTD program with high MoPH authorities and other partners (led by the sponsor, who will be determined by the MoPH). The program will communicate with the committee to organize NTD planning meetings and for social promotion and mobilization.

National launch of the mass distribution campaign (Once a year) (ODC and FOG)

An official launch ceremony is held to mark the start of the MDA each year. The launch, sponsored by the MoPH, provides the program with an official seal of approval and increases its visibility. It brings together everyone involved in NTD prevention and elimination, including the authorities of the MoPH and other ministries, administrative, local and traditional authorities, associations and non-governmental organizations (NGOs) and all other entities that provide support to the NTD program. This year, the NTD program would like the launch to take place in the region of Agadez, where trachoma is experiencing a resurgence.

Advocacy meetings at the health district level (Once a year) (FOG)

These are preparation meetings prior to the start of the MDA in each health district. The meetings bring together district prefects, town mayors, canton heads, religious leaders, associations, NGOs, health and education representatives and all other MDA partners. The primary goal of the meetings is to mobilize the local partners to ensure their contribution to the MDAs, they motivate the CDDs and the supervisors, and they provide transportation (motorcycles, fuel, etc.). The HDs increasingly report instances of community contributions. These include motorcycles, animals, and fuel for CDD transportation. Contributions will be monitored via reminders/awareness-raising during meetings and/or supervision at the regional, district and CSI levels. They will make it possible to gather statements from a sample of leaders and to record the contributions received at all levels.

d. Mapping

Location in Budget: N/A

Total cost for activities in this section: $0 (covered by another donor)

Niger completed mapping of the PCT NTDs in 2014. However, some HDs have a need for trachoma mapping due to gaps in the initial mapping (i.e., urban areas of Maradi Commune, Niamey 1, Niamey 2 and Niamey 3, Niamey 4, and Niamey 5). HKI plans to support mapping in these areas in 2018 with funds from the Conrad N. Hilton Foundation.

e. MDA Coverage

Location in Budget: Planning budget tab, subawards line 124

Total cost for activities in this section: $167,321

7.	**MDA Distribution**		97,213,675	$ 167,321
7.7.a.	Costs for Drug Distribution by CDDs	DRSP	97,213,675	$ 167,321

Table 4: USAID supported coverage results for FY16

NTD	# Rounds of annual distribution	Treatment target (FY16) # DISTRICTS	# Districts not meeting epi coverage target in FY16*	# Districts not meeting program coverage target in FY16*	Treatment targets (FY16) # PERSONS	# persons treated (FY16)	Percentage of treatment target met (FY16) PERSONS
LF	1	21	Diffa (14.4%) N'Guigmi (45.6%)	Diffa: 18% N'Guigmi: 47.0%	7,753,729	7,189,384	92.72%
OV	0	N/A	N/A	N/A	N/A	N/A	N/A
SCH	1	30	Agadez (54.89%), Arlit (52.57%), Mirriah (33.52%), Matamèye (42.73%)	Agadez (68.7%), Arlit (65.7%), Mirriah (74.2%), Matamèye (51.2%)	2,367,481	1,908,710	80.62%
STH	1	34	Agadez (54.89%), Arlit (55.01%), N'Guigmi (ND)	Agadez (68.6%) Arlit (68.8%) Diffa (18%) N'Guigmi (57%)	9,279,921	8,340,596	89.88%
TRA	1	9	Mainé Soroa (49.4%), Guidan Roumdji (67.5%), Madarounfa (79.0%), Mayahi (78.7%) Tessaoua (53.4%) Sub-district N'guigmi (37.3%)	Mainé Soroa (49.4%), Guidan Roumdji (67.5%), Madarounfa (79.0%), Mayahi (78.7%) Tessaoua (53.4%) Sub-district N'guigmi (37.3%)	3,934,515	3,195,147	81.21%

			Sub-district Dakoro (62.5%)	Sub-district Dakoro (62.5%)			

*Epi and Program coverage as defined in the workbooks

Reasons for poor district performance

At the time of elaboration of the workplan, the evaluation of the FY17 MDA campaign was not done. But in FY16 several reasons for low coverage were identified and some of them may still apply for FY17. These include:

- **The overlap of MDA activities with other community based activities** implemented by other health programs, particularly with JNVs. The same community volunteers (CDDs) are implementing the different health interventions. As per MOH policy all other field activities must stop during NIDs. HKI-Niger will continue to coordinate with the WHO (they primarily support the vaccination campaigns) to ensure that NTDs remain a priority and to develop a plan for implementation of both campaign-based activities in FY18.

- **Differences in CDDs compensation across health activities.** The compensations received by the CDDs for the NTD MDA are not the same as for the NIDs. During the NIDs, community distributors receive CFAF 2,500 per day (for a total of four days). For MDA, they receive only 2,500 CFA per batch of medicines (for four to seven days of distribution) with a maximum of 7,500 CFA per NTD MDA. Drug distribution may last as long as one month, depending on the number of batches of drugs and on local geography. This affects CDDs' motivation.

- **Workload and challenging conditions for CDDs** working in desert areas where they walk long distances. This continues to be a challenge despite the improvement in CDD workloads in FY16 (before FY16, each CDD had to treat 500 people; the number was reduced to 300 in FY16).

- **Poor recording of treatment in registers by CDDs.** Supervision always reports cases of CDDs that do not properly complete distribution tools.

- **Difficulties in defining the target population/denominator per district:** While the NTDP uses projections from the last census (2012) to identify MDA target populations and report coverage (as shown in Table 4), the HD uses another reference (communal population), and this creates a level of non-concordance in the population data. Also, in some parts of Niger the populations are very mobile. This means total population figures may not be accurate at certain times of the year. For example, the period after harvest when a significant part of the population leaves Niger to look for work. In recent years, a large part of the population has moved from the Diffa region to the Zinder region due to insecurity thereby increasing the population of Zinder and affecting MDA coverage rates.

- **Localised stock out in the HD and CSI** caused by poor drug dispatching between CSI and the HD.

Strategies to Improve MDA coverage in FY18

The following strategies will be adopted to improve MDA coverage in FY18:

- To avoid overlap of activities (NIDs/MDA), the dates of the campaign will be communicated to the DEP for inclusion in the MoPH's activities master calendar. The first MDA campaign will be organized with the drugs already in country and thus delays due to drug delivery can be avoided.

- To reduce the workload of CDDs, there has been a decrease in the number of people each CDD should cover since FY16 (before FY16, each CDD had to process 500 people, this number has fallen to 300 in FY17), in FY2018 there will likely be another reduction in the workload of these CDDs in the border HDs covered by the NTD/Malaria project in the Sahel (17 of the 44 HDs), thus reducing the number of people to be covered by each CDDs to 100 people.

- CDD training will be reviewed in FY18. In FY17 already, some CDDs have received more practical training, using techniques such as role play. This year, all training will be done on this basis. Each cascade training will be supported by the higher level (the central level will support the regional level and the regional level will support the district). This will help improve the quality of the training given to CDDs and the rate of registration of people receiving treatment. Improved training will also have a real impact on the number of people treated and treatment coverage rates.

- Supervision will be strengthened at all levels through a greater number of teams led by the MOH Coordinator. This will improve both CDD training and MDA. The role of the central level coordinator will be to ensure that the distribution is in line with standards and to facilitate the resolution of problems faced by the field teams. He/she will be in direct contact with the NTD Coordinators and the HKI NTD Manager to solve the most critical problems. The chief medical officer of each HD will be responsible for managing CDD monitoring by the heads of health centers (CSI). Local supervision of CDDs by CSI heads will improve the quality of the completion of the of MDA data registers.

