Niger

FY2014

Control of Neglected Tropical Diseases

Annual Work Plan
OCTOBER 2013 – SEPTEMBER 2014

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Acronyms and Abbreviations

AFRO	WHO Regional Office for Africa
APOC	African Program for Onchocerciasis Control
ASTMH	American Society of Tropical Medicine and Hygiene
BSS	Bureau Santé Scolaire (Health Education Office)
CDD	Community Drug Distributor
CSE	Centre de Surveillance Epidémiologique (Epidemiological Surveillance Center)
CSI	Centre de Santé Intégré (Center for Integrated Health)
DREN	Direction régionale de l'Éducation Nationale (Regional Department of National Education)
DRSP	Direction Régionale de Santé Publique (Regional Department of Public Health)
FHI 360	Family Health International 360
FOG	Fixed Obligation Grant
HD	Health District
HKI	Helen Keller International
HQ	Headquarters
ITI	International Trachoma Initiative
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
MOE	Ministry of Education
MSP	Ministère de Santé Publique (Ministry of Public Health)
NID	National Immunization Day
NTD	Neglected Tropical Disease
ONPPC	Office National des Produits Pharmaceutiques et Chimiques (National Office of Pharmaceutical and Chemical Products)
PNDO/EFL	Programme National de Dévolution de l'Onchocercose et d'Elimination de la Filariose Lymphatique (National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis)
PNLBG	Programme National de Lutte contre la Bilharziose et les Géohelminthes (National Schistosomiasis and Soil-Transmitted Helminths Control Program)
PNLCC	Programme National de Lutte Contre la Cécité (National Prevention of Blindness Program)
PNSO	Programme National de Soins Oculaire (National Eye Health Program)
RISEAL	Réseau International Schistosomiases Aménagement et Lutte (International Network for Planning and Control of Schistosomiasis)
RTI	Research Triangle Institute International
SAE	Serious Adverse Event
SAFE	A strategy that consists of eyelid surgery (S), antibiotics to treat the community pool of infection (A), facial cleanliness (F), and environmental changes (E).
SCH	Schistosomiasis
SCI	Schistosomiasis Control Initiative
SOP	Standard Operating Procedures
STH	Soil-Transmitted Helminths

TAS	Transmission Assessment Survey
TCC	The Carter Center
TIPAC	Tool for Integrated Planning and Costing
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

Executive Summary

Integrated mass drug administration (MDA) campaigns have been conducted in Niger for 6 consecutive years, treating 6 million in 2007; 8 million in 2008; 10.4 million in 2009; 11 million in 2010; 10.6 million in 2011; and 10.8 million in 2012. Program partners include the National Eye Health Program (PNSO), the National Schistosomiasis (SCH) and Soil-Transmitted Helminths (STH) Control Program **(**PNLBG), and the National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis **(**PNDO/EFL). Since October 2011 funding for control of neglected tropical diseases (NTDs) is mainly provided by the United States Agency for International Development (USAID) through Family Health International 360 (FHI 360) and Helen Keller International (HKI). Other partners, such as The Carter Center (TCC) and the International Network for Planning and Control of SCH (RISEAL), are also involved in implementing activities targeting trachoma and SCH.

The fiscal year (FY) 2014 campaign will take place in October 2013 with support from the following traditional partners: the Ministry of Public Health (MSP), the Ministry of Education (MOE), TCC, RISEAL, and the beneficiary communities. The national NTD program anticipates USAID funding for mapping, impact assessments, and MDA activities in FY2014. Mapping for Lymphatic filariasis (LF) is planned in 2 health districts (HDs): Fillingué (mapped in 2003) and Arlit (to be mapped for the first time). Mapping for trachoma is planned in 4 HDs of Agadez region. Transmission Assessment Survey (TAS) for LF is tentatively planned for 9 HDs in the regions of Maradi, Tahoua, Dosso and Tillabéri pending the results of pre-TAS assessments conducted in FY2013. Pre-TAS assessments are also planned for the HDs Niamey-2 and Niamey-3. An integrated SCH/STH impact assessment is planned for the eligible HDs of Arlit, Diffa, Mainé, and N'guigmi. 7 HDs will undergo impact surveys for trachoma in FY2014, as well. LF MDA will be implemented in 30 HDs, SCH MDA in 11 HDs, STH MDA in 34 HDs, and trachoma MDA in 18 HDs.

In preparation for the FY2014 distribution campaign in October 2013, HKI will support the implementation of regional micro-planning workshops to fine-tune activity planning and budgeting in advance of the activities, ensure comprehensive understanding of the program, and enable quicker troubleshooting of problems. After the series of micro-planning sessions, Fixed Obligation Grants (FOGs) will be drafted and submitted to the governors and the Minister of Health for signing before funding is made available to the various recipients, who will immediately launch training and community-mobilization activities. During this time, the National Office of Pharmaceutical and Chemical Products (ONPPC) will transport all necessary tools and drugs to the health districts. The actual distribution will begin immediately after all preparatory activities are completed. In addition to MDA activities, national programs have planned mapping and impact assessment surveys for eligible communities/areas, to take place at the programmatically appropriate time following MDA. These will be implemented as follows: impact assessment will take place at least 6 months after MDA; and mapping will be done at a time to be determined by the NTD programs.

During the MDA, supervision will occur at all levels to ensure the quality of all MDA-related activities. Supervisors will be given the flexibility to address any potential issues that may be detected in the field following discussions with their colleagues to identify the most appropriate solutions. Supervisors will also ensure that serious adverse events (SAEs) are monitored and reported during and after distribution. SAEs will be reported within 24 hours to the National NTD Coordinator, who will inform national officials and the HKI NTD Coordinator. The HKI NTD Coordinator and Country Director will then notify the HKI Headquarters/Regional team, who will inform FHI360.

Alongside MDA activities, targeted NTD awareness-raising efforts will be undertaken at the regional, district, and community levels to ensure that populations are well-informed on NTDs and the MDA campaign. Social mobilization activities will be intensified around the time of the MDA campaigns for optimal effect.

In order to ensure that the data collection indicators are in line with WHO/USAID guidelines and requirements, HKI will ensure that the monitoring and evaluation framework and the disease and program workbooks are available to all NTD stakeholders in Niger and that these stakeholders are able to fill them out correctly. Due to a delay in the receipt of the central-level Ministry of Health (MOH) signature that was needed to authorize the FOG developed for FY2013 MDA planned for May 2013, the NTD program was unable to conduct and report MDA for FY2013 because by the time the signatures were provided it was already too late to begin the cascade trainings and distribution within communities as rainy season was beginning and schools were closing.[1] Consequently, the FY2013 MDA campaign that was scheduled for May 2013 and did not occur is now postponed to FY2014 and MDA data will not be reported for FY2013. The FY2014 MDA campaign is planned for October 2013, which means that the reports for this MDA will be available in December 2013-January 2014.

