Niger

Control of Neglected Tropical Diseases

Annual Work Plan

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Acronyms and Abbreviations

ALB	Albendazole
CSI	Centre de Santé Intégré
CDD	Community Directed Distributors
DCD	Deputy Country Director
DFID	Department for International Development
DPHL/MT	Direction de la Pharmacie, des Laboratoires et de la Médecine Traditionnelle
DRSP	Direction Régionale de Santé Publique
FHI 360	Family Health International 360
HD	Health District
HKI	Helen Keller International
INS	Institut National de la Statistique
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NTDs	Neglected Tropical Diseases
ONPPC	Office National des Produits Pharmaceutiques et Chimiques
PCT	Preventive Chemotherapy
PNDO/EFL	Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filarioses Lymphatiques
PNLBG	Programme National de Lutte contre la Bilharziose et les Géohelminthes
PNLCC	Programme National de Lutte Contre les Cécités
PZQ	Praziquantel
RISEAL	Réseau International Schistosomiases Aménagement et Lutte
SCI	Schistosomiasis Control Initiative
STH	Soil Transmitted Helminths
TAS	Transmission Assessment Survey
USAID	United States Agency for International Development

Executive Summary

To launch the program year, a stakeholders/work planning meeting in December 2011 provided a forum to discuss the National Neglected Tropical Disease (NTD) Control Program's progress, lessons learned, and plans for 2012. As a result of this meeting, the foundation for a solid plan was established that will bring Niger closer to reaching the overarching goals of the 2011-2015 NTD Strategic Plan. A micro-planning workshop in April 2012 will solidify the specific plans and strategies of each region in preparation for the upcoming mass drug administration (MDA). Through the implementation of advocacy and social mobilization activities, MDA campaigns, monitoring and evaluation (M&E) procedures, and drug management, the program will strive to increase coverage rates, improve monitoring of the program's impact, and heighten the program's efficiency in supply chain operations. Through these activities, the capacity of local leaders, health center staff, drug distributors, survey personnel, and trainers/supervisors will be broadened.

Niger's epidemiological profile for lymphatic filariasis (LF) will be completed in 2012. This will include maps from two locations in Agadez: Bilma, which had not previously been mapped and Arlit, which had no recent data. Both of these areas were affected by insecurity and violence.

Niger will strengthen post-endemic surveillance measures, with impact studies for trachoma being conducted in districts that have had three or five rounds of treatment, as well as in districts that are eligible to halt district-wide distribution of antibiotics. In the nine districts that completed five rounds of MDA for LF, HKI (?) will conduct impact assessments of sentinel and spot check sites to determine if they are eligible to begin the transmission assessment surveys (TAS). Advocacy to fund a broader portfolio of NTD control will continue.

This year, 5.59 million people in 30 districts will be treated for schistosomiasis; 9.65 million in 30 districts for LF, 10.8 million in 38 districts for soil-transmitted helminthes (STH) (30 through LF MDA, 7 through (praziquantel) (PZQ)+albendazole (ALB) MDA, and 1 through ALB alone), and 7.63 million in 17 districts for trachoma.

Background

According to figures released by the Institut National de la Statistique (INS), the population of Niger will reach 16,554,437 in 2012. Schistosomiasis, STH, LF and trachoma are endemic throughout Niger with prevalence rates varying from one district to another.

The initial integrated control of NTDs through MDA started in Niger in 2007 and included activities of three programs, namely: the *Programme National de Lutte contre la Bilharziose et les Géo-helminthes* (PNLBG), the *Program National de Lutte Contre la Cécité* (PNLCC) and the *Programme National de Dévolution de onchocercose et d'Elimination de la Filariose Lymphatique* (PNDO/EFL). These programs focused on the control and/or eliminate trachoma, STH, schistosomiasis and LF. Onchocerciasis, once prevalent, has been reduced to a non-public health problem only requiring surveillance. These MDA campaigns were implemented by Schistosomiasis Control Initiative (SCI)/ Réseau International Schistosomiases Aménagement et Lutte (RISEAL) with funding from the USAID NTD Control Program managed by RTI International from 2007 to 2010 and then by HKI with funding from the USAID End in Africa managed by FHI 360 since 2011.