- A DQA survey will be conducted at the national level to obtain an accurate assessment of the quality of distribution data and identification of gaps in the data collection system at all levels and identify leads for improvement.

- Before the start of MDA, a drug inventory will be requested for each structure by the higher level. This will improve the management of drugs. The volume of drugs ordered, calculated in relation to the remaining stock will be more accurate and the number of people treated more realistic. This will avoid drug stock outs.

- At each level, the supervision will make a rapid evaluation of the MDA coverage. This will improve the quality of data collection.

MDA plans for FY18

Like FY17, Niger will split the FY18 MDA into two separate campaigns. The first MDA campaign is planned for November 2017 in Maradi for LF with the drugs already available in-country and for trachoma in nine HDs. This first campaign is unlikely to be delayed given the availability of drug and will also allow enough time for surveys planned for trachoma to be carried out six months after MDA (May 2018). The second MDA campaign will be organized later, tentatively in February 2018, when the other drugs that are ordered through the WHO donation program (ALB, PZQ and IVM) are expected to arrive in country. The strategy of splitting the MDA campaign worked well in FY17, primarily because the Zithromax arrives when the PNSO requests it (November), while the other drug typically arrives later in the fiscal year. In addition, the different programs have noted it is an enormous logistical effort to try and coordinate all the MDA to take place in the same period, and splitting them eases the burden. Below, we detail the MDA by disease and drug package:

Trachoma:
In FY18, nine HDs will receive MDA with Zithromax and 1% TEO. The total target population is 4,682,615, which is 100% of the population in the targeted HDs. CDDs will distribute the drugs using the door-to-door strategy and teachers will treat children in schools. END in Africa will support the costs of drug distribution while The Carter Center will cover the cost of purchasing the TEO. The MDA is planned for November 2017.

Lymphatic filariasis
A total of 16 HDs will be treated for LF in FY18 (IVM + ALB), pending the results of the TAS 1 that will be conducted in July 2017 in three HDs in the Diffa region. The target population is 5,936,555 individuals aged five years and above. The first LF MDA campaign is planned in the Maradi Region in November 2017 and the second campaign will be conducted in the other regions in March 2018. END in Africa is the sole partner for LF distribution in Niger and will support MDA in all 16 HDs.

Schistosomiasis
SCH MDA will be implemented during the second MDA campaign in 22 HDs with support from SCI. HKI and SCI will co-finance integrated MDA for SCH and LF in six HDs (Diffa, Maine Soroa, N'Guigmi, Gaya, Tchintabaraden and Tessaoua). A total of 4,910,520 people will receive MDA for SCH with all funding sources combined (END in Africa and SCI), while END in Africa support will target 1,159,672 persons. The PZQ for school-aged children will be obtained through the WHO donation program and SCI will purchase PZQ for adults. The PZQ will be distributed by CDDs through a door-to-door strategy and by teachers in schools.

Soil-transmitted helminths
All 44 endemic HDs will receive treatment for STH in FY18. With END in Africa support, STH treatment will be combined with LF MDA in 16 HDs. SCI will support SCH/STH treatment in 16 other HDs and will also conduct STH-only MDA in the remaining 12 HDs. The END in Africa target population is 5,936,555 school-aged children.

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

NTD	Age groups targeted (per disease workbook)	Number of rounds of distribution annually	Distribution platform(s)	Number of districts to be treated in FY18[5]	Total number of eligible people to be targeted in FY18
Lymphatic filariasis	5 years and above	1 time/year	Door-to-door in the community and at fixed school sites	16[1]	5,936,555
Onchocerciasis	N/A	N/A	N/A		
Schistosomiasis	-School-age children -High-risk adults in endemic villages	1 time/year 2 times/year 1 time/every 2 years	Door-to-door in the community and at fixed school sites	6[2]	1,159,627
Soil-transmitted helminths	-School-age children (5-14 years)	1 time/year	Door-to-door in the community and at fixed school sites	16[3]	5,936,555
Trachoma	0-6 months 6-59 months 5 years and above	1 time/year	Door-to-door in the community and at fixed school sites	9[4]	4,682,615

1. Three HDs in Diffa region will conduct TAS1 in July 2017. If the HDs pass, only 13 HDs will plan MDA in FY18.
2. SCI will support 22 HDs for SCH MDA, 6 of which will receive integrated LF/SCH/STH MDA with co-financing from HKI. Out of the 43 endemic HDs, 21 will not treat in FY18 in accordance with the national treatment strategy (i.e., these 21 HDs treated every 2 years).
3. All 44 endemic HDs will receive treatment for STH in FY18: 10 HDs will receive IVM+ALB for LF/STH (fully funded by END in Africa); 6 HDs will receive IVM+ALB+PZQ for LF/SCH/STH (funded by END in Africa, with SCI paying the CDD stipend for the PZQ drug package); 16 HDs will receive PZQ+ALB for SCH/STH (funded by SCI) and 12 HDs will receive ALB only for STH (funded by SCI).
4. Trachoma MDA will be conducted in Ouallam, Bilma, Tchirozérine, Tessaoua, Magaria, Gouré, Mirriah, Mainé Soroa, and N'Guigmi HDs.
5. The number of HDs may differ in the workbooks as Niamey 4 and Niamey 5 HDs have not yet been added to the FY18 workbooks, but are counted here in Table 5. In addition, the budget reflects more HDs as it accounts for the recent redistricting; however, the new redistricted workbooks are not yet available.

f. Social Mobilization to Enable NTD Program Activities

Location in Budget: Planning budget tab, ODC lines 157-158, subawards lines 116-118

Total cost for activities in this section: **$83,762**

4.	IEC/Community Mobilization		48,665,719	$ 83,762
7.4.a.	Community Mobilization (Radio) before MDA at the Community Level	DRSP	1,500,000	$ 2,582
7.4.b.	Community Mobilization (Crier/Relai) before MDA at the Community Level	DRSP	23,850,000	$ 41,050
7.4.c.	Awareness-Raising Caravans at the Community Level	National NTD Program	7,175,719	$ 12,351
8.4.a.	Development of TV & radio spots	HKI	1,500,000	$ 2,582
8.4.b.	Dissemination of Health Messages before MDA	HKI	14,640,000	$ 25,198

Social mobilization strategies include mass communication and interpersonal communication. Mass communication is used to convince populations of the benefits of the treatments and avoid the spread of false rumors. Interpersonal communication increases the coverage rate and creates positive support.

Mass communication

The NTDP will conduct dissemination of messages using mass media – national television, national radio, community radio stations – with USAID funding. Mass communication is also done through private radio and television stations with other funding (Sightsavers, SCI/RISEAL, The Carter Center).

National radio and television: These media provide national coverage for the broadcast of key NTD messages. Activities include the transcription, creation and broadcast of radio and television messages via national television and radio. The messages focus on three topics: "Neglected tropical disease transmission and prevention," "Treatment of neglected tropical diseases," and "Benefits of treating neglected tropical diseases". Each of the topics is provided in three languages (French, Hausa, and Zarma, which are the most widely spoken throughout the country). The MoPH issues a televised announcement notifying the public of the campaign dates, the diseases concerned, the target audience, and the availability of treatment free of charge. The national television and radio stations have country-wide reach and are the best way for the NTDP to reach the largest possible audience in all eight regions. Radio will be emphasized in rural areas and television in urban ones. The messages are recorded and distributed on compact discs nationwide so that the same messages are broadcast throughout the country.

- For television, the spots are broadcast in the three languages alternating once a day (before shows, before the news at 8:30 pm and after the regional news) for a month.
- Radio messages on the national station are broadcast in the three languages each day (12:55 pm, 2:00 pm and 2:30 pm), also for one month.