HKI-Niger's FY2014 work plan is in line with Niger's 2012-2016 NTD Strategic Plan and will move the country closer to control and elimination targets for the targeted NTDs.

[1]Note: the MDA data reported in FY2013 refers to the results of MDA that had been planned for FY2012, but was subsequently delayed due to the late arrival of the praziquantel drugs and conducted in FY2013.

Background

The first integrated mass drug administration (MDA) for neglected tropical diseases (NTDs) began in Niger in 2007, bringing together three programs: the National Schistosomiasis and Soil-Transmitted Helminths Control Program (PNLBG), the National Prevention of Blindness Program (PNLCC), and the National Program for the Elimination of Onchocerciasis and Lymphatic Filariasis (PNDO/EFL). Five diseases are taken into account in this program: lymphatic filariasis (LF), onchocerciasis, schistosomiasis (SCH), soil transmitted helminthes (STH) and trachoma.

From October 2007 to September 2011, MDA campaigns were implemented by the Ministry of Health (MOH) through financing provided by the United States Agency for International Development (USAID), Research Triangle Institute International (RTI), the Schistosomiasis Control Initiative (SCI), the International Network for Planning and Control of SCH (RISEAL), and the Carter Center (TCC). Since October 2011, USAID support in Niger has been provided through Family Health International (FHI360) and Helen Keller International (HKI). In 2013, the PNLCC was renamed the National Eye Care Program (PNSO). USAID funding continues to support the three programs of PNSO, PNLBG, and PNDO/EFL to implement MDA activities throughout the country and to conduct program and mapping evaluation surveys. Other partners contributing presently to the National NTD Program include World Vision, the United Nations Children's Fund (UNICEF), the International Trachoma Initiative (ITI), Lion's Club International, the Christian Blind Mission, the African Program for Onchocerciasis Control (APOC), and Sightsavers. Activities included in this work plan are funded by USAID, unless otherwise indicated.

Table 1: NTD program in Niger FY 2014[2]

Disease	Number of endemic districts (at baseline)	Number of non-endemic districts (current)	Number of districts needing mapping	Number of districts with ongoing MDA		Number of districts needing MDA, but MDA not yet started	Number of districts where MDAs have been stopped
				USAID-funded	Others		
Schistosomiasis	41	0	1	35	6		0
Soil-transmitted helminths	42	0[1]	0	40	2[2]		0
Lymphatic filariasis	30	9	3[3]	30	0		0
Onchocerciasis	0	42	5[4]	0	0		0
Trachoma	34	4	4[5]	20[6]	0	0	15[7]

[1]A national survey is currently being conducted in the 42 health districts (HDs) of Niger for STH supported by RISEAL. Following these surveys, Niger will realign its STH treatment strategy to conform to the World Health Organization (WHO) recommended treatment strategies for STH.

[2]These 2 HDs (Fillingué and Loga) are presently not receiving treatment for STH under the SCORE project of RISEAL. However, the NTD program is contemplating treatment in these HDs. The final decision will be made after ongoing SCH/STH evaluation results are analyzed. It is expected that the results of these ongoing SCH/STH evaluations will indicate the necessity of treatment in all 42 HDs.

[3]Mapping was planned to be conducted in Bilma and Arlit in FY2013 but was not done in Arlit due to a change in the security situation in Niger in general. It became necessary to hire armed security guards to accompany the technicians to the field during the mapping exercise. This subsequently created an increase in the budget needed and the amount already approved for mapping in the 2 HDs was insufficient for both HDs. As a result, only Bilma was mapped in FY2013 with results anticipated by the end of the fiscal year. Fillingué was mapped in 2003 and determined non-endemic then. However, because of the high number of clinical cases (hydrocele/lymphedema) documented in the district in recent years, the fact that it is surrounded by LF endemic districts with high baseline LF prevalence and the realization that LF prevalence in the commune of Baléyara within Fillingué surpassed 1%, the national program was advised by the Regional Peer Review Group (RPRG) set up by the WHO Regional Office for Africa (AFRO) NTD Program to remap Fillingué in FY2014.

[4]Epidemiological assessments are planned in the 5 districts that have been undergoing surveillance since the start of the program. We have included this in the mapping column as APOC has termed these "mapping".

[5]Mapping for trachoma completed in Niger between 1999 and 2000 only included Agadez at the regional level (prevalence was then 5.5% for active trachoma). The program estimates that moving towards eliminating trachoma in Niger and the certification of elimination is not possible without mapping at the district-level in Agadez to fully understanding the epidemiology of trachoma; both TF and trichiasis. The Ultimate Intervention

[2]Figures refer to all districts eligible for MDA for SCH/STH, regardless of treatment strategy.

Goal for Antibiotics cannot be met until the prevalence of trachoma falls below 5% at the district and sub-district levels; the true situation in Agadez at district and subdistrict levels is currently unknown. For this reason, the program has requested that the 4 HDs of Agadez region undergo mapping in FY2014.

[6]Among the 20 HDs, 1 HD (Dakaro) will be treating only at subdistrict level but is included here because MDA in this HD will be funded by USAID. The other 19 HDs have TF prevalence >10% based on currently available data. However, 2 of these 19 HDs (Diffa & N'guigmi) have had impact assessment studies for trachoma conducted in July 2013 but results are not yet available. Though the NTD program has not targeted these 2 HDs for treatment in FY2014, the number 20 is left here because this table shows a global "snapshot" and not just what is planned for FY2014 since there are 3 possible outcomes of the impact assessment studies in the 2 HDs: MDA can be stopped completely if prevalence is <5% at district and subdistrict levels; MDA can be continued for 3 years at subdistrict level in areas where prevalence is between ≥5% but <10%; and MDA can be continued at district level for another 3 years if prevalence at district level is >10%.

[7]MDA has stopped at district-level in 15 HDs; but 1 of these HDs, Dakaro, is currently being treated at the sub-district level. Dakaro is therefore put among the 20 districts being treated using USAID funding and also among those where MDA has stopped at district level.

The planned MDA for FY2012 took place in FY2013 due to the late arrival of praziquantel that was related to a production delay attributed to lack of availability of the active pharmaceutical ingredient (API). In summary, 16 HDs were treated for trachoma, 37 were treated for SCH (30 with praziquantel only and 7 with both praziquantel and albendazole), 30 HDs were treated for LF and 37 HDs were treated for STH (7 during the SCH campaign and 30 during the LF campaign). Approximately 10,800,000 people were treated for one or more NTDs. These data were reported in the FY2012 work books.