Since 2007, there have been five rounds of integrated MDAs conducted in Niger in 39 of 42 districts in 8 regions. The number of children and adults treated was respectively 6 million in 2007, 8 million in 2008, 10.4 million in 2009, 11 million in 2010 and 10.6 million in 2011. Treatment in the north, particularly Agadez, has been difficult due to security issues. The 2011 MDA campaigns were conducted in Diffa, Maradi, Zinder, Niamey, Dosso, Tillabéry and Tahoua regions. No MDA campaigns were conducted in the Agadez region due to insecurity. In total, zithromax was distributed in 14 health districts (tetracycline in 13 health districts), PZQ in 13 health districts and invermectin and ALB in 30 health districts in 2011.

A summary table of the situation in Niger follows:

Table 1. Overview of disease endemicity, mapping, and MDA for the NTDs in 42 districts Niger

Disease	Number of endemic districts	Number of non-endemic districts	Number of districts needing mapping	Number of districts with ongoing MDA	Number of districts needing MDA, but MDA not yet started
Schistosomiasis	39	N/A	42 (remapping)*	30	unknown
Soil-transmitted helminthes	N/A	N/A	42	38	Unknown (possibly 4 based on mapping results)
Lymphatic filariasis	30	10	2**	30	Unknown (possibly 2 based on mapping results)
Onchocerciasis	0	42	0	0	0

Disease	Number of endemic districts	Number of non-endemic districts	Number of districts needing mapping	Number of districts with ongoing MDA	Number of districts needing MDA, but MDA not yet started
Trachoma***	18	24	0	17	0

* A remapping of the entire country is planned during this project year with support coming from SCI through DFID. USAID funds will partially support mapping in 5 regions.
** Agadez region: mapping in Bilma district and a reassessment of LF in Arlit.
***Trachoma endemic districts defined as those with trachomatous follicular (TF) prevalence ≥10%

Planned activities to be implemented under this project for FY 2012 are included in the work plan.

Goals for the Year 2012

The general objective of the national NTD control program is to control and reduce morbidity due to schistosomiasis and soil transmitted helminthes (STH), and to eliminate lymphatic filariasis (LF), onchocerciasis, and blinding trachoma through preventive chemotherapy (PCT). Specific objectives include:

- Epidemiologic coverage:
    - Reaching epidemiological coverage of at least 80% of the target population with ivermectin and ALB for LF, at least 90% of the target population with azithromycin and tetracycline for trachoma, and at least 75% of the school age population with PZQ for schistosomiasis (and ALB in areas that are not endemic for LF or STH) are critical goals for 2012.
- Mapping:
    - Mapping for LF in Bilma and Arlit is planned. Mapping in Arlit was last conducted in 2003 and no treatments have taken place since. The goal of the 2012 mapping is to determine the current epidemiologic situation.
    - After many years of MDA, the Niger government decided to conduct a national mapping again to see the current endemic situation. The data will be used to determine the schistosomiasis control focus areas and to adjust the national MDA strategy. Schistosomiasis/STH mapping will be conducted in 5 regions (Maradi, Agadez, Zinder, Niamey, and Diffa) and in conjunction with SCI/RISEAL which will support the mapping in Tilabery and Dosso. The results of the survey will impact the PZQ requirements. Also to be considered is the new WHO SCH elimination roadmap. The KK method will be used and is the same method used for the pre-MDA mapping. In this method, a schistosomiasis survey always includes STH. The only difference between pre-MDA mapping and the current mapping (remapping) is that the remapping is after many years of MDA.

- Post-endemic surveillance activities:
  - HKI will support trachoma impact studies in 3 districts after 3 rounds of MDA and begin post-endemic surveillance in Aguie.
  - LF pre-TAS sentinel site/spot check site assessments will be conduted in 9 districts.

- Advocacy:
  - HKI will increase advocacy efforts by hiring a a full-time national NTD focal point for the MOH.
  - HKI will also advocate for a broader budget for NTD control to allow support for morbidity control/management.
- MDA:
  - In 2012, all 8 regions of Niger, including Agadez will participate in the MDA campaign. In total, 30 health districts will treat for schistosomiasis and STH, 1 district will treat for STH, 30 health districts will provide treatment for LF, and 17 health districts will treat for trachoma.

Main Activities

HKI/ Niger will support the MOH with the following specific activities:

Support NTDCP Planning Process

- To implement the activities planned, a participatory approach involving the national disease-specific program coordinators, the national NTD focal point, and HKI will be emphasized. The identification of districts eligible for the treatment with PZQ and ALB will be done in coordination with the PNLBG. For this activity, the coordinator will work with the regional focal points to update the list of endemic villages. Though planning is done at the district level and MDAs target school aged children throughout a district, MDA targeting at-risk adults focuses on endemic villages.