- Contracts are signed each year with community radio stations at the district level for the broadcast of NTD messages to reach a significant portion of the population before, during and after the MDAs. This ensures all social strata are informed of the distribution. Messages are broadcast at least twice a day in all local languages. There are interviews with health communicators and CSI heads as well as testimonials from community leaders about NTDs.
- Town criers: Each town crier works in a limited geographical area consisting of three to five villages/hamlets and a weekly market. They go up and down all the village streets and lanes in the morning and evening with a tamtam (a drum) to inform the population that community distributors will be coming to the village on a specific date to encourage people to stay in the village and wait for the CDDs.

Financial support from the END in Africa project will be required for the mass communication activities for the MDAs.

Interpersonal communication

- Community distributors: Each community distributor must have a certain number of points of contact (households, concessions, wells), which they visit every day to raise awareness about NTD topics (modes of transmission, treatment and prevention of NTDs) and distribute the drug packages. There is no additional budget line needed for this, as CDDs receive compensation for drug distribution.
- Women liaisons (relais): The use of women relais in the communities began in FY14. The practice will be continued and increased, particularly in regions of Niger where men are not allowed access to homes when the male head of the family is absent. They go from house-to-house and inform the population about the diseases and treatment and convince them to accept the drugs.
- Awareness-raising caravan about NTDs for local populations: This coordinated activity raises awareness of a wide audience by bringing local residents together in one location (such as a public square) in large villages. Awareness-raising sessions are held during the evenings via videos, debates, skits, role-playing and the distribution of flyers and posters about NTDs. The videos are followed by group discussions about the diseases and the benefits of taking the drugs. Question and answer games also involve the audience and tee-shirts and baseball hats are given out.

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.
Participation in mass distribution	-"Neglected tropical disease transmission and prevention," "Treatment of neglected tropical diseases," and "Benefits of treating neglected tropical diseases".	Entire population	-Mass communication (national radio and television, community radio stations; flyers, posters, baseball caps and t-shirts)	-Via television and radio before and during the MDA -Flyers, posters, baseball caps and t-shirts	-TV and radio: three times a day per language for a month -Flyers, posters, baseball	• # of televised message broadcasts • # of radio message broadcasts • # of community radio stations used • # of posters, flyers, baseball caps and t-shirts distributed

	-Date of distribution		-Public criers	during the awareness-raising caravans	caps and t-shirts during the awareness-raising caravans	• % epidemiological coverage for each disease • Independent monitoring will capture data on the channels through which information on the MDA campaign was received by participants
Disease Prevention	-Participation in MDA -Sleeping under mosquito nets -Face and hand washing -The correct use of latrines -Environmental health	Entire population	Inter-personal communication (town criers, women liaisons, awareness-raising caravan)	-Door-to-door before and during the MDA Community -level gatherings	-Morning, afternoon and evening for three weeks -Caravans: one visit each in four HDs, 12 CSIs and 36 villages	• # of message broadcasts • # of women liaisons used • # of public criers used • # of villages covered by the caravan • % epidemiological coverage • % change in epidemiological coverage in HDs between FY16 MDA and FY17 MDA • Independent monitoring will capture data on the channels through which information on the MDA campaign was received by participants

g. Training

Location in Budget: Planning budget tab, ODC line 165, subawards lines

Total cost for activities in this section: **$776,879**

5.	Capacity Building/Training		451,366,880	$ 776,879
7.5.a.	Training on Trachoma Survey Methodology	PNSO	10,373,980	$ 17,855
7.5.b.	Cascade Training/Refresher Training for MDAs	National NTD Program, DRSP	440,000,400	$ 757,316
8.5.a.	Independent Monitoring Training	HKI	992,500	$ 1,708

Training of PNDO/EFL technicians on ELISA technique (travel budget)

The ELISA test will be used to confirm the results of the rapid tests (RDT OV16 and ICT) recommended by the WHO to demonstrate that OV transmission has stopped and to confirm its elimination. The PNDO/EFL has a laboratory built with funds from the Nigerien government and that is now equipped. It will receive and test the samples to be gathered from the OV and LF surveillance network in HDs that have stopped

LF treatment. Capacity-building for the laboratory personnel will enable them to test samples from Niger and receive samples from other countries as a quality control measure for their laboratories. To ensure quality control, a sample of the tests will be sent to another laboratory (such as the one in Accra). END in Africa support is requested to send two PNDO/EFL staff to Accra to undergo a training on the ELISA technique.

Independent monitoring training

Independent MDA monitoring was implemented in FY14 for the first time. It has proven to be very helpful for district MDA monitoring and for identifying the areas in which greater monitoring or support may be required. The activity will continue in FY18. It is carried out in HDs with poor coverage, or in those where problems or shortcomings have been reported by the agents involved in implementing the distribution campaign. Monitoring will begin with the training of 15 people independent of the NTDP to ensure their impartiality during data collection. The training will be provided by HKI M&E staff. The information collected by the surveyors will consist of variables such as age, gender, whether the person has been treated or not, the reasons why they were not treated, the channels through which the information about the campaign was received, an interview with health agents and CDDs about the campaign process, etc. A debriefing will be held every day to inform health agents about the findings in the survey areas. Decisions for improvements will be taken immediately to improve MDA coverage.

Eye technician training/refresher training in trachoma survey methodology

Eye technicians will receive training on the trachoma survey methodology used in the field. This is necessary because the trachoma operating procedure protocol requires a random sampling of households in the field, which first requires an exhaustive survey of all existing households in the villages selected for survey. In addition, identification of the various forms of trachoma (based on the WHO simplified grading system) requires special training as presentations of other ocular conditions resemble certain clinical signs of trachoma. Further, many of the technicians do not know how to grade trachoma. After the training, participants will take a test to identify those who will be coders and those who will be reporters. The technicians will also receive first-time or refresher training in the use of smartphones and tablets to collect data with Tropical Data.

Training on TAS 1 and TAS 2 survey methodology

Prior to TAS1 or TAS2, the PNDO/EFL, with support from HKI, will organize a training for field workers conducting the surveys. The training will bring together district physicians, laboratory technicians and CSI heads at district or regional headquarters level to review the survey protocol, including correct methodology for sampling of the population and households, and to train surveyors on the use of the diagnostic test (FTS). Random draw of the clusters to be evaluated and identification of the villages and their corresponding CSI will be done with the participants.

Training for other DSAs (see M&E section)

Trainings are held prior to all other DSAs for the field workers conducting the surveys to ensure that they understand how to use the diagnostics and know the correct households and populations to survey.

MDA cascade training/refresher training

In order to ensure capacity building for the people involved at all levels, Niger's NTDP will organize training/refresher training for trainers and national supervisors (MoPH and education program agents); at the regional level (DRSP, Regional Directorate for National Education, NTDP regional health and education focal points, education inspectors, district head doctors, NTDP district health and education focal points); at the district level (pedagogical sectors, CSI heads); and at the village level (teachers and

CDDs). The training/refresher training for all levels of health staff will take place before the MDA campaign. The central level trainers and supervisors (NTDP coordination) will participate in training of trainers. They will then be responsible for training regional staff, who in turn, will train the district personnel. The district personnel will then provide training to the CSI heads and educational sector heads who will in turn train the CDDs and teachers. In FY18, cascade training for MDAs will again be carried out using the revised module based on the Information and Logistics Management System which was introduced to Niger with technical assistance from John Snow, Inc. (JSI).

HKI will work in close collaboration with the NTDP to conduct central trainer debriefings and create trainer teams by training group and a schedule for the training of regional trainers. At the regional level, MDA training will be paired with Supply Chain Management training (inventory management, post-campaign stocks, return of remaining drugs and tools) and clearing out/reorganization of drug storage areas over three days. Supervision will be done during the MDA to assess the performance of health agents at various levels and of CDDs. A monitoring audit list will be prepared to ensure standardized and complete supervision.