There was a delay at the level of the Ministry of Public Health (MSP) in signing the central-level fixed obligation grant (FOG) for executing the 2013 NTD activities. Although the Minister signed the FOG in mid-May, the delay affected all activities at regional and district levels. The early arrival of the rainy season (the onset of rain coincided with people's departure to hard-to-reach, extremely remote farmland areas) and the closing of schools in late May, prompted the coordinators, in consultation with their relevant ministries, and HKI to postpone the MDA to October 2013, which corresponds to USAID FY2014. Consequently, no MDA data will be reported in the work book for FY2013.

Despite the delayed MDA, other activities have been progressing this year with USAID support. Activities currently underway are:

- A nation-wide physical inventory of drugs/medicines.
- LF mapping in Bilma (mapping will not be done in Arlit due to security problems that have resulted in an overall increase in the estimated budget for mapping in FY2013).
- SCH/STH mapping in Bilma.
- An impact assessment for SCH/STH in Tahoua (region), Agadez, and Tchirozérine.
- A trachoma sub-district level survey in Tillabéri.
- Pre-Transmission Assessment Survey (TAS) in Aguié, Dakoro, Guidan Roumdji, Madarounfa, Mayayi, Tessaoua, Madaoua, Boboye, and Tillabéri commune.

- TAS in Say, Kollo, Téra, Bouza, Keita, Konni, Illéla, and Tahoua.

In preparation of the FY2014 MDA that will take place in October 2013, plans have also been made for the NTD program at central level to provide training on drug management; training of trainers at national level; and to hold a micro-planning session between July and September 2013. The training will target program coordinators, program agents, and the National School Health Bureau at the central level. Regional health and education directors, health and education focal points, Medical Chiefs, epidemiologists, and education inspectors will also be trained at the regional and district levels.

Goals for FY2014

Overall goal

The overall goal of the MOH's NTD Program is to reduce morbidity caused by SCH and STH and to eliminate LF, onchocerciasis, and blinding trachoma through mass preventive chemotherapy by 2020 (2015 for trachoma). To achieve this goal, the program plans to conduct MDA campaigns for SCH, STH, LF, and trachoma in the regions of Agadez, Tahoua, Diffa, Zinder, Maradi, Dosso, Niamey, and Tillabéri in October 2013. Taken together, these four diseases affect the entire population of Niger.

Specific objectives:

Specific objectives vary depending on the diseases targeted by the National NTD Program:

For SCH and STH

- Conduct MDA in 11 hyper-endemic HDs for SCH; and in 34 HDs for STH.
- Conduct an integrated assessment survey of STH and SCH in the eligible HDs of Arlit, Diffa, Mainé, and N'Guigmi to realign the national treatment strategy with treatment strategies outlined in WHO guidelines.

For trachoma

- Conduct district-level MDA in 17 HDs and sub-district level MDA in 1 HD (18 districts total)[3].
- Conduct treatment impact surveys for trachoma in the eligible HDs of Tahoua, Keita, Bouza, Konni, Madaoua, Mirriah, and Doutchi. Data on district and sub-district levels will be collected simultaneously, meaning that the sample size and methodology will allow for prevalence estimates to be made at both the district- and sub-district level for trachoma folliculitis (TF) and trichiasis.

[3]18 districts are planned for treatment in FY2014; the 2 other districts that have added up to the total of 20 in table 1 above (Diffa and N'guigmi) are currently undergoing impact studies and have not been scheduled for treatment in FY2014 because the PNSO does not plan to treat HDs in the same year that they are assessed. HKI has decided to go with the decision of the PNSO because this policy is accepted by ITI. Subsequent activities for trachoma in these HDs will depend on the results of the impact survey that will be available by September 2013.

- Conduct mapping in 4 HDs of the Agadez region.

For LF

- Conduct MDA in 30 HDs.
- Conduct pre-TAS in 2 HDs: Niamey 2 and Niamey 3.
- Conduct TAS in the HDsof Aguié, Dakoro, Guidan Roumdji, Madarounfa, Mayayi, Tessaoua, Madaoua, Boboye and Tillabéri if they are eligible, depending on the pre-TAS results (pre-TAS conducted in FY2013 and results are expected in September 2013).
- Conduct mapping in Arlit and Fillingué (please see our comments under Table 1 and in the mapping section for details on these 2 HDs).

For onchocerciasis

- Support epidemiological evaluation of onchocerciasis transmission in 5 HDs to provide evidence for certification of onchocerciasis elimination.

Main Activities

Sub grantee support to the MSP will include:

Support NTD Country Program Planning Process

Overall, support provided by HKI for programs and the MOH in FY2014 will be the same as in FY2013, except for the support that End in Africa will provide in improving the supply chain and drug management procedures. Regarding the implementation of planned activities, the HKI NTD team will hold coordination meetings on a quarterly basis with NTD program coordinators to finalize decisions regarding targeted areas, populations identified for each disease, and program planning. HDs eligible for praziquantel and albendazole treatment will be identified according to the national policy for SCH control, and the list of endemic villages will be updated in collaboration with the regional NTD focal points. For trachoma and LF, HDs eligible for treatment have already been identified through selection of HDs eligible for upcoming distributions based on assessment results and the number of treatment rounds already completed.

In preparation for the FY2014 distribution campaign, HKI will support programs to hold regional micro-planning workshops. This micro-planning will take place in each region with participation from focal points, district head doctors, and heads of epidemiological surveillance centers (CSE) based in each HD.

To support the analysis of needs not met by the NTD program, a national evaluation and planning workshop is held each year to address program activities for the coming year. This workshop brings together all key stakeholders (health, education, and partners) so participants can identify strengths, areas for improvement, and lessons learned in order to make the necessary recommendations for program improvement. The Program will share meeting minutes/reports of the national evaluation and planning workshop with USAID.

The Niger NTD program has requested training on the use of the tool for integrated planning and costing (TIPAC) in FY2014; technical assistance request will be provided by END in Africa for this purpose. The training will target the national disease programs, the MSP, the National Office of Pharmaceutical and Chemical Products (ONPPC), and HKI.

HKI will support NTD coordination in developing the annual NTD work plan for FY2015, based on the 2012–2016 NTD strategic plan and the results of the TIPAC. It will also support the validation of the National Monitoring and Evaluation Plan for NTDs.

Mapping

- Lymphatic filariasis
    - As noted above, Arlit was not mapped in FY2013 due to insecurity and the subsequent impact this had on the budget. The program plans to map Arlit in FY2014.
    - Despite the assertion that Fillingué is not endemic based on the 2003 mapping results (mapping supported by the US Centers for Disease Control and Prevention (CDC), WHO, and the MSP), the appearance of increasingly more clinical cases and the fact that it shares border with several other LF-endemic HDssuggests the need for mapping in Fillingué. In fact, prevalence in the commune of Baléyara surpassed 1% based on initial mapping.