- Trachoma impact surveys will be conducted to determine if blinding trachoma has been eliminated in 3 districts in addition of confirming impact study results in Aguie.

- Pre-TAS LF sentinel and spot-check site evaluations in 9 districts will be conducted to determine if they are eligible for LF TAS.

- With funding from WHO, Niger developed the 2011-2015 Strategic Plan for Prevention and Control of Neglected Tropical Diseases in May 2011. The plan has not yet been validated by the Ministry of Health (MOH) due to lack of funding. To complete the process, END Africa funds will finance a workshop in February 2012 for validation of this plan.

- To support the efforts of the strategic plan and facilitate the analysis of unmet needs of the NTD program, a national workshop for evaluation and planning was held in December 2011 in Niamey. This workshop is conducted annually at the end of a MDA campaign. The workshop brought together all key stakeholders and partners to identify the strengths and weaknesses of the MDA, unmet needs, lessons learned and recommendations for improving subsequent campaigns. Examples of unmet needs included inadequate fuel allocation and underestimation of resources needed for community mobilization, trainings, and supervision. The results of the workshop were incorporated into the 2012 work plan.

- Region-specific strategies and timelines will be developed at regional micro-planning workshops in March/April 2012. Participants in these one-day sessions will include the Program Coordinators, HKI and the regional and district stakeholders. The output will be distribution plans and budgets for the districts. These meetings will be held annually to help build ownership of the program at all levels of the health system.

- Strengthening the communication capacity of stakeholders of the national NTD control program is critical. This includes the ability communicate with WHO, drug donation programs, and other international public health partners in a timely and professional manner. Funds from END in Africa will support the installation and ongoing monthly cost of internet connection for PNDO/EFL. END in Africa will finance and supply a laptop computer and printer to the NTDCP of the MOH to enable an environment for improved communication.

Mapping

END in Africa will support mapping for schistosomiasis/STH in the regions of Agadez, Diffa, Zinder, Niamey, and Maradi. SCI/RISEAL will map for schistosomiasis /STH in Tillabery and Dosso using DFID funds. Surveys were conducted in Tahoua in 2010.

LF mapping will be limited to the districts of Bilma and Arlit. No recent data are available for Arlit due to security issues in the past.

Scaling up the national NTD Program[1]

Since the beginning of the national NTD control program, the number of persons treated as well as the number of health districts covered continues to increase. In 2007, 6 million people in 19 health districts were treated; in 2011, 10.6 million people were treated in 37 health districts. In 2012, 39 districts in the 8 regions of Niger will be targeted for MDA.

Mass Drug Administration[2]

The activities in connection with the preparation of the 2012 drug distribution campaign will start in early January 2012.

[1] The Annual MDA Treatment Projections Form is incorporated into this work planning as an attachment.
[2] The plans described here focus on USAID-supported MDA activities only.

Support for Planning: Micro-planning workshops in each of the 8 regions of Niger will start in early March/April 2012. These workshops will provide opportunities for participation to assess the needs of each region, determine the strategies to be adopted, and calculate specific district level budgets. At the end of March, HKI hopes to have all the drugs, data collection tools and sensitization materials required for implementing the distribution. The micro-planning workshop will also address the issue of accountability of unused drugs among the regional delegates. The ONPPC will oversee the distribution of drugs from the central to the district level if the ongoing discussions result in the signing of a memorandum of understanding between HKI and ONPPC. Otherwise, we will use trucks of the MOH and/or rent private trucks for the distribution.

Considerable efforts will be made to improve community mobilization. HKI and MOH will prepare audio material to be aired by community radio stations to sensitize and mobilize the community. Recorded messages designed to mobilize communities to participate in MDAs will be distributed to all functional community radio stations, the national radio station, and wide-coverage regional radio stations. Private radio stations with wide coverage will also be selected. The televised messages will be aired on the national television station during the entire campaign period. The number of common town criers will be increased, and the communities will be invited to contribute to meet the costs associated with this activity. A national campaign launch is scheduled for the month of May. HKI and the MOH will also document success stories to support the advocacy efforts of FHI 360 and USAID.

To ensure compliance with the drug administration protocol, a memory aid (*aide mémoire*) will be distributed to community drug distributors at the end of the training. Registers will also be printed and distributed.

