Niger

FY2016

Control of Neglected Tropical Diseases

Annual Work Plan
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Acronyms and Abbreviations

ALB	Albendazole
APOC	African Program for Onchocerciasis Control
BCC	Behavior Change Communication
BMGF	Bill & Melinda Gates Foundation
CBM	Christoffel BlindenMission
CDD	Community Drug Distributor
CDTI	Community-Directed Treatment with Ivermectin
CERMES	Center for Medical and Health Research
CSI	Center for Integrated Health (Centre de Santé Intégré)
DFATD	Department of Foreign Aid, Trade and Development
DFID	Department for International Development
DHD	District Head Doctor (Médecin Chef de District)
DPHL	Pharmacy and Laboratory Directorate (Direction des Pharmacies et Laboratoires)
DQA	Data Quality Assessment
DRSP	Regional Directorate of Public Health (Direction Régionale de Santé Publique)
DSA	Disease Specific Assessment
EPA	Public Administrative Establishments (Etablissements Publiques Administratives)
EU	Evaluation Unit
FHI 360	Family Health International 360
FOG	Fixed Obligation Grant
GSK	GlaxoSmithKline
HD	Health District
HKI	Helen Keller International
ICT	Immunochromatographic test
IEC	Information, Education and Communication
ILMS	Information and Logistics Management System (Système d'Information et de Gestion Logistique or SIGL in French)
IVM	Ivermectin
JNM	National Micronutrient Days (Journées Nationales des Micronutriments)
JNV	National Vaccination Days (Journées Nationales de Vaccination)
JSI	John Snow Inc.
KAP	Knowledge, Attitudes and Practices
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)
OV	Onchocerciasis
PCT NTDs	Neglected Tropical Diseases targeted through Preventive Chemotherapy
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)
PNLBG	National Schistosomiasis and Soil-Transmitted Helminthiasis Control Program (Programme National de Lutte contre la Bilharziose et les Géohelminthes)
PNSO	National Eye Health Program (Programme Nationale de Santé Oculaire)
Pre-TAS	Pre-Transmission Assessment Survey
PZQ	Praziquantel
RDNE	Regional Directorate of National Education (Direction Régionale de l'Éducation Nationale)
RISEAL	International Network for Planning and Control of Schistosomiasis (Réseau International Schistosomiases Aménagement et Lutte)
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
SCORE	Schistosomiasis Consortium for Operational Research and Elimination
SPIS	Health Information Programming Service (or Service Programmation de l'Information Sanitaire)
STH	Soil-Transmitted Helminthes
TA	Technical Assistance
TAS	Transmission Assessment Survey
TEC	Trachoma Expert Committee
TF	Trachomatous Inflammation - Follicular
TIPAC	Tool for Integrated Planning and Costing
TT	Trachomatous Trichiasis
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

COUNTRY OVERVIEW

The NTD program has a number of partners and donors that support its program activities. These partners are detailed below in Table 1.

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)*	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 - Capacity-building - Assistance with drug donation (Mectizan® and Albendazole for the PNDO/EFL)	No	Several
Helen Keller International (HKI)	National level and all regions	- Overall technical and financial support to the national integrated NTDP, including advocacy, BCC, work planning, implementation, supervision, M&E, and data management and reporting	Yes	No
	Central level and the regions of Diffa, Dosso, Maradi, Tahoua, Zinder and	- Support the PNSO for trichiasis surgery - IEC activities for trachoma (sensitization via community radio stations)	No	Conrad N. Hilton Foundation

	Tillabéri	- - Support to the School Health Office to teach about trachoma in schools		
	National level and all regions	- Provide technical support for the National Vaccination Days (JNV) and National Micronutrient Days (JNM), including deworming of the under 5 year children	No	Department of Foreign Affairs, Trade and Development (DFATD)
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 tetracycline eye ointment 1% - IEC activities for trachoma (sensitization via community radio stations) - Sanitation (latrine construction, support to 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/ RISEAL	Central level and the regions of Dosso, Niamey and Tillabéri	- Support to the PNLBG for surveys - "SCORE" study with the objective of defining a better elimination strategy for schistosomiasis - Support to the PNDO/EFL in organizing hydrocele surgery camps in endemic districts in Dosso, Niamey and Tillabéri	No	Department for International Development (DFID), Bill & Melinda Gates Foundation (BMGF)
UNICEF	Central and regional levels	- Support to the PNLBG to organize deworming campaigns for children <5 years of age combined with National Vaccination Days (JNV) and National Micronutrient Days (JNM) with a donation of mebendazole and albendazole	Yes	Several
Sightsavers	Central level	- Support to the PNDO/EFL in epidemiological and entomological surveillance for onchocerciasis	No	Several
APOC*	Central level	- Support to the PNDO/EFL in epidemiological and entomological surveillance for	No	Several

		onchocerciasis		
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
Hossana Institut du Sahel	Central level and the regions of Dosso, Niamey and Tillabéri	- Support to the PNLBG with a donation of Nitezole (Mebendazole + Tinidazole) and operational costs to distribute the drug	No	Several

*APOC will close at the end of December 2015.
Note: Niger is one of three countries (also, Mali and Burkina Faso) that will receive World Bank funding for NTDs and malaria. However, at the time of this workplanning, it was not clear exactly what the World Bank would fund for NTDs. The intervention will cover border districts in Niger. Workplanning should begin in the first USG fiscal year quarter. Because of the lack of clarity on eligible activities or timing when the funds would be available, the Niger NTDP determined that all activities it was planning for FY16 will be inscribed in the END in Africa workplan submitted to USAID.

National NTD Program Overview

USAID history of support to Niger

The United States Agency for International Development (USAID) support for the integrated Neglected Tropical Disease Program (NTDP) in Niger started in 2007. The integrated NTDP brought together 3 disease-specific programs: the National Schistosomiasis and Geohelminthiasis Control Program (PNLBG); the National Blindness Control Program (which, since 2013, has been renamed the National Eye Health Program, PNSO); and the National Lymphatic Filariasis and Onchocerciasis Elimination Program (PNDO/EFL). From 2007 to 2011, USAID support was provided by the then Neglected Tropical Diseases (NTD) Control Program managed by Research Triangle Institute (RTI) International through the Schistosomiasis Control Initiative/ International Network for Planning and Control of Schistosomiasis (SCI/RISEAL) and with assistance from The Carter Center for trachoma MDA. The first MDA in 2007 took place in the regions of Tahoua, Dosso, and Tillabéri. In 2008, the MDA was expanded to include Maradi region; Niamey was added in 2009; and in 2010, 100% geographical coverage was reached for the districts that had been mapped and shown to require MDA and support remains at that level.

Since 2011, USAID support in Niger has been provided by the END in Africa Project managed by Family Health International (FHI) 360 through HKI. USAID funding continues to support the PNLBG, PNSO, and PNDO/EFL to implement integrated NTD activities throughout the country, including mapping, MDA, strengthening of data collection efforts, community social mobilization, advocacy, and supply chain management. In FY16, support will also be given to the Directorate of Pharmacies and Laboratoires (DPHL), which is a newly created entity within the Ministry of Public Health (MoPH) responsible for ensuring quality assurance of all drug used throughout the country. In addition, support will be given to the new National NTD Coordinator. Assistance will include office supplies and fuel.

Lymphatic Filariasis

Baseline lymphatic filariasis (LF) mapping began in 2003, with mapping of the last districts suspected of being endemic taking place between 2013-2014 (Arlit and Bilma in Agadez, and Fillingué in Tillabéri). Arlit and Bilma had never previously been mapped, and mapping revealed that Arlit now requires MDA, as the prevalence of LF antigenemia by immunochromatographic test (ICT) cards was above 1%. MDA for Arlit began in the FY15 MDA round. Neither Bilma nor Filingue's mapping results indicated a need for MDA. However, due to an elevated number of hydrocele and lymphedema cases in Fillingué, the National Coordinator wanted to remap the district.

MDA began in 2007 in 9 HDs and gradually scaled-up to 100% geographic coverage, when all 31 endemic HDs (including Arlit in FY15) had started treatment. In 2013, 3 HDs successfully reached criteria for stopping MDA and have now stopped MDA (Say, Kollo, and Téra). Additional transmission assessment surveys (TAS 1) took place between November 2014-January 2015 and showed that four of the five evaluation units (EUs) passed, which included the five districts of Guidan Roumdji, Dakoro, Madaoua, Tillabéri, and Boboye. The EU that failed was comprised of the district of Aguié. The five districts that passed TAS 1 were treated in the FY15 MDA but will stop MDA in FY16. This leaves 23 districts that will require treatment in FY16, with a target population of approximately 8.1 million persons. The PNDO/EFL has also planned to conduct a pre-transmission assessment survey (pre-TAS) in nine HDs (Zinder Commune, Mirriah, Gouré, Tanout, Magaria, Matameye, Diffa, Maine Soroa, and N'Guigmi (the latter three are in Diffa region, which is the area of Niger affected by Boko Haram; pre-TAS will only be conducted if security allows)) and TAS 1 in two HDs (Niamey II and Niamey III). These surveys were included in the FY15 workplan; however, since MDA occurred later than scheduled in FY15, the surveys will likely not be possible to begin until October 2015.

In FY16, the PNDO/EFL will conduct a number of DSAs for LF: 11 HDs will undergo Pre-TAS (Gaya, Aguié, Madarounfa, Mayahi, Tessaoua, Konni, Bouza, Illéla, Keita, Tahoua, and Tchintabaraden) and nine HDs will undergo TAS 1 (Matamèye, Magaria, Mirriah, Tanout, Gouré, Zinder, Diffa, Mainé, and N'Guigmi) if they pass pre-TAS as described above.

The MoPH of Niger aims to eliminate LF as a public health problem by 2020 and uses the following strategies:

- Mass treatment with ivermectin (IVM) and albendazole (ALB), with a target of reaching at least 65% of the at-risk population and 80% of the eligible population of endemic districts;
- Surgery for hydrocele cases and care for lymphedema cases, which includes the need to conduct an active search for/census of persons living with lymphedema and hydrocele;
- Improved monitoring of MDA;
- Implementation of behavior change communication (BCC) using information, education and communication (IEC) materials that focus on disease prevention and improving participation in the MDA campaigns;
- Vector control in collaboration with the National Malaria Control Program;
- Operational research; and

- Capacity-building for program actors.

