MSP/NIGER

Fiscal Year 2013

End Neglected Tropical Diseases in Africa

END in AFRICA

Annual Work Plan
October 2012 – September 2013

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Acronyms and Abbreviations

BSSE	Bureau Santé Santé Scolaire
CDD	Community Drug Distributors
CSE	Center for Epidemiological Surveillance
CSI	Centre de Santé Intégré
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
HQ	Head Quater
IHC	Integrated Health Center
INS	Institut National de la Statistique
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
MOE	Ministry of Education
MOH	Ministry of Health
MSP	Ministry of Public Health
NTD	Neglected Tropical Disease
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
RISEAL	Réseau International Schistosomiases Aménagement et Lutte
RTI	Research Triangle Institute International
SAE	Serious Adverse Events
SCI	Schistosomiasis Control Initiative
STH	Soil Transmitted Helminths
TAS	Transmission Assessment Survey
TCC	The Carter Center
TIPAC	Tool for Integrated Planning and Costing
USAID	United States Agency for International Development
WHO	World Health Program

Executive Summary

Since 2007, five consecutive MDA campaigns have been conducted in Niger treating 6 million children and adults in 2007, 8 million in 2008, 10.4 million in 2009, 11 million in 2010, and 10.6 million in 2011. The MDA for 2012 will take place in October with 9.6 million persons targeted for LF, 10.8 million for STHs, 7.6 million for trachoma, and 5.6 million persons targeted for schistosomiasis.

HKI will support the national program in FY 2013, implementing regional micro-planning workshops that will involve the participation of focal points, chief medical doctors, and managers of epidemiological surveillance centers at the district level. The purpose of these workshops is to fine-tune activity planning and budgeting in advance of the activities, ensuring the same level of understanding about implementation among those involved, and allowing quicker troubleshooting of problems later on. Following the workshops, funds will be allocated to health districts (HDs) for the preparation of the FY 2013 campaign. Upon receipt of funds, HDs will carry out training sessions from the regional level down to Integrated Health Centers (IHC) and schools. Simultaneously, the National Office of Pharmaceutical and Chemical Products (ONPPC) will organize the delivery of distribution tools and drugs to the HDs.

In FY 2013, 11 districts (1.8 million people) will be targeted for the treatment of schistosomiasis, 30 districts for lymphatic filariosis (9.9 million people), 18 districts for trachoma (8.3 million people), and 34 districts for STH (10.8 million people) with USAID support. In addition to the MDA, HKI will support the PNLBG in the baseline mapping of schistosomiasis in Bilma and the implementation of an impact evaluation in all districts in Tahoua, Agadez and Tchirozerine, which is in line with the country's schistosomiasis re-assessment strategy. LF transmission assessment surveys (TAS) are planned and will be conducted in 9 health districts in Tera, Say, Kollo, Birnin Konni, Tahoua, Keita, Bouza, Tchintabaradene and Illéla. LF sentinel site and spot check site assessments are planned in the 9 districts that will have completed 5 treatment rounds after the 2012 MDA. Additionally, the mapping of Arlit and Bilma for LF scheduled for FY'2012 will take place in FY'2013. The PNLCC is expected to conduct an impact survey in Diffa, N'guigmim, and a sub-district level survey in Tillaberi for trachoma to determine if treatment is necessary upon cessation of district-level treatment.

Supervision will take place at all levels in order to ensure quality of training and program implementation. The involvement of program coordinators in the development and implementation of monitoring programs will allow ownership of activities in accordance with Ministry of Public Health (MSP) regulations. Supervisors will be given the flexibility to address any potential issues and will discuss among the supervising team the most appropriate

solutions. Supervisors will also ensure that serious adverse events (SAEs) are well monitored and reported during and after distribution.

Alongside MDA activities, NTD awareness will be targeted at the regional, district, and community level to ensure that populations are well-informed on the campaign so that social mobilization can take place most effectively during the campaign.

To ensure that data collection indicators are in line with USAID/FHI360 requirements, HKI will ensure that the monitoring and evaluation framework and that program data (disease and program workbooks) are available to all NTD program implementation entities in Niger. Partners will be able to review and contribute to the data to allow for a complete data set.

HKI-Niger's FY 2013 work plan is in line with Niger's 2012-2016 NTD Strategic Plan and will move the country closer to control and elimination targets for the targeted NTDs.

Background

Niger is a land-locked, dry country in the Sahel with a population of 16.3 million living in 8 health regions (42 health districts). NTDs are a public health problem in Niger with four of the five NTDs requiring MDA: LF, schistosomiasis, STHs, and trachoma. Onchocerciasis is in the post-endemic surveillance phase and does not require MDA.