Actual distribution

The actual drug distribution will start in May 2012, after the community distributors have completed their training. As mentioned in other parts of the work plan, MDA will take place in 17 districts for trachoma, 30 for LF, and 30 for schistosomiasis, and 38 for STH. The targeted population for each disease can be found in the table below.

Table 2. Target districts and estimated target populations for 2012 MDA*

<table>
<tr><th rowspan="2">NTD</th><th colspan="4">Target group by age</th><th rowspan="2">Number of districts</th><th rowspan="2">Targeted Population Total</th></tr>
<tr><th>0 -6 months</th><th>6 - 59 months</th><th>5-14 years</th><th>≥15 years</th></tr>
<tr><td>Schistosomiasis</td><td>0</td><td>0</td><td>3,660,473</td><td>1,923,919</td><td>30</td><td>5,584,392</td></tr>
<tr><td>Lymphatic Filariasis</td><td>0</td><td>0</td><td>2,897,375</td><td>6,760,541</td><td>30</td><td>9,657,916</td></tr>
<tr><td>Soil-transmitted helminths</td><td>0</td><td>0</td><td>4,057,999</td><td>6,760,542</td><td>38</td><td>10,818,541</td></tr>
<tr><td>Trachoma</td><td>152,642</td><td>1,373,778</td><td colspan="2">6,105,681</td><td>17</td><td>7,632,101</td></tr>
</table>

The school-age children will be treated in the schools (15,184 schools) while the children not enrolled in school and adults will be treated in the community. Ivermectin and ALB will be the first package for distribution, followed by PZQ (plus ALB in the non-LF districts), and then Zithromax and tetracycline. The administration of each drug package will require up to seven days. In the districts where several packages are being distributed, the community drugs distributors (CDDs) will distribute the next package immediately following the preceding distribution and begin with the persons who were treated first during the previous distribution. There is not a fixed period of time between the drug packages, although on average, each person receives each package about one week after the previous one.

In FY 2012, target populations in Niger will be as follows:

- PZQ for schistosomiasis (school and community based distribution).
  - Prevalence ≥50% (high risk) → treat all persons age 5 years and older every year, including at-risk adults.
  - Prevalence ≤49% (moderate risk) → treat all school age children every two years, including at risk adults.
- ALB for STH in districts where ALB is distributed with PZQ and in Bilma (school and community based distribution).
  - Prevalence ≥50% → in 2010/2011, treat all school age children once per year; in 2012, target expanded to treat school age children twice per year.
  - Prevalence between 20-49% → treat all school age children once per year.
  - Prevalence <20% → no treatment .
- Azithromycin and tetracycline for trachoma (school and community based distribution)
  - District prevalence of TF ≥10% → treat entire population (infants ≤6 months receive tetracycline eye ointment and all persons older than 6 months receive Zithromax)
- Ivermectin and albendazole for LF (school and community based distribution)
  - Prevalence of ICT test positives ≥1% → treat all eligible persons at district-level each year.

Table 3: Drugs available and anticipated for delivery/distribution for the 2012 MDA

Drug	Source of drug (procured or donated)	Quantity of drug procured or donated	Date of Donation application (MM/YR)	Expected delivery date of drugs (MM/YR)
IVM	MDP	22,375,260 tablets	15 December 2011	03/2012
ALB PNDO/EFL	GSK	9,312,682 tablets	15 December 2011	03/2012
ALB PNLBG	USAID*	2 024 710	10/2011	03/2012
ALB PNLBG school age	GSK (through WHO)	985 000 Tablets	13.12.2011	03.2012

PZQ	USAID	11,096,261 tablets	10/2011	03 or 04/2012
Zithromax	ITI/PFIZER	3,852,000 tablets 75,024 bottles	04/2011	10/2011
Tetracycline eye ointment	TCC/MOH	170,000 tubes	11/2011	04/2012

*Targeting school-aged children not receiving LF treatment.

Training

One of the main critiques of the 2011 campaign preparation was lack of training of trainers (TOT). For the 2012 campaign, trainers will be trained in each Direction Régionale de Santé Publique (DRSP). Trainers will be regional NTD focal point person and district chief medical officer. The trainers in their respective districts will then provide training to the *Centre de Santé Intégré* (CSI) directors and education counselors or heads of the education sectors, which will in turn be responsible for the recruitment and training of the community distributors and teachers.

