



Niger

FY2017

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
CBM	Christoffel BlindenMission
CDD	Community Drug Distributor
CSI	Center for Integrated Health (Centre de Santé Intégré)
DEP	Directorate of Studies and Programming (Directorate des Etudes et de la Programmation)
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
EU	Evaluation Unit
FHI 360	Family Health International 360
FOG	Fixed Obligation Grant
HD	Health District
HDP	Health Development Plan
HKI	Helen Keller International
ICT	Immunochromatographic test
IEC	Information, Education and Communication
IVM	Ivermectin
JNM	National Micronutrient Days (Journées Nationales des Micronutriments)
JNV	National Vaccination Days (Journées Nationales de Vaccination)
JSI	John Snow Inc.
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
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
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
STH	Soil-Transmitted Helminthes
TA	Technical Assistance
TAS	Transmission Assessment Survey
TEC	Trachoma Expert Committee
TF	Trachomatous Inflammation – Follicular
TT	Trachomatous Trichiasis
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

COUNTRY OVERVIEW

General background information on country structure

The Republic of Niger is a land-locked, secular republic covering an area of 1,267,000 km² that shares a border with Mali, Nigeria, Algeria, Libya, Burkina Faso, Benin, and Chad. It is divided into 8 administrative regions and 44 health districts (HDs). As of 2016, the country's population is about 19,251,386, with a projected population of 20,002,190 in 2017. The country is one of the poorest in the world but has significant natural resources, such as uranium and oil.

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

- **Central level** (responsible for strategic support), which includes the central administration (3 general departments and 15 central departments), 8 national specialized reference centers, 16 national programs, 3 national hospitals, and 1 national reference maternity hospital.
- **Intermediate level** (responsible for technical support) includes 8 Regional Directorates of Public Health, 6 regional hospital centers, and 2 regional reference maternity hospitals.
- **Peripheral level** (responsible for operational support) which includes 44 HDs, 33 district hospitals with 26 functioning operating blocks, 889 centers for integrated health and 2,499 health posts. Community involvement is established at the different levels through health committees, management committees, community-based organizations and mutual health insurance groups (groups in which members contribute a fixed amount of money each month, and receive financial support when they fall ill to cover the cost of treatment). "Relais" (village-based health workers) are also involved as community drug distributors (CDDs) during the mass drug administration (MDA) campaigns.

The Ministry of Public Health (MoPH) of Niger receives the following support for neglected tropical diseases (NTDs), in addition to the United States Agency for International Development (USAID) funding:

- **The State:** Provides up to 100 million FCFA a year that is used to support MDA campaigns. However, it should be noted that although allocated to the Neglected Tropical Diseases Program (NTDP), these funds are not always received by the NTDP. Other aspects of the State's support include the salaries of health and education agents, space for storage and meetings, water, electricity, and vehicle use.
- **Conrad N. Hilton Foundation:** Provides funding through The Carter Center and Helen Keller International (HKI) to support the National Eye Care Program's (Programme Nationale de Santé Oculaire or PNSO) implementation of the full SAFE (Surgery, Antibiotics, Facial cleanliness and hygiene, and Environmental improvements) strategy in Niger, with special focus on trachomatous trichiasis (TT) surgery, face washing, behavior change communication (BCC) through radios and school health, latrine construction, and monitoring and evaluation (M&E). MDA campaigns for trachoma is also supported through the procurement of 1% tetracycline ointment for children under six months.
- **Schistosomiasis Control Initiative (SCI):** Supports the National Schistosomiasis and Soil Transmitted Helminthiasis Control Program (Programme National de Lutte contre la Bilharziose

et les Géohelminthes or PNLBG) through the International Network for Planning and Control of Schistosomiasis (Reseau International Schistosomoses Environnement Amenagements et Lutte or RISEAL) as part of impact assessments in the HDs of Tillabéri, Dosso, Maradi, Niamey and Zinder regions. In addition, it provides support to the National program for the elimination of Onchocerciasis and LF (Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filariose Lymphatique or PNDO/EFL) for the organization of hydrocele surgery camps.

- **Sightsavers:** Provides support to the NPEO/LF for surveillance activities in 5 HDs that were previously endemic for onchocerciasis.

Table 1: NTD partners working in country, donor support and summarized activities

Partner	Location (Regions/States)	Activities	Is USAID providing direct financial support to this partner? (Do not include FOG recipients)	List other donors supporting these partners/ activities
Government of Niger	Central level and all 8 regions	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Technical and institutional support • Capacity-building • Assistance with drug donation (Mectizan® and Albendazole for the National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis (Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filariose Lymphatique or PNDO/EFL) 	No	Several
Helen Keller International (HKI)	National level and all regions	<ul style="list-style-type: none"> • Support for the organization of mass drug administration campaigns to control NTDs for the entire process from the cascade training, to social mobilization, distribution, monitoring and assessment including a national report. • Support for all monitoring/assessment and surveillance activities • Support for the planning process for all activities to prevent NTDs • Institutional support for the NTD program 	Yes	No
	Central level and the regions of Diffa, Dosso, Maradi, Tahoua, Zinder	<ul style="list-style-type: none"> • Support the PNSO for trichiasis surgery • Information, education and communication (IEC) activities for trachoma (sensitization via community radio stations) 	No	Conrad N. Hilton Foundation

Partner	Location (Regions/States)	Activities	Is USAID providing direct financial support to this partner? (Do not include FOG recipients)	List other donors supporting these partners/ activities
		<ul style="list-style-type: none"> Support to the School Health Office to teach about trachoma in schools 		
The Carter Center	Central level, and the regions of Diffa, Tahoua, Maradi, Tillabéri and Zinder	<ul style="list-style-type: none"> 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 regions of Dosso, Tahoua, Niamey and Tillabéri	<ul style="list-style-type: none"> Support to the National Schistosomiasis and Soil-Transmitted Helminthiasis Control Program (Programme National de Lutte contre la Bilharziose et les Géohelminthes or PNLBG) for surveys and the management of high-transmission sources. Operations support Support to the PNDO/EFL for the organization of hydrocele surgery camps Schistosomiasis (SCH)/soil transmitted helminthiasis (STH) MDAs in 12 districts starting in FY17 	No	Department for International Development, The Bill & Melinda Gates Foundation
United Nation's Children Fund (UNICEF)	Central and regional levels	<ul style="list-style-type: none"> Support to the PNLBG for the organization of deworming campaigns for children under five jointly with National Vaccination Days (Journée Nationale de la Vaccination or JNV) and National Micro-Nutrient Days (JNM) with an Albendazole donation. 	No	Several
Sightsavers	Central level	<ul style="list-style-type: none"> Support to the PNDO/EFL in epidemiological and entomological surveillance for onchocerciasis 	No	Several
Lions Clubs of Niger	Central level	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Support to the PNSO for complete eye health (including capacity building for health agents) 	No	Several
World Bank	Central level and all regions	<ul style="list-style-type: none"> Support to all NTD/preventive chemotherapy (PCT) programs in the three following areas: Institutional capacity building Community campaigns (with emphasis on cross-border actions) Monitoring/assessment 	No	None

National NTD Program Overview

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

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

Lymphatic filariasis

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

Thirty-three HDs in Niger are endemic and began treatment in 2007 (including Arlit in FY2015). Between 2013-2016, a total of 12 HDs have passed transmission assessment survey (TAS) for stopping MDA (TAS 1) and met the criteria to stop MDA (Say, Kollo, Tillabéri and Téra in the Tillabéri region; Guidan Roundji, Dakoro, Madaoua in the Zinder region; Boboye in the Dosso region; and Niamey 2, 3, 4, and 5 in the Niamey region).

In FY15, the PNDO/EFL conducted a pre-transmission assessment survey (pre-TAS) in nine HDs: Zinder Commune, Mirriah, Gouré, Tanout, Magaria, Matamèye, Diffa, Maine Soroa, and N'Guigmi. All nine districts showed a prevalence level of <1% and the Regional Program Review Group (RPRG) approved 8/9 districts to undergo TAS 1 (Tanout was not approved because the TAS eligibility form to the RPRG did not show 5 rounds of effective coverage. We have advocated with the PNDO/EFL to appeal, since it actually has met this criteria). One district will be surveyed at the end of FY16 and the others in early FY17.

In addition, some districts are ready to conduct their first post-MDA surveillance survey (TAS 2) in FY17: Boboye, Guidan Roundji, Dakoro, Madaoua, Téra, Say, and Kollo.

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

- Mass ivermectin (IVM) and albendazole (ALB) treatments targeting at least 65% of the population at risk and 80% of the eligible population in endemic districts.

- Surgery for hydrocele cases and care for lymphedema cases. This means that active search is required to find the people with these conditions.
- Improved MDA monitoring.
- Implementation of BCC using IEC materials focused on preventing the disease and improved participation during the MDA campaigns.
- Vector control with the cooperation of the National Malaria Control Program.
- Operational research.
- Capacity building for program staff.

Onchocerciasis

Onchocerciasis (OV) mapping via skin snip was conducted between 1974 and 1976. Five HDs were declared OV endemic. Vector control measures were conducted between 1976 and 1987 with the support of the Onchocerciasis Control Program (OCP). The World Health Organization (WHO) declared that the disease was under control in 2002 and that it was no longer a public health problem. Niger has never conducted a Community-Directed Treatment with Ivermectin (CDTI) in the five districts affected by OV since prevalence in these districts is under the threshold requiring treatment. However, all of the OV endemic districts were treated for LF with IVM and ALB.

In January 2015, entomological surveys (with the support of Sightsavers and the African Program for Onchocerciasis Control (APOC) and epidemiological surveys (with USAID support) were carried out in the three districts which successfully passed their LF TAS in 2013 (Kollo, Say and Téra). The prevalence in each district was 0% Mf for the epidemiological survey and 0% for the entomological survey. These districts, and Boboye, met the criteria to stop their LF MDA in FY14. In FY16, the Program planned to carry out epidemiological surveys with ELISA to show if transmission has been stopped. In addition, the Program plans to add OV-16 and skin snip in one district for comparative purposes to determine if the onchocerciasis transmission has been stopped. They will also carry out entomological evaluations in the same districts. Gaya, the fifth OV-endemic district, will conduct an LF pre-TAS in FY16. If it meets the criteria for TAS 1, epidemiological and entomological surveys will be conducted in FY17 to show whether oncho transmission has stopped. Also in FY17, Niger plans to put into place an onchocerciasis elimination committee to review results and help guide the PNDO/EFL in compiling the elimination validation dossier to submit to the WHO. Completion, validation and submission of the dossier will take place following Gaya's elimination verification surveys.