Since 2007, almost 40 million treatments have been given through preventive chemotherapy. Between 2007 – 2011, the integrated national NTD control program was implemented with funding from the United States Agency for International Development (USAID) NTD Control Program managed by RTI International, the Carter Center (TCC), and the Schistosomiasis Control Initiative (SCI)/ Réseau International Schistosomiases Aménagement et Lutte (RISEAL). Since 2011, the integrated national NTD control program has been funded through USAID's END in Africa program managed by FHI360 and implemented by Helen Keller International (HKI). The program also receives financial support from SCI/RISEAL to conduct the SCORE study in six districts, TCC for trichiasis surgery, tetracycline for trachoma MDA, and other support to the PNLCC.

Geographic scale-up of MDA coverage took place through the five consecutive MDA rounds from 2007 – 2011. Results from the 2012 campaign are not yet available since the vast majority of the campaign has been postponed to October 2012, given the late arrival of praziquantel and albendazole. The program initially planned for May but with the late arrival of the drugs the program had to consider pushing the MDA after the rainy season, school holidays, and Muslim fasting.

Table 1. The NTD Program in Niger

Disease	Number of endemic districts (at start of the program)	Number of endemic districts (current)	Number of districts in need of mapping in 2013	Number of districts with ongoing MDA activities		Number of districts needing MDA, but where MDA has not yet started	Number of districts that have stopped MDA
				Funded by USAID	Funded by others		
SCH	41	41	1*	35	6**	0	0
STH	42	42	42	34	0	0	0
LF	30	30	2	30	0	0	0
Onchocerciasis	5	0	0	0	0	0	0
Trachoma	34	20	0	20	0	0	13

*Bilma will be mapped for SCH (and STH at the same time); Tchirozerine and Agadez have been treated three times in the past for SCH but no baseline data exist, yet are included in the total number of endemic districts at the start of the program" (41) in the table.

** Funded by the SCORE study; Tiliberi is undergoing a treatment holiday in FY'13 and will not be treated along with the other 5 SCORE districts.

Overall Goals

The overall goal of the program is to reduce morbidity due to schistosomiasis and STH, and to work towards the elimination of LF, onchocerciasis, and blinding trachoma through preventive chemotherapy and the SAFE strategy for trachoma. In order to achieve this goal, the program will conduct MDA campaigns for LF, schistosomiasis, STH, and trachoma in the regions of Agadez, Tahoua, Diffa, Zinder, Maradi, Dosso, Niamey, and Tillabéri in May 2013. Onchocerciasis is currently in the surveillance phase in Niger.

Specific objectives:
Specific objectives of the national program vary according to the disease targeted:

Schistomiasis*:*

- Treat 11 high and moderate risk districts. Additional 5 districts, including Fillingué, Tilabéri, Loga, Tera, Say and Kolo, will be treated for SCH by RISEAL through the SCORE study.
- Conduct impact evaluations in 6 districts in Zinder (SCI/RISEAL), 3 districts in Diffa (SCI/RISEAL), 7 districts in Maradi (SCI/RISEAL), 8 districts in Tahaoua (HKI), and two districts in Agadez (HKI). Evaluations planed by SCI/RISEAL will be conducted in April 2013. HKI plans to hold theirs in February 2013.
- Conduct a baseline prevalence study in the district of Bilma (HKI), the mapping will take place in February.

Trachoma:

- Treat 18 districts for trachoma in 5 regions at the district level.
- Conduct trachoma impact surveys in the districts of N'guigmi and Diffa.
- Conduct a sub-district level assessment in the Tillaberi district.

LF:

- Treat 30 districts for LF (and STHs) in 7 regions.
- Conduct pre-TAS (sentinel site and spot check site) surveys in 9 districts that will undergo their fifth treatment round in October 2012 (Boboye, Tillabéri, Madaoua, Aguié, Dakoro, Guidan Roumdji, Madarounfa, Tessaoua and Mayahi).
- Conduct TAS in 9 districts where pre-TAS surveys were conducted in September 2012 (Téra, Say, Kolo, Birni Koni, Tahoua, Keita, Bouza, Tchinta and Illéla)--this is conditional upon the districts meeting criteria for the TAS based on pre-TAS results.

STH:

- Treat 34 districts in 7 regions for STHs; 30 will be targeted through the LF campaign (ivermectin and albendazole) and 4 will be targeted through the SCH campaign (praziquantel and albendazole)
- Map 11 districts for STH (along with SCH mapping) with support from HKI
- Conduct a national survey on STH in April (RISEAL), not including the 11 districts supported above.