Table 7: Training targets

Outline all USAID-supported planned training activities in country

Training groups may include default groups found in workbooks

Training Groups	Training Topics	Number to be Trained			Number Training Days	Location of training(s)	Name other funding partner (if applicable, e.g., MOH, SCI) and what component(s) they are supporting
		New	Refresher	Total trainees			
Training of PNDO/EFL technicians on ELISA technique	• Methodology of the techniques of the ELISA chain	2	0	2	15 days	Accra, Ghana (see International Travel in Budget)	None

Training of CSI and sector heads	• Diseases, filling in of media, side effects, drug management	250	400	650	1	All HDs with MDA	None
CDDs and teacher training	• Diseases, filling in of media, side effects, drug management	5,735	34,922	40,657	1	All health centers with MDA	None
Senior ophthalmological care technicians	• Trachoma survey methodology	24	0	24	3 sessions, 5 days each	Maradi	None
Independent Monitors	• General information on NTDs targeted by this MDA campaign, methodology, the various data collection tools, basics on data collection using tablets, role playing	3	12	15	2 days per session (including one practical day in the field)	Niamey (one day outside of Niamey for practical session)	None
Laboratory technicians, Focal Points and CSI Chiefs for TAS 1 and TAS 2	• Training on TAS 1 and TAS 2 survey methodology	450	220	670	2 days	HDs with TAS1 and TAS2	None

h. Drug supply and Commodity Management and Procurement

Location in Budget: Planning budget tab, subawards lines 126-127, ODC line 164

Total cost for activities in this section: **$67,196**

8.	Drug and Commodity Supply Management and Procurement		39,040,678	$ 67,196
7.8.a.	Storage, Repackaging and Distribution of Drug	ONPPC	24,286,120	$ 41,801
7.8.b.	Transport of Materials and Drugs for MDA from	DRSP	11,361,973	$ 19,556
8.8.a.	Drug Storage, Security, and Logistics	HKI	3,392,585	$ 5,839

Given the problems Niger has experienced in NTD drug management, particularly regarding drug expiration on a recurring basis, an emergency plan was developed in FY16 to improve the situation. Implementation was successful in FY17. During the supervision, there were no warnings of expired drugs or drugs nearing expiration. A post-campaign inventory is underway following the second FY17 MDA campaign and will provide precise, updated information on drug stock. Although the FY17 campaign evaluation has not yet been conducted, we can confirm that no major expiration was noted during MDA supervision.

Drug quantification

The quantification of drugs needed is done by the MoPH via the program coordinators. It is based on district eligibility for the MDA (survey data), the population data provided by the MoPH's National Health Information System, the calculation keys (specific to each drug) and remaining stocks (the result of a physical inventory).

The population is broken down by target per the type and/or form of drug: tetracycline ointment, Zithromax syrup and Zithromax tablet, Mectizan, STH, and SCH populations.
Next, quantification is done based on the type of drug by target:

- Tetracycline ointment 1% (children less than six months old): 2% of total population
- Zithromax syrup (6 to 59 months): 18% of total population
- Zithromax tablets (5 years and older): 80% of total population
- Ivermectin (5 years and older): 80% of total population
- Albendazole (5 years and older): 80% of total population
- Praziquantel (5 years and older): 100% of school aged children (in and out of school) in endemic HDs targeted for MDA + 50% of adults in endemic villages in the HDs targeted for MDA.

Preparation of the joint request for selected medicines (JRSM) form

Following the MDA National Assessment for the past year (FY17), the PNDO/EFL and PNLBG completed the Joint Drug Request Form, which includes the results of the previous campaign, epidemiological data, and the drug needs for the next year's MDA. The form was signed by one of the coordinators and then sent to WHO Regional Office for Africa (AFRO) for review in April 2017. In FY18, the WHO joint application package (JAP) will be used for IVM and ALB as well as for PZQ. The PNSO will request Zithromax® from the International Trachoma Initiative (ITI). Requests are reviewed and approved by the Trachoma Expert Committee (TEC). To limit mistakes and delays in the joint order, the NTD program, the programs concerned, DPH, HKI and the support partners will meet to jointly determine the drug needs. This meeting will also improve coordination among the donation sources.

Clearance, transportation and storage in the country

The WHO and the Niger government provide payment for transportation of the drugs to Niger and customs clearance. Once in country, the drugs are stored in ONPPC warehouses (the ONPPC is a MoPH body responsible for drug management) based on an agreement between the ONPPC and HKI.

To ensure the ONPPC can efficiently and correctly manage the drugs and tools, it is very important the NTD focal points send the consolidated plans for the distribution of the MDA drugs and tools to the ONPPC at least two months before the MDA (it takes two to three weeks to package and three to four weeks to transport them to the HDs). Also, for purposes of quality control, the NTD Focal Point will be asked to systematically copy HKI and DPH staff on the distribution plan sent to the ONPPC. HKI and the DPH can thus verify the distribution prepared by the central level. The ONPPC delivers the drugs and tools (dose poles and registers) to the HDs based on the distribution plans provided. The NTD health district's focal point then delivers the drugs and tools to the health center level. The distribution among the health centers is developed at the district level based on the population of the health area and the calculation keys provided. Similarly, the distribution among communities in a single health area is done by the health center.

In addition to the contract with the ONPPC, the NTD program will continue to work with the DPHL for logistics purposes. This MoPH department was created to manage all the drugs used by the MoPH via a focal point whose role is to support the ONPPC and the MoPH's National NTD Focal Point in managing NTD drugs. The support will include completing WHO joint reporting forms, drug management, informing all partners upon receipt of shipping documents, and support for reception of medicines and storage at the ONPPC until the establishment in health facilities.

The ONPPC, via the National Public Health and Reference Laboratory (Laboratoire National de Santé Publique et d'Expertise (LANSPEX)), will be responsible for the control of quality of NTD drugs entering Niger. For this purpose, it is important that the drugs arrive at least one month before their delivery to

the HDs for MDA to enable LANSPEX to control the drugs and ensure they meet the standards required by the government prior to the MDA.

Reverse logistics

After the end of the MDA, the CDDs must send all remaining stocks of drugs to health centers. The heads of the health centers must return the remaining stocks to the HD during the MDA assessment meetings. The HDs retain the drugs and notify the regional levels of the stocks remaining during the regional evaluation meetings. Immediately following the regional assessment meetings, data on the quantities remaining are sent to the National Focal Point to prepare the national assessment. This year, special emphasis will be given to verifying the remaining stocks sent to the HD level during the joint supervision by the HKI logistics manager and the DPHL Focal Point. The supervision will last several weeks and be conducted in all HDs receiving a MDA.

Waste management

Expired product, dose poles, empty bottles and boxes must be managed at all levels:

- At the Health Center level: At the end of the campaign, and following the sub-regional assessments and the physical inventory of drugs and tools, the Health Center heads will be authorized to destroy the empty bottles and boxes used for the campaign in accordance with the destruction guidelines set by the MoPH. The drugs and dose poles inventoried will be sent to the district level.
- At the HD level: A destruction committee is responsible for destroying all expired drugs in accordance with destruction procedures established by the MoPH. Non-expired drugs and dose poles will be inventoried and stored in the warehouses until the next campaign.

Note that there are procedures in place at the MoPH DPHL level for the destruction of expired drugs. There is no activity specifically budgeted for waste management.