Onchocerciasis

Onchocerciasis (OV) mapping was conducted 1974-1976, and there were 5 HDs endemic for OV. Vector control measures took place between 1976 and 1987 supported by the Onchocerciasis Control Program (OCP). In 2002, the disease was declared under control by the WHO and no longer a public health problem. Niger has never conducted Community Directed Treatment with Ivermectin (CDTI) in the 5 OV HDs, since the prevalence in these HDs is lower than the threshold requiring treatment. However, all districts have been treated for LF with IVM + ALB.

In January 2015, entomological (with support from Sightsavers and the African Program for Onchocerciasis Control [APOC]) and epidemiological surveys (with support from USAID) were conducted for the three districts that passed the TAS in 2013 (Kollo, Say and Téra). The prevalence in each district was 0% mf for the epidemiological surveys and 0% for the entomological surveys. These districts, along with Boboye, which reached the criteria to stop LF MDA in FY15, will conduct epidemiological and entomological surveys in FY16 to determine whether these districts have met onchocerciasis elimination target. The fifth district endemic for OV, Gaya, will conduct pre-TAS in FY16 and if it qualifies to conduct TAS 1, then epidemiological and entomological surveys for OV will be conducted in FY17. Once the survey results are obtained, the PNDO/EFL will begin to compile its dossier to submit to the WHO for elimination validation; however, it will need to wait until after Gaya's elimination verification surveys are completed to be able to submit the dossier.

Current strategies pursued by the PNDO/EFL to eliminate OV include:

- Reinforcement of surveillance;
- Conducting epidemiological and entomological surveys to confirm elimination;
- Strengthening of information, education and communication about OV.

Schistosomiasis

The PNLBG was officially launched in 2004. Forty-one of the 42 HDs in the country (all except Bilma) were found to be endemic for schistosomiasis (SCH). Biennial MDA with Praziquantel (PZQ) started in 2004-05, targeting school-aged children and high risk adults with funding from SCI/RISEAL and then with funding from USAID NTD Control Program from 2007. From November 2004 to May 2007, three successive surveys were conducted by the Center for Medical Research and Health in eight sentinel sites located in the regions of Tillabéri, Dosso and Tahoua. The overall average prevalence was 75.4%. A year later, following MDA, the average prevalence significantly decreased to 37.4% and another year later, the prevalence was 35.7%.

In 2010, sentinel site monitoring revealed high reinfection rates, and as a result of this discovery, Niger decided to treat all areas of the river valley regions (Tillabéri, Dosso and Niamey Urban Commune) on an annual basis and other regions once every 2 years (Maradi, Diffa, Agadez, Tahoua and Zinder). Reassessment surveys were conducted between 2011-2014 in all districts, and in November 2014, a meeting of schistosomiasis experts was held to review all the data and realign the treatment strategy with WHO guidelines. Geographic coverage for MDA is 100%, though it should be noted that not all districts are treated annually. In the new strategy, districts will be treated on an annual, biennial, or biannual basis (see Appendix 9 for full strategy). In addition, "hotspots" (all village where the SCH prevalence >45%) will have a particular treatment strategy applied to them (either one or two treatments annually), as well as an intensification of sensitization and case management.

In the FY16 MDA, the PNLBG plans to treat approximately 2.7 million persons (in 18 HDs). In addition to MDA, the PNLBG will continue to implement its other program activities, where needed, including sensitization, case management, capacity-building of program staff, monitoring and evaluation (M&E), and operational research.

One new activity that the SCH program needs to conduct is an update of the list of endemic villages. There have been wide variances in reported coverage in MDA for SCH (for example, in the FY15 MDA, this varied between 51.1% in Matameye district and 150% in Maradi Commune). This is likely due, in part, to inaccurate denominators, since the target populations are projections from the 2001 census, and the list of endemic villages was last updated in 2004. In order to gather the data required, the PNLBG will visit with the head nurses of the health centers for the villages currently on the endemic villages list to go over clinical registers to find whether any clinical cases of SCH have been treated, and if so, their provenance. Then, the PNLBG will visit the current villages on the list to discuss with the village chiefs and counselors whether there are permanent or semi-permanent surface water sources. Any villages where clinical cases are reported and those with permanent or semi-permanent surface water sources will be retained on the endemic villages list. Those villages will be informed of their status and will be targeted for SCH MDA.

Soil-transmitted helminthes

All 42 HDs in Niger are endemic for soil-transmitted helminths (STH); according to WHO definitions, Niger has a moderate prevalence for STH (between 20% and 49.9%). The national strategy (treating all HD despite moderate prevalence) has been based on the fact that most people do not have access to clean water or sanitation facilities, and have poor hygiene practices.

The MoPH control strategy for STH consists of:

- MDA via LF treatment (IVM+ALB) or SCH + STH treatment (PZQ+ALB). It should be noted that not all HDs receive treatment on an annual basis via these mechanisms, as certain HDs are not endemic for LF (or have stopped treatment) and may not treat SCH on an annual basis;
- While not part of the PNLBG, children ages 12-59 months also receive de-worming medications during National Vaccination Days (JNV) financed by UNICEF, which generally distribute de-worming medications twice per year;
- Pregnant women are treated with Albendazole through the Directorate of Mother and Child in the MoPH;
- Implementation of BCC using IEC materials focusing on disease prevention and improving participation in the MDA campaigns;
- Improvements to the supply of clean water and sanitation.

In addition to MDA, 17 sentinel sites in 17 districts now require impact evaluations and the PNLBG plans to conduct these in FY16 in conjunction with SCH sentinel site surveys.

One gap for STH is the lack of support to treat high-risk adults for STH where LF treatment has stopped and where SCH MDA is not taking place. This is detailed in the “Looking Ahead” section below.

Trachoma

Trachoma control efforts began in Niger in 2002 following district-level baseline mapping surveys. At that time, out of the 42 HDs, 33 were considered endemic and required MDA (≥10% trachomatous inflammation follicular (TF) among children ages 1-9 years). Of the remaining 9 districts, four were completely urban and not considered endemic and have never been mapped (Niamey I, II, and III and Maradi); one HD was <5% at baseline (Loga); and the four districts of Agadez region (Arlit, Bilma, Tchirozérine, and Agadez) were considered unlikely to be endemic. However, due to recommendations from the Trachoma Expert Committee, the PNSO later determined that it should map the region of Agadez, which was completed in 2014 with USAID support. Of these four districts, two were discovered to have low-level endemicity (Bilma (9.9%) and Tchirozérine (6.9%), while the other two (Agadez and Arlit) have a TF prevalence <5% among children ages 1-9 years. Thus, 35 districts are now considered to be endemic.

The PNSO has shifted from a control to an elimination strategy and has set a blinding trachoma elimination date of 2018. The MoPH elimination strategy for trachoma consists of the WHO-endorsed SAFE strategy (Surgery, Antibiotic therapy, Facial cleanliness and hygiene, and Environmental improvement), and M&E, which includes impact evaluations following one, three, five, or seven years of MDA, depending on TF prevalence (though no district in Niger has a high enough prevalence to warrant seven rounds of treatment prior to conducting an impact evaluation). Although all the districts suspected of being endemic have now been mapped for trachoma, 100% geographical coverage for MDA is yet to be reached as no district in Agadez has ever received MDA. However, following the mapping that took place in August 2014, two HDs warrant at least one round of MDA, in accordance with the new standard operating procedures developed by the WHO and validated by the RPRG. Drug was ordered and approved and will be available in time for the FY16 MDA. Treatment of these two districts in Agadez region will bring geographic coverage for MDA to 100%.

The current epidemiological situation is as follows:

- 22/42 HDs with TF_{1-9} <5% (either at baseline or impact)
    - Baseline: Loga, Arlit, Agadez
    - Impact: Tillabéri, Tchintabaraden, Téra, Tahoua, Say, Bouza, Abalak, Fillingué, Kollo, Birnin'Konni, Doutchi, Dosso, Madaoua, Tanout, Keita, Ouallam, Illéla, Gaya, Boboye
- 4 HDs with TF_{1-9} between 5-9.9%: N'Guigmi, Tchirozérine, Dakoro, Bilma
- 8 HDs with TF_{1-9} between 10-29.9%: Mayahi, Guidan Roumdji, Zinder, Mirriah, Gouré, Madarounfa, Aguié, Diffa
- 4 HDs with TF_{1-9} between 30-49.9%: Maine Soroa, Tessaoua, Matameye, Magaria
- 4 HDs that have never been mapped and are not suspected of being endemic and for which mapping is not planned (the three districts of Niamey and Maradi)

A total of 22 HDs have stopped district-level MDA out of the 34 that have ever implemented MDA:

- Tillabéri (6) : Téra, Say, Tillabéri, Ouallam, Filingué, Kollo ;
- Dosso (4): Doutchi, Boboye, Dosso, Gaya ;
- Tahoua (8) : Abalak, Tchintabaraden, Tahoua, Bouza, Keita, Madaoua, Birni n'Konni, Illéla ;
- Maradi (2) : Maradi and Dakoro
- Zinder (1): Tanout
- Diffa (1) : N'Guigmi

Two other districts warrant starting MDA: Bilma and Tchirozérine, in the region of Agadez, will conduct one round of MDA in FY16 to be followed by an impact assessment per the new WHO standard operating procedures.