The DPHL/MT will conduct the training for the NTD district focal point and the district store keepers with technical assistance provided from JSI as needed. Prior to the distribution, training will be organized at the regional level. In each region, focal points and store keepers will be trained in one session in supply chain management. We are expecting to train 42 district focal points and 42 district store keepers in supply chain management. The table below outlines the projected training for 2012:

Table 3: Training Events - New and Old Staff

Training Group	Topic	No. to be Trained	No. of Training Days	Location	New training or refresher course?
MOH at central level	TOT on Supervision, MDA implementation,	16	3	Niamey	New and refresher
Trainers	Supervision and MDA implementation	108	3	Regions	New and refresher
Supervisors	Supervision	70	2	Districts	New and refresher
Drug distributors	Drug distribution	25,000	1	CSI	New and refresher

Training Group	Topic	No. to be Trained	No. of Training Days	Location	New training or refresher course?
Other (specify) District store managers/District NTD focal points	Supply chain management (to request as TA from JSI)	84	TBD	TBD	New and refresher

Supervision

In line with the recommendations of the December 2011 evaluation workshop, supervision will take place at all levels. A pool of supervisors will be assigned at each level in order to assure effectiveness and quality.

At the national level, a minimum of ten persons will constitute a pool of national supervisors: the national NTD coordinator, the 3 disease-specific coordinators, 2 staff from HKI, and 4 Ministry of Health staff. The team of national supervisors will supervise the training of trainers, the training of the CSI staff, and the distribution and evaluation at the end of the campaign.

At the regional level, a team of supervisors (2-4 persons) comprised of regional health and education directors will be trained by the national supervisors. They will ensure the supervision of the training sessions of the CSI heads and sector heads and the distribution in health districts. A second technical support team comprised of regional focal points (education and health) and national level staff (five people from the team of the pool of supervisor) will be responsible for supervising the training at the district level, CSIs, distribution, and evaluations. This second team will also be responsible for the supervision of the district NTD focal point person in the management of the MDA drugs.

At the district level, the education and health focal points of the health districts will supervise the CSI heads.

At the level of the CSI, the heads of CSIs will be provided with adequate resources particularly for transport to the sites in accordance with the recommendations of the December 2011 workshop to enable them to efficiently supervise the community distributors. It is envisaged that during the distribution, the heads of CSI and the community distributors will regularly report on the status of the distribution to the community in order to identify any possible errors in the application of the instructions early on. The Coordinator of HKI's NTD Program will ensure that this program is executed in the most rigorous manner.

The activities of the community distributors will be supervised by the CSI heads and, as much as possible, at least two regular debriefing sessions will be held each week between the CSI heads and community distributors in order to assess their progress and daily performance.

Short-term Technical Assistance

Following the evaluation workshop of the distribution campaign of December 2011, the short-term technical assistance needs expressed are summarized in Table 4.

Table 4: Technical Assistance Requirements

Task	Technical skills required	Number of days required
External consultant for LF impact surveys in 9 Districts after 5 rounds of treatment including spot checks, sentinel sites and TAS	Statistics, Epidemiology, laboratory	30 days
Training in drug management for the staff of NTD programs, focal points and drug managers in the regions and districts	Supply chain management advisor with expertise in drug forecasting, logistics management, and training	7 days
Training of national level NTD staff in the use of NTD M&E tools and key terms	Monitoring and evaluation	5 days

Financial Management

After the regional micro-planning workshops, budgets will be prepared at all levels. Before the budgets are made available to grantees, partnership contracts will be signed, specifying the roles and responsibilities of each party and directives of the donor. These contracts will be prepared in English and French so that they can be accessible to all parties. This contract will be attached as an additional annex, specifying for each expenditure line, the quality of the support documents required.

The HKI finance team, in collaboration with FHI 360, developed a financial management training module for the grantees to improve their understanding of USAID regulations. The financial management module will be introduced in the new training modules and taught as part of the regular training. HKI will be leading the training course.

The financial officer of the NTD program will conduct regular supervision missions for educational and problem-preventive reasons. The financial officer will help the district managers to manage expenditures and collect from clients that are in compliance with the standards.

Financial sampling & Capacity building Assessment

FHI 360 will perform financial sampling on records following an MDA. Upon completion of the MDA activities, the original receipts and other expenditures will flow from the MOH system to HKI for review and certification. FHI 360/Regional Hub (Deloitte) will in turn conduct financial sampling using HKI's financial data immediately after the reviews and certifications. FHI 360 will then advise HKI on areas needing improvement and/or corrective action after the sampling reviews.