Schistosomiasis

The PNLBG was officially launched in 2004. Forty-three health districts out of the 44 in the country (with the exception of Bilma) are endemic for SCH. The assessment methods used are urinary filtration and Kato-Katz for stools. MDA with praziquantel (PZQ) were launched in 2004-2005 and took place every other year, targeting school-age children and high-risk adults. The MDAs were financed by SCI/RISEAL, then by the USAID NTD program starting in 2007. From November 2004 to May 2007, three successive survey campaigns were carried out by the Center for Medical and Health Research in eight sentinel sites located in the regions of Tillabéri, Dosso and Tahoua. The total average prevalence rate was 75.4%. A year later, following the MDA, the prevalence had decreased considerably to approximately about 37.4%. After another year, the prevalence was 35.7%.

Sentinel site surveys in 2010 revealed high re-infection rates. As a result, Niger decided to treat all river valley region areas annually (Tillabéri, Dosso and the Urban Commune of Niamey) and the other regions every two years (Maradi, Diffa, Agadez, Tahoua and Zinder). Reevaluation surveys were carried out from

2011 to 2014 in all of the districts. A meeting of SCH experts was held in November 2014 to examine all of the data and realign the treatment strategy to WHO guidelines. According to the new strategy, all endemic districts will receive treatment annually, semiannually or every two years (see the complete strategy in appendix 9). In addition, “hot spots” (all villages where the SCH prevalence is greater than 45%) are covered by a specific treatment strategy (one or two treatments a year) and awareness-raising and case management will be intensified. As part of the implementation of the proposed new strategy of PNLBG, PZQ will be set up at health centers in high prevalence areas for the management of cases outside the campaigns using left over drugs from MDAs.

The PNLBG implements the following activities:

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

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

Starting in FY17, 13 districts in the Tahoua, Dosso and Tillabéri regions will be managed by SCI/RISEAL for the SCH MDA (Abalak, Birni n’Koni, Bouza, Illéla, Keita, Madaoua, Tahoua, Tchintabaraden, Filingué, Ouallam, Dosso, Doutchi and Loga). In addition, the PNLBG will begin to implement the new SCH strategy, which was developed in 2014, which adds a second round of MDA for four districts with high prevalence.

In addition to the MDA, the PNLBG carries out periodic surveys in 17 sentinel sites in 17 districts using the Kato-Katz method. In FY16, the PNLBG planned to assess these sites; however, they have been delayed given the late start to the FY16 MDA in certain districts and will be conducted in FY17.

Soil-transmitted helminths

Niger’s 44 HDs are considered to be endemic for STH. Based on the WHO definition, Niger has a moderate STH prevalence rate (between 20% and 49.9%). The national strategy (treatment of all districts, even those with moderate prevalence) is based on the fact that most people don’t have access to clean water or sanitary installations and have poor hygiene habits.

The MoPH’s STH strategy consists of:

- MDA via LF treatment (IVM+ALB) or SCH + STH treatment (PZQ+ALB). Note that the districts don't all receive annual treatment because certain districts are not LF endemic (or have stopped treatment) and may not treat SCH annually
- Deworming of children 12 to 59 months old during National Vaccination Days (JNV) funded by UNICEF, which also generally distributes a deworming medication twice per year. A campaign has been programmed for October 2016. An assessment of coverage by the immunization program is planned for November 2016 to see if Niger should continue or stop JNVs coupled with deworming
- Pregnant women are treated with ALB via the MoPH's Directorate General of Mother and Child Health
- Implementation of BCC with materials based on disease prevention and by improving the participation level during the MDA campaigns
- Improved access to clean water and sanitation.

In addition to the MDA, the PNLBG carries out periodic surveys at 17 SCH sentinel sites in 17 districts and assesses STH at the same time. The PNLBG planned to conduct these surveys in FY16, but they have not yet been conducted.

Trachoma

Trachoma control began in Niger in 2002 following baseline mapping with the WHO simplified grading system. At the time, 33 of the 44 districts were considered endemic and warranted MDA (trachomatous inflammation-follicular (TF) $\geq 10\%$ in children one to nine years old). Of the other nine districts, four were totally urban and considered non-endemic and have never been mapped (Niamey I, II, and III and Maradi); one district was at less than 5% at the time of reference mapping (Loga) and the four districts of the Agadez region (Arlit, Bilma, Tchirozérine and Agadez) were not suspected to be endemic. However, based on the recommendations of the Trachoma Expert Committee, the PNSO later decided to map the Agadez region. This was completed in 2014 with USAID support. Of the four districts, two had a low endemicity level: Bilma (9.9%) and Tchirozérine (6.9%). The other two (Agadez and Arlit) had a TF prevalence of $< 5\%$ in children one to nine years old. Therefore, 35 districts are considered to be endemic.

The PNSO aims to eliminate trachoma as a public health problem through the WHO-endorsed SAFE strategy. The strategy includes impact assessments after one, three, five or seven years of MDAs depending on TF prevalence (although none of Niger's districts has a sufficiently high prevalence to warrant seven treatment series before an assessment survey)¹.

Two HDs (Tchirozérine and Bilma) conducted their first MDA in FY16 following the mapping of the Agadez region done in August 2014. The treatment of the two Agadez region districts ensured that the MDA geographical coverage expanded to 100%.

Trachoma elimination strategies are based on implementation of the four SAFE strategy components:

- Mass treatment with Zithromax and tetracycline eye ointment (TEO) 1% to interrupt transmission, targeting 100% of the population
- The management of trichiasis cases (trichiasis surgery)
- The promotion of facial cleanliness and hygiene
- Environmental changes (make drinking water available and build latrines)

¹ Per WHO Standard Operating Procedures, 2014

- Operational research
- Capacity building for PNSO staff
- Monitoring and assessment activities, including impact surveys and monitoring surveys.

The current epidemiological situation is as follows:

- 24/44 HDs have $TF_{1-9} < 5\%$ (i.e. reference or baseline)
 - Baseline (3): Loga, Arlit, Agadez
 - Impact (21): Tillabéri, Tchintabaraden, Téra, Tahoua, Say, Bouza, Abalak, Filingué, Kollo, Birnin’Konni, Doutchi, Dosso, Madaoua, Tanout, Keita, Ouallam, Illéla, Gaya, Boboye, Dakoro, and Madarounfa
- 4 HDs have TF_{1-9} between 5% and 9.9%: Tchirozérine, Bilma, Mayahi, and Guidan Roundji
- 8 HDs have TF_{1-9} between 10% and 29.9%: Zinder, Mirriah, Gouré, Aguié, Diffa, N’Guigmi, Maine Soroa, and Tessaoua,
- 2 HDs have a TF_{1-9} between 30% and 49.9%: Matamèye and Magaria
- 6 HDs have never been mapped and are not prone to endemicity: five Niamey districts and Maradi.

A total of 21 HDs out of the 36² that have ever conducted a MDA have met the criteria to stop MDA at the district level:

- Tillabéri (6): Téra, Say, Tillabéri, Ouallam, Filingué, and Kollo
- Dosso (4): Doutchi, Boboye, Dosso, and Gaya
- Tahoua (8): Abalak, Tchintabaraden, Tahoua, Bouza, Keita, Madaoua, Birni n’Konni, and Illéla
- Maradi (2)³: Madarounfa and Dakoro
- Zinder (1): Tanout.

With respect to post-MDA surveillance, district-level surveys are planned for seven districts at the end of FY16: Boboye, Dosso, Kollo, Say, Ouallam, Filingué and Illéla to determine whether disease transmission has stopped.

The surveys are required to prepare the elimination validation dossier which every country needs to create and submit to the WHO to validate elimination. The PNSO will be conducting these surveillance surveys in chronological order, starting with the first district that achieved $TF < 5\%$ among children ages 1-9 years.

² The FY16 work plan stated that 34 districts had never undergone MDA. This is because two districts in the Agadez region (Bilma and Tchirozérine) had not received a MDA at the time of FY16 work planning. However, the first MDAs for trachoma were conducted in these two districts during FY16.

³ Maradi district received MDA when it was part of two other districts in the same region (Guidan Roundji and Aguié). However, once it became its own district, the PNSO determined that it was unlikely to be endemic for trachoma, as it now encompasses only the urban city of Maradi.

Table 2: Snapshot of the expected status of the NTD program in COUNTRY as of September 30, 2016

		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 09/30/16		No. of districts expected to be in need of MDA at any level: MDA not yet started, or has prematurely stopped as of 09/30/16	Expected No. of districts where criteria for stopping district-level MDA have been met as of 09/30/16	No. of districts requiring DSA as of 09/30/16
					USAID-Funded	Others			
Lymphatic filariasis	44 ¹	33	11	0	25 ²	0	0	12 ³	Pre-TAS: 11 districts (Gaya, Aguié, Madarounfa, Mayahi, Tessaoua, Birnin'Konni, Bouza, Illéla, Keita, Tahoua, Tchintabaraden) TAS 1 : 8 districts (Matamèye, Magaria, Mirriah, Gouré, Zinder, Diffa, Mainé Soroa, N'Guigmi, Gaya)
Onchocerciasis		5 ⁴	39	0	0	0	0	5 ⁸	4 districts: Say, Téra, Kollo, Boboye
SCH		43	1	0	37 ⁵	6	0	0	17 sentinel sites ⁶
STH		44	0	0	43 ⁶	1	0	0	17 sentinel sites
Trachoma		35	9	0	14 ⁷	0	0	21	Impact assessments: Gouré, Aguié, Matameye, Magaria, Zinder Commune, Bilma, Tchirozérine, Mayahi, and Guidan Roudmi

1. Niger has 72 districts, but only 44 are functional out of the 72 created in 2014 (in the FY16 workplan, there were 42 functional HDs). It should be noted that the workbooks still only have 42 HDs in them; this is because the additional 2 districts became functional during FY16.
2. This is the actual number of districts which received a MDA in FY16 (including the two new Niamey HDs). Of the districts receiving MDA, four had conducted a TAS 1 in FY16 also. They passed, but the MDA was still carried out in these districts because MDA was scheduled to occur just after the end of the TAS 1 surveys and drug and funds were already being put into place at the time of the survey.
3. The districts include: Téra, Say and Kollo which met the criteria to stop their MDA in 2013 and Guidan-Roundji, Dakoro, Madaoua, Boboye and Tillabéri which met the criteria to stop their MDA in 2014. And Niamey II (now subdivided into Niamey 2, 3 and 4) and Niamey III (now Niamey 5) which met the criteria to stop their MDA in 2016. This means 12 HDs are considered to have passed TAS1 and stopped MDA for LF instead of 10 HDs due to the recent subdivision.