- Trachoma
    - Epidemiological surveys for trachoma were conducted at the regional level in 1997-1999 for Agadez (5.5% TF), however mapping has never been conducted at the district level using a cluster-based methodology. With the elimination of trachoma including a decrease in prevalence of TF to less than 5% at the sub-district level, it is clear that the program cannot move toward the elimination of trachoma in Niger and certification without complete mapping of the entire country. Moreover, the similarity in the agro-ecological areas between the regions of Kidal and Agadez suggests that trachoma may also re-emerge in Agadez. For this reason, the program requests that Agadez (4 districts) undergo mapping in FY2014.[4]
- Schistosomiasis
    - No mapping is planned for FY2014.

[4]The NTD program is requesting mapping for Agadez because the districts of Agadez region have never been mapped and to be eligible for the elimination of trachoma the NTD program needs to map the entire country.

Scaling up NTD National Program[5]

Niger has achieved 100% geographic coverage[6] of targeted diseases for NTDs in known endemic HDs, however, specific issues arise for the individual diseases. In terms of trachoma, 34 out of 42 HDs are known to be endemic. To date, these 34 endemic HDs have received treatment with a geographic coverage of 100% and 15 HDs have stopped district-level treatment. There are 19 HDs that still warrant treatment at the district level and the number of HDs being treated at the sub-district level will increase in future years pending the results of future sub-district surveys; currently only one HD is being treated at the sub-district level (Dakaro). For SCH, 41 out of 42 HDs are known to be endemic and all endemic HDs are treated regularly using the strategy adopted by the national program. To date, no HD has reached the criteria for stopping MDA. The program anticipates mapping/evaluation data on all 42 HDs before the end of FY2014.This data will provide the evidence necessary to realign the national strategy during an experts meeting planned in FY2014.For LF, 30 out of 42 HDs are endemic; all have received treatment. In FY2013, 8 HDs were involved in the TAS; the program will use these TAS results to determine whether or not to stop treatment these HDs in FY2014. Finally, in FY2014 Niger will pilot the use of independent monitoring to improve epidemiological and program coverage in 6 HDs (Niamey 2, Niamey 3, Gaya, Zinder commune, Madarounfa, and Tchintabaraden).

Mass Drug Administration

MDA Strategy

MDA for 2014 is planned to begin in October 2013. All involved HDs will start at the same time. The HDs will have to distribute at least 3 drug packages depending on their epidemiological profile. Overall, the actual mass distribution will last three weeks and immediately, sub-regional, regional, and national evaluations of the campaign will take place. The distribution strategy for NTD drugs mainly relies on community-based distribution. Distribution is carried out by Community Drug Distributors (CDDs) within communities and by teachers in the schools.

Drug distribution for LF and trachoma is done in accordance with the WHO protocol. Drug distribution for SCH is carried out in accordance with a national consensus calling for distribution to take place each year for the 10 river valley HDs[7] with high endemicity (Niamey 1, Niamey 2, Niamey 3, Tillabéri, Say, Kollo, Téra, Boboye, Dosso, and Gaya) and every two years for the other "moderate risk" districts. Beginning in January 2015, all future distribution will be done in accordance with the WHO strategy for SCH.

[5] The Annual MDA Treatment Projections are incorporated in the disease work books which are submitted with this work plan.

[6] The program defines geographic coverage as #districts treated/ # targeted annually.

[7] 16 HDs in total are being targeted for treatment in FY2014; 11 with funding from USAID and 5 through the SCORE study; some of the SCORE HDs are in the high risk zones so the 10 listed here are supported by both USAID and SCORE.

Table 2: Target districts and estimated target populations for FY2014 MDA

NTD	Age group targeted	Frequency of distribution	Distribution platform(s)	Number of districts	# of people Targeted
SCH	5 yrs and older	1	Door-to-door distribution in communities; school-based distribution	11	2,025,400[8]
Onchocerciasis	N/A	N/A	N/A	N/A	N/A
LF	5 yrs and older	1	Door-to-door distribution in communities; school-based distribution	30	9,931,544
STH	5–14 yrs and at-risk adults[9]	1	Door-to-door distribution in communities; school-based distribution	34	11,511,416 (7.1 million adults)
Trachoma	100% of population	1	Door-to-door distribution in communities; school-based distribution	18	8,382,924

Training

Cascade training will be conducted in FY2014. A pool of trainers has been set up in Niamey to go to each region to provide training for regional trainers. The regional trainers will then be responsible for training Center for Integrated Health (CSI) managers and directors in the education sector. Lastly, CDDs and teachers will be trained by the CSI managers and education directors. Training content will address the targeted diseases, the serious adverse events (SAEs), the use of the dose pole and drug quantities, data collection, drug stock management, the importance of activity reports, and meeting submission deadlines when sending these reports and results. To ensure that materials provided to CDDs, CSI managers, teachers, and other stakeholders have been accurately filled out, returning trainees will receive refresher training in order to understand what is expected of them.

[8]This number targeted is based on our disease workbook, not the praziquantel application which will differ slightly based on the source of the population data used (village-level at risk population vs. INS data).

[9]At-risk adults are treated as part of the LF MDA (30 HDs) and in 4 HDs that will receive the praziquantel/albendazole. However, the MSP does not officially recognize the LF treatments as STH treatments when the HDs treated by the LF program are not targeted by the SCH/STH program (deworming is considered to take place only through the SCH/STH program) – however, we have included these as targets in the workbooks since they are in-fact STH treatments in endemic districts.

Table 3: Training Events - New Personnel and Refresher

Training Group	Topics	Number to be Trained			Number Training Days	Location of training(s)
		New	Refresher	Total		
MSP/MOE at Central Level	Briefing for trainers	10	20	30	1	NIAMEY
Supervisors	Supervisors and supply chain managers (district store keepers and the health staff at the CSI) are included in the national, regional, district, and CSI levels in this table.					
Supply chain managers						
Regional trainers	Filling out supporting documents, managing side effects and waste, disease pathology, campaign close-out information	40	152	192	1	Regional Department of Public Health (DRSP)
CSI managers and chief education sector	Filling out supporting documents, managing side effects and waste, disease pathology, campaign close	496	395	891	1	HD
Drug distributors and teachers	Filling out supporting documents, managing side effects, disposing of waste according to national protocols, disease pathology, campaign close	14,550	24,906	39,456	1	CSI
SCH/STH and onchocerciasis survey	Training for survey teams to conduct survey	0	13	13	5	District-level
TIPAC	Training for MOH, ONPPC, and HKI in the use and maintenance of the TIPAC	20	0	20	7	Niamey
TAS	Training for survey teams to conduct survey and for national program/HKI to receive training at WHO AFRO meeting	156	0	156	7	Sub-region and central level
Independent monitoring	Training for independent monitors to be able to carry out independent monitoring tasks during and after the MDA	34	0	34	3	Niamey

Community Mobilization and Information, Education and Communication

Following the official launch of MDA set for the beginning of October 2013, messages will be revised and sent to all functioning community radio stations and to the national and regional radio stations. Broadcasting contracts that have already been signed with community radio stations by TCC and HKI will be drawn upon. Service contracts related to NTDs will be signed with community and/or private radio stations to broadcast NTD messages before and during distribution. Private radio stations with a wide audience and regional radio stations will also be

involved in raising awareness. Recorded televised messages will also be revised and broadcasted on national television during the entire campaign period. Town criers and community leaders will contribute to dissemination methods, and radio discussions will be organized and broadcasted. Advocacy meetings will also be organized at the district level so that community and traditional leaders are kept informed. In coming years, special efforts will be made to specially engage women leaders to promote the MDA and serve as advocates and community mobilizers to increase the participation of women in the campaign.