Main Activities

Supporting the planning process of the national program for the fight against NTDs

HKI will support planning activities, which will be implemented with the participation of program coordinators and the national focal point. The identification of districts eligible for praziquantel treatment and albendazole will be carried out as usual in coordination with the PNLBG program coordinator and in accordance with the national policy against bilharziasis. The coordinator will work with regional focal points on updating the list of endemic villages. Regarding trachoma and lymphatic filariasis, districts eligible for treatment have already been identified. HKI will support the program for the implementation of surveys that will continue to refine the strategies for these diseases.

In order to assist in the analysis of unmet NTD program needs, an evaluation and planning workshop is organized every year at the national level at the end of mass distribution campaigns. This workshop involves the participation of key stakeholders (health, educational

sectors, and other partners) to identify strengths, areas for improvement, lessons learned and to articulate recommendations towards the improvement of the next campaign. This workshop will be held in December 2012 and the micro-planning workshop will follow in February 2013 in each of the eight regions of Niger. The workshops will identify the most appropriate implementation strategies, budgets and needs for each region. In the same period, audio materials will be developed to be broadcast by community-based radio stations for awareness raising and community mobilization. Dose poles and records keeping documents will be produced in the same period.

At the end of March the necessary drugs and tools for data collection and awareness-raising should be in place in order to begin the MDA on time. The transportation of drugs and key materials from the central or regional level to the district level will be carried out by ONPPC in April 2013.

The use of the Tool for Integrated Planning and Costing (TIPAC) will allow NTD program actors to enhance the assessment of unmet needs; therefore we plan to request technical assistance in its implementation so that key personnel of the NTD program in Niger can be properly trained to operate the tool.

Mapping

Bilma in the Agadez region will need mapping in 2013 for schistosomiasis and STH. Mapping did not occur in FY'12 due to insufficient funds for the overall schistosomiasis/STH assessment activity based on the need of the national program that came to light during the project year. A sub-district level survey for trachoma will be conducted in Tillaberi to determine if there are high prevalence pockets of trachoma in need of treatment at the sub-district level. Mapping in Arlit and Bilma for LF did not take place in FY'2012 due to issues in timing, this activity will be conducted in FY 2013.

Mass Drug Administration

Preparations for the 2013 MDA campaign will begin at the end of January 2013 with coordination meetings before key activities are implemented in the following phases:

Supply Chain Management

All drugs to be used for the FY 2013 campaign will be stored in central and regional warehouses of ONPPC. Right before the distribution period, ONPPC will be in charge of packing and delivering the drugs and tools to health districts. Health districts will then dispatch them to the CSIs and schools. In 2012, there was a large amount of Zithromax that was at risk of expiring by the end of August, 2012; to avoid this, these drugs were immediately redistributed to two

districts (Tessahoua and Mirriah) and the MDA in these two districts took place in July/August ,earlier than the rest of the country, so the drugs could be used prior to expiration. To avoid such situations in 2013, an inventory of drugs will be conducted just after the campaign (these occur annually at the end of the campaigns) and remaining drugs will be diverted to districts/regions where they are more likely to be used rapidly. This will ensure drug stocks do not remain on the shelves and are quickly used.

MDA Strategy

After completing their training, community drug distributors (CDDs) will start distributing medicines in May, or June at the latest. To ensure that the medication protocol will be correctly followed, checklists will be distributed at the end of training sessions for reference. The official national launch of the campaign is expected to be held in May.

The MDA strategy is community-based drug delivery with CDDs and school-based drug delivery by teachers in primary schools (over 10,000 schools). The drugs for LF and trachoma are distributed in accordance with the WHO-recommended strategies at district level, whereas the schistosomiasis disease risk is based on geography (village location in relation to the Niger river basin) with drugs delivered through CDDs and teachers. Although no baseline prevalence data exist for STHs, the entire country is considered to be at risk, thus treatments are conducted through the LF MDA (ivermectin and albendazole) and the schistosomiasis MDA in select districts. The first drug package is ivermectin and albendazole, following praziquantel and/or albendazole if LF is not endemic, and the third is Zithromax and tetracycline. There is typically a 7 day window between the distribution of the different drug packages due to how long it takes the CDD to distribute the first package and then begin the following package.

In FY'2013, ivermectin and albendazole will be distributed in 30 districts, praziquantel in 11 districts (4 of them will also receive albendazole), and Zithromax and tetracycline in 18 districts.