SAE Monitoring and Management

Side effects are monitored during each campaign and consolidated. Side effects reported to date are minor, but are still treated. No serious adverse events (SAE) have been reported in Niger since the launch of the integrated mass distribution campaigns. However, should any SAEs occur, they will be immediately reported using the WHO (using the SAE notification form) and managed within 24 hours by the DPHL's National Pharmacovigilance Committee. Doctors at the main regional and national hospitals have been trained to handle these cases. According to the notification procedures for serious cases, the committee will be responsible for informing the MoPH, which in turn must inform the regional WHO office.

i. Supervision for MDA

Location in Budget: Planning budget tab, subawards line 129, ODC line 166

Total cost for activities in this section: **$134,449**

7.9.	Supervision		78,115,027	$ 134,449
7.9.a.	MDA Supervision at Central, Region, and Healt	National NTD Program, DRSP	67,423,970	$ 116,048
8.9.a.	MDA Supervision by NTD Project Staff	HKI	10,691,057	$ 18,401

MDA supervision is one of the most important activities of the campaign. It is conducted in a cascade format to ensure compliance with the preferred protocols and practices established by the MoPH. The goal is to minimize potential problems which can create blockages and to ensure the quality of distribution

and data collection. A regional "Coordinator" (described above) will be positioned in each region during the campaign and act as the Ministry's representative in the region.

- At the **national level**, supervisory teams will supervise the activities at the regional and district levels to ensure that the activities are conducted correctly and to identify and solve problems. The team of monitors will include the national NTDP focal point, the disease coordinators, staff of the NTD programs (PNSO, PNLBG and PNDO/EFL), the School Health Office, and several central level directors. The national teams will supervise meeting preparation, health agent training, distribution, data entry and analysis and final campaign assessment. In FY18, the number of supervisors will be increased to cover the largest number of areas treated, with funding from the government (World Bank).
- At the **regional level**, a team of supervisors consisting of regional health and education managers, including the regional public health director, the regional NTD focal points and education managers, will monitor training of health center and education sector heads and distribution in the HDs. They will ensure the distribution registers are correctly filled in, dose poles are complied with, drugs are administered correctly, data is entered and analyzed and serious adverse events are handled properly.
- At the **district level**, the NTDP focal points and other key personnel (i.e., the district head doctors, communicators, district data managers, and departmental education directors) will ensure that the activities are implemented correctly in cooperation with the health centers and will validate the data collected in the field.
- At the **health center and school level**, the head nurses and the education sector heads will supervise the Community Distributors and the school directors to ensure that distribution is carried out correctly and the registers are filled in properly. They will also provide their support to solve any potential problems reported.

The MDAs present immense logistical and operational challenges for personnel at all levels. Problems of all kinds often occur in the field and must be solved quickly. Each supervisor must report daily on the activities carried out during the campaign. The supervisors will be provided with an amount to cover their communication costs. This will enable them to communicate all problems encountered in the field in real time to the NTDP coordination to manage them. When problems occur during monitoring, the supervisors will be authorized to provide a solution in line with the extent of the problem reported and the level of responsibility of the monitoring team. In any event, problems which cannot be solved on site must be sent to the national level for investigation and action within 24 hours of notification.

Together with the NTDP National Focal Point and the national coordinators specialized in the disease, the HKI NTD Program Coordinator will ensure that supervision is conducted rigorously and in accordance with national policies. To do so, the NTD Program Coordinators (and their staff) and HKI will provide supervision during the MDA, using a checklist that defines the items to be monitored. Having the program coordinators take part in the development and implementation of the monitoring programs will ensure greater involvement in the activities on their part and will ensure they are carried out in accordance with MoPH rules.

Supervision during the MDAs will include a review of the quality of data collected based on the MoPH supervisory grids (for example, correct entry of information in the registers and check forms). Independent monitoring will be another tool for monitoring MDA quality via validation of the data collected by the distributors and communicated by the NTDP. Feedback is provided on a regular basis to

the HDs in which the MDAs are taking place. This activity was carried out in three of the country's regions in FY17 and is planned again in FY18.

Addressing bottlenecks and ensuring adhesion to protocol

The regional and district NTDP focal points hold discussions on a regular basis and with the health center heads during the MDAs to identify blockages and problems and to determine the best solutions to address them in real time. Assessment meetings are held following each campaign to evaluate activity organization, identify strong points and points for improvement, discuss the issues faced and make recommendations for improvement for the next campaign.

Several measures are taken to ensure that the activities adhere strictly to the guidelines:

- MDA supervision starts with training which ensures the proper information is disseminated. If systemic problems are detected with respect to understanding or if incorrect information is taught, the NTDP will identify the actions to be taken to remedy the situation.
- Guides are used to ensure monitoring is standardized and complete and the results are usable.
- Standardized data collection forms ensure all information is collected in a way that minimizes the risk of error.
- In terms of the surveys, the supervision teams are trained on data collection objectives, methods and tools and know the reference protocols including the villages/groups that should be visited and sampled. In addition, a reporting meeting is held at the end of each survey day to summarize findings and ensure the villages/groups were visited and the materials were correctly filled in.
- For the MDAs, the monitoring teams receive information about the target population, the list of HDs to be treated, and at the health center level, the number of villages targeted.

At the community distributor level, it is important to examine the registers with the distributors point-by-point, during training and supervision, to ensure they understand and use the methodology to fill in the registers correctly.

j. Monitoring and Evaluation

Location in Budget: Planning budget tab, subawards lines 132-138, ODC 169-173

Total cost for activities in this section: **$701,097**

7.11.	Monitoring and Evaluation		407,337,495	$ 701,097
7.11.a.	Trachoma impact surveys	PNSO	49,479,108	$ 85,162
7.11.b.	Trachoma surveillance surveys	PNSO	88,102,748	$ 151,640
7.11.c.	TAS 1 Survey	PNDOEFL	82,627,963	$ 142,217
7.11.d.	TAS 2 Survey	PNDOEFL	89,711,757	$ 154,409
7.11.e.	Pre-TAS	PNDOEFL	11,812,440	$ 20,331
7.11.f.	Coverage Survey	PNDOEFL	14,445,506	$ 24,863
7.11.g.	Oncho Surveys	PNDOEFL	30,578,280	$ 52,630
8.11.a.	Independent Monitoring	HKI	9,069,043	$ 15,609
8.11.b.	Survey Supplies	HKI	17,200,000	$ 29,604
8.11.c.	Supervision of Survey	HKI	9,986,325	$ 17,188
8.11.d.	Investigation of Severe Adverse Effects (SAEs)	HKI	926,100	$ 1,594
8.11.e.	Monitoring of Fixed Obligation Grants and form	HKI	3,398,225	$ 5,849
Subtotal			**1,193,572,406**	**$ 2,054,341**

To better prepare Niger to submit its elimination dossiers for trachoma, LF and OV, the NTDP intends to strengthen M&E activities. Several M&E activities have been planned in FY18 toward this objective.

FHI 360 provided technical assistance to HKI and MoPH's NTD programs via training on DQA and the INDB. A pool of NTDP coordinators had previously participated in this same training in Togo. This is part of the preparation for implementing these strategies at the country level to improve NTD data collection and management. The INDB will enable the NTDP and partners to improve data management and will help Niger prepare for its trachoma, LF and oncho elimination dossiers. Data integration will make it possible to generate reports that can be used easily. In FY18, the World Bank will support a practical training on data collection and entry for the INDB with program, regional and district data managers, with the goal of entering NTD data into the database for a specific region. The data entry for the other regions will follow immediately after.