Table 2: Snapshot of the <u>expected</u> status of the NTD program in Niger as of September 30, 2015

		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 09/30/15	No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/15	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/15	No. of districts requiring DSA as of 09/30/15
					USAID-Funded / Others			
Lymphatic filariasis	42	31	11	0	23[1] / 0	0	8[2]	Pré-TAS: 9 district (Matamèye, Magaria, Mirriah, Tanout, Gouré, Zinder commune, Diffa, Mainé, N'Guigmi) TAS: 2 districts (Niamey II et Niamey III)
Onchocerciasis		5[3]	37	0	0 / 0	0	5	4 districts
Schistosomiasis		41	1	0	35[4] / 6[5]	0	0	*17 districts*
Soil-transmitted		42[6]	0	0	42 / 0	0	0	*17 districts*

helminths									
Trachoma		35	7[7]	0	14[8]	0	2[9]	20[10]	7: Guidan Roumdji, Dakoro, Mayahi, Tessaoua, Madarounfa, Mainé Soroa et N'Guigmi;

1. This is the current number of districts requiring MDA; the districts of Niamey II and Niamey III will undergo TAS 1 in late FY15 and may also reach the stop MDA criteria, although they will still be treated in the FY16 MDA, regardless of result.
2. These districts include Téra, Say, and Kollo, which met stop MDA criteria in 2013 and Guidan-Roumdji, Dakoro, Madaoua, Boboye, and Tillabéri which met stop MDA criteria in 2014. This does not include the two HD which will undergo TAS 1 at the end of FY15, Niamey II and Niamey III, since the survey is likely to take place after the end of September 2015.
3. These districts (Téra, Say, Kollo, Boboye and Gaya) are in the elimination phase of OV. Four of these districts will undergo epidemiological and entomological evaluations in FY16; the last, Gaya, is still undergoing LF MDA.
4. Districts are not all treated annually; a new SCH treatment strategy was developed in FY15 and will be implemented in FY16 (see Appendix 9).
5. Support from SCI/RISEAL for these 6 HD will end at the end of December 2015 and will start being treated with support from USAID. The FY16 MDA is planned for November 2015, so only 4 of these HD will receive USAID-supported treatment in FY16, since the new SCH treatment strategy calls for twice yearly treatment; they will be treated in approximately March-April 2016.
6. Niger considers all 42 HD to be endemic for STH due to the hygiene and sanitation conditions in the country, as well as the poverty and nutritional status of its population. The PNLBG has data for 22 of the 42 HD (13 with funding from USAID and 9 from SCI/RISEAL).
7. Includes Niamey I, II, III and Maradi which have never been mapped as they are not suspected of being endemic for trachoma. Also includes Loga, Arlit and Agadez which were <5% TF among children ages 1-9 years at baseline.
8. Includes 12 full HD currently on a treatment schedule and 2 sub-districts also on a treatment schedule. The two districts on a sub-district level treatment schedule will undergo impact evaluations at the end of FY15 and will likely no longer require treatment; thereafter, sub-districts will no longer be used as per the new WHO standard operating procedures. The two districts of Bilma and Tchirozérine with TF 5-9.9% are not captured here, as they have not yet started MDA. Those two HD are captured in column G.
9. 2/4 districts that were mapped in Agadez in calendar year 2014, Bilma and Tchirozérine, had a TF prevalence between 5-9.9%. These HD were not included in the last MDA, as drug was not ordered and approved in time. These two HD will be treated in the FY16 MDA. According to the new WHO standard operating procedures, districts with baseline 5-9.9% TF may treat for one year and then conduct an impact assessment.
10. This includes Maradi, which distributed MDA prior to redistricting (as part of Guidan Roumdji and Madarounfa) and Maradi became a purely urban district but was never mapped as its own district, since trachoma was not suspected to be endemic in this urban area. This is why columns F+G+H≠C+D

PLANNED ACTIVITIES

Project assistance

There are no activities that are specifically gender-focused. However, MDA activities at the operational level are conducted largely by women due to cultural reasons that enable women to enter any household and treat all household members, whereas if men were conducting the distribution, they would not be permitted to enter certain households, which would likely result in a lower treatment coverage. For the same reasons, personnel used in lymphatic filariasis evaluations are also primarily

female, as they are allowed to touch both the females and males in the households to take blood samples, and priority is given to the selection of female griots (traditional singers/entertainers) used to inform populations prior to MDA, since they, too, may go into each household.

Strategic Planning (ODC, FOG)

MoPH annual workplan workshop (Once a year) **[FOG]**
This meeting will precede the annual program review and planning workshop for the activities of the MoPH. Objectives of this meeting include developing an evaluation document for the 2015 activities and an action plan for 2016. This meeting will be held just prior to the annual review of activities for the MoPH. This annual Ministry workplanning will be accompanied by a plan of action budgeted based on the NTD Strategic Plan 2012-2016. Participants in this meeting will include authorities within the MoPH, the national NTD focal point, NTD Program Coordinators and staff, the National Office of Pharmaceutical and Chemical Products (ONPPC), the DPHL, regional NTD staff, representatives from the national educational sector, and other partners working in NTDS (HKI, Hossana Institut du Sahel, World Vision, CBM, Lions Clubs of Niger, APOC, Sightsavers, UNICEF, WHO, RISEAL, The Carter Center). The annual plan will be shared with regional and district partners. A small committee lead by the National NTD Coordinator will be in charge of ensuring this action plan is carried out. The expected results of this meeting are the development of an MOH NTD Program budgeted annual action plan.

Annual post-MDA review meetings at the National, Regional, and District Levels (Once a year) [FOG, ODC]
An evaluation and planning meeting is held at the end of the mass distribution 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, the 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 (DHDs), and the NTD focal points for education and health. A similar assessment meeting is also held at the district level with the CIH 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 for feedback from the partners. The expected results of this meeting are the sharing of the overall results of the NTD campaign as well as development of recommendations to improve future campaigns.

Annual microplanning meetings (Once a year) [FOG, ODC]
Microplanning meetings for the next year's MDA will be held during the annual workplanning and budgeting process for the U.S. Government fiscal year. The main goal of the meetings will be to develop a base budget for all of the activities included in MDA with full involvement of all stakeholders that will then be included in the budget HKI submits to USAID for the next fiscal year. The micro-planning meetings will be held in each region with the participation of the central level (national NTDP and Health Education Office coordinators and agents) and HKI. The recommendations made at these meetings will be reviewed and used to create a working document. The expected results of this meeting are budgets and targets for the next fiscal year's MDA. The budgets and targets developed will roll-up into the NTDP's global budget for activities in 2016 (the NTDP operates on a calendar year basis).

Cross-border meeting between Niger and Burkina Faso (Once a year) [ODC]

This meeting between Niger and Burkina Faso will primarily focus on discussing program activities and follow-up along the new borders that were drawn between Niger and Burkina Faso in 2015 (an area of Niger of approximately 786 km^2, consisting of 14 villages will now become part of Burkina Faso; in addition, an area of Burkina Faso of 277 km^2, consisting of 4 villages, will now become a part of Niger. Since the districts along these borders are at different stages of program implementation (for example, the districts on the Niger side of the border are in the surveillance stage for LF, while one of the bordering districts in Burkina Faso is still implementing MDA), it is important the two countries determine which program will implement in these villages; the goal of the meeting is to have a concrete plan for program implementation in these villages. From each of the two countries, the different NTD coordinators and disease focal points, other Ministry of Health representatives, administrative and traditional leaders in these areas, and HKI will attend these meetings.

Support to the new NTD strategic plan (Once) [FOG]
In 2016, the current NTD strategic plan for the period of 2012-2016 will expire. Unfortunately, a mid-term evaluation of this plan was not carried out; to date, the NTDP has also not expressed a need to conduct a final evaluation of the progress against the objectives set forth in this plan. In May 2015, the WHO organized a workshop in Ouagadougou to assist countries to revise their strategic plans. The principal recommendation from this meeting is that local partners of NTD programs should assist the National Programs to revise their NTD strategic plans. The new strategic plan for the period of 2016-2020 will concern NTDs targeted through preventive chemotherapy (PCT NTDs) (SCH, STH, LF, trachoma, and OV) as well as others that need case management (leprosy, rabies, leishmaniosis, human African trypanosomiasis, and Guinea worm). The WHO envisions engaging the different countries in a dynamic process of development of the new strategic plans beginning in 2016. HKI, in collaboration with the WHO and other partners, will assist the National NTD Program to develop its new strategic plan through technical and financial support, with the expected result of a new 2016-2020 Master Plan. In addition, if the National Program determines that it wants evaluate its current plan, HKI will provide technical and financial assistance in this process.

Meetings with the Regional Governors (Once a year) [ODC]
Regional meetings with the governors from the different regions to sign the Fixed Obligation Grants (FOGs) will be held, with the objective of advocating with the Minister of Health and the Governors for facilitation in signing the FOGs in order to carry out the MDA as planned in FY16. Participants include authorities from the MSP, NTD Program and HKI. Prior to the meetings with the Governors, the NTD Program will ask the Minister of Health to approach his counterpart in the Ministry of the Interior about the importance of signing these FOGs. This first step is necessary, since the Governors' hierarchy is within the Ministry of the Interior, while the contracts are for the Ministry of Public Health to conduct activities. In Niger, the FOGs must be signed by the Governor, rather than the regional health authority, as there is a decree that states that any contract that involves more than one district must be signed by the Governor, regardless of the type of contract or the Ministry implicated. In the past, difficulties with receiving signatures have arisen because this sensitization had not occurred. The expected results of these meetings are to sensitize the Governors to the NTD Program, the purpose of the FOG contracts, and to obtain signatures on the FOGs. The NTDP and HKI will carry out these meetings together.

NTD coordination meetings (Each quarter, four times a year) [ODC]Quarterly meetings will be held between the National NTD Program (the National NTD Focal Point and the Coordinators of the disease programs) and partners that support the National Program, including HKI, WHO, The Carter Center, the World Bank, UNICEF, and RISEAL/SCI. These meetings will be organized every three months to monitor and plan activities and to find solutions to urgent issues that come up during activity implementation.

These meetings will also provide an opportunity to develop contingency plans when faced with potential changes in programming. In FY16, particular attention will be paid to the planning for the MDA during each of these meetings. The expected results of these meetings are to ensure that information is shared among partners, resulting in concrete actions to solve issues as they arise.

TIPAC Review and Update Meeting (Once a year) [TA: not budgeted]
Training for the Tool for Integrated Planning and Costing (TIPAC) took place during FY15 and Niger would like to undertake a review and update in FY16. By the end of FY15, the data entry and analysis of the different reports should be completed. In the context of the new strategic plan which will be developed in FY16, this tool will enable the NTD Program to generate the new document through downloading the needed data from the TIPAC.

For efficiency and efficacy, the TIPAC tool will be maintained at the national level; however, the national coordination will require a computer with higher capacity. In the eight regions, the Health Information Programming Service (or Service Programmation de l'Information Sanitaire (SPIS)) will assist in providing the data necessary to enter into the tool. In addition, during the TIPAC training in 2015, it was noted that certain aspects of the tool were not adapted to Niger; therefore, a revision will be required to update this tool to the Niger context Please note that this activity is not specifically budgeted, as per usual for technical assistance (see Technical Assistance section, page 33).