Table 2. Districts and populations targeted for FY 2013 MDA

Disease	Age Group Targeted	Frequency of Distribution	Distribution Platform	Number of districts targeted in 2013	Number of persons targeted in 2013
Schistosomiasis*	≥5 years (at risk adults are uniquely identified in the endemic villages)	- One treatment per year for the 10 districts considered to be high risk* - One treatment every two years for	Door-to-door distribution in communities; school-based distribution	16**	1,830,852

		the 31 districts considered to be moderate risk			
Onchocerciasis	N/A	N/A	N/A	0	0
Lymphatic Filariasis	≥5 years	One treatment per year for endemic districts	Door-to-door distribution in communities; school-based distribution	30	9,931,544
STHs	≥5 years	One treatment per year in the 30 districts treated for LF and in other SCH districts (PZQ + ALB) as determined by the national program	Door-to-door distribution in communities; school-based distribution	34	13,244,426
Trachoma	Total population	One treatment per year in districts where district-level prevalence of TF is >10%	Door-to-door distribution in communities; school-based distribution	18	8,319,387

*High risk is defined by the national program as those districts situated along the Niger River basin (Tillaberi, Kollo, Say, Tera, Niamey I, Niamey II, and Niamey III, Boboye, Gaya, and Dosso). Moderate risk is defined as all other districts. The risk categories given to the districts are not based on prevalence rates per se, but on geography.
** Five districts in FY'13 will be funded by the SCORE project; Tiliberi, the 6th district, will be on a treatment holiday in FY'13

Training

Trainings will be conducted in cascade fashion: a pool of trainers in Niamey will train regional trainers in every region, they will train IHCs Managers and officials of the educational sector, who in turn will train CDDs and teachers. In FY 2013 full trainings will be conducted for the 266 newly assigned physicians at IHCs and nurses and doctors will have refresher trainings since being initially trained in 2012. These trainings will be instrumental in updating and balancing the skills and knowledge of trainers to ensure correct and consistent information is conveyed to trainees at each level of the process.

Table 3. Training sessions for new personnel and refresher trainings

Training group	Training themes	Number of persons to train			Number of training days	Training location	Comments
		New	Refresher	Total			

Training	Training themes	Number of persons to train			Number	Training	
MPH/MOE at central level	Reviewing the role and content for national trainers and supervisors	10	20	30	2	Niamey	
Medical doctors and nurses	Data collection, management of side effects and SAEs, disease facts, treatment dosages, how to report data and leftover drugs	304	1207	1511	2	In the 8 regions of Niger and 42 district	304 new doctors and nurses were posted to CSIs in 2012 and will be receiving the new personnel training in 2013
Supervisors	Data collection, management of side effects and SAEs, disease facts, treatment dosages	4	6	10	1	Niamey	
Supply chain managment staff	How to manage the movement of drugs, how to manage drug stock, how to fill out the drug management forms	100	0	100	4		The training planned in 2012 was not conducted and is rescheduled for 2013
Teachers and Community-directed distributors	Data collection, management of side effects and SAEs, disease facts, treatment dosages, how to report data and leftover drugs	12,778 (teachers)	26,898 (community directed distributors)	39,676	1	In all CSIs	It is estimated that 1/3 of the distributors previously trained will be replaced by new distributors each year
Others (NTD program staff and finance managers)	TIPAC	0	20	20	5	Niamey	

Community Mobilization and IEC

The community mobilization strategy used for FY 2013 will be same as previous years. New messages will be amended and distributed to all community-based radio stations as well as national and regional stations with high coverage. Private radio stations with large coverage will be involved, as well. TV spots will be updated and broadcasted on the national TV channel over the entire period of the campaign. Posters will be prepared and delivered to CSI managers to display in each CSI and town criers and community leaders will help mobilize their community.

Supervision

The supervision strategy will not differ from that implemented in FY 2011 and 2012. Supervisions will take place by teams of supervisors at all levels to ensure quality.

- **At the national level**, teams consist of the national NTD focal point, coordinators and members of program teams (PNLBG, PNDO/EFL, PNLCC/BSSE) and some central directors. These teams will oversee project activities such as CSI training sessions and distribution and campaign assessments.

- **At the regional level**, teams consist of Regional Directors (Health and Education) who will oversee training sessions (training of CSI managers and area coordinators) and distribution in health districts. A second technical support team of regional focal points will oversee trainings, distributions and assessments at district and CSI levels.

- **At the district level**, health district chief medical doctors and NTD focal points (education and health) will oversee CSI Managers. Activities implemented by CDDs will be supervised by CSI Managers. Debriefing meetings will be held as regularly as possible between CSI Managers and community-drug distributors in order to assess their progress and daily performance.

The involvement of program coordinators in the development and implementation of monitoring programs will allow ownership of activities and their execution in accordance with MSP regulations. The HKI NTD program coordinator will provide overall supervision of the program to ensure proper implementation of the work plan.

When problems arise, supervisors will have the flexibility to provide adequate solutions depending on the severity of the situation, the level of responsibility, or the characteristics of the supervising team. In any event, severe issues will be reported to the national level for consideration with appropriate action taken within 24 hours of notification. Therefore, supervisors will be given a telecommunication allowance to identify and report on field problems in real-time.