TIPAC

Once the new tool for integrated planning and costing (TIPAC) tool is finalized and translated in French, HKI will meet with the MOH to initiate activities for rolling out the new tool. FHI 360 expects this to take place in FY 2013.

Management of Serious Adverse Events

Serious adverse events and side effects are collected using tools specifically developed for the MDA campaign and in conformity with the demands of the donation programs. At the meeting in December, the DPHL/MT stressed the need for better reporting of side effects. There was concern that this information was not properly collected and communicated during the previous campaign. For the 2012 campaign, the training modules and data collection tools will be reviewed to incorporate information on serious adverse events and side effects. During the workshop for tool review, the form for collecting serious adverse events will be integrated into the national system of reporting information. As a result, the DPHL/MT will be notified immediately of serious cases.

Severe adverse events should be notified immediately within 24 hours to the national NTD coordinator who shall inform at the same time the national authorities and the HKI NTD coordinator. The HKI NTD coordinator will inform the Deputy Country Director of HKI and FHI360. SAEs will also be reported to the drug donation program(within 24 hours of notification within Niger.

Immediately after the notification of a serious adverse event, measures will be taken at all levels. At the local level, cases will be referred to the nearest health center capable of providing optimal care and treatment. For that, the available national health system level resources are used (ambulances, health structures, drugs, etc.). A team of investigators constituted by the regional focal point, the focal point of the district in which the incident occurred, and the district Chief Medical Officer will visit the venue to conduct the initial preliminary investigations and inform the national authorities and HKI. These bodies will then move forward to implement the recommendations of the authorities of the MOH. If the causal relation is established, the costs associated with the medical care and treatment will be borne by HKI through END in Africa.

A communication action plan geared towards the traditional authorities and opinion leaders will be put into place in order to inform the populations about all cases of serious adverse events, whether proven or otherwise. Community radio stations will be solicited to anticipate and address all possible rumors.

There has been reduction in the number of minor side effects, cases over the years of mass treatment. The management of minor side effects is the responsibility of the national, regional, and district health authorities. No serious adverse events have been detected in Niger since the beginning of the integrated NTD control program.

Transition to Post-elimination Strategy

Trachoma

Niger's post-endemic surveillance system is being scaled up for trachoma, with the continuation of impact studies and the introduction of surveillance in districts where the prevalence of trachomatous

follicular (TF) is less than 10%. A post-endemic surveillance protocol implemented in Mali has been shared with Niger for use and adaptation in the Nigerien setting. HKI and the Carter Center are continuing their support of the PNLCC to conduct surgeries to prevent blinding trachoma, promote face washing, and enhance environmental improvement to help Niger reach their trachoma elimination target of 2015. Out of the initial 35 trachoma endemic districts in Niger, 18 have TF prevalence rate of above 10%, 4 have prevalence between 5% -10%, and 13 have a prevalence of below 5%. To better refine the map for trachoma, the NTD project supported impact surveys in the districts of Tchintabaraden, Abalak, Tanout and Gouré in December 2011 and final results are expected before the end of March 2012. The program proposes to finance a prevalence survey in the Aguié health district in 2012 to determine if there are high prevalence pockets of trachoma. The program also plans to support trachoma impact studies in Zinder Commune, Diffa, and N'Guigmi districts.

Lymphatic Filariasis

For LF, sentinel site and spot check sites will be assessed in 9 districts using the midnight blood smear method according to the WHO guidelines (2011) to determine if they are eligible for TAS. The recent WHO manual (2011) will be used in moving forward.

Schistosomiasis

For schistosomiasis control, RISEAL plans to conduct prevalence surveys in health districts of the Tillabéri and Dosso regions with CFAF 23 million (USD $46,000) from DFID. Funds from USAID will support prevalence surveys in Diffa, Zinder, Agadez, Maradi, and Niamey. The PNLBG proposes to update/create sentinel sites for producing updated data in partnership with HKI and RISEAL. These data will help to better direct project activities. These sentinel sites were decided upon prior to MDA was initiated and baseline data were collected. Impact studies are to be conducted at these sentinel sites after 3-4 rounds of treatment.

Facilitating Collaboration and Coordination

The impending signing of Memorandum of Understanding between HKI and MOH in the framework of the national NTD control program and the implementation of the National Strategy for the Control of NTDs will facilitate the establishment of a specific NTD budget line. If this line is included in the national budget, additional funding will be available from the MOH for financing activities that are not eligible under the agreement with USAID/FHI 360, such as the purchase of drugs for treating adverse events, surgery for trichiasis and hydrocele, and morbidity management for LF. The signing should be in April/May.