4. The districts (Téra, Say, Kollo, Boboye and Gaya) are currently eliminating OV. Four of the districts will undergo epidemiological and entomological assessments in FY16. The last one, Gaya, is currently conducting a pre-TAS for LF and will conduct a TAS 1 in FY17 if mf<1%.
5. These are all of the districts receiving support for MDA through USAID as of September 30, 2016. The FY16 campaign involved 20 HDs (including the two new Niamey districts). The treatment strategy differs by district: some are treated once a year, others twice a year and others once every two years. Historically, the END in Africa project has supported all but 6 districts for MDA; SCI/RISEAL has been supporting those districts through the SCORE study, which concluded in December 2015. However, SCI/RISEAL still supported MDA in those districts in FY16.
6. Although 44 HDs are considered STH endemic, one district (Bilma) is not also co-endemic for LF or SCH endemic and does not receive MDA.
7. Fourteen districts currently have TF among children ages 1-9 years but because Niger does not treat in the same year impact assessments are conducted, not all of these districts received treatment in FY16 and not all are planned for FY17 (7 impact assessments are currently due, so 7 districts are planned for MDA in FY17).
8. All of these districts were treated through LF treatment. 4/5 districts have now stopped MDA for LF. However, all villages were hypo-endemic for onchocerciasis and below the threshold for treatment. In FY16, the 4 HDs that have stopped LF MDA are undergoing entomological and epidemiological surveys to demonstrate that transmission of oncho has stopped.

PLANNED ACTIVITIES

NTD program Capacity Strengthening

A situational analysis of the NTDs and an assessment of the country's ability to receive additional funds from donors were carried out by World Bank experts as part of the World Bank's new NTD/Malaria Project whose activities began this past year. The analyses revealed that the country's health resource mobilization and management capabilities are satisfactory via management of the joint fund for the implementation of the MoPH's Health Development Plan (HDP). An overall assessment of the management and a financial audit are ordered every year and shared during the National Council on Health meeting. All documents, including the new Niger Health Policy and the new HDP (2016-2020), currently in the approval process this year, take into account an increase in the share of the government budget allocated to health for the purpose of decreasing support or the withdrawal of the financial partners from the sector.

Following a series of capacity building sessions for logistics management and results-based management provided with partner support, the NTDP now has a management framework for the implementation of activities to fight NTDs. However, despite the efforts made in the field, there is still a lot of work to do to ensure the long-term sustainability of the activities because of staff mobility. From the standpoint of governmental financial appropriation of NTD activities, the many national priorities and security and food challenges restrict the government's intervention efforts. While the NTDP needs reinforcement in financial management, the NTDP has a fairly well-developed technical capacity for the implementation of the activities (MDA, monitoring and assessments).

After the elimination and control of the diseases, the NTD program will continue its close cooperation with all of the organizations which can help it consolidate its accomplishments and increase surveillance. To do so, all of the state structures which can provide support to the NTD program to ensure morbidity control and proper management will be involved. In FY17, special emphasis will be put on strengthening the partnership among the MoPH and all of the stakeholders taking part in the fight against NTDs. The strengthening will be done at several levels to enable us to track the implementation of activities over time and assess the progress made. Coordination meetings will be re-energized via the participation of both the Directorate of Studies and Programming (Direction des Etudes et de la Programmation (DEP))

and partners such as the WHO, SCI/RISEAL and The Carter Center. In addition, the Ministry of Public Health is planning to create a task force to bring together all of the partners involved in the fight against NTDs. Representatives from the National Assembly, the Prime Minister's office and other ministries will be part of the task force. The task force will also receive support from the World Bank's NTD/Malaria project and provide a framework for exchange and major decisions. A steering committee was also created jointly with the World Bank's NTD/Malaria project to bring together all of the NTD partners including HKI. The primary role of this body will be to monitor activity implementation. All of these bodies will be driven by the MoPH enabling it to confirm its leadership and ensure the continuity of the goals set once the project has been completed.

Several areas were identified for program capacity building in FY17. The main ones are:

- Management of Fixed Obligation Grants (FOGs). Recipients of FOGs in Niger have had many issues understanding this mechanism of funding, which has led to frustration for all parties. Due to lack of understanding, deliverables are often of poor quality or received late. Another issue has been turnover in the regions, and those persons who previously received training to manage the FOGs are no longer in the system. Therefore, a training will be held for finance managers in the regions on strengthening of performance management skills, ensuring better understanding of MDA resource management responsibilities within the context of FOG funding, and on improving the use of standard operating procedures for financial management and governance.
- To improve MDA coverage, independent monitors will be trained and utilized during both MDA sessions.
- To ensure quality survey data are collected for trachoma, as Niger nears elimination, a training for ophthalmological technicians in trachoma survey methodology and one on electronic data collection methods (e.g. Tropical Data) are planned.
- In addition, trainings are held prior to all other DSAs for the field workers conducting the survey to ensure that they understand how to use the diagnostics and to ensure that they know the correct households and populations to survey. In FY17, pre-TAS and TAS 1 will be conducted for LF and sentinel site surveys for SCH will be conducted.
- Onchocerciasis elimination committee: Niger is currently preparing to submit its dossier for validation of elimination of oncho to WHO. The Program is planning to create a committee of local and international experts for this purpose. The assessments made by the committee will enable the Program to prove that transmission of disease has stopped and that there are no sources which could lead to the resurgence.

Project Assistance

Strategic Planning (Location in budget: Planning budget tab, subaward lines 121-124; ODC lines 159-164)

Total cost for activities in this section: \$149,881

Annual work planning workshop (Once a year)

Each year, a workshop to validate the main activities planned for the next fiscal year for the END in Africa project is held in May or June. This work planning meeting brings together the main partners of NTDP, including the MoPH, the Ministry of Education, the different NTD programs, the health regions, USAID, FHI 360, HKI, The Carter Center and SCI/RISEAL. Prior to this validation workshop, a workshop to develop the first draft of the document is held and attend by the MOH, the NTD programs. Similarly, other documents accompanying the narrative (workbooks and budget) are discussed and completed.

Annual micro-planning meetings (Once a year)

Micro-planning MDA meetings for the FY18 MDA will be held before the work planning and budgeting process for the US government's fiscal year. The primary goal of the meetings is to develop a basic budget for all MDA-related activities with the full participation of all people involved. They will then be included in the budget HKI will submit to USAID for the following fiscal year. The micro-planning meetings will be held in each region with central level participation (National NTD Program, Health and Education coordinators and agents) and HKI. The recommendations from the meetings will be reviewed and used to develop a work plan document. The expected results of the meetings are the MDA budgets and goals for the following fiscal year. The budgets and goals developed will be included in the overall NTD budget for 2018 activities. (The NTD program operates on a calendar year).

Distribution of the new NTD strategic plan (Once)

The new plan takes into account the gaps and shortcomings observed during implementation of the first plan to enable the NTD Program to progress towards the 2020 elimination objectives. New strategic directions have been defined to meet these goals. The new 2016-2020 strategic plan covers the NTDs targeted for chemotherapy (PC NTD) (SCH, STH, LF, trachoma and oncho), as well as other NTDs for which cases are managed (leprosy, rabies, leishmaniasis, African trypanosomiasis and Guinea worm). To ensure better promotion of the plan, distribution activities and the mobilization of technical, financial and social partners is a major strategy of the new plan as recommended by WHO during the workshop held in Ouagadougou in November 2015. A meeting will be held with all NTD partners and the final, approved document reproduced and distributed to ensure the buy-in of all parties.

NTD coordination meetings (four times a year)

Quarterly meetings will be held with the National NTD Program (the National NTD Focal Point and the Program Coordinators) and the partners providing support to the Program including HKI, WHO, The Carter Center, the World Bank, UNICEF and RISEAL/SCI. The meetings will be held every three months to monitor and plan activities and find solutions to urgent problems arising during the implementation of activities. The meetings also provide the opportunity to fine-tune emergency plans to address potential program changes. In FY17, special attention will be paid to MDA planning at each meeting. The meetings should show that the information is being fully disseminated to the partners, resulting in concrete actions to resolve any problems that arise.

Onchocerciasis elimination committee (Twice a year) (ODC)

Oncho control activities have been carried out since 1976 to date in Niger, and the disease is no longer a public health threat. The results of entomological and epidemiological assessments carried out over the past years indicate that oncho is nearing elimination in Niger. The country is now committed to the process of demonstrating oncho elimination and obtaining WHO validation. In line with WHO recommendations, an elimination committee is currently being set up and should begin by December 2016.

The committee will meet twice a year or when needed to take decisions on the activities carried out for the control and monitoring of the disease in order to make operational decisions.

Annual post-MDA review meetings at the National, Regional, and District Levels (Once a year)

An evaluation and planning meeting is held at the end of the MDA campaign each year to capitalize on the lessons learned from the NTD program. The workshop brings together all key stakeholders (health, education and partners) to share the results of the campaign by HDs, to identify areas of strength, areas

for improvement, 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, and the NTD focal points for education and health. A similar assessment meeting is also held at the district level with the health center heads, education sector heads and the administrative authorities and traditional leaders. The NTD programs also present their main activities for the coming year at these meetings 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.