To ensure that data collection forms are delivered to CDDs, CSI Managers, teachers, and other stakeholders will take refresher trainings to better understand what is expected of them. Supervision will include the quality of data collection and how accurately and completely forms are filled in.

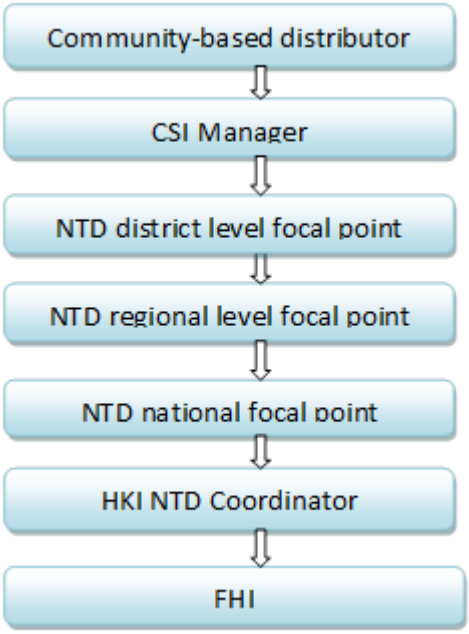
Table4. Drugs available and anticipated for delivery/distribution for the FY 2013 MDA

* The request for LF has not yet been made and will be done after the FY 2012 MDA results are available.

Drug	Drug origin	Quantity of drug requested	Date of the request (Month/Year)	Date shipment was requested (Month/Year)
IVM* 3mg tablets	Merck/MDP	34,797,757	January 2013	April 2013
ALB LF* 400 mg tablets	GSK	13,537,891	January 2013	April 2013
ALB STH 400 mg tablets	GSK/OMS	981,776 (donation from GSK/OMS) 490,889 (school aged children who are not attending school)	April 2012 January 2013	February 2013 April 2013
PZQ 600mg tablets	USAID	4,577,129	April 2012	February 2013
Zithromax Syrup	Pfizer/ITI	380,925	1er March 2012	November 2012
Zithromax 250 mg tablets	Pfizer/ITI	40,632 boites	1er March 2012	November 2012
Tetracycline eye ointment 1%	TCC	169,308	October 2012	November 2012

Management of serious adverse events

The reporting pattern for SAEs is shown below. This is shared during the training sessions at all levels and the procedure that must be followed is reviewed:



Side effects listed below must be reported within 24 hours to the NTD Coordinator. Reporting will take place before the investigation:

- Death
- Threatened vital prognosis
- Hospitalization of the patient or extension of hospitalization
- Persistence of a disability or significant disability
- Congenital abnormalities or abortions
- Occurrence of cancer
- Accidental or intentional overdose

If an SAE occurs, the National NTD Coordinator of the MSP will be notified by telephone within 24 hours. He/she will inform the national and international authorities (Mectizan Donation Program, Glaxo Smith Kline, WHO) immediately and the HKI NTD national coordinator. The HKI NTD Coordinator will inform the Deputy Country Director of HKI who will convey the information to HKI HQ and to FHI 360.

At the local level, the case will be directed towards the nearest health center that is able to organize optimal medical support. Ambulances, health facilities, drugs, etc. will be made available by the national health system. A team of investigators consisting of a regional focal point, a district level focal point, and a Chief Medical Officer of the district where the incident occurred will investigate the suspected SAE. They will inform national authorities and HKI who will make a decision on causality and subsequent SAE management based on recommendations articulated by authorities of the MSP. If the causal relationship is made evident, HKI will pay for all medical fees. It should be noted that no cases of SAEs has ever been reported in Niger since the early MDAs.

Proven or unproven incidents are shared with traditional authorities and opinion leaders in order to inform the communities. Community-based radios stations are used to anticipate or address any possible rumors. Minor side effects remain under the responsibility of the national medical authorities. The occurrence of mild or minor side effects has been decreasing over the years.

Program Monitoring and Evaluation

Monitoring and Evaluation of MDA

To ensure that data collection is in line with USAID/FHI360 requirements, HKI will ensure that the monitoring and evaluation framework, disease workbook, and program workbook are made readily available to Niger NTD stakeholders.

Data from the FY 2012 MDA, which has been delayed until October, will be submitted in the disease and program workbooks at least 60 days after the completion of all MDA activities. In FY 2013, the MDA campaign is expected to end in June, which means that data will be available in July 2013. The Semi-annual Report will be available in March 2013 and the program workbook and disease workbook will be sent at the required time intervals throughout the project year.

Distribution records completed by CDDs will be transferred to CSI Managers at the end of the campaign. CSI Managers will compile data in registers that will be sent to the district medical officer. The district medical officer will compile data from all CSIs and make two copies of the aggregate data: the first copy is for his/her records and the second copy will be forwarded to the region. The region will then compile data from districts in a single document known as the regional data record.