At the national forum on NTDs held in Niamey in July 2010, commitments such as sponsorship of the community distributors and common criers, participation of local elected officers in the sensitization of the populations were made by the regional and sub-regional officials, but not enforced. At the December 2011 evaluation workshop, a suggestion was made for a national committee to follow up on these recommendations. This national committee will organize and conduct advocacy meetings among the governorates and communal authorities involved in some aspect of the mass distribution campaign to increase social mobilization in communities.

The periods for the mass distribution activities are chosen to ensure that they do not conflict with other activities. If, for any reason, this should happen, the stakeholders will be encouraged to seize every opportunity to improve the coverage of the program. For example, in 2011, the community distributors took advantage of the organized logistics for the EPI. In fact, the community distributors managed to board the vehicles of the vaccinators in order access remote localities. Similarly, the districts took advantage of the regrouping of the CSI heads in the EPI activity framework to organize the district evaluations.

To strengthen coordination among partners, HKI will pursue recruit a full-time national level coordinator for the NTD program. Currently the program has a part-time coordinator. In addition to the regular meetings between HKI and the program coordinators, quarterly coordination meetings will be organized with the program coordinators, the MOH and other partners involved in the NTDs. A task force on NTDs will be established to hold twice-yearly meetings.

Cost-effectiveness

The ONPPC is a national structure whose vocation is to import and supply generic essential drugs, specialty drugs and essential medical consumables. It has the expertise and logistical resources needed by the NTD program for achieving NTD program specific objectives. Beginning in January 2012, negotiations will be held with the ONPPC their potential role in the process of ordering, receiving, collecting, storing in ONPPC warehouses, bundling and supplying and where necessary destroying expired drugs. If the negotiation succeeds, this would be a possible solution for logistics sustainability. If an agreement with the ONPPC is not reached before the MDA, HKI and the MOH will find a more adequate warehouse to keep NTD drugs.

With the assumption that 50% of dose poles were preserved and will be available in 2012, we will manufacture the balance (50% of projected need) this year. For social mobilization, community radio stations which have reduced operational costs compared to conventional radio stations will be used while the city halls will be solicited for the use of common criers. Relying on their experience and previous trainings, CDD re-training will be limited to one day. Posters printed in previous years will not be reprinted this year as there are still sufficient numbers available. Print materials are limited in their effectiveness for the largely non-literate target population. Other materials such as registers need to be considered consumables and will need to be reprinted.

Monitoring & Evaluation

The HKI M&E officer, in collaboration with the MOH project coordinators, will revise the data collection tools already in place to improve the process for collection of information and reporting to the national level. The evaluations, including coverage of the distribution campaigns should be completed by district, regional and national personnel, at the latest, one week after the closure of the activities. The distribution reports should be transmitted one month after the distribution so that the national level can carry out the analysis, compilation, and submit to the donor within the 90 days following the end of the activity.

HKI will also assist the MOH by reporting on impact studies and sentinel sites so all stakeholders are aware of program progress.

Coverage rates for 2011 were lower than expected partially due to the delays in start-up causing distribution to take place during the rainy season, farming season and Ramadan. With a timely start-up in 2012, these aspects will be avoided. In addition, improved training and supervision should help increase coverage.

Independent monitoring will be sponsored in randomly selected districts in order to monitor the quality of the MDA. This methodology was introduced in Sierra Leone and consists of two phases: in-process monitoring and end-process monitoring. Both in- and end-process monitoring are used to collect data on the number of people in households and the general community who have taken specific drug packages during the NTD campaign. Data are collected from a sample of eligible household and community members using the same questionnaire for both in- and end-process monitoring. The estimated program coverage (# of eligible people treated/# of eligible people interviewed) derived through independent monitoring can be used to make comparisons to the reported coverage, both by district and at the national level, serving as a valuable monitoring and evaluation tool.

Cost-sharing

Pursuant to the grant agreement, HKI will contribute 10% cost share to the End in Africa program from applicable HKI funding sources. Much of this cost share will be through our Conrad N. Hilton Foundation trachoma grant which covers other aspects of the SAFE strategy, including surgery.