NTD Secretariat

Support to the NTD Focal Point, PNLBG, PNDOEFL (Every month or quarter in the year) [ODC]
The new national NTD Focal Point has been appointed and will need support for her work. This support will primarily be for office and computer supplies, an internet key, and fuel. HKI will provide the NTD Focal Point with a proportion of her needs; the other proportion will be supplied by the Government. This support may be reviewed, once World Bank funding is available. She will also receive support in terms of program management training (see Capacity Building/Training section below).

Similar support will be provided to the PNLBG and PNDO/EFL programs, with funds provided to pay internet and telephone bills and office and computer supplies. The PNSO receives this support from HKI via funding from the Conrad N. Hilton Foundation.

Support to the MoPH's Direction of Pharmacies and Laboratories (Every month or quarter in the year) [ODC]
The MoPH Pharmacy and Laboratory Directorate (DPHL), is the structure responsible for managing medications for national health programs and other NGOs throughout Niger. Through working within this structure, the Ministry will begin to fully participate in the management of NTD drugs. The DPHL will provide a focal point to work with the ONPPC, the different NTD Coordinators, and HKI to coordinate all activities related to the management of NTD drugs before, during and after the campaigns. This will include storage, packaging, shipping, delivery, reporting, post-MDA physical inventory, as well as other supply chain management activities. This support that will be provided to the DPHL will be in the form of computer, office and computer supplies, purchase of an internet key and fuel.

Advocacy

National launch of the mass distribution campaign (Once a year) [FOG, ODC]
Each year, the MDA officially begins with an official launching ceremony. The launch, which provides the program with an official seal of approval and improves the program's visibility, will be sponsored by the MoPH. It will bring together all stakeholders involved in the control and elimination of NTDs, including high authorities within the MoPH and other ministries, administrative, local and traditional authorities, associations and non-governmental organizations (NGOs), and all other relevant entities to support the efforts of the NTD program. This year, the NTD Program would like for the launch to take place in a region outside of Niamey, preferably in an area with persistent or high prevalence of one or more NTDs targeted by the campaign. The reason for this is to bring more local attention to these diseases to try to increase coverage.

Organization of Task Force Meetings (Twice yearly) [FOG, ODC]
This is an intersectoral steering committee (representatives delegated by the Prime Minister's Office, National Assembly, the Ministries of Health, Education, Finance, Water, the Environment, Population, the Promotion of Women and Protection of Children, the Interior and Communication) will advocate for the integration of activities and will be responsible for validating the major strategic direction and finding additional funding for activities, if required. The committee will act as a pressure and advocacy group for the NTD program with the high authorities of the MoPH and other partners. The program will call on the committee for the organization of MDA planning meetings, advocacy, and social mobilization. Meetings will take place every six months.

Advocacy meetings at the health district level (Once a year) [FOG]
These are preparatory meetings in each district that will undergo MDA prior to the start of the MDA. The meetings assemble district prefects, city mayors, chiefs of cantons, religious leaders, associations, NGOs, health and educational representatives, and any other NTD partners. The main objective of these meetings is to mobilize these partners to contribute to the MDAs, by contributing towards motivation for CDDs and supervisors, and providing transport (motorcycles, fuel, etc.), which aim to mobilize all partners at the local level for their full participation in the running of the campaign. They will bring together the prefect, the mayor, religious leaders, representatives of heads of cantons, associations, NGOs and officials of health and education.

The activities planned for FY16 arose from discussions held at post-MDA evaluations, which noted that much of the difficulty for the NTD program over the past years in years past has been due to insufficient involvement and sensitization of administrative, local, traditional and religious authorities at all levels. The activities that are being proposed above will help to address the lack of involvement by these leaders by providing an opportunities to make the NTDP more visible and enabling these leaders to prioritize support to the NTDP. The target populations, in turn, when they see the involvement of their leaders in the NTD activities, will also be more likely to participate in MDA.

Several ways that we can determine whether our advocacy activities have been successful include informal surveys to target populations (during independent monitoring of MDA or other opportunities that bring us to the field) to determine whether they were aware of (or attended) activities such as the national MDA launch, or whether they have heard their leaders have urged them to participate in NTD activities. Likewise, following advocacy meetings with leaders, we will follow-up to determine what steps they have taken to advocate for increased participation by the communities they lead. Finally, where contributions (monetary or in-kind) have been pledged to assist the NTDP, we will determine whether these contributions were actually given and the level of contribution. Prior to this follow-up, we will determine a valuation scale to apply to in-kind donations (for example, donations of the usage of

motorcycles, boats, or animals) to determine the overall contributions contributed by communities and leaders targeted by these advocacy efforts. This valuation of contributions can then be used in future advocacy campaigns, to try to increase the level of support, as well as to ensure that those who did contribute can be properly recognized for their efforts.

Social Mobilization

The main social mobilization activities that the NTDP will implement are the following:
Development of TV & Radio Spots [ODC]
The revision, reproduction and distribution of NTD messages: existing messages will be revised and improved. After reproduction, the messages will be given to all health centers involved in MDA.

Community Mobilization before MDA at the National [ODC] and Community [FOG] Level
Contracts will be signed with community radio stations will diffuse the messages to a large audience before, during and after the MDA to insure that all social levels are informed of the distribution. Radio stations will be supervised during the campaign to ensure that messages are being broadcast according to the terms in the contract. In addition, people in the areas targeted by MDA will be polled to determine whether they are receiving the information broadcast. This supervision will be introduced in the supervisory checklist that will be revised for the FY16 MDA.
Female community "relais" (akin to community health workers) and public criers will be used to sensitize populations about NTDs. Previous experience has shown that using female relais has been beneficial to the NTD Program, according to evaluations of this practice. In certain areas, MDA coverage increased after the NTD Program began using them. This practice will be continued and strengthened, particularly in the areas of Niger when men may not be granted access to households in the absence of the male head of household.

Awareness-Raising Caravans at the Community Level [FOG]

- Organization of sensitization caravans to certain populations on NTDs: the two districts with the lowest coverage will be identified and targeted. The caravan will consist of sensitization sessions held in the evening, where videos will be projected onto screens talking about the successes in NTDs and the advantages of taking the medications. Following the projection of these videos, question and answer sessions will be held with the population and the national program team. In order to determine whether or not the caravans were successful, questions will be added to supervision checklist for the FY15 MDA.

In general, Niger has a low literacy rate, around 25% of the population, and therefore has developed communication strategies adapted to this context. In order to overcome difficulties related to the low level of literacy, the National Program emphasizes using images, particularly those that depict the population and environment of Niger. All posters and fliers are designed using only images. In addition, since much of the population only speaks one or more local languages (and not French), messages broadcast via radio and television also use local languages, particularly Hausa, Djerma, Peulh, Kanouri and Gourmantché. The specific languages used are different region by region to reflect the populations in each area.

Capacity Building/Training

Training of laboratory technicians and healthcare workers, LF Surveillance [FOG]

Prior to implementing the LF surveillance protocol that the PNDO/EFL will develop, a training of heads of CSI, and laboratory technicians in each district that has stopped treatment will need to be held. At least one laboratory technician and one epidemiologist per district and all the heads of CSI of the districts that need surveillance, need to be trained. The training will focus on strengthening the surveillance network and will include taking blood samples, handling/conserving them, and the interpretation of results. The head nurses in health centers will provide blood samples to be sent to the laboratory of the district like indicated in our passive surveillance network. Some of these blood samples will be sent to the national laboratory for confirmation and expertise.

For OV evaluations, the laboratory training will be focused on OV surveillance, including skin snip and blood samples for OV16. Fifteen persons will be trained in each of the 4 districts (Téra, Say, Boboye, and Kollo). To ensure quality control of the samples taken during the training, a sample will be sent to the national laboratory to confirm findings prior to letting these persons work independently.

Onchocerciasis capturer training for entomological evaluation [FOG]
In order to conduct the OV evaluations to determine whether elimination has been reached, capture zones will be updated. Therefore a training for the new capturers is necessary in areas where there are no persons trained; in areas with capturers that were previously trained with APOC and Sightsavers' support, a refresher training will be provided. A total of 70 persons in four districts will need to be trained. This activity is budgeted in the budget for the onchocerciasis surveys.

Training of PNDO/EFL technicians on ELISA technique (by CDC Atlanta or another source) [Sightsavers International: Not budgeted]
The ELISA test will be used to confirm results from rapid tests (RDT OV16 and ICT) which are recommended by the WHO to demonstrate that transmission of OV has stopped and to confirm its elimination. The PNDO/EFL has a laboratory, constructed with funds from the Government of Niger, which is currently being equipped. This laboratory will receive and test samples which will be gathered from the surveillance network for OV and LF in the districts which have stopped treatment for LF. Capacity-building for laboratory staff will ensure that staff will be able to test samples from Niger and also to receive samples from other countries as a quality control measure for their laboratories. In order to ensure quality control, a sample of the tests will be sent to another laboratory (such as in Accra).

Cascade Training/Refresher training for MDAs [FOG]
In order to ensure capacity building for all involved at each level, Niger's NTD program will conduct training/refresher training at the national level (central MoPH directors, program and health education agents); at the regional level (DRSP, Regional Directorate of National Education, regional NTD health and education focal points and education inspectors); at the district level (DHDs, educational counselors, district NTD health and education focal points and the heads of epidemiological monitoring); and at the village level (health center heads, teachers, and CDDs). This training/retraining of health staff at all levels will take place before the MDA campaign. The MoPH Directors and the NTD coordination will attend a training of trainers and will then be responsible for training regional staff who will then train district staff in MDA and monitoring. In turn, the district staff will be responsible for training health center staff who then will train CDDs and teachers. In FY16, cascade training for MDA will again be conducted using the revised module which emphasizes the information and logistics management system (ILMS), a system brought to Niger through technical assistance (TA) from John Snow Inc. (JSI) through previous technical assistance. Supervision will be provided during the MDA to evaluate the performance of the health agents at different levels and the CDDs. A supervisory checklist will be developed to ensure standardized and complete supervision.