This data collection and collation process follows a proven hierarchical system that has been used by partners for almost 6 years. The quality of data at the district level remains the main challenge. In 2013, special emphasis will be placed on the quality of data collected at the operational level through:

- Inventory of remaining drugs at the district level to be conducted after distribution campaigns and to be included in the regional stock counts when performing regional assessments. CSI, the health district, PRSP, and HKI will be involved;
- Formative supervision at all levels with an emphasis on health districts with the lowest coverage rates in FY 2012;
- The use of a supervision template by supervising teams to enhance quality and uniformity of supervision;
- Full involvement of CSE (Center for Epidemiological Surveillance) Managers in NTD program activities;
- Each health district must develop a comprehensive report on activities at the end of each mass distribution campaign and submit it to the national level who will synthesize them by program;
- Reporting on every activity at each level (health districts, DRSP, regional directorate of public health, National) with regional focal points. These reports should be submitted along with supporting documents within 45 days after administration of the last drug package or after the sub-regional evaluation;
- Assessment results of every region must be sent to the national level at least one week prior to the national evaluation. The national team will finalize and submit the results of the campaign to HKI no later than one week after the assessment for HKI to meet submission deadlines.
- The development of an annual work plan by the national team highlighting activities, expected results, performance indicators, means of verification, and the people/organizations in charge.

In addition, independent monitoring will be implemented. The strategy consists of two phases: 1) Monitoring to resolve timely problems such as low coverage, shortage of drugs and other supplies, or the refusal of the community to participate in the campaign, and 2) Monitoring at the end of the process to allow an independent estimate of program coverage.

Independent monitoring will be done in the three regions where HKI already has an office, Diffa, Zinder and Dosso, with two districts in each region and 6 villages per district.

Program Evaluation and Transition to Post-Elimination Strategy

Schistosomiasis

Impact surveys for schistosomiasis will be carried out in eight HDs in Tahoua in FY 2013 with the support of HKI. SCI/ RISEAL has planned to conduct treatment impact surveys in three health districts in Diffa, seven health districts in Maradi, and six health districts in Zinder. Within the framework of the SCORE study, RISEAL supported schistosomiasis impact surveys in the regions of Dosso and Tillabery in FY 2012. The synergy between HKI and RISEAL will allow the collection of evidence based data at the district level for schistosomiasis and STH in every region of Niger within two years. The results from these impact surveys will provide district-level evidence for the treatment strategy in Niger, will be used to realign the SCH and STH distribution strategy to the current WHO guidelines, and to implement a district-level treatment strategy as recommended by the expert panel during the August 2012 Schistosomiasis Strategy Review in Ouagadougou.

STH

In FY 2013, surveys to evaluate the impact of MDAs on STH prevalence and intensity of infection will be conducted in 42 districts. HKI will support surveys in 11 districts concurrently with SCH surveys, and RISEAL will support surveys in the remaining districts. The details of this are currently being coordinated by HKI, RISEAL, and the national program.

Trachoma

Impact surveys for trachoma are expected to be carried out after 3 or 5 years of consecutive MDAs according to prevalence rates (after 3 years if TF prevalence is between 10% and 29% in children aged 1-9 years, and after 5 years if TF prevalence is ≥30% in children aged 1-9 years). In FY 2013, an impact survey will be conducted in health districts in Diffa, N'Guigmi and a sub-district assessment (sub-district level mapping) in Tillabery.

Lymphatic filariasis

At the end of FY 2012 sentinel/spot check site assessments (pre-TAS) will have taken place in nine districts (Tera, Say, Kollo, Birni Konni, Tahoua, Keita, Bouza, Tchintabaradene and Illela) despite low epidemiological coverage (<65%) reported for some years in these districts. The rational to go ahead with pre-TAS, despite low coverage, was that population data was not accurate; these districts included mobile populations and some sentinel site evaluations after 3 rounds of MDA showed LF prevalence was <1%. In FY 2013, TAS in these nine districts will be carried out if pre-TAS shows LF prevalence as <1%. Nine other districts will also be eligible for sentinel site/spot check site assessments in FY 2013 after their 5th round of MDA: Boboye, Tilaber, Aguie, Dakoro, Guidan Roumdji, Madarounfa, Mayahi, Tessaoua, and Madaoua. Both the pre-TAS and TAS are contingent upon the results of the pre-TAS conducted in nine districts at the end of FY'2012, i.e. if LF prevalence is <1% despite low coverage. A consultant is expected to support the program for the implementation of TAS.