Independent monitoring

Independent monitoring of the MDA will be organized in six HDs. This activity is carried out in HDs with poor coverage, or in areas where problems or shortcomings have been reported by the actors involved in drug distribution, with the goal of finding and implementing solutions during the MDA. Monitoring will begin with the training of 15 people independent of the NTDP to ensure their impartiality during data collection. The independent monitors will collect data for eight days within the specified HDs: four days during the drug distribution and four days immediately following drug distribution. The information collected by the monitors will consist of variables such as age, gender, whether the person has been treated or not, the reasons why they weren't, the channels through which the information about the campaign was received, an interview with health agents and CDDs about the campaign process, etc. A debriefing will be held every day to inform heads of CSI about the findings and to decide on and implement improvements immediately. Evaluation of social mobilization materials and messages will be integrated into the independent monitoring. Independent monitors will ask people where they obtained information about the MDA and when.

Coverage Surveys

Coverage surveys will be conducted within two weeks of completing the MDA. External evaluators, independent of the NTD program, will be selected to ensure impartial results. HDs that have reported persistent low performance, or are suspected to be continually low-performing, will be selected to undergo a coverage survey (e.g., those that have failed impact assessment). For example, in FY18, a coverage survey will be done in Aguié HD (Maradi region), which had previously failed pre-TAS twice and failed its TAS 1 despite good reported coverage. Aguié and the other HDs in Maradi that have failed pre-TAS twice are on or near the border with Nigeria where there is a considerable amount of population movement and influx of Nigerian migrants. The coverage surveys will help to: validate reported coverage rates in potential problem areas; identify reasons for non-compliance; detect problems with the supply chain and distribution system; and measure coverage in specific populations.

The results of each survey will be analyzed and discussed at a meeting with participation from the different departments of the MoPH, including the Directorate of Statistics and Health (SNIS), the Directorate of Studies and Programming (DEP) and the Medical and Health Research Center (CERMES), as well as technical partners including HKI. The goal of these meetings will be to determine the factors that enabled a given HD to produce results that show progress (or lack thereof). Results from the coverage survey will be used to determine whether a given HD should continue MDA or proceed to a pre-TAS, if sufficient coverage of consecutive MDA rounds is achieved.

Lymphatic Filariasis

Pre-transmission assessment survey (Pre-TAS)

In FY18, four HDs in the Maradi region (Mayahi, Aguié, Tessaoua and Madarounfa) will be eligible to conduct a re-pre-TAS in May 2018, six months after the FY18 MDA campaign. This will be the second re-Pre-TAS in these four HDs, and thus the pre-TAS will only be conducted if sufficient program coverage of at least 80% is achieved and if this coverage is further corroborated by the coverage survey results, as mentioned above. Gaya and Arlit will also be eligible for a re-pre-TAS and a pre-TAS, respectively, in late 2018, six months after the FY18 MDA which will be conducted in March 2018. However, due to time constraints with the short implementation period in FY18, these pre-TAS have not been programmed under END in Africa and the NTDP will seek out another funding source for these surveys.

Transmission Assessment Survey (TAS 1) for stopping MDA

Niger will conduct TAS1 in seven HDs in FY18: Konni, Illéla, Keita, Tahoua, Bouza, Tchintabaraden (Tahoua region) and Tanout (Zinder region). All TAS 1 surveys will be conducted using FTS, which will be procured through the WHO donation program. END in Africa will support implementation of the TAS 1 in all seven HDs. The TAS 1 surveys are planned for January 2018 in the Tahoua region and in February 2018 in the Tanout HD (Zinder region). Previously, Tanout did not receive RPRG approval to conduct TAS 1 in FY17 because it did not meet the criteria of five rounds of LF MDA with >65% epidemiological coverage. Following the MDA in FY17, Tanout has now met these criteria and is eligible for TAS 1 in FY18.

Post-MDA Surveillance Survey (TAS 2)

TAS 2 will be conducted in eight HDs in FY18: Tera, Say, Kollo, Boboye, Madaoua, Tillabéri, Dakoro and Guidan Roumdji. These HDs have been approved for TAS 2 by the RPRG. The surveys will be conducted prior to MDA in October and November 2017. Three of the eight HDs (Tera, Say and Kollo) are also currently under surveillance for OV. END in Africa will support implementation of the surveys and FTS will be procured from the WHO donation program.

STH + TAS Survey

An integrated TAS 1 + STH survey, following the WHO recommended methodology, will be conducted in the Konni HD in FY18 to explore whether Niger would like to continue with this integrated evaluation strategy in more HDs in the future. Niger has 17 SCH/STH sentinel sites, but there is not a sentinel site located in Konni HD, which is part of the rationale for selecting Konni for the integrated TAS + STH survey. Niger does not have baseline data for STH, however, the last STH sentinel site survey in Konni HD took place in 2013, and results indicated a prevalence of 2.8%. The national program considers the TAS EU in Konni HD to be representative of STH heterogenous ecological zones. STH results generated from this integrated assessment will be used to determine whether the HD has reached the STH elimination threshold of <1% prevalence and whether treatment for STH should continue as part of Niger's SCH/STH transition strategy.

Onchocerciasis

OV Epidemiological Survey (OV16 ELISA)

In FY18, the PNDO/EFL plans to conduct stop MDA OV surveys in accordance with WHO guidelines using OV16 ELISA in Tera, Gaya and Kollo HDs with support from END in Africa, and in Say HD with support from Sightsavers. Fieldwork for the OV surveys (i.e., collection of blood spots) in Tera and Kollo HDs is planned for December 2017, immediately following the LF TAS2 surveys in these same HDs. The OV

survey in Gaya HD will be conducted in February 2018, prior to LF MDA which is scheduled for March 2018. Analysis of results using ELISA will be performed in the PNDO/EFL laboratory in Niamey.

Trachoma

Trachoma Impact Survey

Seven HDs are eligible for TIS in FY18: Mayahi, Guidan Roumdji, Diffa, Bilma, Tchirozerine, Ouallam and Magaria. The PNSO conducted TIS in Tchiro, Bilma and Aguié HDs in April/May 2017 and per initial results, MDA is no longer needed in Aguié (TF 1.58%). But, Tchiro and Bilma HDs both require one additional round of MDA as they had a TF prevalence of 5.18% and 6.92%, respectively. TIS was planned in Mayahi and Guidan Roumdji in FY17 but will be re-programmed to the first quarter of FY18 due to the need to wait six months following MDA, which was conducted in May-June 2017. The other five HDs will conduct TIS in May 2018, six months following the November 2017 MDA campaign.

The survey methodology will consist of a physical examination of the eyelid to determine the presence of TF and TT. The data will be collected on electronic tablets using Tropical Data. END in Africa support is requested for all seven TIS.

Pre-validation surveillance surveys

As part of the trachoma elimination validation process, the new WHO trachoma standard operating procedures require TSS at least two years following TIS where TF<5%. In FY17, the PNSO conducted surveillance surveys in five HDs (Ouallam, Say, Filingué, Tera and Tillabéri) and is still awaiting the results. If results show that TF prevalence has increased to above 5%, additional rounds of MDA will be warranted.

For FY18, the national program plans to conduct surveillance surveys in 13 HDs in October 2017 (please refer to the list of HDs in Table 1b in the NTD Program Overview section). END in Africa support is requested for all 13 surveillance surveys.