Independent Monitoring Training [ODC]
Independent monitoring of MDA is an activity implemented for the first time in FY14 and served as a valuable tool which helps to monitor district MDA coverage and to identify areas where additional supervision or support may be necessary. This activity is planned to be implemented in FY16 and will begin with a training of 12 persons independent to the NTDP to ensure they are unbiased when collecting data. Monitoring allows both the supervision of MDA activities and then to identify possible shortcomings in the implementation of MDA and propose appropriate solutions.

Capacity building of the National NTD Focal Point [TA: Not budgeted]
This training aims to strengthen the capacity of the National NTD Focal Point in health program management and leadership, in order to enable her to fulfil her role in coordinating the NTD program. HKI will work with the National NTD focal point and Deloitte to identify the specific areas where the NTD focal point needs additional training. This training may be through Deloitte or through a private school in Niamey that offers evening courses on program management to professionals.

Table 3: Training targets

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)
		New	Refresher	Total trainees			
Health agents from districts and health centers that stopped treatment for LF during last TAS 1 (20 heads of health centers and an NTD focal point per each of the following HD: Guidan Roumdji, Dakoro, Madaoua, Boboye and Tillabéri)	LF post-MDA surveillance	120		120	2 per district	Districts of Guidan Roumdji, Dakoro, Madaoua, Boboye and Tillabéri	None
Laboratory technicians from districts that passed TAS 1 (Guidan Roumdji, Dakoro, Madaoua, Boboye and Tillabéri)	LF post-MDA surveillance	15	3	18	3 per district	Districts of Guidan Roumdji, Dakoro, Madaoua, Boboye and Tillabéri	None

Health workers in the region, HD, and health centers in the HD of Téra, Say, Kollo, and Boboye	Onchocerciasis epidemiological assessment	60	0	60	3	Districts of Téra, Say, Kollo, Boboye	Sightsavers
Training of village black fly capturers (5 new sites in Boboye and Téra and 10 new sites in Say and Kollo) ; 2 capturers per site	Onchocerciasis entomological assessment	70	0	70	3	Districts of Téra, Say, Kollo, Boboye	Sightsavers
Training of PNDO/EFL technicians on ELISA technique (by CDC Atlanta or another source)	To confirm results from rapid tests (RDT OV16 and ICT) which are recommended by the WHO to demonstrate that transmission of LF and onchocerciasis	4	0	4	10	Niamey	None
Training of trainers and supervisors at the central level (5 persons per program and 5 MOH staff) for MDA	Data collection, management of side effects/SAEs, disease facts, treatment dosages, reporting and leftover drugs	TBD	TBD	20	1	Niamey	None

Training of trainers at the regional level (health : 4 persons/region for a total of 32 persons ; education : 3 persons/region for a total of 24 persons) Training of trainers at the district level (health: 3 persons/district for a total of 90 persons; education: 2 persons/district for a total of 60 persons)	Data collection, management of side effects and SAEs, disease facts, treatment dosages, how to report data and leftover drugs	TBD	TBD	206	1 day for each training	All 8 regions	None

Training of heads of health centers (605) and education sector heads (246)	Data collection, management of side effects and SAEs, disease facts, treatment dosages, how to report data and leftover drugs	TBD	TBD	851	1	Districts	None
Training of CDDs (40,647) and teachers (10,068)	Data collection, management of side effects and SAEs, disease facts, treatment dosages, how to report data and leftover drugs	TBD	TBD	50,715	1	Health Centers and teaching centers	None
Training of independent monitors	Data collection, port data and leftover drug	12	0	12	3	Niamey	None
Capacity building of the National Focal Point MTN	Health program management	0	1	1	TBD	Niamey	None

Note: the number of new vs. returning trainees for the cascade MDAs cannot be determined beforehand, since it depends on a number of factors, such as the number of persons who are still in their posts next year and the number of CDDs who choose to continue.

Mapping

Niger is completely mapped for all five NTDs targeted by this project; no mapping is required in FY16.

MDA Distribution [FOGs, ODC]

The existing MDA gap is the lack of funds for treatment of severe adverse events, should any occur, as well as albendazole for at-risk adults during treatment for STH outside of the LF or SCH MDA (see Looking Ahead section).

Two MDAs are planned for FY16:

- The first will be conducted in November 2015 and will concern all of the targeted HDs across the country where MDA is required for each disease. The November 2015 MDA will target 18 HDs for SCH (PZQ only or PZQ+ALB); 9 HDs for trachoma (azithromycin + tetracycline 1% eye ointment, which is purchased by The Carter Center); and 23 HDs for LF-STH (IVM+ALB). Thirty-two districts will be treated for STH either through SCH or LF MDA. Two strategies will be used for MDA: the community-based, door-to-door strategy carried out by CDDs and the school-based distribution strategy carried out by teachers.

- As per the new SCH strategy validated in FY15, the frequency of treatment will vary based on endemicity and will be treated on once yearly, twice yearly or every other year basis. In addition, it should be noted that the Schistosomiasis Consortium for Operational Research and Elimination (SCORE) study will conclude at the end of December 2015; these districts will henceforth receive support from USAID for MDA. Four of these districts, which will begin a twice yearly treatment schedule, will not receive treatment in the November 2015 MDA but will need to be treated in April-May 2016 to ensure that they can be treated in their second round in November 2016 (Say, Kollo, Téra and Tillabéri).

In FY15, the World Bank announced that it would provide support for NTDs, which is likely to include support for MDAs in certain districts. However, it is unknown when the funding will be available, exactly what support for MDAs will be provided, or which districts will be affected. Therefore, the NTDP has planned that its FY16 MDA will be fully supported through END in Africa.

Table 4: USAID-supported districts and estimated target populations for MDA in FY16

Column definitions correspond to those found in the workbooks

NTD	Age groups targeted (per disease workbook instructions)	Number of rounds of distribution annually (add additional rows for different treatment frequencies)	Distribution platform(s)	Number of districts to be treated in FY16	Total # of eligible people targeted in FY16
Lymphatic filariasis	Persons > 5 years of age	1	Door-to-door in the community ; school distribution ;	23	8 143 708[1]

			fixed point distribution, particularly in desert areas		
Onchocerciasis	No MDA specific to oncho[2]	N/A	N/A	N/A	N/A
Schistosomiasis	School-aged children and adults at-risk	Once per year (12 HD) Twice per year (4 HD) Once every two years (25 HD) (see Appendix 9)	Door-to-door in the community ; school distribution ; fixed point distribution, particularly in desert areas	18	2 793 229[3]
Soil-transmitted helminths	School-aged children and adults at-risk	1 with USAID support	Door-to-door in the community ; school distribution ; fixed point distribution, particularly in desert areas	32	7 647 553[3]
Trachoma	The whole population	1	Door-to-door in the community ; fixed point at schools	9	3 349 749[4]

1. The population used by the PNDO/EFL is the 2012 census; this does not match the workbooks, as they are currently using the 2001 census projected to 2016.
2. 5 districts are endemic for OV and all have been treated as part of MDA for LF; however, 4/5 (Boboye, Téra, Say and Kollo) have now stopped MDA for LF. Gaya is still being treated for LF; Gaya will undergo pre-TAS in FY16 and if it passes, TAS 1 in FY17 and stop MDA as of FY18.
3. The PNLBG uses the National Institute of Statistics population data from 2013 projected to 2016.
4. The PNSO also uses the 2012 census data to set their objectives.

MDA Challenges

Table 5: Explanation of low USAID-supported program and epidemiological coverage

Epidemiological coverage targets are defined below.

Programmatic coverage targets are >=80% eligible population

NTD	Epi coverage targets	Number of districts with complete coverage information *	Number of districts that did not meet coverage targets*	Reason(s) for poor district performance	Proposed remediation actions (bulleted list, with detailed narrative below table)

Lymphatic filariasis	>=65% epi coverage	28	Epi: 2 Diffa (14.4%) N'Guigmi (45.6%)	Insecurity in the region of Diffa and population moved to Zinder	Information updates on population movements between Diffa and Zinder regions
		28	Program: 2 Diffa:18% N'Guigmi : 47.0%	Insecurity in the region of Diffa and population moved to Zinder	Information updates on population movements between Diffa and Zinder regions
Onchocerciasis	>=65% epi coverage	N/A	Epi: N/A	N/A	N/A
		N/A	Program: N/A	N/A	N/A
Schistosomiasis	>=75% epi coverage of SAC	30	Epi : Agadez (54.89%), Arlit (52.57%), Mirriah (33.52%), Matameye (42.73%)		
		30	Program: 4 Agadez (68.7%), Arlit (65.7%), Mirriah (74.2%), Matameye (51.2%)	Inaccurate denominators; revised distribution strategy in the desert zones of Arlit	Updating list of endemic villages
Soil-transmitted helminths	>=75% epi coverage of SAC	34	Epi: Agadez (54.89 %), Arlit (55.01%), N'Guigmi (ND)	Inaccurate denominators, insecurity	Updating list of endemic villages and information updates on population movements between Diffa and Zinder regions
		34	Program : 4 Agadez (68.6%) Arlit (68.8%) Diffa (18%) N'Guigmi (57%)	Inaccurate denominators, insecurity	Updating list of endemic villages and information updates on population movements between Diffa and Zinder regions
Trachoma	>=80% epi coverage	12	Épi: 7 districts Mainé Soroa (49.4%), Guidan Roumdji	Insecurity in the region of Diffa and displacement of the population;	Review the workload and compensation of CDDs; information updates on

			(67.5%), Madarounfa (79.0%), (Mayahi 78.7%) Tessaoua (53.4%) Sub-district N'guigmi (37.3%) Sub-district Dakoro (62.5%)	treatment fatigue by the population after many rounds of MDA ; poor reporting	population movements between Diffa and Zinder regions
		12	Program: same as Epi		

A number of reasons for poor coverage have been identified in the most recent MDA, as well as general reasons over the past years of MDA:

- Overlap of NTD mass health activities with community-based activities of other health programs, particularly the overlap with the National Vaccination Days (JNV). The same actors who distribute the MDA drugs are also the same actors who carry out the JNV campaigns; however, the compensation between the two campaigns is quite different: during JNV, the actors are given 2500 CFA per day (for 4 days total), while they are only given 2500 CFA per drug package, for a maximum of 7500 CFA, for NTD MDA (distribution may last for up to a month, depending on the number of drug packages and the geography of the locality). For MDA, each CDD is to distribute drugs to 500 persons. In much of Niger, where many villages are small and far apart, CDDs are required to travel significant distances to reach their targets and often need to do so on foot.