Short-term technical assistance[1]

Several short-term technical assistance requests will be made in FY 2013:
Once the assessment is completed, PNLBG would like to have technical assistance to calculate prevalence for the Health District given various survey sites. HKI will be able to provide this technical assistance to the program through:

- A consultant will assist the PNDOELF to develop TAS protocols and to implement the TAS. This will provide a model that will be helpful for future surveys.
- Technical assistance will be needed to train the national program in the use and sustained implementation of the TIPAC.

Table 5. Technical Assistance Requests

Task	Technical skill required	Number of Days required
Development of the survey protocol and the implementation of the TAS and pre-TAS for LF	Solid understanding of LF epidemiology and pre-TAS/TAS assessments, survey training skills, data analysis skills	7
Train the national program and partners in the use and implementation of the TIPAC	TIPAC implementation experience	7
Survey and data analysis support for schistosomiasis	Schistosomiasis epidemiology, statistics, and survey skills	4

Financial management

After micro regional planning workshops, budgets will be developed for the ONPPC, each regional office, and the health district at the central level. Since Niger will be implementing the Fixed Obligation Grant (FOG) for the first time in FY 2013, a special training session will be provided to all relevant partners within the MSP by the NTD Finance Manager, who will conduct regular supervision missions.

Facilitating collaboration and coordination

HKI's push for the government to allocate a budget to be devoted to NTD activities seems to have been accepted. The government of Niger has dedicated CFA 9,000,000 (about $18,000) to the program, which HKI is planning to use (if funds are available in time) in order to purchase drugs for side effects.

[1] In accordance with funds available and priority on demands

During the national forum on NTDs held in Niamey in July 2010, commitments were made by regional and sub-regional officials, but these were not fulfilled. We note that some regions such as Diffa decided to support expenses related to town criers and HKI will continue with advocacy efforts.

The timing of the MDAs is chosen so that they do not conflict with other activities. If for any reason this should happen, stakeholders will be encouraged to take every opportunity to improve coverage and quality of activities.

To improve coordination, HKI will continue advocacy with the MSP for the appointment of a nation-wide and full-time NTD program coordinator, instead of a national focal point who is involved in NTD activities on a part-time basis. If a full-time focal point is designated, HKI will advocate that this position has the appropriate support personnel.

In addition to meetings regularly held between HKI and program coordinators, quarterly coordination meetings involving program coordinators, MSP and other partners involved in NTDs will be organized. The WHO will play a more involved role in NTDs at the national level by organizing coordination meetings involving all NTD stakeholders and providing support during the meetings. HKI will provide support as-needed.

Cost-effectiveness

ONPPC is a national department dedicated to importing and supplying public and private health facilities with essential generic drugs, specialties and basic medical supplies. It has the expertise and logistical resources needed by the NTD program to achieve its goals. Negotiations conducted in FY 2011 resulted in the signing of a tri-party (ONPPC/MSP/HKI) Memorandum of Understanding on the storage, packing and delivery of drugs and tools in every region of Niger. Upon assessment of the FY 2012 campaign, we will determine how to extend the assignments of ONPPC to include placement orders and reception of drugs in FY 2013 and beyond.

Plans Proposed for Additional Support to the National NTD Program

As part of its collaboration with different NTD programs, HKI assists the PNLCC and the lymphatic filariasis program by paying their telephone bills and internet connections, which is not the case for the PNLBG. In FY 2013, PNLBG's telephone bills and internet connections will be supported by a grant.

Some coordinators have expressed a need for laptops. Pending the availability of funds, two laptops will be purchased for each program (one for the coordinator and one for the epidemiologist), for a total of 6 laptops.

Cost sharing

For FY 2013, the Government of Niger will provide the project with drugs for side effects, several agents from the national health system, and vehicles - all of which are in-kind contributions. However, with no tools to evaluate these costs, HKI is not able to determine the cost of this contribution.

Through a grant from the Conrad N. Hilton Foundation, HKI provides support to the PNLCC for trichiasis surgeries, radio messaging to promote face washing, a school health curriculum to teach school children about trachoma, and surgeon trainings.

The Carter Center will similarly support the PNLCC to conduct surgery, radio messaging, and surgeon certifications in FY'13, along with their plans to purchase tetracycline for the trachoma MDA. SCI/RISEAL will support treatments for schistosomiasis and STHs in the SCORE study districts.