NTD Secretariat (Location in Budget: Planning budget tab, ODC lines 166-167)

Total cost for activities in this section: \$5,294

Support for the NTD Focal Point, the PNLBG, and the PNDO/EFL (Every month or quarter)

The National NTD Focal Point requires support for its work. The support will primarily consist of office supplies, a computer and fuel. HKI will provide part and the rest will be supplied by the government; this will be reviewed when World Bank funds become available.

The PNLBG and PNDO/EFL programs will benefit from similar support thanks to funds for the payment of telephone and Internet bills and computer supplies. The PNSO receives this support from HKI via financing from the Conrad N. Hilton Foundation.

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

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

Advocacy for Building a Sustainable National NTD Program (Location in Budget: Planning budget tab, subaward lines 127-128; ODC 169-171)

Total cost for activities in this section: \$34,936

The Program made some significant progress in advocacy during FY16. As part of the process of gaining buy-in for NTD activities by the highest MoPH authorities, the national campaign launch was carried out under the sponsorship of the Secretary General of the Ministry of Public Health. In addition, the National Health Policy and HDP (2016-2020) documents currently being approved make the prevention of NTDs an MoPH priority. The inclusion of the NTD budget line at the MoPH level should also be noted, even though funds were not able to be mobilized via this line during the previous year. The increase in the share of health in the overall government budget, which the MPH fought hard for, didn't achieve the results hoped for due to budget constraints resulting from security issues in the north of the country. At the regional and district levels, the meetings held with regional governors and their close collaborators and preparatory district meetings enabled the mobilization of contributions in kind this year, including motorcycles and animals for CDD transportation. The opening of regional MDA evaluation meetings were chaired by the Governors or their Secretary-Generals (SGs) with national radio and television coverage.

A joint HDP implementation fund was created at the MPH level which manages most of the funds from the MPH's partners. This was done to ensure the sustainability of prevention activities and better management and streamlining of resources given the many different funding partners. This organization earned the trust of the World Bank for the management of funds for the World Bank's new NTD/Malaria project.

In FY17, the objectives of the advocacy plan will be to increase buy-in for the NTD control activities with the appointment of a program sponsor (generally appointed among the wives of the Head of State, the Head of the Government or the Chairman of the National Assembly), the creation of a NTD task force (with the full involvement of the National Assembly's Health Commission, the Prime Minister's office and the various Ministries) and the creation of a steering committee (which will bring together MoPH authorities and all partners involved with NTDs). These last two activities will be funded by the World Bank.

Meetings with the regional governors (Once a year)

Meetings will continue to be held each year with the governors of the regions to gain their buy-in for the execution and follow-up of the FOGs. MoPH authorities (central and regional levels) and HKI managers will be involved. The meetings are prepared with the Ministry in of Local Authorities to ensure greater involvement by the governors in the buy-in and execution of activities by local government so that they become sustainable within the program. This first step is a requirement because the governor reports to the Ministry of Local Authorities although, according to the contracts, the Ministry of Public Health is responsible for carrying out these activities. The meetings raised the Governors' awareness about the importance of the NTD Program and about the goal of the FOG contracts and of obtaining FOG signatures. Note that since these meetings have been held, the governors have not been reticent about signing FOG contracts even though there might be a change in governor from one year to the next.

National Stakeholders Meeting (Once a year)

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

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

An official launch ceremony is held to mark the start of the MDA each year. The launch, sponsored by the MoPH, provides the program with an official seal of approval and increases its visibility. It brings together all of the people involved in the prevention and elimination of NTDs, including the authorities of the MoPH and other ministries, the administrative, local and traditional authorities, associations and non-governmental organizations (NGOs) and all other entities that provide their support to the NTD program. This year, the NTD Program would like the launch to take place in Zinder which is an area with persistent prevalence, particularly for trachoma.

Advocacy meetings at health district level (Once a year)

These are preparation meetings prior to the start of the MDA in each district in which a MDA will be conducted. The meetings bring together district prefects, town mayors, canton heads, religious leaders, associations, NGOs, health and education representatives and all other MDA partners. The primary goal of the meetings is to mobilize the partners to ensure their contribution to the MDAs, that they motivate the CDDs and the supervisors and provide transportation (motorcycles, fuel, etc.). The goal is to motivate all local-level partners and ensure that they participate fully in campaign execution. The districts increasingly report cases of community contribution in district-level assessments. They include motorcycles, animals, and fuel for CDD transportation (see table below).

Contributions by region for the previous MDA

Region	Contribution	Value XOF	Total XOF (USD)	Notes
Agadez	200 liters 5 motorcycles	108,000 100,000	208,000 (\$198)	City Hall Dagada (Tchiro) Individual (CR Dabaga)
Diffa	N/A	0	0 (\$0)	
Dosso	16 motorcycles 56 liaisons	480,000 56,000	620,000 (\$1,067)	Doutchi HD
Maradi	N/A	0	0 (\$0)	
Tahoua	12 motorcycles	300,000	300,000 (\$516)	Illéla HD
Tillabéri	N/A	0	0 (\$0)	
Niamey	N/A	0	0 (\$0)	
Zinder	571 Teachers	1,427,500	1,427,500 (\$2,457)	Volunteers
Total			2,555,500 (\$4,399)	

There are several barriers for resource mobilization and sustainable leadership for the prevention of NTDs at the Program level, including the low level of financial contribution by the government for health matters in general and for the control of NTDs, in particular. The percentage allocated to the MoPH in the overall government budget barely exceeds 7-8%, while the objective is 15%. Second, there is difficulty mobilizing the resources in the NTD budget line. Of the 30 million CFA (approximately \$51,000) voted for in 2015, not one franc was released to support the fight against NTDs. There is another joint budget line at the MoPH dedicated to all health programs. However, funds mobilization is very complicated due to the Ministry's many priorities. In addition, NTDs control was not a priority in the 2011-2015 Health Development Plan, which automatically relegates NTDs to also not being prioritized for funding. Generally speaking, of the funds allocated to NTDs (among all partners), only about 1 to 3% are dedicated to advocacy. Such a small budget line does not enable the National Program to ensure the visibility of NTDs to advocate for further resources. Lastly, note that the MoPH's health programs are not sufficiently integrated to enable programs with enough financial partners to support those who have fewer.

Given the future withdrawal of funding partners and the challenges listed above, the MoPH is now focusing on meeting the gaps that will be created. As a result, several strategies are being developed. The two most important ones are: the integration of health programs (not yet in effect) which over time will result in the creation of a single integrated program to control diseases. Some activities are already being implemented, including integrated supervision which is being done from the central level to the regions and districts and also from the regions to the districts. The second strategy involves the creation of a single funding process for health activities called the Common Basket (Fonds Commun). All of the partners accept to pool their financial resources via this process to fund the activities included in the HDP.

Social Mobilization to Enable NTD Program Activities (Location in Budget: Planning budget tab, subaward lines 130-132; ODC lines 173-175)

Total cost for activities in this section: \$77,153

Social mobilization strategies include mass communication and interpersonal communication. Mass communication is used to convince populations of the benefits of the treatments and avoid the spread of false rumors. Interpersonal communication increases the coverage rate and creates positive support (example: The Tahoua sensitization caravan in FY16 in areas that had failed with TAS 1 with a large number of positive cases).

Mass communication

The NTDP will conduct dissemination of messages using mass media: national television, national radio, community radio stations with USAID funding. It also includes publication in newspapers, and private radio and television stations with other funding (Sightsavers, SCI/RISEAL, The Carter Center).

National radio and television: These media provide national coverage for the broadcast of key NTD messages. Activities include the transcription, creation and broadcast of radio and television messages via national television and radio. The messages focus on three topics: “Neglected tropical disease transmission and prevention,” “Treatment of neglected tropical diseases,” and “Benefits of treating neglected tropical diseases”. Each of the topics is provided in three languages (French, Hausa, and Zarma, which are the most widely spoken throughout the country). As the national television and radio stations have country-wide reach, this will enable the NTDP to reach the largest possible audience in the eight regions of Niger. The emphasis will be on radio in rural areas and television in urban areas. In addition, messages are recorded, and distributed on compact discs nationwide so that the same messages are broadcast throughout the country.

- For television, the spots are broadcast in the three languages alternating once a day (before shows, before the news at 8:30pm and after the regional news) for a month.
- Radio messages on the national station are broadcast in the three languages each day (12:55pm, 2:00pm and 2:30pm) for one month also.
- Contracts are also signed each year with community radio stations at the district level for the broadcast of NTD messages to reach a significant portion of the population before, during and after the MDAs. This ensures that all social strata are informed of the distribution. Messages are broadcast at least twice a day in all local languages. There are interviews with health communicators and CSI heads as well as testimonials from community leaders about NTDs.

Financial support from the END in Africa Project is required for the MDA mass communication activities.

Inter-personal communication

- Town criers: Each town crier works in a limited geographical area consisting of three to five villages/hamlets and a weekly market. They go up and down all of the village streets and lanes in the morning and evening with a tamtam (a drum) to inform the population that community distributors will be coming to the village on a specific date. This ensures that the population will stay in the village and wait for the distributors.
- Community distributors: Each community distributor must have a certain number of points of contact (households, dealerships, wells) which they visit every day to raise awareness about the topics (modes of transmission, treatment and prevention of NTDs) and distribute the drugs to prevent NTDs. There is no additional budget line needed for this, as CDDs receive compensation for distribution drugs.
- Women liaisons (“relais”): The use of women liaisons in the communities began in FY14. The practice will be continued and increased, particularly in regions of Niger where men aren’t allowed access to homes when the male head of the family is absent.

- Awareness-raising caravan about NTDs for local populations: This coordinated awareness-raising activity consists in raising the awareness of a wide audience by bringing local residents together in one location (such as a public square) in large villages. Awareness-raising sessions are provided during the evenings via videos, debates, skits, role-playing and the distribution of flyers and posters about NTDs. The videos are followed by group discussions about the diseases and the benefits of taking the drugs. Question and answer games also involve the audience and tee-shirts and baseball hats are given out. This year, we will focus on the regions of Zinder (Mirriah, Magaria) and Maradi (Aguié, Tessaoua), where areas of poor coverage were noticed during the national assessment. We will select three CSIs in each district and three villages per CSI (a total of four districts, 12 CSIs and 36 villages).

Financial support from the END in Africa project will be required for all of the interpersonal activities listed above.