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

NTD	Number of remaining endemic districts (see Table 2)	Type of DSA carried out	Number of DSAs conducted with USAID support	Number of EUs that did not meet critical cutoff thresholds	Why did the EU not « pass » the DSA?	Post-DSA failure activities (be specific about timeframes)
LF	16*	Pre-TAS	30	10	Population displacement and insecurity	Bi-annual treatment; independent monitoring in districts that failed pre-TAS; coverage survey
		Re-Pre-TAS	9	4		
		TAS1	21	6		
Trachoma	6	TIS	26	6	Population displacement and insecurity, which results in poor hygiene conditions	Additional annual MDAs with intensified social mobilization

**Awaiting TAS1 results in three HDs in Diffa region.*

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

Disease	Number of endemic districts	Number of evaluation units	Number of EUs planned for DSA	Type of assessment	Diagnostic method (Mf, FTS, etc.)
Lymphatic filariasis	33	7	7	TAS1	FTS
Lymphatic filariasis	33	8	8	TAS2	FTS
Lymphatic filariasis	33	4	4	Pre-TAS	Mf
Trachoma	35	7*	7	TIS	Clinical eyelid examination
Trachoma	35	13*	13	TSS	Clinical eyelid examination

**The number of evaluation units may be revised depending on the district population sizes and per Tropical Data recommendations.*

k. Supervision for Monitoring and Evaluation and DSAs

Location in Budget: Planning budget tab, ODC lines 176, 178

Total cost for activities in this section: $0 (accounted for in the M&E costs)

To ensure compliance with and application of WHO evaluation guidelines, HKI and the MoPH programs share documents related to these evaluations. These documents are also sent to the higher level (FHI 360, HKI HQ, Expert Committee, etc.) to verify the protocols established by these programs. Comments, suggestions and feedback are provided to help the programs improve and enable them to align with the strategies prescribed by the WHO. The information is shared and disseminated among the stakeholders involved in the fight against NTDs at all levels during the various meetings (Workplan development, development of the MoPH strategic plan, coordination meetings, supervision, campaign evaluations, etc.). Similarly, the project's agents assist in the process of preparing for and implementing evaluations in the field. This involves verifying compliance with the steps referred to in the protocol – from preparation to training for the players, data collection in the field, etc. – through exchanges. The evaluators are reminded to comply with the guidelines set out in the protocols. The coordinators may help by providing detail on certain points or solving problems in the field. Monitoring of the evaluator teams provides an opportunity to inquire into the proper implementation of the activities as planned in advance. Feedback is provided to the teams to remedy any weaknesses identified.

With respect to supervision of the coverage surveys: with the survey protocol in hand, this involves contacting the programs concerned regarding the organization of the activity; and through exchanges with these programs, clarification is sought to determine how the activity will be carried out, in practice, in the field. The survey team is thus monitored in the field. We confirm that the clusters selected are those surveyed and attend the surveyors' training as available. At the cluster level, the teams are monitored from the time they arrive in the village, including exchanges with the village chief, choice of households and administration of the questionnaires. Suggestions are provided on site, based on the context, to improve the process. The materials are then verified to ensure they comply with what was taught previously.

At the integrated health center level, data from the registers and those transmitted to the higher level are analyzed with the evaluators to ensure consistency and identify any weaknesses identified. In addition, after comparing the data, the community distributors are questioned about their work methods (drug distribution and checking-off the individuals treated, recording of the village name in the distribution register, etc.).

l. Dossier Development

Location in Budget: Not budgeted separately

Total cost for activities in this section: $0 (accounted for in the training and M&E costs)

Niger has set a goal of eliminating LF, trachoma and OV as a public health problem by 2020, in line with the country's 2016-2020 NTD Master Plan. To do so, an official recognition of the WHO is required to validate that Niger has met the criteria for elimination of these diseases as a public health problem. Niger would like to request external assistance from the WHO in FY18 to familiarize the NTDP with the dossier requirements to begin "pre-dossier" preparations for trachoma, OV and LF.

In addition, within the framework of Niger's 2016-2020 Master Plan, Niger intends to carry out the following activities in FY18 to address "pre-dossier" development in terms of data collection:

1. Implementation of DQA surveys to improve quality and integrity of data
2. Implementation of the INDB with support from the World Bank (practical training and data entry)
3. Training and implementation for TIS and TSS in line with WHO guidelines and training and implementation of pre-TAS, TAS 1, TAS 2 and TAS 3 surveys
4. Support for the OEC

m. Short-term Technical Assistance

Location in Budget: Planning budget tab, travel line 72, ODC lines 151, 179

Total cost for activities in this section: $0 (these are already accounted for in strategic planning, M&E, and travel costs)

Table 11: Technical Assistance request from 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)				
Workshop to develop STH transition strategy	Need for a transition strategy to ensure continuation of deworming after stopping LF MDA	Expertise in facilitation/development of strategic transition plans	5 days	Country budget (USAID)
TA to start the ELISA chain of the PNDOEFL laboratory	Need for functional laboratory at PNDOEFL	Technician specializing in ELISA chain (Accra)	7 days	Country budget (USAID)
TA for BDIM practical training/data entry	Additional support will ensure that cascade training to regional data managers is of high quality	Expertise in NTD integrated database (FHI360)	3 days	Overall budget (USAID)
External support (e.g., hired consultants)				
	To familiarize themselves with and prepare the	Expertise in this field	3 days	WHO

Meeting to present elimination dossiers to NTDP	dossier for the elimination of trachoma, OV & LF			

3. *Planned FOGs to local organizations and/or governments*

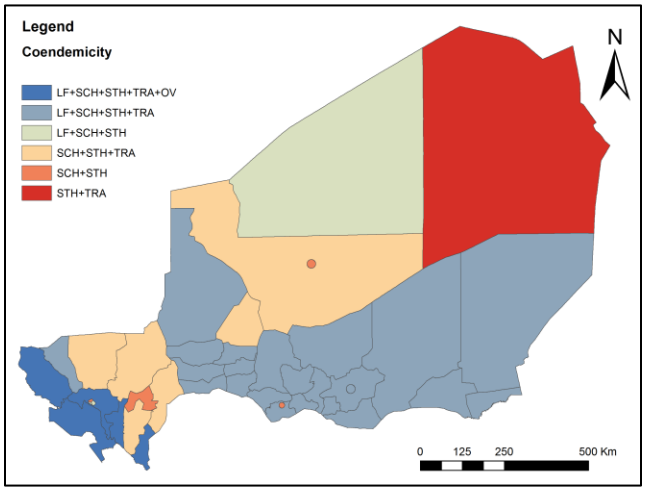
Table 12: Planned FOG recipients—include for all sub-partners as well.

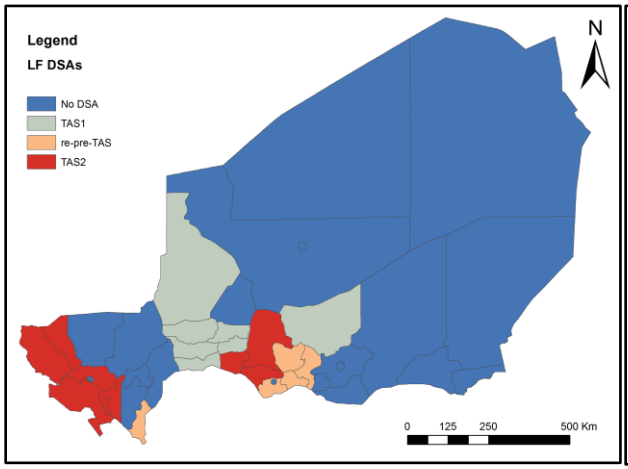
FOG recipient (split by type of recipient)	No. of FOGs	Activities	Target Date of FOG application to USAID
Central level (national NTD contact point)	1	▪ Annual post-MDA meeting at the national level ▪ National MDA launch ▪ Central-level MDA supervision	September 2017
PNSO	1	▪ FY18 TIS ▪ FY18 TSS	September 2017
PNDO/EFL	1	▪ FY18 pre-TAS ▪ FY18 TAS 1 ▪ FY18 TAS 2 ▪ Coverage survey	September 2017
ONPPC	1	▪ Drug storage, repackaging and transportation	September 2017
Regions (Agadez, Diffa, Dosso, Maradi, Niamey and Zinder)	10	▪ Transportation of equipment and drugs to the distribution site for the district MDA ▪ MDA supervision at the regional and district levels ▪ Drug distribution by the CDDs ▪ Cascade MDA training for Regional and Health District personnel, the Health Centers and the CDDs ▪ Social (community) mobilization (radio) before MDA ▪ Social (community) mobilization (criers, relais) before MDA ▪ District-level information sessions ▪ District-level post-MDA review meetings ▪ Regional-level post-MDA review meetings	September 2017