Travel Plans

- HKI Representative, Deputy Representative, and Program Coordinator in Dakar for the HKI AFRO NTD meeting;
- Finance manager (Issaka Alzuma) and chief accountant (Ibrahim Malam Djibo) in Dakar for the annual finance managers meeting.
- Emily Toubali from New York to Niger for program supervision and finance supervision by Alison McCarthy.
- Yaobi Zhang from London to Niger for the program supervision.
- From New York/London to Dakar for the regional meeting (HKI Director of NTDs (MacArthur), HKI Program Manager of NTDs (Toubali), HKI Regional Technical Advisor for NTDs (Zhang).
- International travel for Niger NTD team for international meetings:
    - Dr. Salissou to attend the Global Alliance for Lympatic Filariasis in Washington (November)
    - Dr. Gnandou to attend WHO schisto meeting (TBD)
    - MSP program staff and HKI staff to attend WHO trainings as they arise (TBD)

Staffing

The project is staffed by a Program Coordinator, Monitoring and Evaluation Manager, and an Accountant. In FY'2013, the project would like to expand the staff to include a new position: Assistant Program Coordinator. This new position would provide critical support to the HKI and MOH team, allowing HKI to spend more time in the field monitoring activities and providing more on-the-ground support.

Based on FOG training that HKI has received, it is imperative to the success of the program that short-term staff be hired to oversee FOG compliance and completion of milestones (one for each of the 8 regions) during the height of the MDA activities. These positions are included in the FY'13 budget. HKI will also open four 3-month internship positions to help support the management of the program and to allow for better monitoring and evaluation and skill-building.

At the MSP level, there are three vertical disease programs each composed of a coordinator, epidemiologist, a manager/logistician, and two to three technicians. Together, these coordinators are overseen by one NTD focal point.

Environmental Monitoring Plan

As stated in the sub-agreement, the activities of the NTD program that pose adverse risk to the environment is 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, which will be included in the training of health agents. All of the health centers have an incinerator for disposing of medical waste or are buried. With NTD products, the procedures mandated by the MOH and the donation programs will be used. The list of expired products will be prepared, a destruction committee set up, and the products incinerated. As for the empty packages, their labels will be systematically removed and the empty boxes incinerated or buried. HKI is also sensitive for the need to reduce paper and will recycle materials whenever possible, relying on digital formats where appropriate.

Timeline

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
National Coordination Support													
Organization of coordination meetings (every three months)	MSP/HKI												
Organization of biannual task force meetings	MSP/HKI												
Annual planning workshop of the MSP for NTDs	MSP/HKI												
MDA (preparation)													
Regional microplanification meetings	MSP/HKI												
Drug requests	Drug coordinators												
Preparation of dose poles, registers, and posters	MSP/HKI												
Finalization of the implementation plan	Drug coordinators												
Packaging of drugs and MDA materials	ONPPC												
Delivery of the drugs and materials to the regions	ONPPC												
Transport of drugs and materials to the CSIs	Districts												
MDA (training)													
Training of the national-level trainers	NTD Focal Point												
Training of trainers (health and education focal points) at the level of the DRSP	NTD Focal Point												
Preparatory meeting at district level	District												
Training of CSI heads	District												
Training of teachers	District												
Selection of CDDs	CSI												
Training of CDDs	CSI												
IEC/Social Mobilization													
Revision of messages	HKI												
Transport of cassettes to the radio stations	ONPPC												

Diffusion of messages on the television and through radios	HKI												
National Launch of the Campaign	Focal Point												
MDA Activities													
MDA – first drug package (IVM + ALB)	CSI												
MDA – second drug package (SCH, or SCH/ALB)	CSI												
MDA –third drug package (ZITH+TETRA)	CSI												
Submission of completed registers and other important materials (CSI working with CDDs)	CSI												
SUPERVISION													
National level supervision and technical support	NTD Focal Point												
Supervision at the level of the DRSP and DREN	DRSP												
Supervision of CDDs by the CSI heads	CSI												
Supervision of the CSI heads by the education and health focal points	District												
Receipt of reports and other materials from the CSIs	District												
Identification of the physical stock after distribution	MSP/HKI												
Supervision of the quality of data submitted by the districts	MSP/HKI												
Independent monitoring	HKI												
Post-MDA Evaluation													
District evaluation meetings	District												
Regional evalution meetings	DRSP												
National evaluation meeting	HKI												
Pre-TAS for LF in 9 districts	PNDOEFL												
TAS for LF in 9 districts	PNDOEFL												
Trachoma impact assessment in N'guigmi and Diffa	PNLCC												
Sub-district level mapping of trachoma in Tilabéri	PNLCC												
SCH/STH mapping in 3 districts	PNLBG												
SCH impact study (and STH mapping) in 8 districts of Tahoua	PNLBG												

LF mapping of Arlit and Bilma	PNDOEFL												
Other Activities													
Submission of coverage data	HKI												
Semi-Annual Report	HKI												
FY'2014 Drug Estimates	MSP												
FY'2014 Work Planning Meeting	MSP/HKI												
Activities from the FY'2012 workplan carried over to FY'2013													
MDA	NTD Focal Point												
MDA evaluation	NTD Focal Point												