Table 3 Social Mobilization/Communication Activities and Materials Checklist for NTD work planning

Category	Key Messages	Target Population	IEC Strategy (materials, medium, activity etc.)	Where/when will they be distributed	Frequency	Is there an indicator/mechanism to track this material/activity? If yes, what?	Other Comments
Participation in mass distribution	<ul style="list-style-type: none"> • “Neglected tropical disease transmission and prevention,” • “Treatment of neglected tropical diseases,” • “Benefits of treating neglected tropical diseases” 	Entire population	Mass communication (national radio and television, community radio stations; flyers, posters, baseball caps and t-shirts)	<ul style="list-style-type: none"> • Via television and radio before and during the MDA • Flyers, posters, baseball caps and t-shirts during the awareness-raising caravans 	TV and radio: three times a day per language for a month Flyers, posters, baseball caps, and t-shirts during the awareness-raising caravans	<ul style="list-style-type: none"> • # of televised message broadcasts • # of radio message broadcasts • # of community radio stations used • # of posters, flyers, baseball caps and t-shirts distributed • % epidemiological coverage for each disease 	
Disease prevention through MDA and other NTD interventions	<ul style="list-style-type: none"> • Participation in MDA • Sleeping under mosquito nets • Face and hand washing • The correct use of latrines • Environmental health 	Entire population	Inter-personal communication (town criers, women liaisons, awareness-raising caravan)	<ul style="list-style-type: none"> • Door-to-door before and during the MDA • Community-level gatherings 	<ul style="list-style-type: none"> • Morning, afternoon and evening for three weeks • Caravans are one visit each in four districts, 12 CSIs and 36 villages 	<ul style="list-style-type: none"> • # of message broadcasts • # of women liaisons used • # of public criers used • # of villages covered by the caravan • % epidemiological coverage • % change in epidemiological coverage in HDs in FY16 MDA and FY17 MDA 	

Training (Location in Budget: Planning budget tab, subaward lines 134-136; ODC lines 177-179)

Total cost for activities in this section: \$554,447

MDA cascade training/refresher training

In order to ensure capacity building for the people involved at all levels, Niger's NTD Program will organize training/refresher training for trainers and national supervisors (MoPH and education program agents); at the regional level (DRSP, Regional Directorate for National Education, NTDP regional health and education focal points, education inspectors, district head doctors, NTDP district health and education focal points); at the district level (pedagogical sectors, CSI heads); and at the village level (teachers and CDDs). The training/refresher training for all levels of health staff will take place before the MDA campaign. The central level trainers and supervisors (NTDP coordination) will participate in training of trainers. They will then be responsible for training regional staff, who in turn, will train the district personnel. The district personnel will then provide training to the CSI heads and educational sector heads who will in turn train the CDDs and teachers. In FY17, cascade training for MDAs will again be carried out using the revised module based on the Information and Logistics Management System which was introduced to Niger with technical assistance (TA) from John Snow, Inc. (JSI).

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

FOG management training

Niger received technical assistance from Deloitte in 2014 to train trainers on FOG management. About thirty central and regional staff were trained for a week in Niamey. There has since been discussion of continuing the training at the health district level for the benefit of the district management teams. This training was one of the recommendations made by the regions during the assessment of the last MDA. The main shortcomings noted in funding are partially due to a poor understanding of the FOG funding system, particularly by the health districts, which provide the majority of the deliverables and supporting documents. The training will be held in two sessions, and staff from four different regions will participate in each session. One session will be held in Dosso (Dosso, Tillabéri, Tahoua, and Niamey regions will participate); the second session will be held in Zinder (Zinder, Agadez, Maradi, and Diffa regions will participate). Each session will last two days. Those receiving the training will be the finance managers from each of the 44 health districts in the country. A pre- and post-test are planned for the start and end of training to measure what participants learned during the training.

Independent monitoring training

Independent MDA monitoring was implemented in FY14 for the first time. It has proven to be very helpful for district MDA monitoring and for identifying the areas in which greater monitoring or support may be required. The activity will continue in FY17. The activity is carried out in districts with poor coverage, or in those where problems or shortcomings have been reported by the agents involved in implementing the distribution campaign, which then results in finding appropriate solutions. Monitoring will begin with the training of 12 people independent of the NTDP to ensure their impartiality during data collection. The number of people trained may vary depending on the problems and shortcomings found during the campaigns. The information collected by the monitors will consist of variables such as age, gender,

whether the person has been treated or not, the reasons why they weren't, the channels through which the information about the campaign was received, an interview with health agents and DCs about the campaign process, etc. A debriefing will be held every day to inform health agents about the findings in the survey areas. Decisions for improvements will be taken immediately.

Eye technician training in trachoma survey methodology

This activity will enable capacity building for technicians in the survey methodology used in the field. This is necessary because the trachoma operating procedure protocol requires a random sampling of households in the field, which first requires an exhaustive survey of all existing households in the villages selected for survey. In addition, identification of the various forms of trachoma (based on the WHO simplified grading system) requires special training as presentations of other ocular conditions resemble certain clinical signs of trachoma. In addition, many of the technicians do not know how to grade trachoma. This training will be held in conjunction with the impact assessments described in the M&E section below.

Trachoma agent training in the use of tablets for surveys

The WHO rolled out the Tropical Data system for trachoma impact assessments and surveillance surveys in 2016 and the PNSO plans to use this system for its impact assessments. Four PNSO staff participated in this training and will serve as trainers of trainers to the personnel who will carry out the field surveys. HKI, with funding from the Conrad N. Hilton Foundation, provided the PNSO with tablets for this activity in FY16. This training will be held in conjunction with the impact assessments described in the M&E section below.

Table 4: 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			
Central supervisor and trainer training	The different diseases, Supply Chain Management, the management of side effects and Filling in of the MDA data collection tools	2	6	8	1	Niamey	None
Regional trainer training (district participants = 144; DRSP participants = 32)	Diseases, filling in of media, side effects (including supply chain management and clearing out/ reorganization of warehouses)	40	63	103	2	Zinder, Maradi, Tahoua, Niamey	None
Training of CSI and sector heads	Diseases, filling in of media, side effects, drug management	415	829	1,244	1	All districts with MDA	None
CDDs and teacher training	Diseases, filling in of media, side effects, drug management	15,185	45,778	60,963	1	All health centers with MDA	None
Senior ophthalmological care technicians	trachoma survey methodology	38	0	38	3 sessions; 7 days each	Maradi	None
Senior ophthalmological care technicians and supervisors	Agent training in data collection with tablets	24	0	24	3 sessions; 5 days each	Maradi	None
Independent Monitors	General information on NTDs targeted by this MDA campaign, Methodology, The various data collection tools, Basics on data	2	10	12	3 days per session (including one practical)	Niamey (one day outside of Niamey for practical session)	None

	collection by tablets, Role playing				day in the field)		
FOGs Management	Definitions, structure, function, advantages and conditions, case examples, practice	44	0	44	2 days	Dosso, Zinder	None

Mapping (Not budgeted)

Total cost for activities in this section: \$0

Niger finalized mapping of the main NTDs in 2014.

MDA Coverage and Challenges (Location in budget: Planning budget tab, subawards line 144, ODC 182-183)

Total cost for activities in this section: \$428,989

In FY17, Niger will formally split the MDA into two separate campaigns, primarily because the Zithromax arrives when the PNSO requests it (November 2016), while the other drug, which is ordered through the WHO donation program (ALB, PZQ, and IVM) generally arrives much later. In addition, the different programs have noted that it is an enormous logistical work to try to coordinate all the MDA to take place in the same period, and splitting them should ease the burden. Therefore, the first MDA is being planned for trachoma in November 2016. If the same districts are also treating for other diseases, then drug left from the FY16 MDA will be used to treat as many as the leftover drug will allow. The second MDA will take place as soon as the other drugs arrive in Niger, tentatively in March 2017. Below, we detail the MDA by disease:

Trachoma

In FY17, 7 districts will receive MDA (Zithromax + TEO 1%), for a total target population of 3,762,953, which is 100% of the population of these districts. The drugs will be distributed by CDDs using a door to door strategy; teachers treat children in schools. END in Africa will support the costs of distribution; The Carter Center will cover the cost of purchasing the TEO.

LF

A total of 21 districts will be treated for LF (IVM+ALB); the target population is 8,622,475 (population ages 5 and above). The drugs are distributed by CDDs through door-to-door strategy; teachers treat children in schools. END in Africa is the sole partner for MDA distribution for LF.

SCH

Two rounds of MDA for SCH will be distributed. In the first round, a total of 37 HD will be treated with PZQ with a total target population of 8,665,218 (6,137,519 for END in Africa). END in Africa will support 26 districts; SCI/RISEAL will support 11⁴ districts.

Per the new SCH treatment strategy developed in 2014, four districts (Kollo, Say, Tera, and Tillabéri) should be treated twice per year, given the high prevalence of the disease (see Appendix 9). These districts will be supported by END in Africa.

⁴ Above, we reported that SCI/RISEAL will support 13 HD. Two HD that will be supported by SCI/RISEAL do not require MDA in FY17.

The target population to be treated are school-aged children in endemic districts and adults in endemic districts. The PZQ will be obtained through the WHO donation program for FY17. The PZQ will be distributed by CDDs through a door-to-door strategy and by teachers in school.

STH

A total of 39 districts will be treated for STH, with a total target population of 14,865,318 (12,367,086 through END in Africa support). It should be noted, however, that the PNLBG only officially recognizes having treating for STH through the PZQ+ALB strategy (which is planned in 18 districts); the other 21 districts will be functionally treated through the LF MDA (IVM+ALB). Six districts will be supported by SCI/RISEAL. CDDs conduct MDA using a door-to-door strategy; teachers conduct distribution in the schools.