- The MDA is carried out as one-time activity during the year (lasting approximately 1-2 months), which limits appropriation by MoPH actors at all levels. In addition, sensitization of the populations only takes place just prior to and during the MDA, rather than all year.

- Sub-optimal distribution and/or reporting by CDDs due to the compensation issues listed above.

- There has been significant displacement of certain populations due to the insecurity caused by the terrorist group Boko Haram in Diffa. A large proportion of the population in this region has been displaced over the last year; much of this population is now in the region of Zinder. This is seen in the MDA data by very low coverage in Diffa and high coverage in Zinder. However, because NTDP was unable to keep track of the proportion of persons treated in Zinder region who were from Zinder vs. Diffa, it is also unclear what proportion of the Zinder population was treated.

In order to improve coverage during the next MDA, the NTDP has come up with some strategies to help improve coverage that were drawn on lessons learned from previous MDAs:

- The NTDP has a newly named national focal point who will ensure that an NTD task force will be created for advocacy purposes within the MoPH. This will ensure that NTDs will be included as a priority within the MoPH's action plan and that all NTD activities are inscribed in the MoPH's planning calendar. As a result, the MoPH will be obligated to ensure that other MoPH activities do not conflict with the MDA. As an example, this will ensure that JNV is not scheduled at the same time as MDA, thus enabling CDDs to be fully committed to the MDA.

- Social mobilization activities will be planned to take place during the entire year, to ensure that populations and leaders at all levels and in all sectors are continuously aware of NTDs. Ensuring these activities take place throughout the year, rather than just prior to MDA will ensure that the NTDP can make adjustments in their messaging or in the way populations are being targeted based on feedback they will solicit when they are in the field.

- During the MDA microplanning meeting for FY16, the NTDP will review the workload of CDDs and determine whether and where it is possible to reduce the workload for certain CDDs, particularly in areas where populations are small and villages spread far apart. For example, in certain areas, a CDD may be asked to reach 300 persons instead of 500. In addition, a special strategy will be developed in nomadic zones, whereby MDA will take place at water points, rather than house to house, since households are very spread out, and families may move on a daily basis to find pasturage for their animals, making it difficult to find the population. However, the water points that are being used by a given population can be identified and already act as an assembly point for the population on a daily basis.

- As the period when MDA takes place has an influence on the availability of the population, it was determined that November-December is the period when the majority of the population is in available. In addition, students have just returned to school, which will ensure that the school-based distributions will reach most students. In order to accomplish this, the NTDP need to ensure that all preparations for the MDA have taken place in time for this to happen. We will ensure this in several ways: meeting with the governors of each region will be held to ensure that FOG contracts are signed once we have received approval from USAID/END in Africa on the FY15 workplan. All drugs have already been ordered and the NTDP has been assured that they will receive them in time for a November distribution. Procurement processes have already started for dose poles, CDD sacs and other items. Funds for MDA cascade training were budgeted in FY15 so that this activity can be completed prior to distribution.

- As we have seen over this past year with the insecurity in Diffa, population movements can have a large impact on the MDA data. The NTDP plans to solicit assistance from the United Nations High Commissioner for Refugees (UNHCR) and the Red Cross/Red Crescent, which follow population movements for humanitarian purposes, to obtain more complete information about

the magnitude of these movements, as well as where populations are moving from and where they are settling.

- In order to deal with the denominator problem, it was decided that targets should be set using the census data updated for 2015 which will be obtained from the SNIS (the disease and program workbooks for END in Africa/USAID Integrated NTD program are using the 2001 census data with a projection for the current year). The PNLBG also plans to update its list of endemic villages.

- In addition, the trachoma program conducted a coverage survey in FY15; once data are available, they will be used to determine whether actual coverage approaches reported coverage, and reasons that people did not participate in the MDA. This information can then also be used to improve MDA next year, or even determine whether mop-up needs to be conducted before the end of FY15.

- The MDA strategy in nomadic areas will be slightly modified: persons who belong to these communities will be selected and trained as CDDs, as they better understand the population dynamics. However, instead of asking these CDDs to return to the nearest health center after each drug package, the CDD will be given all packages (if >1) at once as well as information about when to distribute each one. At the end of all the MDAs, these CDDs will bring back any excess drug and the reporting forms.

- In addition, the number of CDDs will be increased, as the workload has been identified as too heavy. Currently, each CDD is required to distribute drug to 500 persons; in FY16, this will be decreased to 300 persons.

Drug and Commodity Supply Management and Procurement (FOGs, ODC)

All drugs for the FY2016 campaign, as well as tools (dose poles, registers), will be received and stored in the ONPPC storage units (ONPPC is a structure of the MoPH responsible for management of medicines), per an agreement signed between HKI and ONPPC. In order for the ONPPC to effectively and correctly manage the supply chain for MDA drug and materials, it is very important that drug distribution plans are sent to the ONPPC at least two months in advance of the MDA (it takes several weeks to package drugs and 3-4 weeks to transport them to the HDs). Using the distribution plans, the ONPPC ensures the delivery of supplies (drugs, dose poles, and registers) to the HDs. The district NTD focal points will then deliver the drugs and tools from the HDs to the health centers. HKI plans to hire a full-time logistics expert to assist the NTD program, as there have been frequent mistakes by the ONPPC and HKI NTD staff, who do not have specific logistical expertise, have had to devote many hours of their time to assisting the ONPPC.

In addition to a contract with the ONPPC to handle the logistics, the NTDP will also work with the Directorate of Pharmacies and Laboratories (DPHL), which is a new entity within the MoPH created to manage all drugs used within the MoPH. Its primary function will be quality control and pharmacovigilance.

At the end of their training at the health centers, CDDs and school directors will return to their villages with the necessary quantities of drugs and tools for distribution in their schools and health areas. There are two possible scenarios for drugs to be delivered to schools, depending on the heads of district-level health and education institutions: either the trained teachers will be supplied with drugs and tools for all packages at the level of their health centers right after training, or they will be supplied by the heads of the educational sectors.

One other function of the ONPPC is to control the quality of all drugs entering Niger. To that end, it is also important that drugs arrive well in advance of the MDAs so that the ONPPC may test the drug and ensure that it meets the quality standards required by the government prior to implementation of MDA.

After the MDA, CDDs will be expected to send all remaining drug stocks to the health center level. Heads of health centers then return remaining stock to the HDs during the MDA evaluation workshops. Immediately following completion of the regional evaluation meetings, the task of conducting a physical count of the remaining drugs will be assigned to the national level. END in Africa has supported physical inventories.

Expired products and empty bottles will be managed at all levels:

- At the health center level: at the end of the campaign and after sub-regional assessments and physical inventory of the drugs and tools, health center heads are authorized to dispose of or destroy the empty boxes and bottles used during the campaign in accordance with set disposal/destruction procedures.
- At the HD level: A destruction committee is responsible for destroying all expired drugs in accordance with destruction procedures.

To request drug, the WHO Joint Request form is used for IVM and ALB; in FY16, PZQ will also be requested via this format as well as through END in Africa. For Zithromax®, the PNSO requests drug through the International Trachoma Initiative; applications are reviewed and eventually approved by the Trachoma Expert Committee (TEC). GlaxoSmithKline (GSK) is responsible for clearing the drugs ordered through the Joint Request Form at the port. Once the drugs arrive in-country, they are stored at the ONPPC's storage facilities. The MoPH is responsible for clearing the other drugs. None of the MDA drugs require cold-chain; the only product used by the NTDP that does require specific temperature are the ICT cards used for TAS. When ICT cards are ordered, they are stored in cold warehouses of the ONPPC that are also used to conserve vaccines.

JSI provided technical assistance in FY14 to improve the data collection tools for MDA; these tools were used in the FY15 MDA. An evaluation of the tools is currently ongoing, and recommendations stemming from this evaluation will be used to improve the tools for the FY16 MDA.

No case of severe adverse event (SAE) has been reported in Niger since the launch of the integrated mass distribution campaigns; however, should they occur, SAEs will be reported immediately within 24 hours to the National NTD Coordinator, who will inform national officials and the HKI NTD Coordinator. The HKI NTD Coordinator and the HKI Country Director will then inform the HKI headquarters/regional teams, who will inform FHI360, who in turn, will inform USAID. The MoPH is also responsible for informing WHO and the pharmaceutical companies of any SAE that occurs during MDAs. In case of reporting of a case of SAE, the following immediate measures will be taken:

- At the local level, the case will be directed to the nearest health center/hospital able to provide treatment; however, as there are no current funds to pay for these patients' care, the patients themselves will need to pay for their own treatment as part of the cost recovery system. A team of investigators made up of the regional NTD focal point, the NTD focal point for the district where the SAE occurred, and the DHD, will conduct a preliminary investigation and inform national officials and HKI with the results. Formal communication will then be sent to traditional officials, and opinion leaders will be enlisted to inform communities about all cases of adverse events, whether or not these have been proven to be related to the MDA. This is because if the NTD program does not address these issues, the communities may think that the program is hiding information from them, making them less likely to participate in future MDAs. Community radio stations will also be asked to quell or address any possible rumors. Case management of minor side effects will be handled by national medical officials, though paid for by the cases themselves.

- As the WHO has now published a new manual on managing SAEs, the NTDP will make adjustments to its SAE management policies and procedures, once the NTDP receives the new manual (as it is currently only available in English) or if the WHO provides training on the new manual.

Supervision (FOGs, ODC)

Supervision of the MDA is one of the most important activities of the campaign and takes place in a cascade fashion, with the goal of ensuring adherence to the protocols and best practices established by the MoPH to help mitigate issues that might cause bottlenecks, and to ensure quality data collection.

- At the national level, teams of national supervisors will supervise activities at the regional level to ensure activities are well-carried out and identify and help resolve any issues. Supervisors will include the national NTD focal point, disease-specific coordinators, team members from the different NTD programs (PNSO, PNLBG, and PNDO/ELF), the school health office, and some central-level directors. These teams of national supervisors will conduct supervision missions to supervise preparation meetings, training of health workers, distribution, data recording and reporting, and final evaluation of the campaign.