The Carter Center will participate in the 2012 campaign and provide funding for the purchase of 100,000 tubes of tetracycline at a cost of CFAF 13,500,000 (USD 27,000). The MOH will purchase of 70,000 tetracycline tubes at a total cost of FCFA 9,450,000 (USD 18,900). We also anticipate funding from the government of Niger for the supply of drugs for treating the side effects which are part of the national essential drug list. It's expected that the government will have a budget line for the NTD control up to 90,000,000 FCFA (USD180,000).

Travel Plans

MOH NTD Focal Point/3 designated disease coordinators:

- One trip to Cameroon or Burkina Faso for a study tour of the national program and to inquire about best practices.
- Two trips to international meetings (location and date TBD).

HKI Niger:

- One trip to Cameroon or Burkina Faso for HKI Coordinator and M&E Officer for a study tour of the national program and to inquire about best practices.

HKI Headquarters/Regional office:

- Two trips from New York and four trips from Dakar/London for project monitoring, evaluation, and support.

Staffing

The staffing structure of the NTD Program is made up of a Program Coordinator, a M&E Officer and an NTD Accountant. After extensive recruitment, a NTD coordinator for HKI has been identified and was hired in March. In total, the program will be implemented with the following staff:

- A Program Coordinator (successfully recruited)
- A Monitoring and Evaluation Officer
- An accountant

Environmental Monitoring Plan

As stated in the sub-agreement, the activities of the NTD program that pose adverse risk to the environment are the disposal of expired drugs and the management of health waste materials resulting mostly from surveys where blood, feces, and/or urine are taken and require proper and safe disposal. The Niger health system has an approved procedure in place for safely disposing of expired products and medical wastes. Training on these procedures will be included in the training course given to health agents. All of the health centers have an incinerator for disposing of medical waste. In 2012, a list of expired products will be prepared, a destruction committee set up, and the products incinerated. Labels will be systematically removed from empty boxes and will be incinerated or buried. HKI is sensitive to the need to reduce paper and will recycle materials whenever possible and rely on digital formats when appropriate.

Timeline

During FY2012, the main activities/timeline and milestones are represented in the following chart.

Timeline

	2011	2012											
	December	Jan.	Feb.	March	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	December
STRENGTHENING THE NATIONAL COORDINATION													
Quarterly coordination meetings													
Twice-yearly Task Force meetings													
Validation of the 2011-2015 strategic plan (TBD)													
Training of district focal point and district store keepers in SCM (TBD)													
MASS DISTRIBUTION (preparation)													
Regional micro-planning workshops													
Placement of the drugs order													
Workshop for review of the training and data collection tools													
Preparation of measuring rods, registers, posters													
Meeting with the ONPPC													
Preparation of the input supply plan													
Bundling of the drugs and distribution tools at the central level													
Identification of vehicles for													

the supply of inputs													
Transportation of the drugs from Niamey to the Regions													
Supply of the drugs and tools in the CSIs													
MASS DISTRIBUTION (TRAINING)													
Training of national trainers													
Briefing/Training of trainers (MCD and health and education focal points) at the level of the DRSP													
Preparatory meeting at district level													
Training of heads of CSIs													
Training of teachers													
Selection of community distributors (contract/CSI)													
Training of community distributors													
IEC/COMMUNITY COMMUNICATION MOBILIZATION													
Review of messages and recording of audio cassettes													
Supply of the cassettes to community radio stations													
Airing of the messages on television channels and radio stations													
National launching of the 2012 campaign													
National caravan for sensitization on NTDs													

ACTUAL DISTRIBUTION ACTIVITIES													
Distribution of the first package													
Distribution of the second package													
Distribution of the third package													
Restitution of completed registers, remaining drugs and payment of community distributors													
SUPERVISION													
Supervision and technical support at national level													
Supervision of DRSPs and DREN													
Supervision of community distributors by the CSI heads													
Supervision of CSI heads by the health and education focal points													
Collection of reports, remaining drugs and measuring rods in the CSIs													
Identification of physical stocks after the distribution campaign													
Supervision of the quality of expenditure support documents at the level of the districts													
Independent monitoring of the distribution													

POST-MDA EVALUATION													
District evaluation													
Regional evaluation													
National evaluation													
Survey on LF after 5 distributions of invermectin in 5 health districts													
Survey on prevalence of LF after 5 distributions of invermectin in 4 health districts													
Survey on prevalence of trachoma after 3 or 5 distributions													
Schisto mapping activities and sentinel sites													
OTHER ACTIVITIES													
Report on distribution coverage													
Semi-annual report													
Planning of 2013 activities													
Writing of the 2013 work plan													
Estimation of drug needs for 2013													