MDA Challenges

There are a number of reasons for the poor coverage identified during the FY16 MDA. The reasons include:

- The overlapping of mass activities with the community actions of other health programs, particularly overlapping with the JNV. The same people distribute MDA drugs and conduct the JNV campaigns. Per MoPH policy, all other health field activities should stop during JNV. This has been raised as an issue with the MoPH, but the Program is awaiting a response on measures that can be taken to avoid this in the future in order to respect the microplanning calendars.
- CDD compensation is not the same for the two campaigns: During the JNVs, the community distributors receive 2,500 CFA per day (for a total of four days). They only receive 2,500 CFA per drug package (during four to seven distribution days) with maximum 7,500 CFA for the NTD MDA (distribution can last a month depending on the number of drug packages and the local geography).
- Conditions are difficult for the CDDs who work in desert areas where they often have to travel long distances on foot. This continues to be true despite the improvement in CDD workloads in FY16 (before FY16, each CDD had to treat 500 people; the number was reduced to 300 in FY16).
- MDAs have often been delayed over the past years. One of the main reasons for the delay is that the National Program would ideally like to conduct MDA in November/December of each year, since this is a time when the populations are available and less mobile. However, the WHO drug donation of IVM and ALB generally arrive in March or April. Given that the WHO requires 8 months between receiving MDA results/request for more drug, it has not been possible to submit reports in time to then receive the next drug shipment earlier. It should be noted that there is an internal validation process of the MDA data before they can be transmitted to the WHO, and this can also take a couple of months. This has had a negative impact the Program, as initial planning is not respected, other activities are postponed, and drugs for the next MDA are ordered late (which then may lead to a delay in the next MDA).
- The organization of a single, integrated MDA for all of the districts throughout the country is heavy and difficult. When expanded to the scale of the entire country, both drug placement and monitoring lack of technical resources.

- Incorrect quantification of drug required by districts or delivered to districts during the drug delivery process. This led to two districts, Mirriah and Magaria, not having enough drug to complete the FY16 MDA until more drug could be delivered. However, once the mop-up occurred, coverage increased from 25% to 64%. CDDs don't always complete the treatment forms. They often fail to check boxes because they are distracted. This leads to many drugs being distributed, but few people checked off. It has been noted that CDDs who work in pairs get much better results than those working alone.
- Shortcomings in cascade training prior to the MDA, especially for CDDs. Supervision still sometimes reveals CDDs who have not mastered the distribution techniques.
- Significant population movement from the Diffa to Zinder regions due to insecurity caused by the Boko Haram terrorist group. This has increased the population in Zinder and reduced drug coverage rates.
- Poor census numbers used for certain districts which don't match the actual populations in the field.
- Insufficient local supervision of CDDs. The extensive size of the country, the large number of CDDs and the overloading of the CSI heads responsible for supervision, who are often alone in the health training, makes local supervision difficult.

Strategies to improve coverage in FY17

The following strategies will be implemented to improve coverage during the FY17 MDA:

- One of the objectives of the MoPH NTD work plan development meeting is to set the campaign dates. The dates will be provided to the DEP for inclusion in the schedule of major MoPH activities. This will prevent overlapping with other activities and delayed campaigns. It may also reduce the occurrence of drug expiration.
- Two campaigns are planned in FY17. One will be conducted in November 2016 in districts with trachoma and a second campaign will be carried out in March 2017 for districts with lymphatic filariasis.
- In FY17, the trainings for CDDs will be revised. Previously, training has been theoretical; however, it has been shown that many CDDs are not understanding certain concepts, like proper dosing. Therefore, in FY17, the training will be practical, using techniques such as role-playing.
- In FY17, 12 health districts will be transferred to SCI/RISEAL for the SCH MDA. Having an additional MDA partner will assist in reinforcing the capacity of the NTD program in the execution of the MDA and management of the drugs, which should help reduce potential drug losses.
- In FY17, each region will select the precise dates of the MDA, and the campaign dates will be broadcast in the press and via national television and radio. This is a change from the previous strategy, where the general campaign dates were broadcast, but the actual dates in a given region may have been somewhat different. The length of the campaign will be set for each region based on the number of packages. The coordinator of each region, representing the MoPH, will be responsible for ensuring

that the length of the campaign in their area is complied with. This will ensure that the campaigns don't drag on indefinitely and also avoid drug expiration.

- Supervision will be strengthened at all levels with a greater number of teams led by the Coordinator representing the MoPH. This will improve the quality of both training and distribution. The role of the Coordinator will be to ensure compliance with distribution standards and also to facilitate the resolution of problems faced by supervisory teams. S/he will be in direct contact with the NTD Coordinators and NTD Manager of HKI to solve the most critical problems.

All of the strategies will be assessed at the end of the MDA during overall campaign evaluation to draw lessons for future campaigns.

Lessons learned from FY15 coverage survey and MDA evaluation

The trachoma program carried out a coverage survey in FY15. The difference between the survey data and the rate of coverage reported by the districts indicated the need for an improvement in the distribution and reporting strategies in the districts to be treated (see table below).

Region	District	Coverage (MDA reports)	Coverage (coverage survey)
Zinder	Zinder Commune	116.89%	72.90%
	Magaria	94.60%	43.80%
	Madarounfa	78.97%	79.70%
	Dakoro	62.46%	86.90%

The results of the trachoma coverage survey were discussed during the national assessment of the FY16 campaign, which brought together the NTD programs, the DEP, HKI, the DRSPs and certain districts. The following corrective actions were recommended to improve training and supervision, based on the disparate results:

- Each cascade training will get the benefit of support from the level above (the central level to the regional level and the regional level to the district). This will contribute to improving the quality of training provided to CDDs and the rate of box checking for people who have received treatment. This will also have a real impact on the number of people treated and the rates of drug coverage.
- Before the start of distribution, an audit of drugs will be requested from each organization by the level above. This will improve drug management. The drugs positioned, calculated based on remaining stocks, will be more accurate and the number of people treated more realistic. This will also avoid frequent drug shortages.
- The Head Doctor of each district will be responsible for managing CDD monitoring by the health center heads. Local supervision of CDDs by the CSI heads will improve the quality of box checking for people treated as well as treatment coverage.
- Regular updates will be implemented at each level (health center to HD, HD to Region, and Region to Central level). This will improve the quality of data collection and, thereby, improve coverage rates.
- Supervision at each level will include a rapid assessment of coverage of the beneficiaries of the MDA. This will improve data collection quality.

- A data quality assessment (DQA) survey should be conducted in certain districts to gain an accurate appreciation of the quality of distribution results and check the compliance of the health pyramid at all levels. This will improve data collection quality.
- The distribution register will be reviewed to collect data by village (increase in the number of checking forms). This will facilitate compilation at data collection time.

Table 5: USAID supported coverage results for FY15/16 ** and targets for FY17

NTD	# Rounds of annual distribution	Treatment target (FY15/16) # DISTRICTS	# Districts not meeting epi coverage target in FY15/16*	# Districts not meeting program coverage target in FY15/16*	Treatment targets (FY15/16) # PERSONS	# persons treated (FY15/16)	% of treatment target met (FY15/16) PERSONS	FY17 treatment targets # DISTRICTS	FY17 treatment targets # PERSONS
LF	1	28	Diffa (14.4%) N'Guigmi (45.6%)	Diffa: 18% N'Guigmi: 47.0%	8,762,440	7,189,384	82.05%	21	8,622,475
OV	0	N/A			N/A	N/A	N/A	0	0
SCH	1	30	Agadez (54.89%), Arlit (52.57%), Mirriah (33.52%), Matamèye (42.73%)	Agadez (68.7%), Arlit (65.7%), Mirriah (74.2%), Matamèye (51.2%)	2,740,420	1,908,710	69.65%	26	6,137,519
STH	1	34	Agadez (54.89%), Arlit (55.01%), N'Guigmi (ND)	Agadez (68.6%), Arlit (68.8%), Diffa (18%), N'Guigmi (57%)	1,155,0719	8,340,596	72.21%	33	12,367,086
TRA	1	9	Mainé Soroa (49.4%), Guidan Roudji (67.5%), Madarounfa (79.0%), (Mayahi 78.7%) Tessaoua (53.4%) Sub-district N'guigmi (37.3%) Sub-district Dakoro (62.5%)	districts Mainé Soroa (49.4%), Guidan Roudji (67.5%), Madarounfa (79.0%), (Mayahi 78.7%) Tessaoua (53.4%) Sub-district N'guigmi (37.3%) Sub-district Dakoro (62.5%)	4,001,884	2,842, 501	71.03% Data not including 3 districts (Aguié, Bilma & Tchirozérine)	7	3,762,953

Drug and Commodity Supply Management and Procurement (Location in Budget, Planning budget tab, subawards lines 141-142; ODC line 185)

Total cost for activities in this section: \$63,479

After the various problems that Niger has experienced in the management of NTD drugs, in particular, the recurrent expiration of drugs, a contingency plan has been developed to allow an improvement of the situation (see Appendix 10 attached)

Drug quantification

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

The population is then distributed by target according to the type and/or form of drug: tetracycline ointment, Zithromax syrup and Zithromax tablet, Mectizan, STH, and SCH populations.

Next, quantification is done based on the type of drug by target:

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

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

Following the national MDA evaluation, the PNDOEFL and the PNLBG will complete the joint drug request form which includes the results of the past campaign, epidemiological data and drug requirements for the next MDA. The form must be signed and stamped by one of the coordinators, then sent to WHO AFRO for review. In FY2017, the WHO joint drug order form will be used for IVM and ALB as well as for PZQ. The PNSO will request Zithromax® from the International Trachoma Initiative. Requests are reviewed and approved by the Trachoma Expert Committee (TEC). There is no specific activity budgeted under the joint request form category.

Clearance, transportation and storage in the country

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

To ensure that the ONPPC can efficiently and correctly manage the drugs and tools, it is very important that MDA implementation plans for the drugs and tools be sent to the ONPPC at least two months before the MDA (it takes two to three weeks to package and three to four weeks to transport them to the HDs). The ONPPC delivers the drugs and tools (dose poles and registers) to the HDs based on the implementation plans. The NTD district focal points then deliver the drugs and tools to the health center level.

In addition to the contract with the ONPPC, the NTDP will continue to work with the DPHL for logistics purposes. This MoPH department was created to manage all of the drugs used by the MoPH via a focal

point whose role is to support the ONPPC and the MoPH's National NTD Focal Point in managing NTD drugs. The support will include the filling of WHO joint reporting forms, drug management, informing all partners upon receipt of shipping documents, and support for reception of medicines and storage at the ONPPC until the establishment in health facilities.