- At the regional level, a team of supervisors made up of regional staff (including the regional director of health, regional NTD focal points, and regional education staff) will provide supervision of trainers (training for health center managers and leaders in the disease sectors) and distribution in the HDs. They will check that distribution registers, dose measurements, supervised drug administration, data recording and reporting and handling of side effects are implemented correctly.

- At the district level, the district NTD focal points, and other key staff (e.g. health communicator, manager, head physician) will ensure NTD activities are implemented through working with health centers and validate the data collected in the field.

- At the health center and school level, health center heads and schoolteachers will supervise CDDs to ensure that registers are correctly filled out and assist with issues notified by the CDDs.

The HKI NTD Program Coordinator will work with the national NTD focal point and disease-specific national coordinators to ensure that supervision is executed with the rigor and according to national policies. This will be accomplished through supervision conducted by the NTD Program Coordinator

(and his staff) during the MDA; an independent monitoring activity that will be carried out independent from the national program to try to eliminate bias; and restitution meetings to discuss any issues encountered, leading to improvements in the next MDA. Involving the program coordinators in the development and implementation of supervision programs will allow for greater ownership of activities and ensure that they are implemented in accordance with MoPH regulations.

Supervision during MDA will incorporate a review of the quality of the data being collected, such as whether registries and tally sheets are being filled out correctly. Independent monitoring of MDA was implemented for the first time in FY2014 and served as a valuable tool to help supervise the quality of MDA by validating the data collected by CDDs and reported by the NTDP. This activity was also carried out in FY15 and is planned for FY16.

Supervision is conducted during planning meetings, trainings, IEC activities, advocacy activities, drug logistics/management activities, distribution, data collection, and evaluation meetings to ensure compliance with MoPH and WHO guidelines. In order to ensure that activities follow guidelines, a number of different steps are taken:

- Supervision for the MDA begins with attending trainings to ensure that the correct information is being shared. If there are systematic issues detected with comprehension or in incorrect information being taught, then the NTDP will identify the proper corrective actions to address the situation.
- The NTDP ensures that all levels are provided with updated information as it is released from the WHO or from higher levels within the MOPH. For example, once the new SAE information is available in French, the NTDP will ensure that all levels are aware of changes.
- Supervisory checklists are used to ensure standardized and comprehensive supervision.
- Standardized data collection forms are provided to ensure that all information is collected and in a standardized fashion to minimize errors.
- For surveys, supervision teams are trained on the objectives, methods and data collection tools and then provided with the protocols to use as a reference, which includes information such as the villages/clusters to visit and the sampling. In addition, a debriefing session is held at the end of each day's survey to synthesize results and ensure that the correct villages/clusters were visited.
- For MDA, supervision teams are provided with information on the target population, the list of districts that should be treated and the drug packages for each district, and at the health center level, the number of health centers and villages targeted.
- At the CDD level, it is important to review the registers with the CDDs and go over the information item by item to ensure that they understand the register and have correctly filled it out.

As MDAs are extremely logistically and operationally challenging for actors at all levels, issues often arise in the field that need to be resolved. Every person involved in supervision must provide a daily debriefing of the activities carried out during the campaign. Supervisors will be allocated communication expenses to enable them to inventory all problems found in the field in real time and to communicate with the NTDP coordination regarding their management. When problems arise during supervision, the supervisors will have the authority to provide appropriate solutions, depending on the seriousness of the reported issue and the level of responsibility/quality of the supervision team. In any case, problems that cannot be solved on site will be referred to the national level for investigation and appropriate

action within 24 hours of notification. The supervisors will have communication funds for this purpose so they can report problems that arise in the field in real time.

Regular discussions are held with NTD focal points at the regional and district levels, as well as with heads of health centers during MDAs, to identify any bottlenecks or problems that have arisen and to determine the best solution to resolve the issue. After each activity, debriefings or evaluation meetings are held to review the organization of the activity, the strong and weak points of the activity, discuss any specific problems that arose, and make recommendations to improving the activity the next time it is carried out.

One specific bottleneck that has been identified is the number of days of supervision allocated to the supervisors at different levels. As MDA takes place over the majority of the territory of Niger, it is impossible to visit every CDD and every village; however, at the MDA evaluation, it was recommended that supervisors now be given 2 days per package and per district of supervision in contrast to the 4 days total previously allocated. This will help to ensure greater coverage by the supervisory teams. To go along with the increased number of days of per diem, the supervisory fuel budget will also be increased in FY16.

Short-Term Technical Assistance (Not specifically budgeted)

Table 6: Technical Assistance request from END in Africa

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
TA to update the TIPAC for FY2015. (Strategic Planning)	The NTDP has indicated that they cannot do the updating of the tool on their own	Expertise on TIPAC (RTI/HQ/Deloitte)	1 week, Q1
DQA training	Shortcomings in Data collection quality assessment and processing	DQA expertise	2 weeks, Q4
Integrated NTD database (BDIM)	Current NTD program does not have a comprehensive database to store data	Expertise in DB (RTI/HQ)	Five days, Q2

Updating the TIPAC

The TIPAC is a tool for NTD programs planning and budgeting at country level. It helps to identify financing gaps and gives the opportunity to MoPH to develop resource mobilization strategy to fund not yet covered needs and optimize resource allocation. While TIPAC training and data entry was conducted in FY15, in FY16, the drug module will be updated with the leftover stock from the previous MDA. Those that will take part in this update include officers from the MoPH, the MoPH national NTD Focal Point, the NTD programs and technical and financial partners supporting NTD. The expected results will enable the MoH to develop a new strategic plan 2016-2020.

DQA training

The data quality assessment (DQA) can help to identify where the greatest problems of data reporting lay and therefore enable the NTDP, along with those involved with reporting data from different levels. This training will concern the officers from the MoPH, the MoH national NTD Focal Point, the NTD programs officers and HKI. This training and subsequent exercise will be very useful for the PNSO and PNDO/EFL as they will soon be compiling their elimination dossiers, in which data validation is a performance measure. During the training on conducting the DQA, the NTDP would like to ensure that they are provided with assistance to determine the most appropriate sampling strategies and sites for the DQA.

Integrated NTD database

The Integrated NTD Database is a tool that can be used by national NTD programs to facilitate data entry, analysis, storage, reporting and feedback for national NTD program needs. The generic database can be tailored to each country's context and data management requirements. The training will concern the officers from the MoPH, the MoH national NTD Focal Point, the NTD programs officers and HKI. The data compiled in the integrated database will assist the PNSO and PNDO/EFL to compile their elimination dossiers once they are ready to do so.

M&E (FOGs, ODC)

Schistosomiais and Soil-Transmitted Helminthes

The PNLBG has prevalence data for schistosomiasis in all 42 districts. In accordance with WHO recommendations from 2015, the program needs to conduct SCH+STH surveys in sentinel sites. The PNLBG currently has 17 sentinel sites; according to WHO recommendations, the number of sites should correspond to approximately 200,000-300,000 school-aged children; depending on the population growth, the number of sentinel sites may need to periodically increase. The table below shows the sentinel sites followed by the PNLBG. During the surveys, both urine and fecal samples will be taken from each participating child (necessitating the purchase of urinary filtration and Kato-Katz kits). In FY16, the PNLBG plans to conduct SCH+STH sentinel site surveys in 17 sites.

PNLBG Sentinel Sites

Region	District	Sentinel Site	Prevalence % (year of last survey)
Tillabéri	Filingué	Bonberi	88 (2011-2012)
	Say	Rouga Say	84 (2011-2012)
	Kollo	Firwa	67 (2011-2012)
	Tera	Ingui	96 (2011-2012)
	Ouallam	Gabdey Bangou	80 (2011-2012)
Maradi	Tessaoua	Takassaba	96 (2013-2014)
	Dakoro	Mougoudou	76 (2013-2014)
	Madarounfa	Doutchi Begoua	68 (2013-2014)
Zinder	Mirriah	Doungouram	74 (2013-2014)
	Zinder Com	Middick	76 (2013-2014)
Tahoua	Tchintabaraden	Gambane	66 (2013)
	Madaoua	Teké	64 (2013)
Dosso	Gaya	Kawran Debé	68 (2011-2012)
	Boboye	Falmado	80 (2011-2012)
Diffa	Mainé Soroa	Boudoum	72 (2013-2014)

Agadez	Tchirozérine	El mecki	44 (1989)
Niamey	Niamey 1	Saga Gourma	58 (2011-2012)

Lymphatic Filariasis

For LF, in FY16, 11 HD will conduct the pre-TAS: Gaya, Aguié, Madarounfa, Mayahi, Tessaoua, Birni n'Konni, Bouza, Illéla, Keita, Tahoua, and Tchintabaraden). If they pass, then they will all conduct TAS in FY17. It should be noted that of these districts, a number of them previously failed the TAS in 2013 (Bouza, Keita, Illéla, Tahoua, and Birni n'Konni). However, all of these districts have since had two rounds of MDA with epidemiological coverage of at least 65%. Also in FY16, nine districts will likely undergo TAS 1 (depending on the results of the pre-TAS in FY15 that has not yet taken place). These districts are Matameye, Magaria, Mirriah, Tanout, Gouré, Zinder, Diffa, Maine Soroa, and N'Guigmi.

Onchocerciasis

There are five districts that are considered endemic for OV and all are co-endemic for lymphatic filariasis. Four of these districts (Kollo, Say, Téra, and Boboye) have now stopped MDA for LF. In FY14, epidemiological and entomological surveys were conducted in Kollo, Say and Téra to determine the prevalence of disease; all results (both epidemiological and entomological) were 0%. In FY16, the PNDO/EFL will be ready to evaluate whether the elimination criteria have been achieved in these four HDs. In FY16, the PNDO/EFL will conduct entomological and epidemiological surveys PCR of the oncho vector and OV16 ELISA. Sightsavers has still committed to supporting skin snip in Gaya and RDT in Say, Tera and Kollo. . As previously stated, the PNDO/EFL will also need to update fly capture sites (see above in Capacity Building/Training section).

Trachoma

For trachoma, seven HDs will undergo impact assessment to determine whether they may stop MDA: Gouré, Aguié, Matameye, Magaria, Zinder Commune, Bilma and Tchirozérine. It should be noted that both Bilma and Tchirozérine had baseline TF prevalence between 5-9.9%, and according to the new WHO standard operating procedures validated by the RPRG in 2015, these districts may conduct at least one round of MDA (which is planned for FY16) and then conduct an impact evaluation.