Supervision

Supervision will take place at all levels, and supervision pools will be set up by level to ensure the quality of activities.

- At the **national level**, teams of national supervisors will include the national NTD focal point, coordinators, team members from programs (PNLBG, PNDO/EFL, PNSO), the Health Education Office (Bureau Santé Scolaire (BSS)), and some central-level directors. These teams of national supervisors will conduct supervision missions to supervise preparation meetings, training of CSI workers, distribution, and final evaluation of the campaign.
- At the **regional level**, a team of supervisors made up of regional directors (health and education) will provide supervision of trainers (training for CSI managers and leaders in the disease sectors) and distribution in the HDs.
- A second team for technical support made up of regional focal points (health and education) will be in charge of supervising the district-level and CSI training sessions, distribution, and evaluations.
- At the **district level**, the district head doctors and focal points from the HDs (education and health) will supervise the CSI managers, and, in turn, the CSI managers will supervise the CDDs.

The HKI NTD Program Coordinator will ensure that planning for this will be executed with the utmost rigor. Involving the program coordinators in the development and implementation of supervision programs will allow for greater ownership of activities and ensure that they are implemented in accordance with MSP regulations.

When problems arise during supervision, the supervisors will have the flexibility to provide appropriate solutions depending on the seriousness of the reported issue and the level of responsibility/quality of the supervision team. In any case, problems that cannot be solved on site will be referred to the national level for investigation and appropriate action within 24 hours of notification. The supervisors will have communication funds for this purpose so they can report problems that arise in the field in real time.

In order to have an exact count of the remaining drugs left over from the FY2014 MDA campaign, plans have been made for a thorough inventory of leftover drugs after the distribution to be conducted immediately after the national evaluation.

Supervision during mass distribution will incorporate the quality of data collection and the filling-out of forms provided to the various stakeholders.

Supply Chain Management

All drugs for the 2014 campaign as well as tools (dose poles, registers) will be received and stored in ONPPC storage units. For this, it is very important that drug orders are made six-eight weeks in advance (it takes 2 weeks to package drugs and 3-4 weeks to transport them to the HD) so that bundling of all inputs (drugs and tools) can be done in one step. The coordinators will develop their distribution plan that they will submit to the ONPPC for execution two months in advance of the distribution. Using the distribution plan, the ONPPC is able to ensure the delivery of inputs (drugs, dose poles, and registers) to the HDs. The district NTD focal points will then deliver the drugs and tools from the HDs to the CSIs. At the end of their training, the CSI managers and school directors will return with the necessary quantities of drugs and tools for distribution in their schools and health areas. After the MDA, CDDs will be expected to send all remaining drug stocks to the CSIs. CSI managers should then return all remaining stock to the HDs during evaluation workshops. Immediately following completion of the regional evaluation meetings, the task of conducting a physical count of the remaining drugs will be assigned to the national level.

Due to the delay of the FY'13 MDA, Niger is currently dealing with the expiry of Zithromax that was intended for use during the MDA in May 2013[10], but will expire before the end of the fiscal year. The national program is in the process of conducting an inventory in all regions of the country to find and quarantine all Zithromax that is set to expire soon. Once this has been done, the full quantity at risk of expiry will be confirmed and measures will be put in place to use the drug that will expire in August and September during a small scale MDA in August, and then dispose of the drug that has already expired using the procedures set forth by ITI and the Government of Niger. There is a "drug destruction committee" consisting of 4-5 members at the level of the HD and CSI that oversees the district and CSI storage and is responsible for the destruction of expired drugs after the national inventory is taken. In order to mitigate such issues in the future and maximize the management of the supply chain, the program is requesting technical assistance from John Snow Incorporated (JSI) in the following areas:

[10]Niger is a country where many HDs have stopped MDA based on impact study results which brings about a surplus of Zithromax in-country. In addition, there have been inventory management challenges with drugs at the district level and at the ONPPC-central level. The Zithromax at risk of expiring this year was destined to be used during the MDA in May 2013. ITI was aware of the quantity of drugs at risk of expiring and the dates of expiry and had included this quantity as part of the approved drug quantity for Niger for 2013, so the delay in MDA contributed greatly to the expiry of these drugs. The inventory has been completed at the district level and is still ongoing at the health center level and all drugs discovered with an August/September expiry date will be distributed during the August MDA in Guidam Roumdji and Mayayi.

1. Develop a computerized data management tool to help monitor the amount of drugs/medicines used during treatment, the amount returned and to maintain an inventory of stock.
2. Improve warehousing and storage conditions at the district level, ensuring adherence to the First In-First Out (FIFO) protocol.
3. Develop procedures for collecting and disposing expired medicine from the HDs.
4. Customize the Standard Operating Procedures (SOPs) and develop complimentary training materials for use in subsequent years.

The program proposes that a situation analysis is conducted by JSI during the upcoming trainings for the FY2014 MDA in September, October, and November 2013 to determine the best steps forward.

Tables 4a & 4b below summarize the key dates selected for the ordering process and receipt of the various drugs for the FY2014 and FY2015 campaigns. All drugs are already in-country for the FY2014 MDA.

Table 4a: NTD drugs received for the FY2014 campaign planned for October 2013

Drug	**Source of drug (Donation program, USAID-funded source, or government procurement) *Indicated name of donation program, if applicable.**	**Quantity of drug received**	**Date of delivery (Month/Year)**
IVM 3mg tablets	Merck/MDP	32 041 500	May 2013
ALB 400 mg tablets	GSK/WHO (LF) GSK/WHO (STH)	1 215 400 491 000	May 2013 March 2013
PZQ	USAID	4 577 50011	February 2013
Zithromax Syrup	Pfizer/ITI	364 416	April 2013
Zithromax tablet	Pfizer/ITI	18 660 000	April 2013

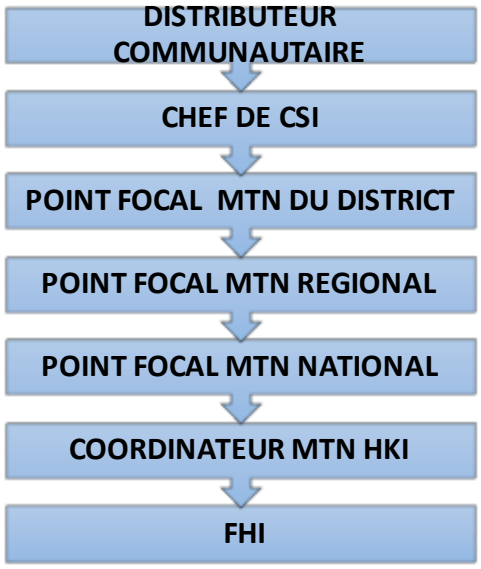
[11]This was the amount noted on the signed goods receipt notice sent to RTI/JSI on 2/13/2013.