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

Reverse logistics

After the end of the MDA, the CDDs must send all remaining stocks of drugs to health centers. The heads of the health centers must return the remaining stocks to the HD during the MDA assessment meetings, which are then sent to the regional levels during the regional evaluation meetings. Immediately following the regional assessment meetings, the national level will be tasked with taking stock of the drugs remaining after the campaign. This year, special emphasis will be put on verifying the remaining stocks sent to the HD level during the joint supervision by the HKI logistics manager and the DPHL Focal Point. The supervision will last several weeks and be conducted in all HDs receiving a MDA.

Waste management

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

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

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

SAE Monitoring and Management

No Serious Adverse Events (SAE) have been reported in Niger since the launch of the integrated mass distribution campaigns. However, if there are any, they would be immediately reported using the WHO SAE form and managed within 24 hours by the DPHL's National Pharmacovigilance Committee. Doctors at the main regional and national hospitals have been trained to handle these cases. According to the notification procedures for serious cases, the committee will be responsible for informing the MoPH, which in turn must inform the regional WHO office.

WHO has published a document on SAE management in English. It would be preferable to receive technical assistance for training in order to better prepare the teams in the country for the potential occurrence of this type of event. WHO's new SAE notification forms will be adapted in the materials used by the various players at different levels.

Supervision (Location in Budget: Planning budget tab, FOGs line 144, ODC line 187)

Total cost for activities in this section: \$165,057

MDA supervision is one of the most important activities of the campaign. It occurs in a cascade format to ensure that the preferred protocols and practices established by the MoPH are complied with. The goal is to minimize potential problems which can create blockages and also to ensure quality of distribution and data collection. A regional “Coordinator” (described above) will be positioned in each region during the campaign and act as the Ministry’s representative in the region.

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

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

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

Supervision during the MDAs will include a review of the quality of data collected based on the MoPH supervisory grids (for example, correct entry of information in the registers and check forms). Independent monitoring will be another tool for monitoring MDA quality via validation of the data collected by the distributors and communicated by the NTDP. Feedback is provided on a regular basis to the districts in which the MDAs are taking place. This activity was carried out in three of the country's regions in FY16 and is planned again in FY17.

Addressing bottlenecks and ensuring adherence to protocol

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

A number of measures are taken to guarantee strict adherence of the activities to the guidelines:

- MDA supervision starts with training which ensures that the right information is disseminated. If systemic problems are detected with respect to understanding or if incorrect information is taught, the NTDP will identify the actions to be taken to remedy the situation (see training table).
- The NTDP ensures that all levels receive the updated information provided by WHO or higher MoPH echelons.
- Guides are used to ensure monitoring is standardized and complete and the results are usable.
- Standardized data collection forms ensure that all information is collected in a way that minimizes the risk of error.
- In terms of the surveys, the supervision teams are trained on data collection objectives, methods and tools and know the reference protocols including the villages/groups that have to be visited and sampled. In addition, a reporting meeting is held at the end of each survey day to summarize findings and ensure the villages/groups were visited and the materials were correctly filled in.
- For the MDAs, the monitoring teams receive information about the target population, the list of districts to be treated, and at the health center level, the number of villages targeted.
- At the community distributor level, it's important to analyze the registers with the community distributors and examine the information point-by-point to ensure that they understand the methodology used to fill in the registers and that they are correctly filled in.

Short-Term Technical Assistance (Location in Budget: Not budgeted)

Total cost for activities in this section: \$0

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	Funding source (e.g., country budget, overall budget, CDC funding)
Internal support (e.g., RTI/HQ, USAID, CDC)				
Workbook support	Errors in workbooks have led to slow reviews and multiple revisions; TA may alleviate the overall workload for all parties	Workbook expertise (FHI 360 M&E Advisor)	3 days	Not budgeted

HKI Niger has requested technical assistance from the END in Africa project to review the overall logic and requirements of the M&E workbooks. In particular, it would be useful to review and discuss common workbook problems (in general) and those that are specific to the Niger workbooks. The expected outcome of the TA is better quality of reporting and fewer rounds of questions/responses for all parties involved. The plan for the TA is to work directly with the HKI NTD team for two days, since HKI fills this out on behalf of the NTD Programs and then use the third day to additionally meet with the different NTD data coordinators so that they understand the data we are required to submit in reports. This activity is not specifically budgeted, as the main expense would be travel by the M&E advisor, which should be covered by FHI 360's travel line.

Monitoring & Evaluation (Location in Budget: Planning budget tab, subawards lines 147-154; ODC lines 190-193)

Total cost for activities in this section: \$250,407

The NTD Program is facing a number of difficulties related to M&E, but the first and most significant is the issue of denominators. The problem is not just the fact that the NTDP uses projections based on old censuses to identify MDA and survey target populations, but also the fact that, in certain parts of Niger, the population is very mobile. This means that, even if the overall population numbers are accurate, they may not be at certain times of the year such as, for example, the period after harvest when a significant portion of the population leaves Niger to look for work or at other times of the year when grazing is scarce. This makes the M&E activities difficult because the basis on which sampling is conducted may not capture a certain percentage of the population.

The NTDP had planned to conduct a DQA in FY16 but was not able to find a time to do so. While the NTDP recognizes that DQA can help to identify where the greatest problems of data reporting exist and to focus on improvements in those areas. In FY17, a DQA has not been planned, given the NTDP's preference to focusing on ensuring that MDA and DSA take place on schedule, given the fact that the END in Africa project only has two additional years and therefore, core activities must take place as planned.

Lymphatic Filariasis

The NTDP follows WHO guidelines and RPRG recommendations for LF M&E activities. The following activities are planned for LF in FY17:

Mid-term sentinel site evaluation

In-line with WHO guidelines for lymphatic filariasis, a National Program may select to conduct a sentinel site evaluation after 3 rounds of MDA. The district of Arlit will undergo its third round of MDA in FY17, and the PNDO/EFL would like to survey this district, given that this district is one of the most remote (and insecure) districts in the country and supervision during MDA may not be possible in all areas. In addition, Niger has had some districts fail TAS 1, which is another reason the PNDO/EFL would like to monitor this site at this time. The survey methodology will be through mf. END in Africa support is requested for this survey.

Transmission Assessment Survey (TAS 1) for stopping MDA

Niger will conduct some TAS 1 assessments originally planned for FY16 in FY17, given the late start to the MDA in many districts (due to the late arrival of drug). Because a six-month window must be observed between the MDA and the TAS 1, this now falls into FY17. The districts are: Matamèye, Magaria, Mirriah, Zinder, Diffa, Maine Soroa, and N'guigmi.

In addition, a number of districts are undergoing pre-TAS in FY16. If mf<1% and the RPRG provides approval, then these districts will be ready to conduct TAS 1. The PNDO/EFL plans to conduct 1 TAS 1 at the end of FY17 (Gaya, given the fact that it is also a district endemic for oncho), with the rest to take place at the beginning of FY18.

FTS will be used for all TAS 1 surveys in FY17. END in Africa support will be required for all these surveys.

Trachoma

Trachoma impact assessments

At the end of FY16, 7 HD were eligible for impact assessments: Magaria, Gouré, Matamèye, Zinder, Bilma, Tchirozérine and Aguié. The National Program plans to conduct several of these at the end of FY16, but three will now take place in FY17: Bilma, Tchirozérine, and Aguié. Depending on the results, districts may stop MDA or require 1, 3, or 5 additional rounds.

Two other districts will be eligible to undergo impact assessments at the end of FY17: Mayahi, and Guidan Roundji.

Survey methodology will consist of physical examination of the eyelid to determine the presence of TF and TT. Data will be collected via electronic tablets, potentially with Tropical Data. As described in the training section above, the National Program will conduct training on survey methodology and tablet utilization prior to the surveys. END in Africa support is requested for all of these surveys.

Pre-validation surveillance surveys

As part of the trachoma elimination validation process, the new trachoma SOP require surveillance surveys at least two years following impact assessments where TF<5%. The NTDP has planned to conduct two surveillance surveys in 2 districts in FY17 (Tera and Tillabéri). In addition, surveillance surveys in three districts (Ouallam, Say, Filingué) planned in FY16 will take place in FY17.

The methodology for these surveys is the same as for the trachoma impact assessments. As with the impact assessments, if TF≥5%, then additional rounds of MDA may be warranted. END in Africa support is requested for these surveys.

Table 7: Reporting of DSA supported with USAID funds that did not meet critical cutoff thresholds*

NTD	Number of endemic districts	Type of DSA carried out (add extra rows as needed for each type)	Number of DSAs conducted with USAID support	Number of EU that did not meet critical cutoff thresholds
Lymphatic filariasis	33 (21 still under MDA)	Pre-TAS	13 HD (Niamey 2,3,4,5, Gouré, Magaria, Matamèye, Mirriah, Tanout, Zinder Commune, Diffa, Mainé et N'Guigmi)	0 (11/11 had mf<1%)
		TAS 1	4 HD (2 EUs)	0
Onchocerciasis	5 (0 under MDA)	N/A	0	N/A
Trachoma	35 (14 still under MDA)	Impact survey	7	4: Mayahi (TF 8.49%), Tessaoua (TF 10.63%), Mainé Soroa (TF 15.38%), N'guigmi (TF 11.24%)

*FY15 survey data reported

Table 8: Planned Disease-specific Assessments for FY17 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	33	1 (Arlit)	Mid-term evaluation of Sentinel site	mf
	33	1 (Gaya)	TAS 1	FTS
	33	8 (Matamèye, Magaria, Mirriah, Zinder, Diffa, Maine Soroa, N'guigmi) (TAS 1 planned for FY16 but delayed to FY17)	TAS 1	FTS
Trachoma	35	3 (Tchirozérine, Bilma, Aguié) (FY16 activity delayed to FY17)	Impact assessment	Physical eyelid examination
Trachoma	35	2 (Mayahi, Guidan Roundji)	Impact assessment	Physical eyelid examination
Trachoma	35	3 (Say, Filingué, Ouallam) (FY16 activity delayed to FY17)	Pre-validation surveillance survey	Physical eyelid examination
Trachoma	35	2 (Téra and Tillabéry)	Pre-validation surveillance survey	Physical eyelid examination

Planned FOGs to local organizations and/or governments

Table 9: Planned FOG recipients—include for all subpartners as well.