4. *Cross-Portfolio Requests for Support*

Identified Issue/Activity for which support is requested	Which USAID partner would likely be best to provide this support?	Estimated time needed to address activity
Evaluation of the prevalence of hydrocele and elephantiasis cases in LF-hyperendemic HDs	MMDP	30 days

5. *Maps*


Legend
Coendemicity
LF+SCH+STH+TRA+OV
LF+SCH+STH+TRA
LF+SCH+STH
SCH+STH+TRA
SCH+STH
STH+TRA
N
0 125 250 500 Km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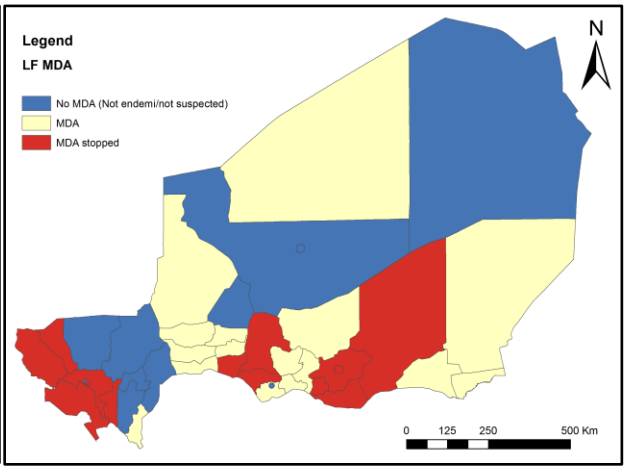
LF DSAs
No DSA
TAS1
re-pre-TAS
TAS2
N
0 125 250 500 Km


Legend
LF MDA
No MDA (Not endemi/not suspected)
MDA
MDA stopped
N
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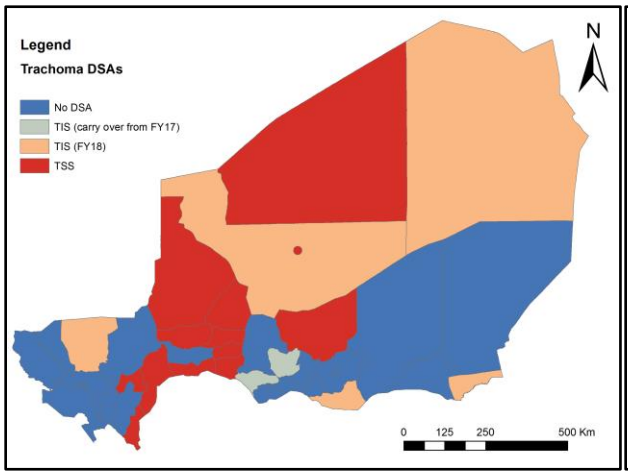
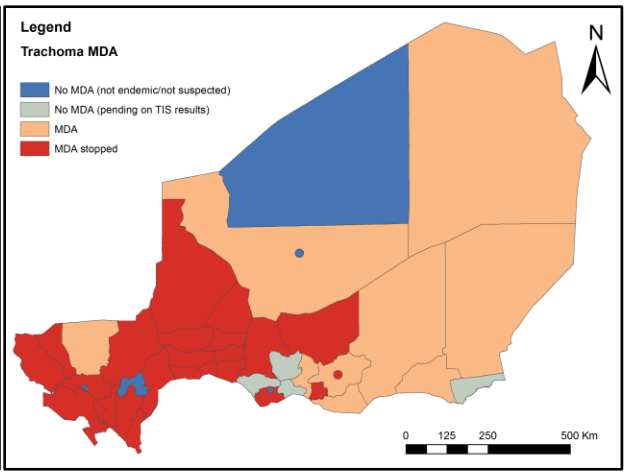
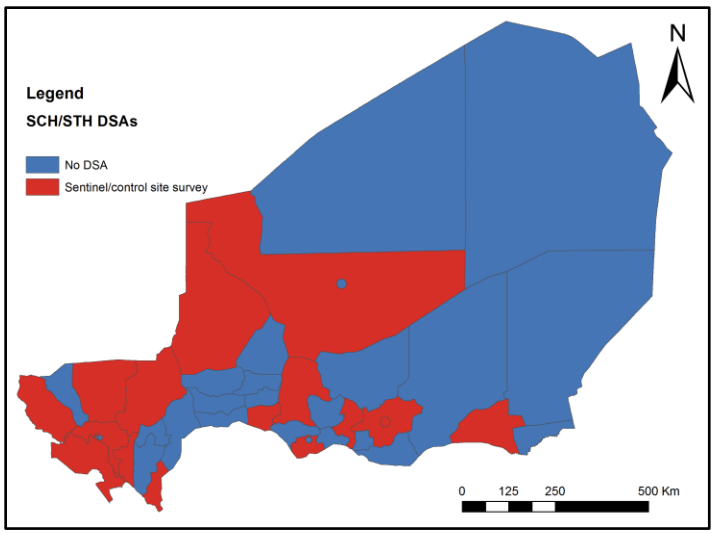
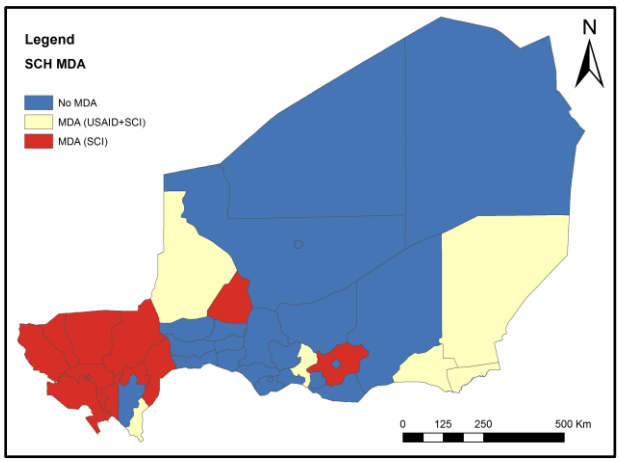
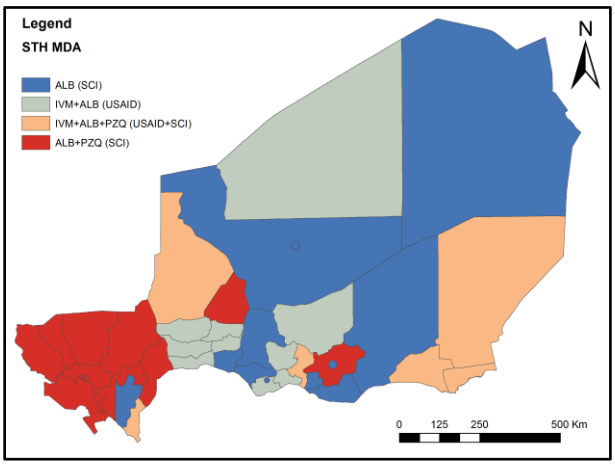

Legend
Trachoma DSAs
No DSA
TIS (carry over from FY17)
TIS (FY18)
TSS
N
0 125 250 500 Km


Legend
Trachoma MDA
No MDA (not endemic/not suspected)
No MDA (pending on TIS results)
MDA
MDA stopped
N
0 125 250 500 Km







APPENDICES

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