Table 4b: NTD Medicines Estimated for FY2015

Drug	Source of drug (Donation program, USAID-funded source, or government procurement) *Indicated name of donation program, if applicable.	Quantity of drug requested	Date of Application (Month/Year)	Requested delivery date (Month/Year)
IVM 3mg tablets	Merck/MDP	28 768 021	December 2013	April 2014
DEC	GSK	0	0	0
ALB 400 mg tablets	GSK/WHO	11 301 723 (LF) 943 173 (soil-transmitted helminths)	December 2013 June 2013	April 2014 January 2014
MEB	0			
PZQ	USAID	15 930 789	April 2013	January 2014
Zithromax Syrup	Pfizer/ITI	324 900	March 2013	March 2014
Zithromax tablet	Pfizer/ITI	12 995 981	March 2013	March 2014

Management of Serious Adverse Events

The overall diagram for notification of cases of SAEs, reviewed during the training sessions and presented below, shows the existing procedure:



The side effects listed below are serious and must be reported to the NTD Coordinator within 24 hours of their appearance:

- Death
- Life threatening prognosis
- Patient hospitalization or extension of a pre-existing hospitalization
- Persistent or severe disability
- Birth defects or abortions
- Onset of cancer
- Accidental or intentional overdose

SAEsshould be reported immediately within 24 hours to the National NTD Coordinator, who will inform national officials and the HKI NTD Coordinator at the same time. The HKI NTD Coordinator and the HKI Country Director will then inform the HKI Headquarters/regional team, who will inform FHI360, and FHI360 will inform USAID. The MSP is responsible for informing WHO and the pharmaceutical companies of any SAE that occurs during MDAs. Immediately following the reporting of a case of SAE, measures will be taken at all levels. At the local level, the case will be directed to the nearest health center that is able to provide optimal treatment. National health system resources will be used for this (ambulances, health facilities, drugs, etc.). A team of investigators made up of the regional focal point, the focal point for the HD where the incident occurred, and the district head doctor, will arrive on the scene to make the initial preliminary investigation and inform national officials and HKI, who will then decide what action to take based on recommendations from MSP officials. In all cases, HKI will cover costs

related to medical treatment if a causal relationship is established. Formal communication will then be sent to traditional officials, and opinion leaders will be enlisted to inform communities about all cases, proven or not. Community radio stations will be asked to quell or address any possible rumors. Case management of minor side effects will be handled by national medical officials.

It should be noted that no case of SAE has been reported in Niger since the launch of the integrated mass distribution campaigns. In terms of mild or minor side effects, there has been a decrease in the number of cases over the years of mass treatment.

Program Monitoring and Evaluation

Monitoring and Evaluation of MDA

In order to ensure that data collection indicators used by the NTD program are in line with FHI360 guidelines and requirements, HKI will ensure that the Monitoring and Evaluation framework and the disease and program workbooks are available to all NTD stakeholders [12] in Niger, and that they are able to fill them out correctly.

Distribution registers will be provided to CDDs and teachers for data collection. These registers are filled out by CDDs and teachers who send them to the CSI managers at the end of the campaign. The CSI managers compile the data they receive in the summary registers that they send to the District Health Manager, who in turn compiles all data from all the CSIs in the health area. Two copies of the summary registers are made, the first for the district archives and the second to be sent to the Regional Department of Public Health (DRSP). The DRSP compiles the data for all HDs into a single summary report of the region's data.

To improve coverage during MDAs in FY2014, independent investigators—commonly called "independent observers"—will conduct independent monitoring of the MDA under the supervision of the NTD Monitoring and Evaluation Manager and the Assistant to the NTD Coordinator. Since this is the first time that Niger will be conducting independent monitoring only 6 HDs will be covered so that the independent observers can gain some experience on independent monitoring before covering many districts. The focus will be on those districts where there have historically been coverage or operational issues to better understand, monitor and address them. This activity will be conducted in the HDS of Niamey 2, Niamey 3, Madarounfa, Zinder commune, Tchintabaraden and Gaya.

In addition, specific emphasis will be placed on data quality through the following activities:

[12] MOH and NTD Program Coordinators, Partners (i.e., Carter Center, School Health Program, RISEAL).

- Assessing drugs left over after the distribution and their return to the warehouse during sub-regional evaluations (at this level, everyone must be involved: CDDs, heads of sectors, CSI, HD, DRSP, national level, HKI), including a physical inventory of stock.
- Close formative supervision at all levels.
- Use of supervision checklists for supervision teams.
- Full involvement in NTD activities of the CSI manager who oversees the NTD data for the HD; this person is based at the HD and is sometimes the same person as the district-NTD focal point.
- Production of a report for each implemented activity by each implementation level (HD, DRSP, National) using the outline provided to regional and district NTD focal points. These various reports must be sent at the same time as the vouchers, within 45 days after the administration of the last package.

After the regional evaluations, results by region should be sent to the national level at least one week prior to the national evaluation. The national level should be able to finalize and transmit the campaign results to HKI within one week after the national evaluation so that HKI can meet the deadline for submitting results. Each HD must produce an overall summary report of activities at the end of each MDA campaign. These reports should be sent to the national level, which is responsible for producing a summary by program.

The FY2014 campaign will begin in October 2013 and end in December 2013, with the national evaluation and data anticipated in January 2014. The first semi-annual report will be available in March 2014, and the second in September 2014.

Program Assessments and Transition to Post-MDA Elimination Strategy

Lymphatic filariasis

- TAS surveys on LF will take place in the 9 HDs of Maradi region (Aguié, Dakoro, Guidan Roumdji, Madarounfa, Mayayi, Tessaoua), Tahoua region (in the HD of Madaoua), Dosso region (Boboye) and Tillabéri region (in the HD of Tillabéri) if results from the pre-TAS confirm that the TAS should proceed.
- Pre-TAS surveys will take place in Niamey 2 and Niamey 3.