FOG recipient (split by type of recipient)	No. of FOGs	Activities	Target Date to USAID
Central level (National NTD contact point)	1	<ul style="list-style-type: none"> ▪ Annual post-MDA meeting at the national level ▪ MDA micro-planning meetings ▪ National MDA launch ▪ Awareness-raising caravans at the community level ▪ MDA cascade training of trainers' workshop ▪ Central-level MDA supervision 	October 2016
PNSO	1	<ul style="list-style-type: none"> ▪ FY16 Trachoma impact assessments ▪ FY17 Trachoma impact assessments ▪ FY16 Trachoma surveillance surveys ▪ FY17 Trachoma surveillance surveys 	October 2016
PNDO/EFL	1	<ul style="list-style-type: none"> ▪ Mid-term evaluation of 1 sentinel site ▪ FY16 TAS 1 ▪ FY17 TAS 1 	October 2016
ONPPC	1	<ul style="list-style-type: none"> ▪ Drug storage, repackaging and transportation 	October 2016
Regions (Agadez, Diffa, Dosso, Maradi, Niamey,	8	<ul style="list-style-type: none"> ▪ Transportation of equipment and drugs to the distribution site for the district MDA ▪ MDA supervision at the regional and district levels 	October 2016

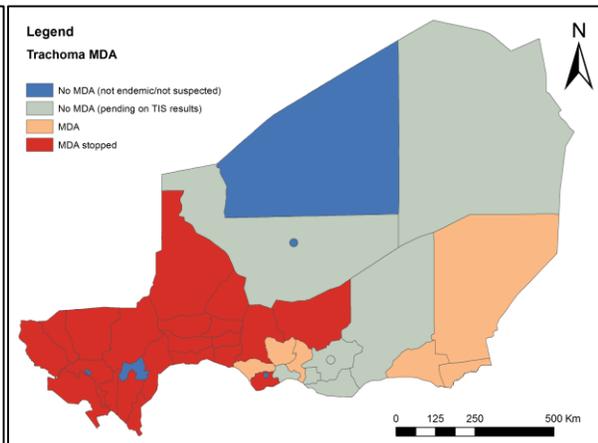
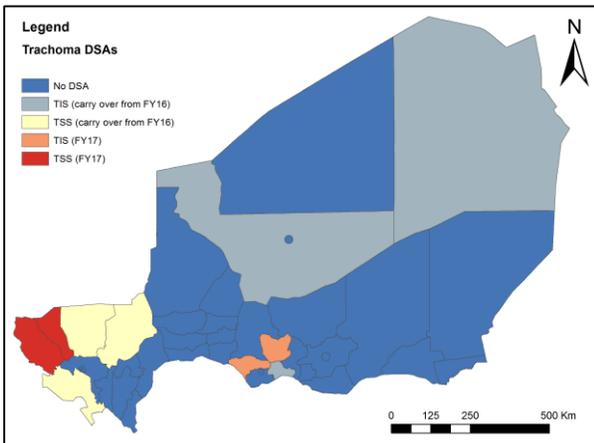
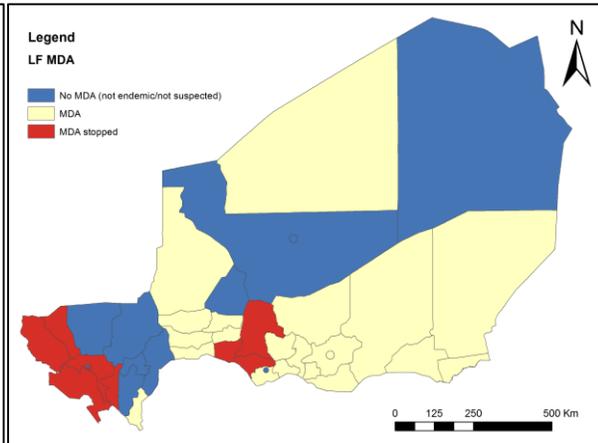
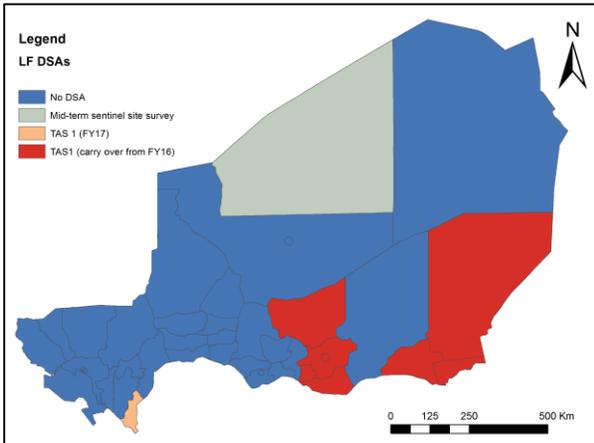
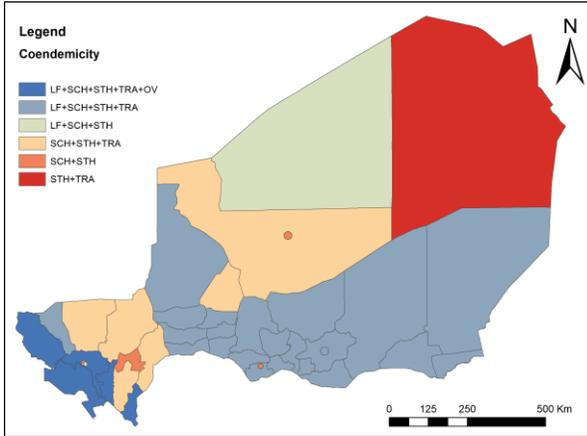
Tahoua, Tillabéri, and Zinder		<ul style="list-style-type: none"> ▪ Drug distribution by the CDDs ▪ Cascade MDA training for Regional and Health District personnel, the Health Centers and the CDDs ▪ Social (community) mobilization (radio) before MDA ▪ Social (community) mobilization (criers, relais) before MDA ▪ District-level information sessions ▪ District-level post-MDA review meetings ▪ Regional-level post-MDA review meetings 	
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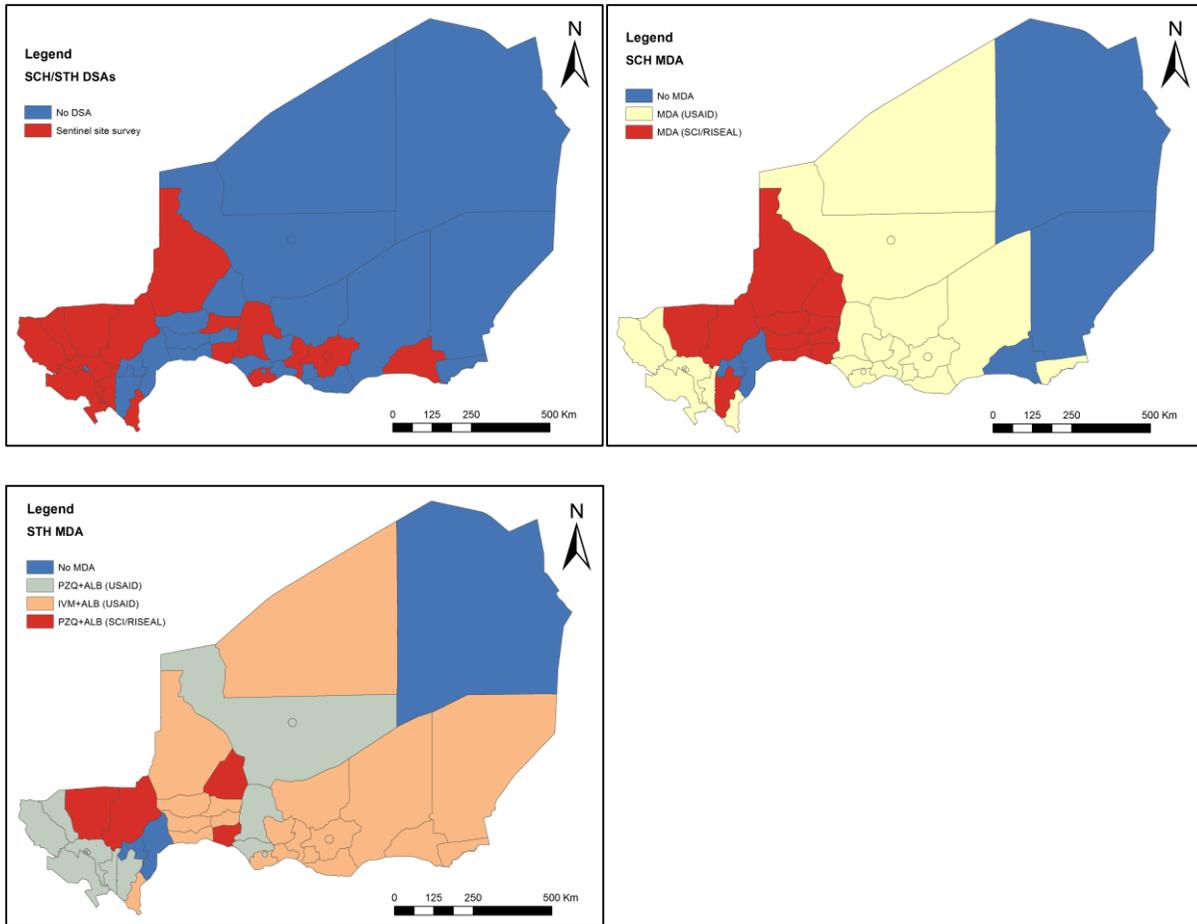
Cross-Portfolio Requests for Support

Table 10: Cross-Portfolio Requests for Support

Identified Issue/Activity for which support is requested.	Which USAID partner would likely be best positioned to provide this support?	Estimated time needed to address activity

Maps





APPENDICES

1. Country staffing/partner org chart
2. Work plan timeline
3. Work plan deliverables
4. Table of USAID-supported provinces/states and districts
5. Program Workbook
6. Disease Workbook
7. Country budget
8. Travel Plans
9. Schistosomiasis Treatment Strategy
10. Drug Management Contingency Plan