The new standard operating procedures also outlined the procedures to follow once MDA has been stopped: another district-level survey (surveillance survey) should be conducted at least two years after the TF<5%. These surveys will be required as part of the elimination dossier each country will need to compile and submit to the WHO for elimination validation. Therefore, in FY16, seven districts will undergo surveillance surveys: Boboye, Dosso, Kollo, Say, Ouallam, Filingué and Illéla. While there are other districts with <5% TF at impact, the PNSO determined that it would start in chronological order, with those districts that reached the elimination target first undergoing these surveys first.

Coverage Surveys

The NTDP also plans to conduct integrated NTD coverage surveys following the MDA in November 2015. The surveys will be held within two weeks of the end of MDA. External surveyors from the NTDP will be selected to ensure impartial results. The selection of survey districts will be determined based on the reported performance in the FY16 MDA and may also take into account areas where chronic poor performance is noted or suspected.

The results of each survey will be analyzed and discussed in a meeting, in which the different MoPH departments will be invited to participate, including the Directorate of Health Statistics (SNIS), the Directorate of Studies and Programming (DEP), and the Center for Medical and Health Research

(CERMES), as well as technical partners such as HKI. The meetings will aim to determine the factors that enabled a given district to obtain results that show progress (or lack thereof). Recommendations on whether to stop treatment or change treatment strategy will also be made. If appropriate, results will then be sent to confirmatory bodies, such as the Regional Program Review Group (RPRG) at the WHO or the TEC if drug approval hinges on the results.

M&E challenges

A number of M&E challenges exist for the NTDP, but first and foremost is the issue of denominators. The issue is not only the fact that projections on old census data are being used to determine target populations for MDA and also for surveys, but also with the fact that in parts of Niger, the population is quite mobile, so that even if overall population figures were accurate, they may not be accurate at specific times of the year, such as after the harvest, when large proportions of the populations leave Niger in search of employment or at other times of the year when pasturage is scarce. This makes planning M&E activities difficult, as the sampling frames may not be able to capture a representative proportion of the population. Therefore, assistance from END in Africa's M&E specialist who is a trained demographer would be very useful to help address these issues.

The DQA planned for FY15 did not take place as planned, as it was determined that this activity should take place in FY16 instead. However, Niger will greatly benefit from this activity, as a number of data issues, such as denominator problems and data collection forms not being filled out correctly. The DQA can help identify where the greatest problems of data reporting lay and therefore enable the NTDP, along with those involved with reporting data from different levels (region, district, health center, etc.) to identify ways to improve reporting.

Table 7: Planned Disease-specific Assessments for FY16 by Disease

Disease	No. of endemic districts	No. of districts planned for DSA	Type of assessment	Diagnostic method (Indicator: Mf, ICT, hematuria, etc)
Lymphatic Filariasis	31	9 districts : Matamèye, Magaria, Mirriah, Tanout, Gouré, Zinder, Diffa, Mainé Soroa, N'Guigmi	TAS 1	ICT/FTS cards
Lymphatic Filariasis	31	11 districts : Gaya, Aguié, Madarounfa, Mayahi, Tessaoua, Birnin'Konni, Bouza, Illéla, Keita, Tahoua, Tchintabaraden	Pré TAS	Night blood survey and Microscopy
Onchocerciasis	5	4 districts: Say, Téra, Kollo, Boboye	Epidemiological and entomological evaluations	PCR of OV vector and OV16 ELISA.
Schistosomiasis and Soil-transmitted helminthes	42	17 sentinel sites in 17 HD : Filingué, Say, Kollo, Téra, Ouallam, Tessaoua, Dakoro, Madarounfa, Mirriah, Zinder Commune,	Prevalence survey	Urine filtration and Kato Katz

		Tchintabaraden, Madaoua, Gaya, Boboye Maine Soroa, Tchirozérine, Niamey 1		
Trachoma	35	7: Gouré, Aguié, Matameye, Magaria, Zinder Commune, Bilma and Tchirozérine	Impact assessments	Physical examination of the eyelid
Trachoma	35	7: Boboye, Dosso, Kollo, Say, Ouallam, Filingué and Illéla	Surveillance surveys	Physical examination of the eyelid

Planned FOGs to local organizations and/or governments

Table 8: Planned FOG recipients

FOG recipient (split by type of organization)	Number of FOGs	Activities
Central level (National NTD Focal Point)	1	▪ MDA microplanning meeting ▪ Central level MDA supervision ▪ MDA training of trainers workshop ▪ Support to the MoPH's annual workplanning meeting ▪ Support MOH in the development of a new NTD strategic plan ▪ National Launch of the MDA ▪ Annual Post-MDA Review Meeting at National Level
PNSO	1	▪ Trachoma impact surveys ▪ Trachoma surveillance surveys
PNDO/EFL	1	▪ Pre-TAS ▪ TAS 1 ▪ LF surveillance training ▪ OV Epidemiological survey ▪ OV entomological survey
PNLBG	1	▪ SCH/STH survey in sentinels sites ▪ Update endemic villages list
ONPPC	1	▪ Drug storage, repackaging and transport
Regions (Agadez, Diffa, Dosso, Maradi, Niamey, Tahoua, Tillabéri, and Zinder	8	▪ Transport of Materials and Drugs for MDA from district to Distribution sites ▪ MDA Supervision ▪ Drug Distribution by CDDs ▪ MDA training of Trainers and Cascade Trainings for Health Regions, Districts & Health Center Staff and for CDDs ▪ Social Mobilization for MDA ▪ Information Sessions at District Level ▪ Post-MDA Review Meetings at District Level ▪ Post-MDA Review Meetings at Regional Level

Looking Ahead

There are four main gaps that the NTDP has identified:

1. STH are treated via LF treatment (IVM+ALB) or coupled with SCH treatment (adding ALB to PZQ). However, eight districts have stopped treatment for LF and not all districts treat for SCH every year (and one, Bilma, is not endemic for SCH or LF but is considered endemic for STH due to the hygiene and sanitation conditions). The NTDP is able to treat children in these districts via funding from other sources; however, they do not have funding to treat the high-risk adults. The number of districts and persons concerned is variable by year (depending on the SCH treatment cycle and LF districts that are stopping MDA), but in FY16, Dosso, Doutchi, Loga,

Guidan Roumdji and Maradi all have HRA that will not receive treatment with an estimated population of approximately 1.2 million.

2. Morbidity case management for LF: The LF program made a large effort to determine the number of hydrocele and lymphedema cases, but Niger has yet to identify a partner to assist those living with these sequelae. The PNDO/EFL estimates that there are 380,000 persons with hydrocele and 160,000 with lymphedema.

3. There are several districts with persistent high prevalence of LF and that failed the TAS despite passing pre-TAS and reporting epidemiological coverage of at least 65% for five years. The PNDO/EFL would like to lead operational research to examine the reasons for this through conducting coverage surveys to validate reported coverage coupled with a Knowledge, Attitudes and Practices (KAP) survey. This survey will focus on the acceptability of and participation in the MDA.

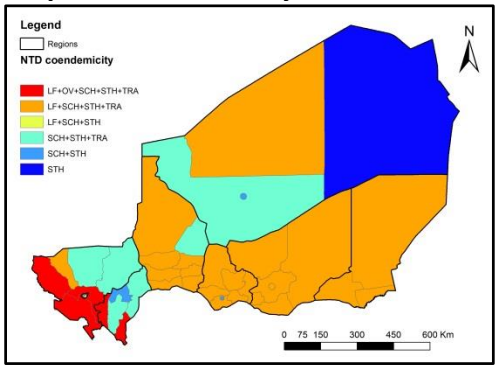
4. Training of agents to conduct a morbidity assessment. This training will identify community leaders and peer-educators who can report data on LF morbidity in order for the PNDO/EFL to have more current morbidity data by building a network of community surveillance to detect current and new cases so that case management may be offered to these cases, should funding sources be identified.

Table 9: Remaining gaps to be addressed

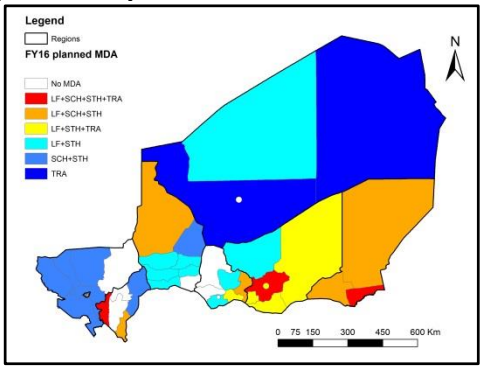
Identified gap or activity	Would external support be needed –funding or technical (outside of existing partners)?	Estimated time needed to address activity	Estimated cost to carry out activity
STH treatment for HRA	Yes—financial support	2 weeks	$ 31 500
LF morbidity case management	Yes—financial support	All the year	$ 66 000
LF coverage + KAP survey in persistent high prevalence districts	Yes—financial support	1 month	$ 20 000
LF morbidity assessment training	Yes—financial support	5 days	$ 15 000

Maps

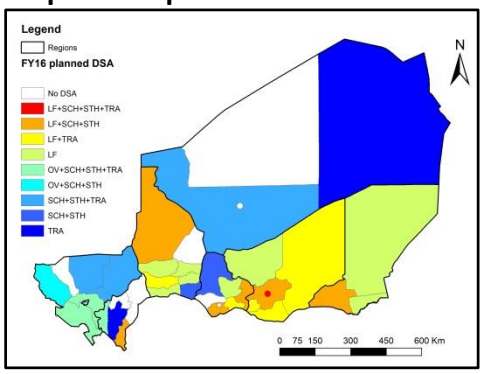
Map 1: Co-endemicity of diseases in Niger



Map 2: MDA planned for FY16



Map 3: DSA planned for FY16



APPENDICES

1. **Country staffing/partner org chart (replicated from overall work plan) (PDF)**
2. **Work plan timeline (MS Word)**
3. **Work plan deliverables (MS Word)**
4. **Table of USAID-supported provinces/states and districts—refer to this in the narrative instead of listing out all districts/sub-districts (MS Word or MS Excel)**
5. **Program Workbook (MS Excel)**
6. **Disease Workbook (MS Excel)**
7. **Country budget (MS Excel)**
8. **Travel Plans (MS Word or MS Excel)**