Onchocerciasis

- Results from the entomological and epidemiological evaluations reported in Niger dating back over ten years suggest an end to onchocerciasis transmission in Niger. An epidemiological evaluation was conducted by APOC in 2012 in 12 out of 118 villages, which confirmed the previously reported results showing zero transmission. In view of these results, the PNDO/EFL is requesting technical and financial support for an

epidemiological evaluation of onchocerciasis transmission in a greater number of sentinel villages in order to move toward certification for elimination of this disease.

Schistosomiasis/STH

- The integrated SCH/STH impact assessment will take place in the eligible HDs of Arlit, Diffa, Mainé and N'guigmi in FY2014.

Trachoma

- In FY2014, 7 HDs will be eligible to undergo an impact assessment survey after conducting their third or fifth distribution rounds of MDA depending on baseline prevalence[13]. These HDs are: Tahoua, Keita, Bouza, Konni, Madaoua, Mirriah, and Doutchi. Impact assessment survey will be conducted at the district and sub-district levels simultaneously because this is cost-effective, consistent with WHO guidelines and will allow for gathering results at both levels (both TF data and trichiasis data), which is essential for Niger with a trachoma elimination date of 2015. In large and vastly populated HDs such as Mirriah, this methodology will provide more robust data.

Sustainability issues

The NTDs are included in the national health information system. It should be noted that new materials for reporting NTDs within this system have been revised; once these are validated NTDs can be reported in the national health information system. Program implementation requires the mobilization of financing that the MOH is not able to mobilize regularly. This lack of funding from the MOH can become an obstacle for sustainability of program achievements. It is hoped that this problem can be addressed through continued advocacy within the MSP by meeting with the Minister of Public Health to reinforce the necessity of NTD budget lines in the national MSP budget and also to advocate for an increased allocation to the budget for NTDs.

The inventory of hydrocele and elephantiasis cases shows that the number of people with manifestation of the disabling disease LF increasing in Niger. In 2012, there were 436 cases of hydrocele reported in the HDs of Magaria, Matameye and Aguié and 100 newly reported cases of elephantiasis in Niger. HKI will continue its advocacy to ensure that funding is mobilized for surgical treatment of hydrocele cases. If these cases of morbidity are not addressed, elimination of LF will not be possible in Niger.

Unique country features that can affect programme performance

With the onset of the Malian crisis, Niger has hosted an estimated 50,000 Malian refugees on its borders and inside the country. In 2013, these refugees received MDA with support from HKI

[13] 5 annual rounds of treatment for trachoma is conducted for HDs with baseline prevalence ≥50% and 3 annual rounds for HDs with baseline prevalence ≥10% but <50%.

through the End in Africa project. However, plans based on population figures for Niger do not take into account these refugees who are coming from NTD endemic regions of Mali. The lack of a clearly defined strategy to treat this additional population is likely to jeopardize the successes gained after several years of NTD control in Mali and Niger and this will be discussed with the National Program after the elections results in Mali are finalized, since this is likely to influence the refugee situation. Also, future plans should take into account this situation. HKI will continue to advocate so that these refugees will receive routine mass treatment for the coming years. A budget for the distribution activities in the refugee camps for FY'2014 will be presented to USAID in this work plan for approval.

Short term Technical Assistance Request

During the course of FY2014, there are several technical assistance requests planned with USAID funding, as outlined in Table 5. The first is refresher training for the use of the disease and program workbooks to ensure that all data managers at the MSP, disease coordinators, and HKI staff are fully aware of the correct use of the workbook. The second will be a training for the implementation of the TIPAC. Niger was trained in the use of the funding gap analysis tool (FGAT) many years ago, however the new tool is very different and technical assistance is needed in order for this to be implemented. Given the very recent Zithromax expiry issue, technical assistance is needed at all levels of the supply chain to ensure that inventory management procedures are properly conducted. Finally, Niger is in the process of conducting surveys to obtain data necessary to realign their SCM strategy from a control strategy to an elimination strategy. After all surveys have been completed, an internal review meeting will be held with technical assistance provided from HKI and WHO to review the results and draft strategic recommendations for the future. USAID support is requested to support a WHO representative to attend the meeting.

Table 5: Technical Assistance Requests

Task	Why needed	Technical skill required	Number of days required
Refresher training on the program and disease workbooks	To improve knowledge on the workbooks among HKI and MOH staff that are involved in completing the work books	Excellent knowledge and understanding of the work books	3
Training on TIPAC	Training on FGAT was conducted in the past but TIPAC training needed because TIPAC is different from FGAT	Excellent knowledge on TIPAC and experience in conducting training on TIPAC	15

	and HKI and MOH staff have to use it		
Training on supply chain management	Following the recent zithromax expiry issue in Niger it was noted that training on supply chain management is needed to improve inventory management procedures within the NTD program at all levels	Excellent knowledge on supply chain management at all levels	15[14]
Participation of a WHO SCH expert at the planned internal SCH review meeting	Input from a WHO expert is important for proper realignment of the national SCH strategy with the latest WHO guidelines	Excellent knowledge of SCH and the latest WHO guidelines and decisions on SCH	2

Financial Management

Following the regional micro-planning workshops, budgets will be drafted for each regional department and each HD; the same will occur for activities at the central level and ONPPC. In order to ensure funding is available, the FOGs will be drafted and signed with the MSP for activities at the central level and with the Regional Governors for activities at the regional level in accordance with the circular note from the Minister of Public Health. Accountants and the NTD Coordinator will provide training for stakeholders to familiarize them with the FOG process. Additional needs for training will be identified during the TIPAC training. To mitigate FOG-related delays that might impact program implementation, the Regions will be presented with FOGs two months in advance of the date of the activity. Advocacy will take place at all levels by HKI and the NTD Program to ensure FOGs are signed quickly.

Facilitate Collaboration and Coordination

- HKI will continue its advocacy within the MSP to ensure that the budget set up for NTDs is supplied, allocated amounts are revised upward, and disbursements are made on time.
- At the community level, the program will continue to sensitize local officials so that they continue to take greater ownership of the community mobilization and distribution

[14]The first trip of JSI would be at the end of FY'13 (in September) when the central and regional level trainings begin; and then again in Oct/Nov when the district/CSI/community trainings take place immediately before the MDA; we can add a trip for JSI for assistance with training manuals (15 days total for both).

activities by taking responsibility for town criers and CDDs. HKI will also continue to advocate for implementation of resolutions from the national forum on NTD financing, held in Niamey in 2010.

- Once the work plan is finalized and approved, program coordinators will spend a work day to review it so they can take ownership of the agreed upon activities. The timeline and implementation plan will be widely disseminated. An official presentation of the document will be made to officials from the MSP.
- Periods for mass distribution activities have been selected so that they do not conflict with other activities. If for whatever reason a conflict occurs, stakeholders will be encouraged to seize any opportunity to improve program coverage.
- Consideration is in progress to see under what circumstances vitamin A distribution could be included with NTD drug distribution once national immunization days (NIDs) have come to an end.
- Until now the NTD focal point still does not have a coordination team. Advocacy will continue to strengthen the NTD program with a coordination unit that has an office, staff, and adequate logistical means.
- In addition to the regular meetings held between HKI and program coordinators, quarterly coordination meetings bringing together program coordinators, the MSP, and other partners involved in NTD will be organized.
- HKI will support the NTD program to improve its collaboration with the Water, Sanitation and Hygiene (WASH) program of the MSP. The WASH program can support the sanitation and hygiene aspect of sensitization and social mobilization relating to SCH, STH and trachoma in districts where these diseases are endemic.
- HKI and the MSP will explore other partnerships based on needs identified during the TIPAC training.

Proposed Plans for Additional Support to the National NTD Program

Through funding from the Conrad N. Hilton Foundation, HKI and TCC support trichiasis surgery in the regions of Zinder, Maradi, Tahoua, Dosso, and Diffa. These surgical activities will continue in 2014, along with activities to construct wells, build latrines, and promote the SAFE (surgery, antibiotics, facial cleanliness, and environmental changes) strategy through behavior change communication. The inventory of hydrocele and elephantiasis cases shows that the number of people with manifestation of the disabling disease LF is increasing. HKI will continue its advocacy to ensure that funding is mobilized to treat LF-related morbidity.

Environmental Monitoring Plan

As stated in the sub-agreement, the activities of the NTD program that pose adverse risk to the environment are the disposal of expired drugs and the management of health waste materials resulting mostly from surveys where blood, feces, and/or urine are taken and require proper and safe disposal. The Niger health system has an approved procedure in place for safe disposal of expired products and medical wastes, which will be included in the cascade training of health agents. All of the HDs and health centers have a medium temperature incinerator for disposing

of medical waste. Concerning NTD products, the policies and procedures mandated by the MSP and the donation programs will be used, which require that a list of all expired products be prepared, a destruction committee set up, and the expired products incinerated at the CSI- or district-level depending on their location. As for the empty packages, their labels will be systematically removed if the boxes have to be reused. All empty boxes that will not be reused will be incinerated or buried. HKI is also sensitive to the need to reduce use of paper and will recycle materials whenever possible and rely on digital formats instead of printouts where appropriate.

Travel Plans

The following international trips are planned for FY2014:

- HKI Niger Country Representative and Assistant Representative to Dakar.
- HKI Niger Finance Manager and Head Accountant to Dakar.
- HKI NTD team to international meetings (place to be determined depending on opportunities).
- Two HKI staff members to attend the AFRO training on NTDs.
- MSP and PNDO/EFL coordinator to attend the Joint Action Forum for onchocerciasis control/elimination. This meeting is attended by MOH representatives from countries where onchocerciasis prevails. This is the place to advocate for support to put Niger on the road to certification for the elimination of onchocerciasis transmission.
- Presentation of scientific publications in Washington (American Society of Tropical Medicine and Hygiene (ASTMH)) by the NTD focal point and program coordinators.
- Travels for HKI Headquarters/Regional Office staff to Niamey for program supervision, training, technical assistance in data analysis and publications, work planning, and financial monitoring.

Staffing

The Niger NTD program support staff at HKI is composed of an NTD Program Coordinator assisted by an Assistant Program Coordinator, a Monitoring and Evaluation Manager, and an accountant. Organizational restructuring includes the Hilton Project Coordinator, who manages trichiasis surgery under the authority of the HKI NTD National Coordinator. This restructuring is due to the fact that trichiasis—a complication of trachoma—is included as an indicator for assessing trachoma elimination.

Timeline

2014 ACTIVITY TIMELINE													
	Head	**2013**			**2014**								
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept
STRENGTHENING NATIONAL COORDINATION													
Organization of quarterly coordination meetings	Focal Point	X			X			**X**			**X**		
Organization of biannual task-force meetings	Focal Point				X						**X**		
MSP annual planning workshop for NTDs	HKI				X								
MDA Preparation													
Regional micro-planning workshop	Focal Point					X	X						
Drug orders	NTD Coord				X								
Preparation of dose poles, registers and posters for MDA	HKI					X	X						
Reception of drugs	ONPPC									X			
Preparation of input delivery plan	NTD Coord										X		
Packaging of drugs and distribution tools (ONPPC)	ONPPC											X	
Delivery of drugs and tools from Niamey to regions	ONPPC												X
MDA Training													
Training of national-level trainers	Focal Point												X
Training of trainers (Health District Managers and focal points in MOH and MOE) at the DRSP level	Focal Point												X
Preparation meeting at district level	District Team												X
Training of CSI managers and sector managers	District												X

2014 ACTIVITY TIMELINE													
	Head	**2013**			**2014**								
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept
	Team/inspectors												
Selection of community distributors (forfait/CSI)	CSI												X
Training of CDDs and teachers	CSI												X
MDA IEC/SOCIAL MOBILIZATION													
Revision of the messages and production of audio cassettes	HKI					X							
Transport of cassettes to community radio stations	ONPPC						X						
Diffusion of messages on television and radio stations	HKI	X											X
National launch of the FY2014 campaign	Focal Point	X											X
MDA ACTIVITIES													
MDA of first drug package (IVM+ALB)	CSI	X											
MDA of second drug package (PZQ/PZQ+ALB)	CSI		X										
MDA of third drug package (ZITH+TETRA)	CSI		X										
Return of completed registers, left-over drugs, and payment to CDDs	CSI	X	X										
MDA SUPERVISION													
National-level supervision and technical support	Focal Point	X											X
Supervision at the level of the DRSP and Regional Department of Public Health (DREN)	DRSP	X											X
Supervision of CDDs by CSI managers	CSI	X											
Supervision of CSI managers by the health and education focal points	District Team	X											
Receipt of reports, left-over drugs, and dose	District Team	X	X										

2014 ACTIVITY TIMELINE													
	Head	**2013**			**2014**								
		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept
poles from CSIs													
Identification of physical stock after distribution	HKI		X										
Independent monitoring of distribution	HKI	X	X										
POST-MDA EVALUATION													
District evaluation	District Team		X										
Regional evaluation	DRSP		X	X									
National evaluation	HKI			X									
Pre-TAS for LF	PNDO/EFL							X					
TAS for LF	PNDO/EFL							X	X				
Epidemiological evaluation of onchocerciasis	PNDO/EFL							X					
Trachoma impact assessment	PNSO								X	X			
Assessment survey for SCH/STH	PNLBG							X	X	X			
OTHER ACTIVITES													
Semi-annual report and workbooks	HKI						X						X
Workshop to develop work plan for FY2015	HKI									X	X		
Submission of 2014 workbook	HKI									X	X		
Technical Assistance	See table	Timeline to be determined											